2023 Evidence of Coverage
UCare Value (HMO-POS)

ucare®

Notice of Nondiscrimination

UCare complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability or sex. UCare does not exclude people or treat them differently because of race, color, national origin, age, disability or sex.

We provide aids and services at no charge to people with disabilities to communicate effectively with us, such as TTY line, or written information in other formats, such as large print.

If you need these services, contact us at **612-676-3200 (voice)** or toll free at **1-800-203-7225 (voice)**, **612-676-6810 (TTY)**, or **1-800-688-2534 (TTY)**.

We provide language services at no charge to people whose primary language is not English, such as qualified interpreters or information written in other languages.

If you need these services, contact us at the number on the back of your membership card or **612-676-3200** or toll free at **1-800-203-7225 (voice)**; **612-676-6810** or toll free at **1-800-688-2534 (TTY)**.

If you believe that UCare has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability or sex, you can file an oral or written grievance.

Oral grievance

If you are a current UCare member, please call the number on the back of your membership card. Otherwise please call **612-676-3200** or toll free at **1-800-203-7225 (voice)**; **612-676-6810** or toll free at **1-800-688-2534 (TTY**). You can also use these numbers if you need assistance filing a grievance.

Written grievance

Mailing Address
UCare
Attn: Appeals and Grievances
PO Box 52
Minneapolis, MN 55440-0052
Email: cag@ucare.org
Fax: 612-884-2021

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 1-800-537-7697 (TDD)

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 612-676-3200/1-800-203-7225 (TTY: 612-676-6810/1-800-688-2534).

LUS CEEV: Yog tias koj hais lus Hmoob, cov kev pab txog lus, muaj kev pab dawb rau koj. Hu rau 612-676-3200/1-800-203-7225 (TTY: 612-676-6810/1-800-688-2534).

XIYYEEFFANNAA: Afaan dubbattu Oroomiffa, tajaajila gargaarsa afaanii, kanfaltiidhaan ala, ni argama. Bilbilaa 612-676-3200/1-800-203-7225 (TTY: 612-676-6810/1-800-688-2534).

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 612-676-3200/1-800-203-7225 (TTY: 612-676-6810/1-800-688-2534).

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 612-676-3200/1-800-203-7225（TTY：612-676-6810/1-800-688-2534）。

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 612-676-3200/1-800-203-7225 (телетайп: 612-676-6810/1-800-688-2534).

ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັງຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທຣ 612-676-3200/1-800-203-7225 (TTY: 612-676-6810/1-800-688-2534).

ማስታወሻ: የሚናገሩት ቋንቋ አማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ሊያግዝዎት ተዘጋጀተዋል፡ ወደ ሚከተለው ቁጥር ይደውሉ 612-676-3200/1-800-203-7225 (**መስማት ለተሳናቸው**: 612-676-6810/1-800-688-2534).

ဟ်သူဉ်ဟ်သး–နမ့်ကတိၤ ကညီ ကျိာ်အဃိ, နမၤနှ် ကျိာ်အတၢ်မၤစၢၤလၢ တလာ်ဘူဉ်လာ်စ့ၤ နီတမံၤဘဉ်သ့နှဉ်လီၤ.
ကိး 612-676-3200/1-800-203-7225 (TTY: 612-676-6810/1-800-688-2534).

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 612-676-3200/1-800-203-7225 (TTY: 612-676-6810/1-800-688-2534).

ប្រយ័ត្ន៖ បើសិនជាអ្នកនិយា ភាសារ៉ែខ្មរ, រសវាជំនួយរ័ផ្តកភាសា ដោយមិនគិតឈ្លួល គឺអាចមានសំរាប់បំរីអ្នក។ ចូរ ទូរស័ព្ទ 612-676-3200/1-800-203-7225 (TTY: 612-676-6810/1-800-688-2534)។

ملحوظة :إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان .اتصل برقم 612-676-3200/1-800-203-7225 (رقم هاتف الصم والبكم: 612-676-6810/1-800-688-2534).

ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 612-676-3200/1-800-203-7225 (ATS : 612-676-6810/1-800-688-2534).

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 612-676-3200/1-800-203-7225 (TTY: 612-676-6810/1-800-688-2534) 번으로 전화해 주십시오.

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 612-676-3200/1-800-203-7225 (TTY: 612-676-6810/1-800-688-2534).

January 1 – December 31, 2023

Evidence of Coverage:

Your Medicare Health Benefits and Services as a Member of UCare Value (HMO-POS)

This document gives you the details about your Medicare health care 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 612-676-3600 or 1-877-523-1515 (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 Value, 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 Value.)

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

The 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 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.

Y0120_2459_7966_082022_C

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

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CHAPTER 1
Getting started as a member

SECTION 1 Introduction

Section 1.1 You are enrolled in UCare Value, which is a Medicare HMO Point-of-Service Plan

You are covered by Medicare, and you have chosen to get your Medicare health care through our plan, UCare Value. 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 Value is a Medicare Advantage HMO Plan (HMO stands for Health Maintenance Organization) with a Point-of-Service (POS) option approved by Medicare and run by a private company. "Point-of-Service" means you can use providers outside the plan's network for an additional cost. (See Chapter 3, Section 2.4 for information about using the Point-of-Service option.) UCare Value does not include Part D 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 medical care. 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 words "coverage" and "covered services" refer to the medical care and services available to you as a member of UCare Value.

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 our 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 Value covers your care. Other parts of this contract include your enrollment form 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 Value 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 Value after December 31, 2023. We can also choose to stop offering the plan in your service area after December 31, 2023.

Medicare (the Centers for Medicare & Medicaid Services) must approve UCare Value 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.

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 2.2 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

Section 2.2 Here is the plan service area for UCare Value

UCare Value 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 this state: Minnesota.

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 2.3 U.S. Citizen or Lawful Presence

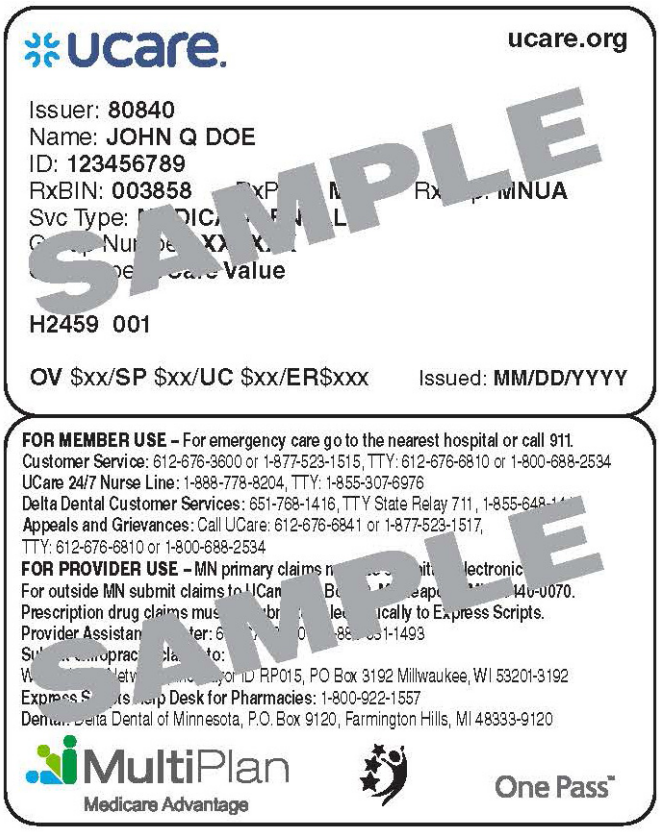
A member of a Medicare health plan must be a U.S. citizen or lawfully present in the United States. Medicare (the Centers for Medicare & Medicaid Services) will notify UCare Value if you

are not eligible to remain a member on this basis. UCare Value 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. You should also show the provider your Medicaid card, if applicable. Here's a sample membership card to show you what yours will look like:



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 Value 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, medical groups, 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 Value authorizes use of out-of-network providers.

Coverage is available for certain services from out-of-network providers and facilities through the Point-of-Service (POS) benefit. POS benefits are covered at the out-of-network cost-sharing level. You do not need a referral from your PCP before using POS benefits. Refer to Chapter 4, Section 2.3 for more information about the POS benefit.

The most recent list of providers 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.

SECTION 4 Your monthly costs for UCare Value

- Plan Premium (Section 4.1)
- Monthly Medicare Part B Premium (Section 4.2)

Medicare Part B premiums differ for people with different incomes. If you have questions about these premiums review your copy of *Medicare & You 2023* handbook, the section called "2023 Medicare Costs." If you need a copy, you can download it from the Medicare website (www.medicare.gov). Or, you can order a printed copy by phone at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users call 1-877-486-2048.

Section 4.1 Plan premium

As a member of our plan, you pay a monthly plan premium. For 2023, the monthly premium for UCare Value is $29.

Section 4.2 Monthly Medicare Part B Premium

Many members are required to pay other Medicare premiums

In addition to paying the monthly plan premium, you must continue paying 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 5 More information about your monthly premium

Section 5.1 There are several ways you can pay your plan premium

There are six ways you can pay your plan premium. We list our payment options on the enrollment form. You can pick one when you fill out the form. Or, contact us by phone or in writing to choose your payment option.

Option 1: Paying by check

You can pay your monthly plan premium by check. We'll send you a monthly billing statement. Mail us a check, made payable to:

UCare
PO Box 9122
Minneapolis, MN 55480-9122

Payments are due on the 1st of each month.

Option 2: Paying online

You can pay your monthly plan premium by credit card online. Sign up for a secure, online Member Account at **member.ucare.org**. With your Member Account, you can make a one-time credit card payment. We'll still send you a billing statement each month.

Option 3: Paying by phone

You can pay your monthly plan premium by phone. Call Customer Service and follow the prompts. With this method, you can pay with a credit/debit card or checking/savings account. We'll still send you a billing statement each month.

Option 4: Paying by Electronic Funds Transfer (EFT)

You can have your monthly plan premium automatically taken out of your checking or savings account. Call Customer Service to get an Automatic Payment form. Fill out the form and send

it back to us to set up your monthly payments. You can also find the form online at **ucare.org/formembers**.

We'll take out your premium payments between the 7th and 10th day of each month. You won't get a monthly billing statement in the mail.

Option 5: Having your plan premium taken out of your monthly Social Security check

You can have the plan premium taken out of your monthly Social Security check. Contact Customer Service for more information on how to pay your plan premium this way. We will be happy to help you set this up.

Option 6: Having your plan premium taken out of your monthly Railroad Retirement Board check

You can have the plan premium taken out of your monthly Railroad Retirement Board check. Contact Customer Service for more information on how to pay your plan premium this way. We will be happy to help you set this up.

Changing the way you pay your premium

If you decide to change the way you pay your premium, it can take up to three months for your new payment method to take effect. While we are processing your request for a new payment method, you are responsible for making sure that your plan premium is paid on time. To change your payment method, contact us by phone or in writing.

What to do if you are having trouble paying your plan premium

Your plan premium is due in our office by the 1st of the month. If we have not received your premium payment by the 12th of the month, we will send you a notice telling you that your plan membership will end if we do not receive your premium within 90 days.

If you are having trouble paying your premium on time, please contact Customer Service to see if we can direct you to programs that will help with your costs.

If we end your membership because you did not pay your plan premiums, you will have health coverage under Original Medicare. At the time we end your membership, you may still owe us for premiums you have not paid. In the future, if you want to enroll again in our plan (or another plan that we offer), you will need to pay the amount you owe before you can enroll.

If you think we have wrongfully ended your membership, you can make a complaint (also called a grievance); see Chapter 7 for how to file a complaint. If you had an emergency circumstance that was out of your control and it caused you to not be able to pay your premiums within our grace period, you can make a complaint. For complaints, we will review our decision again. Chapter 7, Section 9 of this document tells how to make a complaint, or you can call us at 612-676-3600 or 1-877-523-1515 (this call is free) between 8 am – 8 pm, seven days

a week. TTY users should call 612-676-6810 or 1-800-688-2534 (this call is free). You must make your request no later than 60 days after the date your membership ends.

Section 5.2 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.

SECTION 6 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, 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 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.

SECTION 7 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

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

CHAPTER 2
Important phone numbers and resources

SECTION 1 **UCare Value 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 member card questions, please call or write to UCare Value Customer Service. We will be happy to help you.

Method	Customer Service - Contact Information
CALL	612-676-3600 1-877-523-1515 (this call is 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 (this call is 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 7 *(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** 612-676-3600 1-877-523-1515 (this call is free) 8 am – 8 pm, seven days a week
TTY	612-676-6810 1-800-688-2534 (this call is 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 7 *(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 (this call is free) 8 am – 4:30 pm, Monday – Friday
TTY	612-676-6810 1-800-688-2534 (this call is 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 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 7 *(What to do if you have a problem or complaint (coverage decisions, appeals, complaints))*.

Method	Complaints About Medical Care – Contact Information
CALL	**Customer Service** 612-676-3600 1-877-523-1515 (this call is free) 8 am – 8 pm, seven days a week
TTY	612-676-6810 1-800-688-2534 (this call is 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 Value 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 you have received

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 5 *(Asking us to pay our share of a bill you have received for covered medical services)*.

