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).


XIYYEEFFANNA: Afaan dubbattu Oroomiffa, tajajilaa gargaarsa afaanii, kanfaltidhaan 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).

โปรดที่: ท่านที่ต้องการคำบรรยาย ขอ, แทนชีวิตที่อยู่อย่างดีเยี่ยม, ได้ยินสุญใจ, แม้บันทึกล่าชีวิตที่. โปรด 612-676-3200/1-800-203-7225 (TTY: 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 nagigasalita 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).
Evidence of Coverage:

Your Medicare Health Benefits and Services and Prescription Drug Coverage as a Member of UCare Medicare Group Plans (HMO-POS)

This booklet gives you the details about your Medicare health care and prescription drug coverage from January 1 - December 31, 2019. It explains how to get coverage for the health care services and prescription drugs you need. **This is an important legal document. Please keep it in a safe place.**

This plan, **UCare Medicare Group Plans** 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 Medicare Group Plans.)

UCare Minnesota is an HMO-POS plan with a Medicare contract. Enrollment in UCare Minnesota depends on contract renewal.

Upon request, we can give you information in Braille, in large print, or other alternate formats if you need it.

Benefits, premium, deductible, and/or copayments/coinsurance may change on January 1, 2020.

The formulary, pharmacy network, and/or provider network may change at any time. You will receive notice when necessary.
Chapter 7  Asking us to pay our share of a bill you have received for covered medical services or drugs ..................................................145
Explains when and how to send a bill to us when you want to ask us to pay you back for our share of the cost for your covered services or drugs.

Chapter 8  Your rights and responsibilities .................................................................153
Explains the rights and responsibilities you have as a member of our plan. Tells what you can do if you think your rights are not being respected.

Chapter 9  What to do if you have a problem or complaint (coverage decisions, appeals, complaints) .............................................163
Tells you step-by-step what to do if you are having problems or concerns as a member of our plan.
• Explains how to ask for coverage decisions and make appeals if you are having trouble getting the medical care or prescription drugs you think are covered by our plan. This includes asking us to make exceptions to the rules or extra restrictions on your coverage for prescription drugs, and asking us to keep covering hospital care and certain types of medical services if you think your coverage is ending too soon.
• Explains how to make complaints about quality of care, waiting times, customer service, and other concerns.

Chapter 10  Ending your membership in the plan .........................................................211
Explains when and how you can end your membership in the plan. Explains situations in which our plan is required to end your membership.

Chapter 11  Legal notices ..........................................................................................219
Includes notices about governing law and about non-discrimination.

Chapter 12  Definitions of important words ..................................................................225
Explains key terms used in this booklet.
CHAPTER 1

Getting started as a member
SECTION 7  More information about your monthly premium........................................17
Section 7.1  There are several ways you can pay your plan premium.........................17
Section 7.2  Can we change your monthly plan premium during the year?.....................19

SECTION 8  Please keep your plan membership record up to date .............................19
Section 8.1  How to help make sure that we have accurate information about you ...........19

SECTION 9  We protect the privacy of your personal health information......................20
Section 9.1  We make sure that your health information is protected ..........................20

SECTION 10  How other insurance works with our plan ............................................20
Section 10.1  Which plan pays first when you have other insurance? .........................20
Medicare must approve our plan each year

Medicare (the Centers for Medicare & Medicaid Services) must approve our plan each year. You can continue 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 (Section 2.2 tells you about Medicare Part A and Medicare Part B)
- and – you live in our geographic service area (Section 2.3 below describes our service area)
- and – you are a United States citizen or are lawfully present in the United States
- and – you do not have End-Stage Renal Disease (ESRD), with limited exceptions, such as if you develop ESRD when you are already a member of a plan that we offer, or you were a member of a different plan that was terminated.