Please note: If you send us a payment request and we deny any part of your request, you can appeal our decision. Refer to Chapter 7 *(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** 612-676-3600 1-877-523-1515 (this call is free) 8 am – 8 pm, seven days a week
TTY	612-676-6810 1-800-688-2534 (this call is 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
WRITE	**Attn: DMR Department** UCare PO Box 52 Minneapolis, MN 55440-0052
WEBSITE	**ucare.org**

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) (This call is 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. (This call is 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 Value: • **Tell Medicare about your complaint:** You can submit a complaint about UCare Value 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 (this call is free)
TTY	Call the Minnesota Relay Service at 711 or use your preferred relay service. (This call is free.)
WRITE	Minnesota Board on Aging PO Box 64976 St. Paul, MN 55164-0976
WEBSITE	www.seniorlinkageline.com

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 (this call is free) 9 am – 5 pm, Monday – Friday 11 am – 3 pm on weekends
TTY	1-888-985-8775 (this call is 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.

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 (This call is 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. (This call is 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. Some people with Medicare are also eligible for Medicaid.

The programs offered through Medicaid help people with Medicare pay their Medicare costs, such as their Medicare premiums. These "Medicare Savings Programs" include:

- **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 Medicaid benefits (QMB+).)
- **Specified Low-Income Medicare Beneficiary (SLMB):** Helps pay Part B premiums. (Some people with SLMB are also eligible for full Medicaid benefits (SLMB+).)

- **Qualifying Individual (QI):** Helps pay Part B premiums.
- **Qualified Disabled & Working Individuals (QDWI):** Helps pay Part A premiums.

To find out more about Medicaid and its programs, contact the Minnesota Department of Human Services.

Method	Minnesota Department of Human Services (Minnesota's Medicaid program) - Contact Information
CALL	651-431-2670 (Twin Cities Metro area) 1-800-657-3739 (outside the Twin Cities Metro area) (this call is free) 8 am – 5 pm, Monday – Friday
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.) (This call is free.)
WRITE	Minnesota Department of Human Services PO Box 64976 St. Paul, MN 55164-0976
WEBSITE	mn.gov/dhs

SECTION 7 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 (This call is 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 8 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.

CHAPTER 3
Using the plan for your medical services

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

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

For the details on what medical care is covered by our plan and how much you pay when you get this care, use the benefits chart in the next chapter, Chapter 4 (*Medical Benefits Chart, what is covered and what you pay*).

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 and your cost-sharing amount 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 go to a network provider, you pay only your share of the cost for their services.
- "**Covered services**" include all the medical care, health care services, supplies, and equipment that are covered by our plan. Your covered services for medical care are listed in the benefits chart in Chapter 4.

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

As a Medicare health plan, UCare Value must cover all services covered by Original Medicare and must follow Original Medicare's coverage rules.

UCare Value 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).

- **In general, you 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 four 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 learn what emergency or urgently needed services means, refer to Section 3 in this chapter.

  - You can obtain certain covered services through the Point-of-Service (POS) benefit at the out-of-network cost-sharing level. You do not need a referral from your PCP before getting services through the POS benefit. Refer to Chapter 4, Section 2.2 for more information about the POS benefit.

  - If you need medical care that Medicare 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 authorization from us prior to seeking care. In this situation, you will pay the same as you would pay if you got the care from a network provider. For information about getting approval to go to 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

Section 2.1 You must choose a Primary Care Provider (PCP) to provide and oversee your medical 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'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. 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 6 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 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 in our plan. 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.

Section 2.2 What kinds of medical care 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

You can see any specialist in the network on your own without a referral. To see an **out-of-network** doctor or specialist at the **in-network** cost-sharing level, you or your PCP must obtain prior authorization from us in order for those services to be covered. You can also use the Point-of-Service (POS) benefit and pay the out-of-network cost sharing. Refer to Chapter 4, Section 2.2 for details on the POS benefit.

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?

It is important that you know that 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 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.
- 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 7.

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

Coverage is available for certain services from out-of-network providers and facilities through the Point-of-Service (POS) benefit. POS benefits are covered at the out-of-network cost-sharing level. You do not need a referral from your PCP before using POS benefits.

Refer to Chapter 4, Section 2.2 for more details.

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 world.

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. However, if you choose to remain with out-of-network providers, you will have to pay the Point-of-Service (POS) coinsurance. Refer to Chapter 4, Section 2.2 for more details.

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 urgent care providers online at **ucare.org/searchnetwork**, or by calling Customer Service at the number on the back cover of this booklet. To find out how to access urgently needed care, you can call your provider, or call the 24/7 nurse line, which is answered 24 hours a day, 7 days a week. (The phone number is on the back of your plan membership card.) The nurse line can give you information on how to access care after normal business hours.

Our plan covers worldwide emergency and urgent care services outside the United States under the following circumstances. If you have an emergency or an urgent need for care outside of the U.S. and its territories, you may have to pay for those services upfront. If this happens, you then have to ask us to pay you back. Your provider may also choose to submit a claim on your behalf.

We'll pay you back (or will pay the provider if they submit the claim) at rates no greater than the rates at which Original Medicare would pay, had the services been performed in the locality where you live in the U.S. We'll subtract any cost-sharing amount you owe from the amount we pay. The amount we pay may be less than the amount you pay the foreign provider. This is because we'll pay at rates no greater than what Original Medicare would pay, and because foreign providers might charge more for services than the rates at which Original Medicare would pay. Because of this, you may want to consider purchasing travel insurance when you are planning to travel outside of the United States.

Worldwide emergency and urgent care services are a supplemental benefit not generally covered by Medicare. You must send proof of payment to UCare so we can pay you back. Refer to Chapter 4 (*Medical Benefits Chart, what is covered and what you pay*) for more information. If you've already paid for the covered services, we'll pay you back for our share of the cost. You can send the bill with medical records to us for payment consideration. Refer to Chapter 5

(*Asking us to pay our share of a bill you have received for covered medical services*) for information about what to do if you get a bill or if you need to ask us to pay you back.

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.

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 covered services

If you have paid more than your plan cost-sharing for covered services, or if you have received a bill for the full cost of covered medical services, go to Chapter 5 (*Asking us to pay our share of a bill you have received for covered medical services*) for information about what to do.

Section 4.2 If services are not covered by our plan, you must pay the full cost

UCare Value 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-network 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. For services with a benefit limit, any additional cost beyond the benefit limit will not count toward your out-of-pocket maximum.

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. If you tell us that you are in a qualified clinical trial, then you are only responsible for the in-network cost sharing for the services in that trial. If you paid more, for example, if you already paid the Original Medicare cost-sharing amount, we will reimburse the difference between what you paid and the in-network cost sharing. 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 difference between the cost sharing in Original Medicare and your in-network cost sharing as a member of our plan. This means you will pay the same amount for the services you receive as part of the study as you would if you received these services from our plan. However, you are required to submit documentation showing how much cost sharing you paid. Please see Chapter 5 for more information for submitting requests for payments.

Here's an example of how the cost sharing works: Let's say that you have a lab test that costs $100 as part of the research study. Let's also say that your share of the costs for this test is $20 under Original Medicare, but the test would be $10 under our plan's benefits. In this case, Original Medicare would pay $80 for the test and you would pay the $20 copay required under Original Medicare. You would then notify your plan that you received a qualified clinical trial service and submit documentation such as a provider bill to the plan. The plan would then directly pay you $10. Therefore, your net payment is $10, the same amount you would pay under our plan's benefits. Please note that in order to receive payment from your plan, you must submit documentation to your plan such as a provider bill.

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 condition applies:
  - You must have a medical condition that would allow you to receive covered services for inpatient hospital care or skilled nursing facility care.

You are covered for unlimited days in the hospital, as long as your stay meets Medicare coverage guidelines. For more information, see "Inpatient hospital care" in the Medical Benefits Chart in Chapter 4 of this document.

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 Value, however, you usually will

not acquire ownership of rented DME items no matter how many copayments you make for the item 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 Value 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 Value 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 go to 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 and what you pay)

SECTION 1 Understanding your out-of-pocket costs for covered services

This chapter provides a Medical Benefits Chart that lists your covered services and shows how much you will pay for each covered service as a member of UCare Value. 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 Types of out-of-pocket costs you may pay for your covered services

To understand the payment information we give you in this chapter, you need to know about the types of out-of-pocket costs you may pay for your covered services.

- A "**copayment**" is a fixed amount you pay each time you receive certain medical services. You pay a copayment at the time you get the medical service. (The Medical Benefits Chart in Section 2 tells you more about your copayments.)
- "**Coinsurance**" is a percentage you pay of the total cost of certain medical services. You pay a coinsurance at the time you get the medical service. (The Medical Benefits Chart in Section 2 tells you more about your coinsurance.)

Most people who qualify for Medicaid or for the Qualified Medicare Beneficiary (QMB) program should never pay deductibles, copayments or coinsurance. Be sure to show your proof of Medicaid or QMB eligibility to your provider, if applicable.

Section 1.2 What is the most you will pay for Medicare Part A and Part B covered medical services?

Because you are enrolled in a Medicare Advantage Plan, there is a limit on the total amount you have to pay out-of-pocket each year for in-network medical services that are covered under Medicare Part A and Part B. This limit is called the maximum out-of-pocket (MOOP) amount for medical services. For calendar year 2023 this amount is $3,400.

As a member of UCare Value, you will have two different limits on how much you have to pay out-of-pocket for medical services. These limits are the **in-network** and **out-of-network** maximum out-of-pocket amounts.

The most you will have to pay out-of-pocket for **in-network** covered Part A and Part B services in 2023 is $3,400. The amounts you pay for copayments and coinsurance for in-network covered services count toward this maximum out-of-pocket amount. The amounts you pay for your plan premiums do not count toward your in-network maximum out-of-pocket amount. In addition, amounts you pay for some services do not count toward your maximum out-of-pocket

amount. These services are marked with a checkmark in the Medical Benefits Chart. If you reach the in-network maximum out-of-pocket amount of $3,400, you will not have to pay any out-of-pocket costs for the rest of the year for in-network covered Part A and Part B services. However, you must continue to pay your plan premium and the Medicare Part B premium (unless your Part B premium is paid for you by Medicaid or another third party).

The most you will have to pay out-of-pocket for **out-of-network** covered Part A and Part B services in 2023 is $7,500. The amounts you pay for copayments and coinsurance for out-of-network covered services count toward this maximum out-of-pocket amount. The amounts you pay for your plan premiums do not count toward your out-of-network maximum out-of-pocket amount. In addition, amounts you pay for some services do not count toward your maximum out-of-pocket amount. These services are marked with a checkmark in the Medical Benefits Chart. If you reach the out-of-network maximum out-of-pocket amount of $7,500, you will not have to pay any out-of-pocket costs for the rest of the year for out-of-network covered Part A and Part B services. However, you must continue to pay your plan premium and the Medicare Part B premium (unless your Part B premium is paid for you by Medicaid or another third party).

Section 1.3 Our plan does not allow providers to "balance bill" you

As a member of UCare Value, an important protection for you is that you only have to pay your cost-sharing amount when you get services covered by our plan. Providers may not add additional separate charges, called “balance billing.” This protection applies even if we pay the provider less than the provider charges for a service and even if there is a dispute and we don’t pay certain provider charges.

Here is how this protection works.

- If your cost sharing is a copayment (a set amount of dollars, for example, $15.00), then you pay only that amount for any covered services from a network provider.
- If your cost sharing is a coinsurance (a percentage of the total charges), then you never pay more than that percentage. However, your cost depends on which type of provider you go to:
  - If you receive the covered services from a network provider, you pay the coinsurance percentage multiplied by the plan’s reimbursement rate (as determined in the contract between the provider and the plan).
  - If you receive the covered services from an out-of-network provider who participates with Medicare, you pay the coinsurance percentage multiplied by the Medicare payment rate for participating providers. (Remember, the plan covers services from out-of-network providers only in certain situations, such as when you get a referral or for emergencies or urgently needed services.)

  - If you receive the covered services from an out-of-network provider who does not participate with Medicare, you pay the coinsurance percentage multiplied by the Medicare payment rate for non-participating providers. (Remember, the plan covers services from out-of-network providers only in certain situations, such as when you get a referral or for emergencies or urgently needed services.)

- If you believe a provider has "balance billed" you, call Customer Service.

SECTION 2 Use the *Medical Benefits Chart* to find out what is covered and how much you will pay

Section 2.1 Your medical benefits and costs as a member of the plan

The Medical Benefits Chart on the following pages lists the services UCare Value covers and what you pay out-of-pocket for each service. The services listed in the Medical Benefits Chart are covered only when the following coverage requirements are met:

- Your Medicare-covered services must be provided according to the coverage guidelines established by Medicare.

- 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.

- 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 may 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:

- Like all Medicare health plans, we cover everything that Original Medicare covers. For some of these benefits, you pay *more* in our plan than you would in Original Medicare. For others, you pay *less.* (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. However, if you also are treated or monitored for an

existing medical condition during the visit when you receive the preventive service, a copayment will apply for the care received for the existing medical condition.

- If Medicare adds coverage for any new services during 2023, either Medicare or our plan will cover those services.

 You will see 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.

✓ You will see this checkmark next to services that do not apply to your out-of-pocket maximum.

Medical Benefits Chart

You may be responsible for more than one cost share (copayment or coinsurance) payment if more than one service is provided at an appointment. Examples:

- Copayment for the office visit and additional cost share for diagnostic tests (including x-rays) performed while you are there.
- The hospital will ask for separate cost sharing for outpatient hospital medical services and any radiological tests or Medicare Part B drugs administered while you are there.
- The specific cost sharing depends on which services you receive. The Medical Benefits Chart below lists the cost sharing that applies for each specific service.