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

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

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

Section 2.3  Here is the plan service area for our plan

Although Medicare is a Federal program, the plan 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 the state of Minnesota and the following counties in the State of Wisconsin: Ashland, Barron, Bayfield, Buffalo, Burnett, Chippewa, Crawford, Douglas, Dunn, Eau Claire, Grant, Iowa, Jackson, Juneau, La Crosse, Monroe, Pepin, Pierce, Polk, Richland, St. Croix, Sauk, Sawyer, Trempealeau, Vernon and Washburn. If you plan to move out of the service area, please contact Customer Services (phone numbers are printed on the back cover of this booklet). 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.
and hospice services). You may be asked to show your new Medicare card if you need hospital services. Keep your new red, white, and blue Medicare card in a safe place in case you need it later.

**Here’s why this is so important:** If you get covered services using your new red, white, and blue Medicare card instead of using your plan membership card while you are a plan member, you may have to pay the full cost yourself.

If your plan membership card is damaged, lost, or stolen, call Customer Services right away and we will send you a new card. (Phone numbers for Customer Services are printed on the back cover of this booklet.)

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**Section 3.2 The Provider Directory: Your guide to all providers in the plan’s network**

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

**What are “network providers”?**

**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. We have arranged for these providers to deliver covered services to members in our plan. The most recent list of providers and suppliers is available on our website at [ucare.org](http://ucare.org).

**Why do you need to know which providers are part of our network?**

It is important to know which providers are part of our network because, with limited exceptions, while you are a member of our plan you must use network providers to get your medical care and services. The only exceptions are emergencies, urgently needed services when the network is not available (generally, when you are out of the area), out-of-area dialysis services, and cases in which the plan authorizes use of out-of-network providers. See Chapter 3 (**Using the plan’s coverage for your medical services**) for more specific information about emergency, out-of-network, and out-of-area coverage.

You can also obtain certain covered services from out-of-network providers through the Point-of-Service (POS) benefit at the out-of-network cost-sharing level. See Chapter 4, Section 2.3 for more information about the POS benefit.

If you don’t have your copy of the **Provider Directory**, you can request a copy from Customer Services (phone numbers are printed on the back cover of this booklet). You may ask Customer Services for more information about our network providers, including their qualifications. You can also see the **Provider Directory** at [ucare.org](http://ucare.org), or download it from this website. Both Customer Services and the website can give you the most up-to-date information about changes in our network providers.

---

**Section 3.3 The Pharmacy Directory: Your guide to pharmacies in our network**

**What are “network pharmacies”?**

Network pharmacies are all of the pharmacies that have agreed to fill covered prescriptions for our plan members.
Section 4.1  How much is your plan premium?

As a member of our plan, you or your employer group pay a monthly plan premium. Please contact either UCare or your former employer for plan premium information. In addition, you must continue to pay your Medicare Part B premium (unless your Part B premium is paid for you by Medicaid or another third party).

**In some situations, your plan premium could be less**

The “Extra Help” program helps people with limited resources pay for their drugs. Chapter 2, Section 7 tells more about this program. If you qualify, enrolling in the program might lower your monthly plan premium.

If you are already enrolled and getting help from one of these programs, the information about **premiums in this Evidence of Coverage may not apply to you**. We sent you a separate insert, called the “Evidence of Coverage Rider for People Who Get Extra Help Paying for Prescription Drugs” (also known as the “Low Income Subsidy Rider” or the “LIS Rider”), which tells you about your drug coverage. If you don’t have this insert, please call Customer Services and ask for the “LIS Rider.” (Phone numbers for Customer Services are printed on the back cover of this booklet.)

**In some situations, your plan premium could be more**

In some situations, your plan premium could be more than the amount listed above in Section 4.1. These situations are described below.

- If you signed up for extra benefits, also called “optional supplemental benefits,” then you pay an additional premium each month for these extra benefits. Some UCare Medicare Group Plans members have the option of purchasing the Classic Choice Dental benefit package. The monthly premium for this optional supplemental benefit is $21. If you have any questions about your plan premiums, please call Customer Services (phone numbers are printed on the back cover of this booklet).

- Some members are required to pay a Part D late enrollment penalty because they did not join a Medicare drug plan when they first became eligible or because they had a continuous period of 63 days or more when they didn’t have “creditable” prescription drug coverage. (“Creditable” means the drug coverage is expected to pay, on average, at least as much as Medicare’s standard prescription drug coverage.) For these members, the Part D late enrollment penalty is added to the plan’s monthly premium. Their premium amount will be the monthly plan premium plus the amount of their Part D late enrollment penalty.
  