Services that are covered for you	**What you must pay** when you get these services In-Network	**What you must pay** when you get these services Out-of-Network
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.	There is no coinsurance, copayment, or deductible for members eligible for this preventive screening.	There is no coinsurance, copayment, or deductible for members eligible for this preventive screening.

Services that are covered for you	**What you must pay** when you get these services In-Network	**What you must pay** when you get these services Out-of-Network
Acupuncture for chronic low back pain 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. Provider Requirements: Physicians (as defined in 1861(r)(1) of the Social Security Act (the Act)) may furnish acupuncture in accordance with applicable state requirements. Physician assistants (PAs), nurse practitioners (NPs)/clinical nurse specialists (CNSs) (as identified in 1861(aa)(5) of the Act), and auxiliary personnel may furnish acupuncture if they meet all applicable state requirements and have: • a masters or doctoral level degree in acupuncture or Oriental Medicine from	$35 copayment for each Medicare-covered visit.	$35 copayment for each Medicare-covered visit.

Services that are covered for you	**What you must pay** when you get these services In-Network	**What you must pay** when you get these services Out-of-Network
Acupuncture for chronic low back pain (continued) a school accredited by the Accreditation Commission on Acupuncture and Oriental Medicine (ACAOM); and, • a current, full, active, and unrestricted license to practice acupuncture in a State, Territory, or Commonwealth (i.e., Puerto Rico) of the United States, or District of Columbia. Auxiliary personnel furnishing acupuncture must be under the appropriate level of supervision of a physician, PA, or NP/CNS required by our regulations at 42 CFR §§ 410.26 and 410.27.		
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. UCare follows Original Medicare. Original Medicare doesn't cover ambulance services	$100 copayment for each one-way Medicare-covered trip.	$100 copayment for each one-way Medicare-covered trip.

Services that are covered for you	**What you must pay** when you get these services In-Network	**What you must pay** when you get these services Out-of-Network
Ambulance services (continued) if you're not transported. This means that we won't pay for ambulance services, including treatment performed, if one is dispatched for you and you're not transported. When multiple ground and/or air ambulance providers respond, we only pay for the ambulance provider that transports you.		
Annual physical exam In addition to the Annual Wellness Visit or the "Welcome to Medicare" preventive visit, you are covered for the following, once per calendar year: • Comprehensive preventive medicine evaluation including examination, and counseling/anticipatory guidance/risk factor reduction interventions. **Note:** Doesn't include lab or diagnostic tests (ex: x-rays, blood tests, MRIs, etc). Additional copayments or coinsurance may apply to any lab or diagnostic testing performed during your visit, as described for each separate service in this Medical Benefits Chart.	There is no coinsurance, copayment, or deductible for the annual physical exam.	This service is not covered out-of-network. ✓
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	There is no coinsurance, copayment, or	There is no coinsurance, copayment, or

Services that are covered for you	**What you must pay** when you get these services In-Network	**What you must pay** when you get these services Out-of-Network
Annual wellness visit (continued) 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.	deductible for the annual wellness visit.	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.	There is no coinsurance, copayment, or deductible for Medicare-covered bone mass measurement.	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 women aged 40 and older • Clinical breast exams once every 24 months	There is no coinsurance, copayment, or deductible for covered screening mammograms.	There is no coinsurance, copayment, or deductible for covered screening mammograms.

Services that are covered for you	**What you must pay** when you get these services In-Network	**What you must pay** when you get these services Out-of-Network
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 programs that are typically more rigorous or more intense than cardiac rehabilitation programs.	$35 copayment for each Medicare-covered visit.	20% coinsurance for each Medicare-covered visit.
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.	There is no coinsurance, copayment, or deductible for the intensive behavioral therapy cardiovascular disease preventive benefit.	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).	There is no coinsurance, copayment, or deductible for cardiovascular disease testing that is covered once every 5 years.	There is no coinsurance, copayment, or deductible for cardiovascular disease testing that is covered once every 5 years.

Services that are covered for you	**What you must pay** when you get these services In-Network	**What you must pay** when you get these services Out-of-Network
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	There is no coinsurance, copayment, or deductible for Medicare-covered preventive Pap and pelvic exams.	There is no coinsurance, copayment, or deductible for Medicare-covered preventive Pap and pelvic exams.
Chiropractic services* Covered services include: • We cover only manual manipulation of the spine to correct subluxation	$10 copayment for each Medicare-covered visit.	This service is not covered out-of-network. ✓
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:	There is no coinsurance, copayment, or deductible for a Medicare-covered colorectal cancer screening exam.	20% coinsurance for Medicare-covered barium enema. There is no coinsurance, copayment, or deductible for other Medicare-covered colorectal cancer screening exam.

Services that are covered for you	**What you must pay** when you get these services In-Network	**What you must pay** when you get these services Out-of-Network
Colorectal cancer screening (continued) • 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		
Dental services In general, preventive dental services (such as cleaning, routine dental exams, and dental x-rays) are not covered by Original Medicare. We cover: • Oral examination – two per calendar year • Routine cleaning of teeth – two per calendar year • Topical application of fluoride in conjunction with a routine cleaning, or topical fluoride varnish application in conjunction with a routine dental examination, as deemed necessary by a dental provider. No frequency limitations for either type of fluoride application. • Bite-wing x-rays every 12 months (one set – up to four films). • Full mouth x-rays every five years. • Four periapical x-rays in a 12-month period.	$2,000 combined in-network and out-of-network benefit maximum. $75 dental deductible per year (does not apply to preventive services or periodontal maintenance). $0 copayment You must see a Delta Dental National Medicare Advantage network dentist of your choice to receive this benefit at the in-network benefit level.	$2,000 combined in-network and out-of-network benefit maximum. $75 dental deductible per year (does not apply to preventive services or periodontal maintenance). $0 copayment If your dental services are performed by a dentist outside of the Delta Dental National Medicare Advantage network (must be within the United States and its territories), you will

Services that are covered for you	**What you must pay** when you get these services In-Network	**What you must pay** when you get these services Out-of-Network
Dental services (continued)		
		be responsible for paying the difference between the dentist's fees and the UCare dental fee schedule. ✓ If the dental provider is unable to submit the claim on your behalf, it should be submitted to: Delta Dental of Minnesota PO Box 9120 Farmington Hills, MI 48333-9120
Comprehensive dental services: We cover:		
• Periodontal maintenance cleanings (deep cleaning of the gums).	$0 copayment for periodontal maintenance cleanings only.	If your dental services are performed by a dentist outside of the Delta Dental National Medicare Advantage network (must be within the United States and its territories), you will be responsible for paying the difference between the dentist's fees and

Services that are covered for you	What you must pay when you get these services In-Network	What you must pay when you get these services Out-of-Network
Dental services (continued)		
		the UCare dental fee schedule. ✓ If the dental provider is unable to submit the claim on your behalf, it should be submitted to: Delta Dental of Minnesota PO Box 9120 Farmington Hills, MI 48333-9120
We also cover: • Emergency treatment for pain relief (minor procedures). • Restoration of lost tooth structure as a result of tooth decay or fracture, when restored with amalgams (silver fillings) or resins (white fillings). – When resins are replaced in posterior teeth, or if inlays, onlays, or three-quarter (3/4) crowns are placed, coverage is limited to the same surfaces and allowances for amalgam. **Limitation:** Fillings and restorations covered once every 24 months per tooth. • Consultation, by a provider other than your current provider, as needed for diagnosis and recommending a treatment plan (such as a second opinion).	30% coinsurance of the UCare dental fee schedule.	30% coinsurance of the UCare dental fee schedule. If your dental services are performed by a dentist outside of the Delta Dental National Medicare Advantage network (must be within the United States and its territories), you will be responsible for paying the difference between the dentist's fees and the UCare dental fee schedule. ✓ If the dental provider is unable to

Services that are covered for you	What you must pay when you get these services In-Network	What you must pay when you get these services Out-of-Network
Dental services (continued)		
• General anesthesia or intravenous sedation is a separate covered dental service in conjunction with a complex surgical dental covered service. • Endodontic services: – Root canal therapy on permanent teeth, including pulpotomies, indirect pulp-cap, and root canal retreatment (mutually exclusive of final restoration). **Limitation:** one per tooth per lifetime. • Other Periodontal services: – Full-mouth debridement. **Limitation:** Coverage is limited to once every 36 months. – Non-surgical periodontics: Procedures, such as scaling and root planing, necessary for the treatment of diseases of the gingival tissues (gums). **Limitation:** Coverage is limited to one non-surgical periodontal treatment per quadrant every 36 months. – Surgical periodontics: The surgical procedures necessary for the treatment of the gingival tissues (gums) and bone supporting the teeth. **Limitation:** Coverage is limited to one surgical periodontal treatment per quadrant every 36 months. • Oral/Maxillofacial surgery – Surgical and non-surgical extractions for tooth removal, including pre- and post-operative care.		submit the claim on your behalf, it should be submitted to: Delta Dental of Minnesota PO Box 9120 Farmington Hills, MI 48333-9120

Services that are covered for you	**What you must pay** when you get these services In-Network	**What you must pay** when you get these services Out-of-Network
Dental services (continued) – Bone grafting as part of surgical procedure. **Limitation:** Coverage is limited to once per site (upper/lower ridge) in conjunction with building the bony ridge needed for successful placement of an implant or removable prosthetics (partial/full dentures).		
We also cover: • Major restorative services – Emergency services – major procedures. – Crowns. **Limitation:** Once every 60 months, per tooth. – Cast onlays for treatment of severe carious lesions and severe fracture. **Limitation:** Once every 60 months, per tooth. • Prosthetics: Removable and fixed **Waiting period:** Waiting periods apply for teeth that were missing prior to the start of UCare dental coverage. Members must be enrolled in a UCare Medicare Advantage plan for twenty-four (24) consecutive months before plan coverage applies for these teeth. – Bridges, standard partial dentures, and full dentures for the replacement of extracted permanent teeth. – Replacement benefit for prosthetic services: A prosthetic appliance (i.e.,	60% coinsurance of the UCare dental fee schedule.	60% coinsurance of the UCare dental fee schedule. If your dental services are performed by a dentist outside of the Delta Dental National Medicare Advantage network (must be within the United States and its territories), you will be responsible for paying the difference between the dentist's fees and the UCare dental fee schedule. ✓ If the dental provider is unable to submit the claim on your behalf, it should be submitted to:

Services that are covered for you	What you must pay when you get these services In-Network	What you must pay when you get these services Out-of-Network
Dental services (continued)		
bridge or denture) for the purpose of replacing an existing appliance. **Limitation:** Once every five years and only when the existing appliance is not and cannot be made satisfactory. Services necessary to make an appliance satisfactory are covered. – Replacement benefit for fixed prosthetics: **Limitation:** Once every five years. The fabrication of the bridge due to the loss of an existing tooth does not set aside the five-year exclusion on cast restorations. – Alveolectomy, alveoloplasty, and vestibuloplasty when required to prepare for dentures. • Prosthetic repair and adjustments – Prosthetics: Provides for the repair and adjustment to prosthetic appliances when they are serving as the permanent prosthetic appliance. **Limitation:** Tissue conditioning, relining and rebasing are limited to once every two years. • Implant services – Surgical placement of an implant body to replace a single missing natural tooth. – Porcelain or ceramic crown over implant body. **Waiting Period:** Waiting periods apply to implants for teeth that were missing prior to UCare dental coverage. Members must be enrolled in a UCare Medicare Advantage plan		Delta Dental of Minnesota PO Box 9120 Farmington Hills, MI 48333-9120

Services that are covered for you	What you must pay when you get these services In-Network	What you must pay when you get these services Out-of-Network
Dental services (continued) for twenty-four (24) consecutive months before plan coverage applies. **Limitation:** Once per tooth per lifetime. We do not cover: • Services that are not medically necessary or specifically covered • Hospitalization or other facility charges • Prescription drugs • Cosmetic dental procedures • Services performed before your effective date of coverage • Anesthesiologist services • Dental procedures, appliances, or restorations that are necessary to alter, restore, or maintain occlusion, including but not limited to: increasing vertical dimension, replacing or stabilizing tooth structure lost by attrition (wear), realignment of teeth, periodontal splinting, and gnathologic recordings • Direct diagnostic surgical or non-surgical treatment procedures applied to jaw joints or muscles, except as provided under Oral Surgery above • Artificial material implanted or grafted into soft tissue, including surgical removal of implants, with exceptions • Oral hygiene instruction and periodontal exam • Services for teeth retained in relation to an overdenture. Overdenture appliances are limited to an allowance for a standard full denture. • Any oral surgery that includes surgical endodontics (apicoectomy, retrograde		

Services that are covered for you	What you must pay when you get these services In-Network	What you must pay when you get these services Out-of-Network
Dental services (continued) filling) other than that listed under Oral Surgery above • Analgesia (nitrous oxide) • Removable unilateral dentures • Temporary procedures • Splinting • Consultations by the treating provider and office visits • Initial installation of implants, full or partial dentures or fixed bridgework to replace a tooth or teeth extracted prior to your effective date. **Exception:** This exclusion will not apply for any member who has been continuously covered under a UCare Medicare Advantage plan for more than 24 months. • Occlusal analysis, occlusal guards (night guards), and occlusal adjustments (limited and complete) • Veneers (bonding of coverings to the teeth) • Orthodontic treatment procedures • Corrections to congenital conditions, other than for congenital missing teeth. • Athletic mouth guards • Retreatment or additional treatment necessary to correct or relieve the results of previous treatment, except as noted above • Space maintainers **Additional Dental Information:** **Selecting Your Dentist.** You should select a Delta Dental National Medicare Advantage network dental provider from the *Provider and Pharmacy Directory*. This provider will be responsible for the coordination of all covered dental services and for ensuring continuity of care. The network dental provider will provide most services either directly or through a		

Services that are covered for you	What you must pay when you get these services In-Network	What you must pay when you get these services Out-of-Network
Dental services (continued)		

licensed dental professional. For more information, call Delta Dental customer service at 651-768-1416 or 1-855-648-1416 (this call is free), 7 am – 7 pm, Monday – Friday, or call the TTY line at 711. You can also call UCare Customer Service. (Phone numbers are printed on the back cover of this booklet.)