  - If you are required to pay the Part D late enrollment penalty, the cost of the late enrollment penalty depends on how long you went without Part D or creditable prescription drug coverage. Chapter 1, Section 5 explains the Part D late enrollment penalty.
  
  - If you have a Part D late enrollment penalty and do not pay it, you could be disenrolled from the plan.
Third, if you are under 65 and currently receiving Medicare benefits, the Part D late enrollment penalty will reset when you turn 65. After age 65, your Part D late enrollment penalty will be based only on the months that you don’t have coverage after your initial enrollment period for aging into Medicare.

Section 5.3  In some situations, you can enroll late and not have to pay the penalty

Even if you have delayed enrolling in a plan offering Medicare Part D coverage when you were first eligible, sometimes you do not have to pay the Part D late enrollment penalty.

You will not have to pay a penalty for late enrollment if you are in any of these situations:

- If you already have prescription drug coverage that is expected to pay, on average, at least as much as Medicare’s standard prescription drug coverage. Medicare calls this “creditable drug coverage.”
  Please note:
  - Creditable coverage could include drug coverage from a former employer or union, TRICARE, or the Department of Veterans Affairs. Your insurer or your human resources department will tell you each year if your drug coverage is creditable coverage. This information may be sent to you in a letter or included in a newsletter from the plan. Keep this information, because you may need it if you join a Medicare drug plan later.
  - **Please note:** If you receive a “certificate of creditable coverage” when your health coverage ends, it may not mean your prescription drug coverage was creditable. The notice must state that you had “creditable” prescription drug coverage that expected to pay as much as Medicare’s standard prescription drug plan pays.
  - The following are *not* creditable prescription drug coverage: prescription drug discount cards, free clinics, and drug discount websites.
  - For additional information about creditable coverage, please look in your Medicare & You 2019 Handbook or call Medicare at 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.
- If you were without creditable coverage, but you were without it for less than 63 days in a row.
- If you are receiving “Extra Help” from Medicare.

Section 5.4  What can you do if you disagree about your Part D late enrollment penalty?

If you disagree about your Part D late enrollment penalty, you or your representative can ask for a review of the decision about your late enrollment penalty. Generally, you must request this review **within 60 days** from the date on the first letter you receive stating you have to pay a late enrollment penalty. If you were paying a penalty before joining our plan, you may not have another chance to request a review of that late enrollment penalty. Call Customer Services to find out more about how to do this (phone numbers are printed on the back cover of this booklet).

**Important:** Do not stop paying your Part D late enrollment penalty while you’re waiting for a review of the decision about your late enrollment penalty. If you do, you could be disenrolled for failure to pay your plan premiums.
Many members are required to pay other Medicare premiums

In addition to paying the monthly plan premium, many members are required to pay other Medicare premiums. As explained in Section 2 above, in order to be eligible for our plan, you must have both Medicare Part A and Medicare Part B. Some plan members (those who aren't eligible for premium-free Part A) pay a premium for Medicare Part A. Most plan members pay a premium for Medicare Part B. **You must continue paying your Medicare premiums to remain a member of the plan.**

If your monthly income is at or below $1,528 for an individual or below $2,050 for a married couple, you may qualify for a government program that could help you save money each month on your Medicare Part B premiums (amounts may change during the year). My Advocate helps you enroll at no cost to you. To learn more, call My Advocate at 1-866-252-2659, 9 a.m. to 6 p.m., Monday – Friday (TTY users call 1-855-368-9643) or visit the website: MyAdvocateHelps.com.

Some people pay an extra amount for Part D because of their yearly income. This is known as Income Related Monthly Adjustment Amounts, also known as IRMAA. If your income is greater than $85,000 for an individual (or married individuals filing separately) or greater than $170,000 for married couples, **you must pay an extra amount directly to the government (not the Medicare plan)** for your Medicare Part D coverage.

- If you are required to pay the extra amount and you do not pay it, you **will be disenrolled from the plan and lose prescription drug coverage.**
- If you have to pay an extra amount, Social Security, **not your Medicare plan,** will send you a letter telling you what that extra amount will be.
- For more information about Part D premiums based on income, go to Chapter 1, Section 6 of this booklet. You can also visit [https://www.medicare.gov](https://www.medicare.gov) on the Web or call 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 may call Social Security at 1-800-772-1213. TTY users should call 1-800-325-0778.

Your copy of *Medicare & You 2019* gives information about the Medicare premiums in the section called “2019 Medicare Costs.” This explains how the Medicare Part B and Part D premiums differ for people with different incomes. Everyone with Medicare receives a copy of *Medicare & You* each year in the fall. Those new to Medicare receive it within a month after first signing up. You can also download a copy of *Medicare & You 2019* from the Medicare website ([https://www.medicare.gov](https://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 7.1 There are several ways you can pay your plan premium

There are two ways you can pay your plan premium. Payment options are listed on the enrollment form and can be selected when filling out the form. Or, you can contact us directly and request a payment option. If you want to change your payment option, please contact Customer Services by phone or in writing.

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.
Section 7.2  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.

However, in some cases the part of the premium that you have to pay can change during the year. This happens if you become eligible for the “Extra Help” program or if you lose your eligibility for the “Extra Help” program during the year. If a member qualifies for “Extra Help” with their prescription drug costs, the “Extra Help” program will pay part of the member’s monthly plan premium. A member who loses their eligibility during the year will need to start paying their full monthly premium. You can find out more about the “Extra Help” program in Chapter 2, Section 7.

SECTION 8  Please keep your plan membership record up to date

Section 8.1  How to help make sure that we have accurate information about you

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

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

Let us know about these changes:

- Changes to your name, your address, or your phone number
- Changes in any other health insurance coverage you have (such as from your employer, your spouse’s employer, workers’ compensation, or Medicaid)
- If you have any liability claims, such as claims from an automobile accident
- If you have been admitted to a nursing home
- If you receive care in an out-of-area or out-of-network hospital or emergency room
- If your designated responsible party (such as a caregiver) changes
- If you are participating in a clinical research study

If any of this information changes, please let us know by calling Customer Services (phone numbers are printed on the back cover of this booklet).

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.
• 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.

If you have other insurance, tell your doctor, hospital, and pharmacy. If you have questions about who pays first, or you need to update your other insurance information, call Customer Services (phone numbers are printed on the back cover of this booklet). 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.
CHAPTER 2

Important phone numbers and resources
 SECTION 1  UCare Medicare Group Plans contacts  
(how to contact us, including how to reach Customer Services at the plan)

How to contact our plan’s Customer Services
For assistance with claims, billing, or member card questions, please call or write to UCare Customer Services. We will be happy to help you.

<table>
<thead>
<tr>
<th>Method</th>
<th>UCare Customer Services – Contact Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>CALL</td>
<td>612-676-6840</td>
</tr>
<tr>
<td></td>
<td>1-877-447-4385 (toll free).</td>
</tr>
<tr>
<td></td>
<td>24 hours a day, 7 days a week.</td>
</tr>
<tr>
<td></td>
<td>Customer Services also has free language interpreter services available for non-English speakers.</td>
</tr>
<tr>
<td>TTY</td>
<td>612-676-6810</td>
</tr>
<tr>
<td></td>
<td>1-800-688-2534 (toll free).</td>
</tr>
<tr>
<td></td>
<td>These numbers require special telephone equipment and are only for people who have difficulties with hearing or speaking.</td>
</tr>
<tr>
<td></td>
<td>24 hours a day, 7 days a week.</td>
</tr>
<tr>
<td>FAX</td>
<td>612-676-6501</td>
</tr>
<tr>
<td></td>
<td>1-866-457-7145 (toll free).</td>
</tr>
<tr>
<td>WRITE</td>
<td>UCare</td>
</tr>
<tr>
<td></td>
<td>Attn: Medicare Customer Services</td>
</tr>
<tr>
<td></td>
<td>P.O. Box 52</td>
</tr>
<tr>
<td></td>
<td>Minneapolis, MN 55440-0052</td>
</tr>
<tr>
<td>WEBSITE</td>
<td>ucare.org</td>
</tr>
</tbody>
</table>
**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, see Chapter 9 (What to do if you have a problem or complaint (coverage decisions, appeals, complaints)).