Seeing a specialized network dental provider does not require a referral from your usual network dental provider, but it is recommended that you consult with your usual network dental provider before going to a specialist. Enrolling in this benefit does not guarantee that you will obtain any given dental services from any particular dentist.

Using Out-of-Network Dentists. You may use a dentist not in the Delta Dental National Medicare Advantage network. However, services must be obtained within the United States and its territories. If you receive covered dental services from a dentist or other dental provider who is not in the network, you will be responsible for the coinsurance shown in the above chart plus 100% of the difference between the actual billed charge and the UCare dental fee schedule. If your dentist is unable to submit a claim for you, you may request out-of-network reimbursement, by submitting the claim obtained from your dentist to:

Delta Dental of Minnesota
P.O. Box 9120
Farmington Hills, MI 48333-9120

Reimbursement may be delayed if submitted without the required documentation listed above.

Coordination of Benefits (COB). When you have other insurance, 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 Delta Dental is the secondary payer, a copy of the primary payer's Explanation of Benefits must be submitted with the claim. When a primary carrier's payment exceeds the UCare dental fee schedule, the administrator will consider the claim paid in full and no further payment will be made on the claim.

If you have other insurance, tell your dental provider. If you have questions about who pays first, call Delta Dental customer service at 651-768-1416 or 1-855-648-1416 (this call is free), 7 am – 7 pm, Monday – Friday, or call the TTY line at 711. You can also call UCare Customer Service. (Phone numbers are printed on the back cover of this booklet.)

Services that are covered for you	**What you must pay** when you get these services In-Network	**What you must pay** when you get these services Out-of-Network
Dental services (continued) **Benefit Exclusions/Limitations/Waiting Period:** • **Exclusions and Limitations:** services or procedures not covered by the dental benefits or excluded from coverage because they are not medically necessary (e.g. teeth whitening). • **Frequency Limits**: a specific amount of time between initial plan coverage for a service and subsequent plan coverage for the same type of service. For example, a crown may be covered immediately after a member's effective date, however, the plan will not cover it again until five (5) years have passed. • **Waiting Periods:** a specific amount of time a member must be enrolled in the plan before coverage begins.		
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.	There is no coinsurance, copayment, or deductible for an annual depression screening visit.	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 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.	There is no coinsurance, copayment, or deductible for the Medicare-covered diabetes screening tests.	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 In-Network	**What you must pay** when you get these services Out-of-Network
Diabetes screening (continued) Based on the results of these tests, you may be eligible for up to two diabetes screenings every 12 months.		
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.	20% coinsurance for each Medicare-covered continuous glucose monitor and supplies. $0 copayment for other Medicare-covered diabetes monitoring supplies. Coverage is limited to specific manufacturer brands. $0 copayment for each Medicare-covered pair of therapeutic shoes or inserts. $0 copayment for Medicare-covered diabetes self-management training.	20% coinsurance for each Medicare-covered continuous glucose monitor and supplies. 20% coinsurance for other Medicare-covered diabetes monitoring supplies. Coverage is limited to specific manufacturer brands. 20% coinsurance for each Medicare-covered pair of therapeutic shoes or inserts. 20% coinsurance for Medicare-covered diabetes self-management training.

Services that are covered for you	**What you must pay** when you get these services In-Network	**What you must pay** when you get these services Out-of-Network
Durable medical equipment (DME) and related supplies*		
(For a definition of "durable medical equipment," refer to Chapter 10 of this document as well as Chapter 3, Section 7.) Covered items include, but are not limited to: wheelchairs, crutches, powered mattress systems, diabetic supplies, hospital beds ordered by a provider for use in the home, IV infusion pumps, speech generating devices, oxygen equipment, nebulizers, and walkers. 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**.	20% coinsurance for Medicare-covered benefits. Your cost sharing for Medicare oxygen equipment coverage is 20% coinsurance in-network, every month.	This service is not covered out-of-network. ✓
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 a pregnant woman, loss of an unborn child),	$100 copayment for each emergency room visit. You do not pay this amount if you are admitted to the hospital on an inpatient basis within 24 hours for the same condition. If you receive emergency care at	$100 copayment for each emergency room visit. You do not pay this amount if you are admitted to the hospital on an inpatient basis within 24 hours for the same condition. If you receive emergency care at

Services that are covered for you	**What you must pay** when you get these services In-Network	**What you must pay** when you get these services Out-of-Network
Emergency care (continued)		
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. Cost sharing for necessary emergency services furnished out-of-network is the same as for such services furnished in-network.	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 and your cost is the cost sharing you would pay at a network hospital. See "Inpatient hospital care" in this benefits chart for information on inpatient hospital cost sharing.	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 and your cost is the cost sharing you would pay at a network hospital. See "Inpatient hospital care" in this benefits chart for information on inpatient hospital cost sharing.
<u>Worldwide emergency care:</u> Worldwide emergency care applies to emergency care outside the United States and its territories. Coverage includes: • Emergency care: Services furnished by a provider qualified to furnish emergency services and needed to evaluate or stabilize an emergency medical condition, as well as services provided after stabilization and provided to maintain the condition. Post-stabilization services end at discharge.	$100 copayment for each worldwide emergency care visit. ✓ $100 copayment for each one-way worldwide ground emergency transportation. ✓	$100 copayment for each worldwide emergency care visit. ✓ $100 copayment for each one-way worldwide ground emergency transportation. ✓

Services that are covered for you	**What you must pay** when you get these services In-Network	**What you must pay** when you get these services Out-of-Network
Emergency care (continued) • Ground ambulance for emergency transportation to the nearest appropriate hospital for emergency care. Air ambulance (fixed wing or rotary wing) is not covered. Transportation back to the United States or its territories is also not covered. If you have an emergency outside of the U.S. and its territories, you may have to pay for those services upfront. If this happens, you then have to ask us to pay you back. Your provider may also choose to submit a claim on your behalf. Please see Chapter 5, Section 2 for information on how to get paid back for medical services.		
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 various online platforms. Please see Chapter 10 for a definition of E-visit.	$0 copayment for each E-visit.	This service is not covered out-of-network. ✓
Health and wellness education programs Use one of the two fitness programs based on the fitness club network of your preferred fitness location:		

Services that are covered for you	**What you must pay** when you get these services In-Network	**What you must pay** when you get these services Out-of-Network
Health and wellness education programs (continued)		
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 copayment	This service is not covered out-of-network. ✓

Services that are covered for you	**What you must pay** when you get these services In-Network	**What you must pay** when you get these services Out-of-Network
Health and wellness education programs (continued)		
Health Club Savings Program If you belong to a participating health club that isn't in the One Pass™ network, we'll reimburse you. You can get a reimbursement of up to $30 each month towards your health club membership fee. To get started, show your UCare member ID card at a participating health club. For more information, go to **ucare.org/healthwellness**.	$0 copayment	This service is not covered out-of-network. ✓
Companion Services UCare offers companion services to members through Accra Care. Companion services include: • Household chores: light cleaning, laundry and pet care • Cooking: meal preparation and clean up • Companionship: board games, cards and conversation • Grocery shopping: shopping with you or for you • Transportation: rides to and from medical appointments, stores and other locations Eligible members receive access to 60 hours of help per year at no additional cost. Learn more or schedule an appointment by calling 833-951-3193.	$0 copayment	This service is not covered out-of-network. ✓

Services that are covered for you	**What you must pay** when you get these services In-Network	**What you must pay** when you get these services Out-of-Network
Health and wellness education programs (continued)		
UCare Rewards Benefit Mastercard® The UCare Rewards Benefit Mastercard is a reloadable card that features: • Flexibility, choice and ease of use • Access to your preloaded annual eyewear allowance. Use your UCare Rewards Benefit Mastercard to purchase prescription glasses or contact lenses at a preferred eyewear retailer that accepts Mastercard	There is no cost for this card.	There is no cost for this card.
UCare 24/7 nurse line For reliable health information 24 hours a day, seven days a week, UCare members can call the UCare 24/7 nurse line. The nurses can offer health advice or answer your health questions. The 24/7 nurse line can also give you information on how to access urgently needed care after normal business hours. Call the phone number on the back of your plan membership card.	There is no cost for this service.	There is no cost for this service.
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.	$35 copayment for each Medicare-covered visit. $0 copayment for one routine hearing exam annually.	20% coinsurance for each Medicare-covered visit. Routine hearing exam, hearing aids and hearing aid fittings and evaluations are not

Services that are covered for you	**What you must pay** when you get these services In-Network	**What you must pay** when you get these services Out-of-Network
Hearing services (continued)		
We offer additional supplemental hearing services through TruHearing. Coverage includes: • Routine hearing exam once annually • Hearing aids (up to two TruHearing-branded hearing aids every year) • Benefit is limited to TruHearing's Advanced and Premium hearing aids, which come in various styles and colors • Hearing aids are available for two different copay amounts for Advanced and Premium models • No additional cost per aid for optional hearing aid rechargeability on some Premium aid styles • Fittings and evaluations for hearing aids **How to access hearing aid benefits:** • The benefit is only available through TruHearing. • For more information on covered hearing aids or to schedule an appointment with a TruHearing provider, call 1-833-725-6519 (for TTY, dial 711), 8 am – 8 pm, Monday – Friday. • For general information about TruHearing benefits visit: TruHearing.com/Select.	$599 copayment per aid for Advanced Aids ✓ $899 copayment per aid for Premium Aids ✓ $0 copayment for up to three (3) hearing aid fittings and evaluations per year.	covered out-of-network. ✓

Services that are covered for you	**What you must pay** when you get these services In-Network	**What you must pay** when you get these services Out-of-Network
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	There is no coinsurance, copayment, or deductible for members eligible for Medicare-covered preventive HIV screening.	There is no coinsurance, copayment, or deductible for members eligible for Medicare-covered preventive HIV screening.
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. You must be homebound, which means leaving home is a major effort. Covered services include, but are not limited to: • Part-time or intermittent skilled nursing and home health aide services (to be covered under the home health care benefit, your skilled nursing and home health aide services combined must total fewer than 8 hours per day and 35 hours per week) • Physical therapy, occupational therapy, and speech therapy • Medical and social services • Medical equipment and supplies	$0 copayment for all home health visits provided by a network home health agency when Medicare criteria are met. There is cost sharing for durable medical equipment and related supplies. Please refer to "Durable medical equipment and related supplies."	20% coinsurance for all home health visits provided by an out-of-network home health agency when Medicare criteria are met. For durable medical equipment and related supplies, please refer to "Durable medical equipment and related supplies."

Services that are covered for you	**What you must pay** when you get these services In-Network	**What you must pay** when you get these services Out-of-Network
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	These services will be covered as described in the following sections found in this Medical Benefits Chart: Please refer to "Physician/ Practitioner services, including doctor's office visits," "Durable medical equipment (DME) and related supplies" and "Medicare Part B prescription drugs."	These services will be covered as described in the following sections found in this Medical Benefits Chart: Please refer to "Physician/ Practitioner services, including doctor's office visits," "Durable medical equipment (DME) and related supplies" and "Medicare Part B prescription drugs."
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	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 Value.	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 Value.

Services that are covered for you	What you must pay when you get these services In-Network	What you must pay when you get these services Out-of-Network
Hospice care (continued) 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 When you are admitted to a hospice you have the right to remain in your plan; if you chose to remain in your plan you must continue to pay plan premiums. 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 and any Part A and Part B services related to 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. You will be billed Original Medicare cost sharing. For services that are covered by Medicare Part A or B and are not related to your terminal prognosis: 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 in our plan's network and follow		

Services that are covered for you	**What you must pay** when you get these services In-Network	**What you must pay** when you get these services Out-of-Network
Hospice care (continued) plan rules (such as if there is a requirement to obtain prior authorization). • If you obtain the covered services from a network provider and follow plan rules for obtaining service, you only pay the plan cost-sharing amount for in-network services • If you obtain the covered services from an out-of-network provider, you pay the cost sharing under Fee-for-Service Medicare (Original Medicare) For services that are covered by UCare Value but are not covered by Medicare Part A or B: UCare Value 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. You pay your plan cost-sharing amount for these services. **Note:** If you need non-hospice care (care that is not related to your terminal prognosis), you should contact us to arrange the 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 In-Network	**What you must pay** when you get these services Out-of-Network
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 • Other vaccines if you are at risk and they meet Medicare Part B coverage rules	There is no coinsurance, copayment, or deductible for the pneumonia, influenza, Hepatitis B and COVID-19 vaccines. Refer to "Medicare Part B prescription drugs" in this Medical Benefits Chart.	There is no coinsurance, copayment, or deductible for the pneumonia, influenza, Hepatitis B and COVID-19 vaccines. Refer to "Medicare Part B prescription drugs" in this Medical Benefits Chart.
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	$200 copayment for each Medicare-covered hospital stay until discharge. If you get authorized inpatient care at an out-of-network hospital after your emergency condition is stabilized, your cost is the cost sharing you would pay at a network hospital. For inpatient hospital care, the cost sharing described above applies each time	20% coinsurance for each Medicare-covered hospital stay until discharge. For inpatient hospital care, the cost sharing described above applies each time you are admitted to the hospital. For each inpatient hospital stay, you are covered for unlimited days as long as the hospital stay is covered. Your inpatient benefits will begin

Services that are covered for you	**What you must pay** when you get these services In-Network	**What you must pay** when you get these services Out-of-Network
Inpatient hospital care* (continued)		
• 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. 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 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 Value 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	you are admitted to the hospital. For each inpatient hospital stay, you are covered for unlimited days as long as the hospital stay is covered. Your inpatient benefits will begin on day one each time you are admitted or transferred to a specific facility type, including Inpatient Rehabilitation facilities, Long-Term Acute Care (LTAC) facilities, Inpatient Acute Care facilities, and Inpatient Psychiatric facilities.	on day one each time you are admitted or transferred to a specific facility type, including Inpatient Rehabilitation facilities, Long-Term Acute Care (LTAC) facilities, Inpatient Acute Care facilities, and Inpatient Psychiatric facilities.

Services that are covered for you	**What you must pay** when you get these services In-Network	**What you must pay** when you get these services Out-of-Network
Inpatient hospital care* (continued) **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 health services provided in a psychiatric unit of a general hospital.	$200 copayment for each Medicare-covered hospital stay until discharge. Each Medicare-covered hospital stay is limited to 90 days. Plus an additional 60 lifetime reserve days.	20% coinsurance for each Medicare-covered hospital stay until discharge. Each Medicare-covered hospital stay is limited to 90 days. Plus an additional 60 lifetime reserve days.

Services that are covered for you	**What you must pay** when you get these services In-Network	**What you must pay** when you get these services Out-of-Network
Inpatient services in a psychiatric hospital (continued)		
	For inpatient hospital care, the cost sharing described above applies each time you are admitted to the hospital.	For inpatient hospital care, the cost sharing described above applies each time you are admitted to the hospital.
	Your inpatient benefits will begin on day one each time you are admitted or transferred to a specific facility type, including Inpatient Rehabilitation facilities, Long-Term Acute Care (LTAC) facilities, Inpatient Acute Care facilities, and Inpatient Psychiatric facilities.	Your inpatient benefits will begin on day one each time you are admitted or transferred to a specific facility type, including Inpatient Rehabilitation facilities, Long-Term Acute Care (LTAC) facilities, Inpatient Acute Care facilities, and Inpatient Psychiatric facilities.
Inpatient stay: covered services received in a hospital or SNF during a non-covered inpatient stay		
If you have exhausted your inpatient benefits or if the inpatient stay is not reasonable and necessary, we will not cover your inpatient stay. However, in some cases, we will cover certain services you receive while you are in the hospital or the skilled nursing facility	When your stay is no longer covered, these services will be covered as described in the following sections found in	When your stay is no longer covered, these services will be covered as described in the following sections found in

Services that are covered for you	**What you must pay** when you get these services In-Network	**What you must pay** when you get these services Out-of-Network
Inpatient stay: covered services received in a hospital or SNF during a non-covered inpatient stay (continued)		
(SNF). Covered services include, but are not limited to: • Physician services • Diagnostic tests (like lab tests) • X-ray, radium, and isotope therapy including technician materials and services • Surgical dressings • Splints, casts and other devices used to reduce fractures and dislocations • Prosthetics and orthotics devices (other than dental) that replace all or part of an internal body organ (including contiguous tissue), or all or part of the function of a permanently inoperative or malfunctioning internal body organ, including replacement or repairs of such devices • Leg, arm, back, and neck braces; trusses; and artificial legs, arms, and eyes including adjustments, repairs, and replacements required because of breakage, wear, loss, or a change in the patient's physical condition • Physical therapy, speech therapy, and occupational therapy	this Medical Benefits Chart: "Physician/ Practitioner services, including doctor's office visits" "Outpatient diagnostic tests and therapeutic services and supplies" "Prosthetic devices and related supplies" "Outpatient rehabilitation services"	this Medical Benefits Chart: "Physician/ Practitioner services, including doctor's office visits" "Outpatient diagnostic tests and therapeutic services and supplies" "Prosthetic devices and related supplies" "Outpatient rehabilitation 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.	There is no coinsurance, copayment, or deductible for members eligible for	There is no coinsurance, copayment, or deductible for members eligible for

Services that are covered for you	**What you must pay** when you get these services In-Network	**What you must pay** when you get these services Out-of-Network
Medical nutrition therapy (continued) 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.	Medicare-covered medical nutrition therapy services.	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.	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:	20% coinsurance for each Medicare-covered Part B drug. Starting April 1, 2023, certain drugs	20% coinsurance for each Medicare-covered Part B drug. Starting April 1, 2023, certain drugs

Services that are covered for you	**What you must pay** when you get these services In-Network	**What you must pay** when you get these services Out-of-Network
Medicare Part B prescription drugs* (continued)		
• 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 • 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**.	may have a lower coinsurance. Starting July 1, 2023, you will not pay more than $35 for a one-month supply of Part B insulin. Deductibles do not apply. Additionally, for the administration of that drug, you will pay the cost sharing that applies to primary care provider services or specialist services (as described under "Physician/ Practitioner services, including doctor's office visits" in this benefit chart). 20% coinsurance for each Medicare-covered Part B chemotherapy drug and the administration of that drug.	may have a lower coinsurance. Starting July 1, 2023, you will not pay more than $35 for a one-month supply of Part B insulin. Deductibles do not apply. Additionally, for the administration of that drug, you will pay the cost sharing that applies to primary care provider services or specialist services (as described under "Physician/ Practitioner services, including doctor's office visits" in this benefit chart). 20% coinsurance for each Medicare-covered Part B chemotherapy drug and the administration of that drug.

Services that are covered for you	What you must pay when you get these services In-Network	What you must pay when you get these services Out-of-Network
Medicare Part B prescription drugs* (continued) We also cover some vaccines under our Part B prescription drug benefit.		
Member Assistance Program		
• **Counseling Services** Short-term counseling, information and referral services. Counseling sessions are led by a licensed mental health professional and available in-person, telephonically or virtually. To access counseling services call 612-672-2190 or go to www.fairview.org/ucaremembers.	$0 copayment	This service is not covered out-of-network. ✓
• **Support for Caregivers through Caregiver Assurance™** One 60-minute telephonic support session with a dedicated caregiver advisor, per year. To access support for caregiver services call 612-672-2190 or go to www.fairview.org/ucaremembers.	$0 copayment	This service is not covered out-of-network. ✓
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.	There is no coinsurance, copayment, or deductible for preventive obesity screening and therapy.	There is no coinsurance, copayment, or deductible for preventive obesity screening and therapy.

Services that are covered for you	**What you must pay** when you get these services In-Network	**What you must pay** when you get these services Out-of-Network
Obesity screening and therapy to promote sustained weight loss (continued)		
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 • Toxicology testing • Intake activities • Periodic assessments	$0 copayment for each Medicare-covered opioid treatment program service.	20% coinsurance for each Medicare-covered opioid treatment program service.
Outpatient diagnostic tests and therapeutic services and supplies Covered services include, but are not limited to: • X-rays	10% coinsurance for each Medicare-covered standard x-ray service.	20% coinsurance for each Medicare-covered standard x-ray service.

Services that are covered for you	**What you must pay** when you get these services In-Network	**What you must pay** when you get these services Out-of-Network
Outpatient diagnostic tests and therapeutic services and supplies (continued)		
• Radiation (radium and isotope) therapy including technician materials and supplies	10% coinsurance for each Medicare-covered radiation (radium and isotope) therapy service, including technician materials and supplies.	20% coinsurance for each Medicare-covered radiation (radium and isotope) therapy service, including technician materials and supplies.
• Diagnostic radiology services (for example: MRI, CT and PET scans)	10% coinsurance for each Medicare-covered diagnostic radiology service.	20% coinsurance for each Medicare-covered diagnostic radiology service.
• Other outpatient diagnostic tests	10% coinsurance for each Medicare-covered other diagnostic test. Your cost share for x-ray, radiation therapy, diagnostic radiology services, and other outpatient diagnostic test services in a single day will not exceed $50.	20% coinsurance for each Medicare-covered other diagnostic test.
• Surgical supplies, such as dressings • Splints, casts and other devices used to reduce fractures and dislocations	20% coinsurance for each Medicare-covered medical supply.	20% coinsurance for each Medicare-covered medical supply.

Services that are covered for you	**What you must pay** when you get these services In-Network	**What you must pay** when you get these services Out-of-Network
Outpatient diagnostic tests and therapeutic services and supplies (continued)		
• Laboratory tests	$0 copayment for each Medicare-covered laboratory test.	$0 copayment for each Medicare-covered laboratory test.
• Blood - including storage and administration. Coverage of whole blood and packed red cells, and all other components of blood are covered beginning with the first pint of blood that you need.	$0 copayment for Medicare-covered blood services.	20% coinsurance for Medicare-covered blood services.
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 and pay the cost-sharing amounts for outpatient hospital services. Even if you stay in the hospital overnight, you might still be considered an	$250 copayment for Medicare-covered outpatient hospital observation services included in a single stay.	20% coinsurance for Medicare-covered outpatient hospital observation services included in a single stay.

Services that are covered for you	What you must pay when you get these services In-Network	What you must pay when you get these services Out-of-Network
Outpatient hospital observation (continued) "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	$250 copayment for each Medicare-covered outpatient hospital service, including observation, outpatient surgery or procedure. In addition, please refer to the following sections found in this Medical Benefits Chart: "Emergency care" or "Outpatient surgery, including services provided at hospital	20% coinsurance for each Medicare-covered outpatient hospital service, including observation, outpatient surgery or procedure. In addition, please refer to the following sections found in this Medical Benefits Chart: "Emergency care" or "Outpatient surgery, including services provided at hospital

Services that are covered for you	**What you must pay** when you get these services In-Network	**What you must pay** when you get these services Out-of-Network
Outpatient hospital services (continued)		
• 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 and pay the cost-sharing amounts for outpatient hospital services. 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. 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 facilities and ambulatory surgical centers." "Outpatient diagnostic tests and therapeutic services and supplies." "Outpatient mental health care" or "Partial hospitalization services." "Medicare Part B prescription drugs."	outpatient facilities and ambulatory surgical centers." "Outpatient diagnostic tests and therapeutic services and supplies." "Outpatient mental health care" or "Partial hospitalization services." "Medicare Part B prescription drugs."
Outpatient mental health care*		
Covered services include: Mental health services provided by a state-licensed psychiatrist or doctor, clinical psychologist, clinical social worker, clinical nurse specialist, nurse practitioner, physician assistant, or other Medicare-qualified mental health care professional as allowed under applicable state laws.	$35 copayment for each Medicare-covered visit.	$35 copayment for each Medicare-covered visit.

Services that are covered for you	**What you must pay** when you get these services In-Network	**What you must pay** when you get these services Out-of-Network
Outpatient rehabilitation services Covered services include: physical therapy, occupational therapy, and speech language therapy. Outpatient rehabilitation services are provided in various outpatient settings, such as hospital outpatient departments, independent therapist offices, and Comprehensive Outpatient Rehabilitation Facilities (CORFs).	$35 copayment for each Medicare-covered visit.	$35 copayment for each Medicare-covered visit.
Outpatient substance use disorder services Covered services include: Substance abuse services provided in an outpatient hospital setting by a state-licensed psychiatrist or doctor, clinical psychologist, clinical social worker, clinical nurse specialist, nurse practitioner, physician assistant, or other Medicare-qualified health care professional as allowed under applicable state laws, and conducted under the supervision and direction of a physician.	$35 copayment for each Medicare-covered visit.	20% coinsurance for each Medicare-covered visit.
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 and pay the cost-sharing amounts for outpatient surgery. Even if you stay in the hospital overnight,	$225 copayment for each Medicare-covered outpatient surgery or procedure at an ambulatory surgical center.	20% coinsurance for each Medicare-covered outpatient surgery or procedure at an outpatient hospital facility or

Services that are covered for you	**What you must pay** when you get these services In-Network	**What you must pay** when you get these services Out-of-Network
Outpatient surgery, including services provided at hospital outpatient facilities and ambulatory surgical centers* (continued)		
you might still be considered an "outpatient."	$250 copayment for each Medicare-covered outpatient surgery or procedure at an outpatient hospital facility.	ambulatory surgical center.
Over-the-Counter (OTC) benefit through Healthy Savings		
<u>The OTC Benefit includes</u> • A Healthy Savings card with an allowance to use semiannually. • Dollars you don't use will expire semiannually on June 30 and December 31. These dollars can't be redeemed for cash. • Eligible items may include: cough drops, first aid supplies, pain relief, sinus medications, toothpaste, and much more. Only eligible items are covered. **<u>How to use the OTC Benefit</u>** You can use the barcode on the back of your Healthy Savings card to shop: • In-store at participating retailers. • Online at <u>Walmart.com</u> • Over the phone at 1-833-862-8276 (TTY 711).	$75 allowance to use semiannually. Allowance available to members via mail order, online order, or in-store purchase at participating retail locations.	This service is not covered out-of-network. ✓