<table>
<thead>
<tr>
<th>Method</th>
<th>Appeals For Medical Care – Contact Information</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>CALL</strong></td>
<td>Appeals and Grievances</td>
</tr>
<tr>
<td></td>
<td>612-676-6841</td>
</tr>
<tr>
<td></td>
<td>1-877-523-1517 (toll free).</td>
</tr>
<tr>
<td></td>
<td>8 a.m. to 4:30 p.m., Monday – Friday.</td>
</tr>
<tr>
<td><strong>TTY</strong></td>
<td>612-676-6810</td>
</tr>
<tr>
<td></td>
<td>1-800-688-2534 (toll free).</td>
</tr>
<tr>
<td></td>
<td>These numbers require special telephone equipment and are only for people who have difficulties with hearing or speaking.</td>
</tr>
<tr>
<td><strong>FAX</strong></td>
<td>612-884-2021</td>
</tr>
<tr>
<td></td>
<td>1-866-283-8015 (toll free).</td>
</tr>
<tr>
<td></td>
<td><strong>Attn: Appeals and Grievances</strong></td>
</tr>
<tr>
<td><strong>WRITE</strong></td>
<td>UCare</td>
</tr>
<tr>
<td></td>
<td><strong>Attn: Appeals and Grievances</strong></td>
</tr>
<tr>
<td></td>
<td>P.O. Box 52</td>
</tr>
<tr>
<td></td>
<td>Minneapolis, MN 55440-0052</td>
</tr>
<tr>
<td></td>
<td>Or, <strong>email</strong> us at <a href="mailto:cag@ucare.org">cag@ucare.org</a></td>
</tr>
</tbody>
</table>
How to contact us when you are asking for a coverage decision about your Part D prescription drugs

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

<table>
<thead>
<tr>
<th>Method</th>
<th>Coverage Decisions For Part D Prescription Drugs - Contact Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>CALL</td>
<td>Express Scripts</td>
</tr>
<tr>
<td></td>
<td>1-877-558-7521 (toll free).</td>
</tr>
<tr>
<td></td>
<td>24 hours a day, 7 days a week.</td>
</tr>
<tr>
<td>TTY</td>
<td>1-800-716-3231 (toll free).</td>
</tr>
<tr>
<td></td>
<td>24 hours a day, 7 days a week.</td>
</tr>
<tr>
<td></td>
<td>This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.</td>
</tr>
<tr>
<td>WRITE</td>
<td>Express Scripts</td>
</tr>
<tr>
<td></td>
<td>Attn: Medicare Reviews</td>
</tr>
<tr>
<td></td>
<td>P.O. Box 66571</td>
</tr>
<tr>
<td></td>
<td>St. Louis, MO 63166-6571</td>
</tr>
</tbody>
</table>
How to contact us when you are making a complaint about your Part D prescription drugs

You can make a complaint about us or one of our network pharmacies, including a complaint about the quality of your care. This type of complaint does not involve coverage or payment disputes. (If your problem is about the plan’s coverage or payment, you should look at the section above about making an appeal.) For more information on making a complaint about your Part D prescription drugs, see Chapter 9 (What to do if you have a problem or complaint (coverage decisions, appeals, complaints)).