Services that are covered for you	**What you must pay** when you get these services In-Network	**What you must pay** when you get these services Out-of-Network
Over-the-Counter (OTC) benefit through Healthy Savings (continued) If you're interested, we have a mobile app to make your shopping experience easier. The app includes: • The store finder • A digital card • Real-time access to your benefit balance and transaction history Download the Healthy Savings app from the Apple App Store or Google Play™. Data fees may apply. **Find out more** Visit us online at **www.healthysavings.com/UCare**, or call 1-833-862-8276 (TTY: 711). Healthy Savings is a registered trademark of Solutran, Inc.		
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 copayment for Medicare-covered benefits.	20% coinsurance for Medicare-covered benefits.
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 copayment for medical care furnished by a primary care	$0 copayment for medical care furnished by a primary care

Services that are covered for you	**What you must pay** when you get these services In-Network	**What you must pay** when you get these services Out-of-Network
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 see 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	provider. Or, under certain circumstances, by a nurse practitioner or physician's assistant or other non-physician health care professionals (as permitted under Medicare rules). $35 copayment for services obtained from a specialist. Or, under certain circumstances, by a nurse practitioner or physician's assistant or other non-physician health care professionals (as permitted under Medicare rules). NOTE: Medicare-covered telehealth services will be subject to the same cost sharing as services you would receive in-person. If you have surgery or procedures done in a certified ambulatory surgical center or hospital outpatient setting,	provider. Or, under certain circumstances, by a nurse practitioner or physician's assistant or other non-physician health care professionals (as permitted under Medicare rules). $35 copayment for services obtained from a specialist. Or, under certain circumstances, by a nurse practitioner or physician's assistant or other non-physician health care professionals (as permitted under Medicare rules). NOTE: Medicare-covered telehealth services will be subject to the same cost sharing as services you would receive in-person. If you have surgery or procedures done in a certified ambulatory surgical center or hospital

Services that are covered for you	**What you must pay** when you get these services In-Network	**What you must pay** when you get these services Out-of-Network
Physician/Practitioner services, including doctor's office visits (continued)		
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 • 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	see the "Outpatient surgery, including services provided at outpatient hospital facilities and ambulatory surgical centers" and/or the "Outpatient hospital services" sections in this benefits chart for applicable copayments or coinsurance amounts.	outpatient setting, see the "Outpatient surgery, including services provided at outpatient hospital facilities and ambulatory surgical centers" and/or the "Outpatient hospital services" sections in this benefits chart for applicable copayments or coinsurance amounts.

Services that are covered for you	**What you must pay** when you get these services In-Network	**What you must pay** when you get these services Out-of-Network
Physician/Practitioner services, including doctor's office visits (continued) • Consultation your doctor has with other doctors by phone, internet, or electronic health record • Second opinion by another network provider prior to surgery		
• E-visits Please see the E-visits section of the Medical Benefits Chart for more information and Chapter 12 for a definition of E-visit.	$0 copayment for each E-visit.	This service is not covered out-of-network. ✓
• 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)	$0 copayment for each Medicare-covered visit.	20% coinsurance for each Medicare-covered visit.
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	$35 copayment for each Medicare-covered visit.	$35 copayment for each Medicare-covered visit.
Prostate cancer screening exams For men aged 50 and older, covered services include the following - once every 12 months:	There is no coinsurance, copayment, or	20% coinsurance for an annual Medicare-

Services that are covered for you	**What you must pay** when you get these services In-Network	**What you must pay** when you get these services Out-of-Network
Prostate cancer screening exams (continued) • Digital rectal exam • Prostate Specific Antigen (PSA) test	deductible for an annual digital rectal exam and PSA test.	covered digital rectal exam. There is no coinsurance, copayment, or deductible for an annual PSA test.
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.	20% coinsurance for Medicare-covered prosthetic and orthotic devices, including repair and/or replacement. 20% coinsurance for Medicare-covered supplies.	20% coinsurance for Medicare-covered prosthetic and orthotic devices, including repair and/or replacement. 20% coinsurance for Medicare-covered supplies.
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.	$20 copayment for each Medicare-covered visit.	20% coinsurance for each Medicare-covered visit.

Services that are covered for you	**What you must pay** when you get these services In-Network	**What you must pay** when you get these services Out-of-Network
Screening and counseling to reduce alcohol misuse We cover one 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.	There is no coinsurance, copayment, or deductible for the Medicare-covered screening and counseling to reduce alcohol misuse preventive benefit.
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	There is no coinsurance, copayment, or deductible for the Medicare-covered counseling and shared decision making visit or for the LDCT.	There is no coinsurance, copayment, or deductible for the Medicare-covered counseling and shared decision making visit or for the LDCT.

Services that are covered for you	What you must pay when you get these services In-Network	What you must pay when you get these services Out-of-Network
Screening for lung cancer with low dose computed tomography (LDCT) (continued) 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.		
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 provider and take place in a primary care setting, such as a doctor's office.	There is no coinsurance, copayment, or deductible for the Medicare-covered screening for STIs and counseling for STIs preventive benefit.	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 In-Network	**What you must pay** when you get these services Out-of-Network
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.	$0 copayment for Medicare-covered benefits.	20% coinsurance for Medicare-covered benefits.
• 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)	20% coinsurance for Medicare-covered benefits received from an in-network provider in your service area or from any provider when you are temporarily outside the service area.	20% coinsurance for Medicare-covered benefits.
• Inpatient dialysis treatments (if you are admitted as an inpatient to a hospital for special care)	Please refer to the "Inpatient hospital care" section found in this Medical Benefits Chart.	Please refer to the "Inpatient hospital care" section found in this Medical Benefits Chart.

Services that are covered for you	**What you must pay** when you get these services In-Network	**What you must pay** when you get these services Out-of-Network
Services to treat kidney disease (continued)		
• 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."	20% coinsurance for Medicare-covered benefits.	20% coinsurance for Medicare-covered benefits.
Skilled nursing facility (SNF) care*		
(For a definition of "skilled nursing facility care," see Chapter 10 of this document. Skilled nursing facilities are sometimes called "SNFs.") 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	$0 copayment for days 1-20; $125 copayment per day for days 21-100, per benefit period. A benefit period begins on the first day you go to a Medicare-covered inpatient hospital or a skilled nursing facility. The benefit period ends when you haven't been an inpatient at any hospital or SNF for 60 days in a row.	20% coinsurance for each Medicare-covered stay. A benefit period begins on the first day you go to a Medicare-covered inpatient hospital or a skilled nursing facility. The benefit period ends when you haven't been an inpatient at any hospital or SNF for 60 days in a row. If you go to the hospital (or SNF) after one benefit

Services that are covered for you	**What you must pay** when you get these services In-Network	**What you must pay** when you get these services Out-of-Network
Skilled nursing facility (SNF) care* (continued)		
• 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, packed red cells, and all other components of blood are covered beginning with the first pint of blood that you need. • 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 pay in-network cost sharing for 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 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	If you go to the hospital (or SNF) after one benefit period has ended, a new benefit period begins. There is no limit to the number of benefit periods you can have.	period has ended, a new benefit period begins. There is no limit to the number of benefit periods you can have.

Services that are covered for you	**What you must pay** when you get these services In-Network	**What you must pay** when you get these services Out-of-Network
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; however, you will pay the applicable cost sharing. Each counseling attempt includes up to four face-to-face visits.	There is no coinsurance, copayment, or deductible for the Medicare-covered smoking and tobacco use cessation preventive benefits.	There is no coinsurance, copayment, or deductible for the Medicare-covered smoking and tobacco use cessation preventive benefits.

Services that are covered for you	**What you must pay** when you get these services In-Network	**What you must pay** when you get these services Out-of-Network
Smoking and tobacco use cessation (counseling to stop smoking or tobacco use) (continued)		
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 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.	$0 copayment 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.	This service is not covered out-of-network. ✓
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	$30 copayment for each Medicare-covered visit.	20% coinsurance for each Medicare-covered visit.

Services that are covered for you	**What you must pay** when you get these services In-Network	**What you must pay** when you get these services Out-of-Network
Supervised Exercise Therapy (SET) (continued) • 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 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.		
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 i) you need immediate care during the weekend, or ii) you are temporarily outside the service area 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	$45 copayment per visit. $100 copayment for each worldwide urgent care visit. ✓	$45 copayment per visit. $100 copayment for each worldwide urgent care visit. ✓

Services that are covered for you	**What you must pay** when you get these services In-Network	**What you must pay** when you get these services Out-of-Network
Urgently needed services (continued) urgently needed services from a provider out-of-network. <u>Worldwide urgent care:</u> Worldwide urgent care applies to urgent care outside the United States and its territories. Coverage includes: • Urgently needed services that are medically necessary and immediately required as a result of an unforeseen illness, injury, or condition Transportation back to the United States or its territories is not covered. If you have urgently needed services outside of the U.S. and its territories, you may have to pay for those services upfront. If this happens, you then have to ask us to pay you back. Your provider may also choose to submit a claim on your behalf. Please refer to Chapter 5, Section 2 for information on how to get paid back for medical services.		

Services that are covered for you	**What you must pay** when you get these services In-Network	**What you must pay** when you get these services Out-of-Network
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	$35 copayment for each Medicare-covered visit.	20% coinsurance for each Medicare-covered visit.
• One routine vision (eye) examination and up to two refractions annually	$0 copayment for one routine vision exam and up to two refractions annually.	This service is not covered out-of-network. ✓
• 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	$0 copayment for each Medicare-covered glaucoma screening.	20% coinsurance for each Medicare-covered glaucoma screening.
• For people with diabetes, screening for diabetic retinopathy is covered once per year	$0 copayment for each Medicare-covered diabetic retinopathy exam.	20% coinsurance for each Medicare-covered diabetic retinopathy exam.

Services that are covered for you	**What you must pay** when you get these services In-Network	**What you must pay** when you get these services Out-of-Network
Vision care (continued)		
• 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.)	$0 copayment for one pair of standard Medicare-covered eyeglasses or contact lenses. Progressive lenses, no-line bifocal or trifocal lenses, tinting (except for certain ultraviolet-screening coatings), scratch-resistant coatings, or oversized lenses are not covered unless required by Medicare coverage guidelines.	20% coinsurance for one pair of standard Medicare-covered eyeglasses or contact lenses. Progressive lenses, no-line bifocal or trifocal lenses, tinting (except for certain ultraviolet-screening coatings), scratch-resistant coatings, or oversized lenses are not covered unless required by Medicare coverage guidelines.

Services that are covered for you	**What you must pay** when you get these services In-Network	**What you must pay** when you get these services Out-of-Network
Vision care (continued)		
• Eyewear allowance for prescription eyeglasses (frame and/or lenses) or contact lenses annually from any eyewear provider. You can access your eyewear allowance using your UCare Rewards Benefit Mastercard. You can use the UCare Rewards Benefit Mastercard to pay for eyewear purchases up to the allowable amount at the eyewear retailer. If you did not use the UCare Rewards Benefit Mastercard by mistake, or the retailer does not accept the UCare Rewards Benefit Mastercard, you may send your itemized eyewear receipt to UCare at: **Attn: DMR Department** UCare PO Box 52 Minneapolis, MN 55440-0052 If the receipt is acceptable, a reimbursement check will be sent to the address on record and the eyewear balance will be removed as redeemed from the UCare Rewards Benefit Mastercard.	$150 benefit allowance per year (combined in and out-of-network).	$150 benefit allowance per year (combined in and out-of-network).
"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	There is no coinsurance, copayment, or	There is no coinsurance, copayment, or

Services that are covered for you	**What you must pay** when you get these services In-Network	**What you must pay** when you get these services Out-of-Network
"Welcome to Medicare" preventive visit (continued)		
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.	deductible for the "Welcome to Medicare" preventive visit.	deductible for the "Welcome to Medicare" preventive visit. 20% coinsurance for a one-time Medicare-covered EKG screening if ordered as a result of your "Welcome to Medicare" preventive visit. Please refer to the "Outpatient diagnostic tests and therapeutic services and supplies" section found in this Medical Benefits Chart for other EKGs.

Section 2.2 Point-of-Service benefit

Coverage is available for certain covered services provided by out-of-network providers and facilities under the Point-of-Service benefit. Services must be obtained within the United States and its territories. You cannot use out-of-network providers who have opted out of the Medicare program (see Chapter 9, Section 10 for more information about provider opt-out).

Please note: Medicare requires that renal (kidney) dialysis services you receive when you are temporarily outside the plan's service area be the same as in-network cost sharing. Dialysis services must be provided by a Medicare-certified dialysis facility. Medicare also requires that emergency care and urgently needed care be covered in-network and out-of-network. For

applicable copayments, see the corresponding benefit descriptions in the Medical Benefits Chart in this Chapter 4.

Point-of-Service plan benefit maximum

Under the Point-of-Service benefit, there is a $100,000 plan benefit maximum. After you reach this $100,000 plan benefit maximum, you are responsible for any charges for benefits received from out-of-network providers.

The allowed amount depends on the provider's Medicare participating status. For out-of-network providers, the amount paid by UCare for services and supplies is the lesser of the provider's billed amount or the Medicare-allowed amount. **The Medicare-allowed amount** is dependent upon the provider's Medicare participating status.

- For providers who have an agreement with CMS to accept assignment, the allowed amount is the Medicare fee schedule.

- For providers who do not accept assignment, they are not required to accept the Medicare fee schedule amount as payment in full. They may charge a higher amount, which is called the Medicare limiting charge. The limiting charge is 115% of the Medicare fee schedule amount for those providers who accept assignment.

Balance billing by the provider for amounts above the maximum charge is not allowed.

Before getting services or items under this Point-of-Service benefit, you should ask the out-of-network provider or supplier whether or not he/she accepts assignment of Medicare benefits.