<table>
<thead>
<tr>
<th>Method</th>
<th>Complaints About Part D prescription drugs – Contact Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>CALL</td>
<td>Customer Services</td>
</tr>
<tr>
<td></td>
<td>612-676-6840</td>
</tr>
<tr>
<td></td>
<td>1-877-447-4385 (toll free).</td>
</tr>
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<td>24 hours a day, 7 days a week.</td>
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<td></td>
<td>1-866-283-8015 (toll free).</td>
</tr>
<tr>
<td></td>
<td>Attn: Appeals and Grievances</td>
</tr>
<tr>
<td>WRITE</td>
<td>UCare</td>
</tr>
<tr>
<td></td>
<td>Attn: Appeals and Grievances</td>
</tr>
<tr>
<td></td>
<td>P.O. Box 52</td>
</tr>
<tr>
<td></td>
<td>Minneapolis, MN 55440-0052</td>
</tr>
<tr>
<td></td>
<td>Or, email us at <a href="mailto:cag@ucare.org">cag@ucare.org</a></td>
</tr>
<tr>
<td>MEDICARE WEBSITE</td>
<td>You can submit a complaint about UCare directly to Medicare.</td>
</tr>
<tr>
<td></td>
<td>To submit an online complaint to Medicare go to</td>
</tr>
</tbody>
</table>


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.

<table>
<thead>
<tr>
<th>Method</th>
<th>Medicare - Contact Information</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>CALL</strong></td>
<td>1-800-MEDICARE, or 1-800-633-4227.</td>
</tr>
<tr>
<td></td>
<td>Calls to these numbers are free.</td>
</tr>
<tr>
<td></td>
<td>24 hours a day, 7 days a week.</td>
</tr>
<tr>
<td><strong>TTY</strong></td>
<td>1-877-486-2048</td>
</tr>
<tr>
<td></td>
<td>This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.</td>
</tr>
<tr>
<td></td>
<td>Calls to this number are free.</td>
</tr>
</tbody>
</table>
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 independent (not connected with any insurance company or health plan). It is a 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 with your Medicare questions or problems. They 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 understand your Medicare plan choices and answer questions about switching plans.

<table>
<thead>
<tr>
<th>Method</th>
<th>Senior LinkAge Line® (Minnesota SHIP) - Contact Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>CALL</td>
<td>1-800-333-2433 (toll free)</td>
</tr>
<tr>
<td>TTY</td>
<td>Minnesota Relay Service at 1-800-627-3529 (toll free) or 711. These numbers require special telephone equipment and are only for people who have difficulties with hearing or speaking.</td>
</tr>
</tbody>
</table>
| WRITE  | Minnesota Board on Aging  
P.O. Box 64976  
St. Paul, MN 55164-0976 |
| WEBSITE| www.seniorlinkageline.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. Social Security handles the enrollment process for Medicare. To apply for Medicare, you can call Social Security or visit your local Social Security office.

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

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

<table>
<thead>
<tr>
<th>Method</th>
<th>Social Security- Contact Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>CALL</td>
<td>1-800-772-1213</td>
</tr>
<tr>
<td></td>
<td>Calls to this number are free.</td>
</tr>
<tr>
<td></td>
<td>Available 7:00 a.m. to 7:00 p.m., Monday through Friday.</td>
</tr>
<tr>
<td></td>
<td>You can use Social Security’s automated telephone services to get recorded information and conduct some business 24 hours a day.</td>
</tr>
<tr>
<td>TTY</td>
<td>1-800-325-0778</td>
</tr>
<tr>
<td></td>
<td>This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.</td>
</tr>
<tr>
<td></td>
<td>Calls to this number are free.</td>
</tr>
<tr>
<td></td>
<td>Available 7:00 a.m. to 7:00 p.m., Monday through Friday.</td>
</tr>
<tr>
<td>WEBSITE</td>
<td><a href="https://www.ssa.gov">https://www.ssa.gov</a></td>
</tr>
</tbody>
</table>
SECTION 7  Information about programs to help people pay for their prescription drugs

Medicare’s “Extra Help” Program
Medicare provides “Extra Help” to pay prescription drug costs for people who have limited income and resources. Resources include your savings and stocks, but not your home or car. If you qualify, you get help paying for any Medicare drug plan’s monthly premium, yearly deductible, and prescription copayments. This “Extra Help” also counts toward your out-of-pocket costs.

People with limited income and resources may qualify for “Extra Help.” Some people automatically qualify for “Extra Help” and don’t need to apply. Medicare mails a letter to people who automatically qualify for “Extra Help.”