Your costs may be higher for non-Medicare-covered dental services performed by a dentist outside of the Delta Dental Medicare Advantage network (must be within the United States and its territories). You may also be responsible for submitting their dental claim to Delta Dental. If your provider is not able to submit your dental claim to Delta Dental on your behalf, you can submit your claim for reimbursement to:

Delta Dental of Minnesota
PO Box 9120
Farmington Hills, MI 48333-9120

Accessing the Point-of-Service benefit

At the time of service, show your plan membership card. The out-of-network provider should send the bill to us at the address on the back of the card. You pay your portion of the bill at the time of service or when billed by the provider.

If you intend to use this benefit for inpatient hospitalization, we recommend you call Customer Service. (Phone numbers are printed on the back cover of this booklet.)

Whenever a claim is processed for the Point-of-Service (POS) benefit, members receive an Explanation of Benefits (EOB) outlining the payment made for the POS service(s). Appeal

rights are also sent with the EOB. The Point-of-Service benefit is subject to the same appeals process as any other benefit.

SECTION 3 What services are not covered by the plan?

Section 3.1 Services we do *not* cover (exclusions)

This section tells you what services are "excluded" from Medicare coverage and therefore, are not covered by this plan.

The chart below lists services and items that either are not covered under any condition or are covered 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 receive 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 7, Section 5.3 in this document.)

Services not covered by Medicare	Not covered under any condition	Covered only under specific conditions
Acupuncture		✓ 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 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.	✓	
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.)

Services not covered by Medicare	Not covered under any condition	Covered only under specific conditions
Fees charged for care by your immediate relatives or members of your household	✓	
Full-time nursing care in your home	✓	
Home-delivered meals	✓	
Homemaker services include basic household assistance, such as light housekeeping or light meal preparation.	✓	
Naturopath services (uses natural or alternative treatments)	✓	
Non-routine dental care		✓ Dental care required to treat illness or injury may be covered as inpatient or outpatient care.
Orthopedic shoes or supportive devices for the feet		✓ 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.

Services not covered by Medicare	Not covered under any condition	Covered only under specific conditions
Personal items in your room at a hospital or a skilled nursing facility, such as a telephone or a television	✓	
Private room in a hospital		✓ Covered only when medically necessary.
Radial keratotomy, LASIK surgery, and other low vision aids		✓ Eye exam and one pair of eyeglasses (or contact lenses) are covered for people after cataract surgery.
Reversal of sterilization procedures and or non-prescription contraceptive supplies	✓	
Routine chiropractic care		✓ Manual manipulation of the spine to correct a subluxation is covered.
Routine foot care		✓ Some limited coverage provided according to Medicare guidelines (e.g., if you have diabetes).
Services considered not reasonable and necessary, according to Original Medicare standards	✓	

CHAPTER 5

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

SECTION 1 Situations in which you should ask us to pay our share of the cost of your covered services

Sometimes when you get medical care, you may need to pay the full cost. Other times, you may find that you have paid more than you expected under the coverage rules of the plan or you may receive a bill from a provider. In these cases, 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 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.

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. First try to resolve the bill with the provider. If that does not work, 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:

   - You are only responsible for paying your share of the cost for emergency or urgently needed services. Emergency providers are legally required to provide emergency care. If you accidentally 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.
   - 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.
     - If you have already paid more than your share of the cost of the service, we will determine how much you owed and pay you back for our share of the cost.

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

   Network providers should always bill the plan directly and ask you only for your share of the cost. But sometimes they make mistakes and ask you to pay more than your share.

- You only have to pay your cost-sharing amount when you get covered services. We do not allow providers to add additional separate charges, called "balance billing." This protection (that you never pay more than your cost-sharing amount) applies even if we pay the provider less than the provider charges for a service and even if there is a dispute and we don't pay certain provider charges.
- Whenever you get a bill from a network provider that you think is more than you should pay, send us the bill. We will contact the provider directly and resolve the billing problem.
- If you have already paid a bill to a network provider, but you feel that you paid too much, send us the bill along with documentation of any payment you have made and ask us to pay you back the difference between the amount you paid and the amount you owed under the plan.

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 covered services 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 your worldwide emergency, urgently-needed services or emergency transportation benefits

If you have an emergency, urgent need for services or emergency transportation, outside of the U.S. and its territories, you'll have to pay for those services upfront. You'll then have to ask us to pay you back.

We'll pay you back at rates no greater than the rates at which Original Medicare would pay, had the services been performed in the locality where you live in the U.S. We'll subtract any cost sharing amount you owe from the amount we pay you back. The amount we pay you back may be less than the amount you pay the foreign provider. This is because we'll pay at rates no greater than what Original Medicare would pay, and because foreign providers might charge more for services than the rates at which Original Medicare would pay.

Save your receipts and send us copies when you ask us to pay you back. Your receipts should show that it's for an emergency or urgently-needed service. Depending on the language, we may not be able to translate the bill into English to process the claim. In some situations, we may need to get more information from you or the provider in order to pay you back for our share of the cost. Please see Chapter 5, Section 2.1 for how and where to send us your request for payment.

All of the examples above are types of coverage decisions. This means that if we deny your request for payment, you can appeal our decision. Chapter 7 of this 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

You may request us to pay you back by sending us a request in writing. If you send a request in writing, send your bill and documentation of any payment you have made. It's a good idea to make a copy of your bill and receipts for your records. **You must submit your claim to us within 12 months** of the date you received the service or item.

To make sure you are giving us all the information we need to make a decision, you can fill out our claim form to make your request for payment.

- You don't have to use the form, but it will help us process the information faster.
- Either download a copy of the form from our website (**ucare.org/formembers**) or call Customer Service and ask for the form.

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

Attn: DMR Department
UCare
PO Box 52
Minneapolis, MN 55440-0052

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 and how much we owe

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

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

Section 3.2 If we tell you that we will not pay for all or part of the medical care, 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 7 of this document.

CHAPTER 6
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. In this case, you will only pay in-network cost sharing. If you find yourself in a situation where there are no specialists in the plan's network that cover a service you need, call the plan for information on where to go to obtain this service at in-network cost sharing.

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

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 also have the right to go to a women's health specialist (such as a gynecologist) without a referral. We do not require you to get referrals to go to 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.

If you think that you are not getting your medical care within a reasonable amount of time, Chapter 7 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. 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.

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 Value, 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 organization, its services, its practitioners and providers, and member rights and responsibilities. It also includes information about the number of appeals made by members and the plan's Star Ratings, including how it has been rated by plan members and how it compares to other Medicare health plans.

- **Information about our network providers.** You have the right to get information about the qualifications of the providers in our network and how we pay the providers in our network.

  - For a list of the providers in the plan’s network, refer to the *Provider and Pharmacy Directory*.

  - For more detailed information about our providers, you can call Customer Service or visit our website at **ucare.org/searchnetwork**.

- **Information about your coverage and the rules you must follow when using your coverage.** Chapters 3 and 4 provide information regarding medical services.

- **Information about why something is not covered and what you can do about it.** Chapter 7 provides information on asking for a written explanation on why a medical service is not covered or if your coverage is restricted. Chapter 7 also provides information on asking us to change a decision, also called an appeal.

  - If you are not happy or if you disagree with a decision we make about what medical care is covered for you, you have the right to ask us to change the decision. You can ask us to change the decision by making an appeal. For details on what to do if

something is not covered for you in the way you think it should be covered, see Chapter 7 of this document. It gives you the details about how to make an appeal if you want us to change our decision. (Chapter 7 also tells about how to make a complaint about quality of care, waiting times, and other concerns.)

- **Information about how UCare evaluates new technology for inclusion as a covered benefit.**
  - When new technologies enter the marketplace (devices, procedures or drugs), UCare's medical leaders carefully evaluate them for effectiveness. We use information gathered from many sources and standard-setting organizations in our evaluation.
  - UCare's clinical and quality committees and medical directors carefully research and review new technologies before determining their medical necessity and/or appropriateness.
  - UCare uses information from many sources in our evaluation efforts, including the Hayes, Inc. Technology Assessment Reports, published peer-reviewed medical literature, consensus statements and guidelines from national medical associations and physician specialty societies, the U.S. Food and Drug Administration (FDA), other regulatory bodies, and internal and external expert sources.

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

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

You have the right to get full information from your doctors and other health care providers. 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.
- **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. Of course, if you refuse treatment, you accept full responsibility for what happens to your body as a result.

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 of these situations are called "**advance directives**." There are different types of advance directives and different names for them. Documents called "**living will**" and "**power of attorney for health care**" are examples of advance directives.

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

- **Get the form.** 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.
- **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 7 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).

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 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.
- **If you have any other health insurance coverage in addition to our plan, or separate prescription drug coverage, 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 whenever you get your medical care.
- **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.

  - 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.
- **Be considerate.** We expect all our members to respect the rights of other patients. We also expect you to act in a way that helps the smooth running of your doctor's office, hospitals, and other offices.
- **Pay what you owe.** As a plan member, you are responsible for these payments:
  - You must pay your plan premiums.
  - You must continue to pay your Medicare Part B premium to remain a member of the plan.
  - For some of your medical services covered by the plan, you must pay your share of the cost when you get the service.
- **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).

SECTION 3 If you want more information or have suggestions on information in this chapter

Section 3.1 If you have questions or concerns about information in this chapter

Call Customer Service for help if you have questions or concerns. We also welcome any suggestions you may have for improving our plan.

Phone numbers and calling hours for Customer Service are printed on the back cover of this booklet.

Section 3.2 You have the right to make recommendations regarding our member rights and responsibilities policy

Call Customer Service to provide that information to us. We welcome your feedback.

Phone numbers and calling hours are printed on the back cover of this booklet.

CHAPTER 7

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 two types of processes for handling problems and concerns:

- 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.

Both of these processes have been approved by Medicare. Each process has a set of rules, procedures, and deadlines that must be followed by us and by you.

The guide in 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” 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).

SECTION 3 To deal with your problem, which process should you use?

If you have a problem or concern, you only need to read the parts of this chapter that apply to your situation. The guide that follows will help.

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 4, "A guide to the basics of coverage decisions and appeals."**

No.

Skip ahead to **Section 9** at the end of this chapter: "**How to make a complaint about quality of care, waiting times, customer service or other concerns.**"

COVERAGE DECISIONS AND APPEALS

SECTION 4 A guide to the basics of coverage decisions and appeals

Section 4.1 Asking for coverage decisions and making appeals: the big picture

Coverage decisions and appeals deal with problems related to your benefits and coverage for medical services, 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. 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.

We are making a coverage decision for you whenever we decide what is covered for you and how much we pay. In some cases, we might decide a service 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). 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 8 in this chapter explains the Level 3, 4, and 5 appeals processes).

Section 4.2 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:

- You **can call Customer Service**.
- You **can get free help** from your State Health Insurance Assistance Program.
- **Your doctor 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's website at www.cms.gov/Medicare/CMS-Forms/CMS-Forms/downloads/cms1696.pdf or on our website at **ucare.org/formembers**.
  - For medical care or Part B prescription drugs, your doctor 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.
- **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 4.3 Which section of this chapter gives the details for your situation?

There are three different 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 5** of this chapter: "Your medical care: How to ask for a coverage decision or make an appeal"

- **Section 6** 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 7** of this chapter: "How to ask us to keep covering certain medical services if you think your coverage is ending too soon" (*Applies only to these services:* 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. You can also get help or information from government organizations such as your SHIP.

SECTION 5 Your medical care: How to ask for a coverage decision or make an appeal of a coverage decision

Section 5.1 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 our share of the cost of 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 and what you pay)*. To keep things simple, we generally refer to "medical care coverage" or "medical care" which 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 5.2.**
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 5.2.**
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 5.3.**
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 5.5.**
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 5.3.**

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 6 and 7 of this chapter. Special rules apply to these types of care.

Section 5.2 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, or 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 c*ause 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. See Section 9 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". (See Section 9 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 5.3 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 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 5.2 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.** Chapter 2 has contact information.
- **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 copy of the information regarding your medical decision. 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 our plan is 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 5.4 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. (Refer to Section 9 of this chapter for information on complaints.)
  - 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 5.4 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 30 calendar days** if your request is for a medical item or service, or **within 7 calendar days** if your request is for a Medicare Part B prescription drug.

- **If our plan says no to part or all of your appeal,** we will automatically send your appeal to the independent review organization for a Level 2 appeal.

Section 5.4 Step-by-step: How a Level 2 appeal is done

Legal Terms
The formal name for the "Independent Review Organization" is the "I**ndependent 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: 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 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.
- 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.

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 it's decision in writing and explain the reasons for it.

- **If the 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 decision from the review organization for standard requests. For expedited requests, we have 72 hours from the date we receive the decision from the review organization.
- **If the review organization says yes to part or all of a request for a Medicare Part B prescription drug**, we must authorize or provide the Part B prescription drug within **72 hours** after we receive the decision from the review organization for **standard requests**. For **expedited requests**, we have **24 hours** from the date we receive the decision from the review organization.
- **If this organization says no to part or all of your appeal**, it means they agree with us 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

Step 3: 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 to a Level 3 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 8 in this chapter explains the Levels 3, 4, and 5 of the appeals processes.

Section 5.5 What if you are asking us to pay you for our share of a bill you have received for medical care?

Chapter 5 describes when you may need to ask for reimbursement or to pay a bill you have received from a provider. It also tells how to send us the paperwork that asks us for payment.

Asking for reimbursement is asking for a coverage decision from us

If you send us the paperwork asking for reimbursement, you are asking for a coverage decision. To make this 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 we say yes to your request**: If the medical care is covered and you followed all the rules, we will send you the payment for our share of the cost within 60 calendar days after we receive your request. If you haven't paid for the services, we will send the payment directly to the provider.
- **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 60 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 provider within 60 calendar days.

SECTION 6 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 6.1 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 6.2 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, see Section 6.4.

- 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 6.3 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. This is called "upholding the decision."
- 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 8 in this chapter tells more about Levels 3, 4, and 5 of the appeals process.

Section 6.4 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 9 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 8 in this chapter tells more about Levels 3, 4, and 5 of the appeals process.

SECTION 7 How to ask us to keep covering certain medical services if you think your coverage is ending too soon

Section 7.1 *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 our share of the cost 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 7.2 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 7.3 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 7.5.

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 7.4 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 8 in this chapter tells more about Levels 3, 4, and 5 of the appeals process.

Section 7.5 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. Section 9 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 attorney adjudicator. Section 8 in this chapter tells more about Levels 3, 4, and 5 of the appeals process.

SECTION 8 Taking your appeal to Level 3 and beyond

Section 8.1 Appeal Levels 3, 4 and 5 for Medical Service 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 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

MAKING COMPLAINTS

SECTION 9 How to make a complaint about quality of care, waiting times, customer service, or other concerns

Section 9.1 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?

Complaint	Example
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, or other health professionals? Or by our Customer Service or other staff at the plan? – Examples include waiting too long on the phone, or in the waiting or exam room.
Cleanliness	• Are you unhappy with the cleanliness or condition of a clinic, hospital, or doctor's office?
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 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 9.2 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 9.3 Step-by-step: Making a complaint

Step 1: 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 30 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.

- The **deadline** for rmaking a complaint is **60 calendar days** from the time 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 because 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 a**n 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 9.4 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 9.5 You can also tell Medicare about your complaint

You can submit a complaint about UCare Value 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 8
Ending your membership in the plan

SECTION 1 Introduction to ending your membership in our plan

Ending your membership in UCare Value 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 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 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"). This is the time when you should review your health and drug coverage and make a decision 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.

Section 2.2 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 2.3 In certain situations, you can end your membership during a Special Enrollment Period

In certain situations, members of UCare Value may be eligible to end their 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 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.

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.

Your membership will usually end on the first day of the month after your request to change your plan is received.

Section 2.4 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.

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. • You will automatically be disenrolled from UCare Value when your new plan's coverage begins.
• Original Medicare *with* a separate Medicare prescription drug plan.	• Enroll in the new Medicare prescription drug plan. • You will automatically be disenrolled from UCare Value when your new plan's coverage begins.
• Original Medicare *without* a separate Medicare prescription drug plan.	• **Send us a written request to disenroll** or visit our website to disenroll online.

	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 Value when your coverage in Original Medicare begins.

Note: If you also have creditable prescription drug coverage (e.g., standalone PDP) and disenroll from that coverage, you may have to pay a Part D late enrollment penalty if you join a Medicare drug plan later after going without creditable prescription drug coverage for 63 days or more in a row.

SECTION 4 Until your membership ends, you must keep getting your medical services through our plan

Until your membership ends, and your new Medicare coverage begins, you must continue to get your medical care through our plan.

- **Continue to use our network providers to receive medical care.**
- **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 Value must end your membership in the plan in certain situations

Section 5.1 When must we end your membership in the plan?

UCare Value 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 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 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 do not pay the plan premiums for 90 days.
  - We must notify you in writing that you have 90 days to pay the plan premium before we end your membership.

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 Value 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 9
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, or geographic location within the service area. 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 Value, 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 Notice about member's term of coverage

Your coverage under this *Evidence of Coverage* will begin on the CMS-confirmed effective date and will end on the date of disenrollment, or on December 31. Services must be received (expenses must be incurred) during the term of your coverage. In no event is there coverage under the plan before your effective date or after your disenrollment date with one exception. If

on December 31 you are an inpatient in a hospital, a rehabilitation hospital, or a distinct part of a hospital used as an inpatient rehabilitation unit, your coverage for Medicare Part A inpatient expenses will continue until you are discharged from that place of confinement.

SECTION 5 Notice about amendments

From time to time, this *Evidence of Coverage* may be amended. If that happens, either a whole new Evidence of Coverage or relevant amendment pages will be sent to you. Any change or any rider added to this *Evidence of Coverage* is effective on its own specific effective date.

No change will be made to this *Evidence of Coverage* unless made by an amendment or a rider that has received prior approval from CMS. No one has the authority to make any oral changes or amendments to this *Evidence of Coverage*.

SECTION 6 Notice about assignment of rights

No rights under this *Evidence of Coverage* are assignable by you or your representative. Any attempted assignment will be void. However, you may assign payment for covered services to your physician or other provider.

SECTION 7 Notice about conformity with statutes

Any provision of this *Evidence of Coverage* that is in conflict with the requirements of Federal statutes and regulations, or the applicable statutes and regulations of the jurisdiction in which it is delivered, to the extent not preempted by Federal law, is hereby amended to conform to the requirements of such statutes and regulations. If during the term of this *Evidence of Coverage* any Federal or state laws or regulations are amended, this *Evidence of Coverage* is hereby amended to conform to the minimum requirements of such changes, as of their legislative effective dates.

SECTION 8 Notice about clerical error

A clerical error will neither deprive you of coverage nor create a right to benefits not covered under this *Evidence of Coverage*.

SECTION 9 Appointed representatives

You can name (appoint) someone to serve as your personal representative. You can name a relative, friend, advocate, doctor, or someone else to act for you. Some other persons may already be authorized under state law to act for you. If you currently have a Power of Attorney, you will need to send a copy of the papers to us so that this information will be saved in your file. If you want someone to act for you, then you and the person you want to act for you must

sign and date a statement that gives this person legal permission to act as your representative. This statement must be sent to us at the address shown in Chapter 2. You can call the Customer Service number in Chapter 2 to learn how to name your representative and to receive the Statement of Representative form. Please note that we cannot discuss member-specific information with someone other than the member or member's representative unless otherwise allowed by law.

SECTION 10 Provider opt-out of Medicare

A physician or other provider can choose to opt-out of the Medicare program by providing most services that would otherwise be covered by Medicare to any Medicare beneficiary through a private contract. Services provided by such physicians and providers will not be covered under this plan nor under Original Medicare. Emergency care, urgently needed care, and services provided as a supplemental benefit by a physician or practitioner are exceptions to this rule. You are responsible for asking out-of-network physicians or providers if they have opted out of the Medicare program.

SECTION 11 Third party liability

If you suffer an injury or illness for which a third party is liable or responsible due to a negligent or intentional act or omission causing such illness or injury to you, you must promptly notify us of the illness or injury. A "third party" is any person other than you or UCare, and includes any insurer providing coverage available to you, including but not limited to: liability, uninsured motorist, underinsured motorist, personal umbrella, workers' compensation and all other first party types of coverage. We will send you a statement of the amounts we paid for services provided in connection with the injury or illness. If you recover any sums from any third party in connection with the illness or injury, we shall be reimbursed out of such recovery for the payments we made on your behalf, subject to the limitations in the following paragraphs:

1. **Our payments are less than the judgment or settlement amount.** If our payments are less than the total recovery amount from any third party (the "third party recovery amount"), then our reimbursement will be calculated as follows:

   Step One: Determine the ratio of the procurement costs to the third party recovery amount. "Procurement costs" means attorney's fees and other costs and expenses incurred in obtaining a settlement or judgment in connection with the third party recovery amount.

   Step Two: Apply the ratio calculated in Step One to our payments. The result is our share of the procurement costs.

   Step Three: Subtract our share of the procurement costs from our payments. The remainder is our reimbursement amount.

2. **Our payments equal or exceed the judgment or settlement amount.** If our payments equal or exceed the third party recovery amount, our reimbursement amount is the total third party recovery amount minus the total procurement costs.

3. **We incur procurement costs because of opposition to its recovery.** If we must bring suit against the party that received the third party recovery amount because that party opposes our reimbursement, our reimbursement amount is the lower of the following:
    a. Our payments made on your behalf for services; or
    b. The third party recovery amount, minus the party's total procurement cost.

Subject to the limitations stated above, you agree to grant us an assignment of, and a claim and a lien against, any amounts so recovered through settlement, judgment or verdict. You may be required by us to execute documents and to provide information necessary to establish the assignment, claim, or lien to ascertain our right to reimbursement.

CHAPTER 10
Definitions of important words

Chapter 10. Definitions of important words

Allowed Amount – For in-network providers, the maximum amount paid by UCare for covered health plan services. For out-of-network providers, the amount paid by UCare for covered health plan services is the lesser of the provider's billed amount or the Medicare-allowed amount.

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.

Annual Enrollment Period – The time period of October 15 until December 7 of each year when members can change their health or drug plans or switch to Original Medicare.

Appeal – An appeal is something you do if you disagree with our decision to deny a request for coverage of health care services or payment for services you already received. You may also make an appeal if you disagree with our decision to stop services that you are receiving.

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 Value, 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 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. A new benefit period can begin only after any existing benefit period ends and there is no limit to the number of benefit periods. For both our plan and Original Medicare, a benefit period is used to determine coverage for inpatient stays in skilled nursing facilities. For inpatient hospital care, the cost sharing described in the Medical Benefits Chart in Chapter 4 applies each time you are admitted to the hospital.

Calendar Year – A twelve (12) month period that begins January 1 and ends twelve (12) consecutive months later on December 31.

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.

Coinsurance – An amount you may be required to pay, expressed as a percentage (for example 20%) as your share of the cost for services .

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") – An amount you may be required to pay as your share of the cost for a medical service or supply, like a doctor's visit, hospital outpatient visit, or a prescription. A copayment is a set amount (for example $10), rather than a percentage.

Cost Sharing – Cost sharing refers to amounts that a member has to pay when services are received. (This is in addition to the plan's monthly premium.) Cost sharing includes any combination of the following three types of payments: (1) any deductible amount a plan may impose before services are covered; (2) any fixed "copayment" amount that a plan requires when a specific service is received; or (3) any "coinsurance" amount, a percentage of the total amount paid for a service, that a plan requires when a specific service is received.

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.

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.

Deductible – The amount you must pay for health care before our plan pays.

Disenroll or Disenrollment – The process of ending your membership in our plan.

Durable Medical Equipment (DME) – Certain medical equipment that is ordered by your doctor for medical reasons. Examples include walkers, wheelchairs, crutches, powered mattress systems, diabetic supplies, IV infusion pumps, speech generating devices, oxygen equipment, nebulizers, or hospital beds ordered by a provider for use in the home.

Emergency – 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 a pregnant woman, loss of an unborn child), loss of a limb, or loss of 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.

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.

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.

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.

Grievance – A type of complaint you make about our plan or providers, including a complaint concerning the quality of your care. This does not involve coverage or payment disputes.

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).

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 – A hospital stay when you have been formally admitted to the hospital for skilled medical services. Even if you stay in the hospital overnight, you might still be considered an "outpatient."

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.

Lifetime Reserve Days – In Original Medicare, these are additional days that Medicare will pay for when you're in a hospital for more than 90 days. You have a total of 60 reserve days that can be used during your lifetime. For each lifetime reserve day, Medicare pays all covered costs except for a daily coinsurance.

Low Income Subsidy (LIS) – Refer to "Extra Help."

Maximum Charge (Limiting Charge) – Non-participating providers can charge more than the Medicare-approved amount. The "limiting charge" is 15% over Medicare's approved amount. The limiting charge only applies to certain services and doesn't apply to supplies or equipment.

Maximum Out-of-Pocket Amount – The most that you pay out-of-pocket during the calendar year for in-network covered Part A and Part B services. Amounts you pay for your plan premiums and Medicare Part A and Part B premiums do not count toward the 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 Necessary – Services, supplies, or drugs that are needed for the prevention, diagnosis, or treatment of your medical condition and meet accepted standards of medical practice.

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**. UCare Value does not offer Medicare 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-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 Fee Schedule – A listing of fees used by Original Medicare to pay providers or other suppliers.

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 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).

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."

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 Provider or Out-of-Network Facility – A provider or facility that does not have a contract with out 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 services received is also referred to as the member's "out-of-pocket" cost requirement.

Part C – Refer to "Medicare Advantage (MA) Plan."

Part D – The voluntary Medicare Prescription Drug Benefit Program.

Point-of-Service Benefit – Coverage for certain covered services provided by out-of-network providers, within the United States and its territories, that may be at a higher cost sharing level (out-of-network level). See Chapter 4, Section 2.2 for more information.

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.

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. Covered services that need prior authorization are marked in the Benefits Chart in Chapter 4.

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.

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.

Rehabilitation Services – These services include physical therapy, speech and language therapy, and occupational therapy.

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 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.

Special Enrollment Period – A set time when members can change their health or drug plan or return to Original Medicare. Situations in which you may be eligible for a Special Enrollment Period include: if you move outside the service area, if you move into a nursing home, or if we violate our contract with you.

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.

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 – 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 Value Customer Service

Method	Customer Service - Contact Information
CALL	612-676-3600 1-877-523-1515 (this call is 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 (this call is 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 (this call is free)
TTY	Call the Minnesota Relay Service at 711 or use your preferred relay service. (This call is free.)
WRITE	Minnesota Board on Aging PO Box 64976 St. Paul, MN 55164-0976
WEBSITE	www.seniorlinkageline.com

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