You may be able to get “Extra Help” to pay for your prescription drug premiums and costs. To see if you qualify for getting “Extra Help,” call:

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

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

- First, contact Customer Services. We will help you identify what documentation must be sent to us. Upon receipt of your documentation, we will review it and determine if it meets Medicare requirements. If the documentation meets Medicare requirements, we will correct your cost-sharing amount. If the documentation does not support a change in your cost-sharing amount, we will notify you.

- When we receive the evidence showing your copayment level, we will update our system so that you can pay the correct copayment when you get your next prescription at the pharmacy. If you overpay your copayment, we will reimburse you. Either we will forward a check to you in the amount of your overpayment or we will offset future copayments. If the pharmacy hasn’t collected a copayment from you and is carrying your copayment as a debt owed by you, we may make the payment directly to the pharmacy. If a state paid on your behalf, we may make payment directly to the state. Please contact Customer Services if you have questions (phone numbers are printed on the back cover of this booklet).
For information on eligibility criteria, covered drugs, or how to enroll in the program, please call:

<table>
<thead>
<tr>
<th>Method</th>
<th>AIDS Drug Assistance Program (ADAP) - Contact Information</th>
</tr>
</thead>
</table>
| **CALL** | Twin Cities Metro area:  
651-431-2414 (phone)  
651-431-7414 (fax)  
Statewide:  
1-800-657-3761 (phone) (toll free)  
1-800-627-3529 or 711 (TTY) |
| **WRITE** | HIV/AIDS Programs Department of Human Services  
P.O. Box 64972  
St. Paul, MN 55164-0972 |

**What if you get “Extra Help” from Medicare to help pay your prescription drug costs? Can you get the discounts?**

No. If you get “Extra Help,” you already get coverage for your prescription drug costs during the coverage gap.

**What if you don’t get a discount, and you think you should have?**

If you think that you have reached the coverage gap and did not get a discount when you paid for your brand-name drug, you should review your next Part D Explanation of Benefits (Part D EOB) notice. If the discount doesn’t appear on your Part D Explanation of Benefits, you should contact us to make sure that your prescription records are correct and up-to-date. If we don’t agree that you are owed a discount, you can appeal. You can get help filing an appeal from your State Health Insurance Assistance Program (SHIP) (telephone numbers are in Section 3 of this Chapter) or 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.
CHAPTER 3

Using the plan’s coverage for your medical services
SECTION 1  Things to know about getting your medical care covered 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, 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”?

Here are some definitions that can help you understand how you get the care and services that are covered for you as a member of our plan:

-  **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 see 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 Medicare Group Plans must cover all services covered by Original Medicare and must follow Original Medicare’s coverage rules.

The plan 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 booklet).

-  **The care you receive is considered medically necessary.** “Medically necessary” means that the services, supplies, or drugs are needed for the prevention, diagnosis, or treatment of your medical condition and meet accepted standards of medical practice.

-  **You 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, see Section 2.1 in this chapter).
• Follow-up care.

• Care from doctors who are specialists (you can see any specialist in the network on your own without a referral).

“Coordinating” your services includes checking or consulting with other network providers about your care and how it is going. In some cases, your PCP will need to get prior authorization from us (see Chapter 4 for details). Because your PCP will provide and coordinate your medical care, you should have all of your past medical records sent to your PCP’s office. Chapter 8 tells you how we will protect the privacy of your medical records and personal health information.

How do you choose your PCP?

You can choose a Primary Care Clinic and PCP by reviewing the Provider Directory or by getting help from Customer Services. The Primary Care Clinic that you choose should be noted on the enrollment form when it is submitted. If there is a particular network hospital that you want to use, check first to be sure your PCP uses that hospital. Members may change PCPs.

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.

You only need to change your PCP if you are changing your Primary Care Clinic. You may change your clinic at any time during the month, effective the first of the next month. To change your clinic, call Customer Services. They will change your membership record to show the name of your new clinic, and tell you when the change to your new clinic will take effect.

Section 2.2 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. See Chapter 4, Section 2.3 for details on the POS benefit.

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

We may make changes to the hospitals, doctors, and specialists (providers) that are part of your plan during the year. There are a number of reasons why your provider might leave your plan, but if your doctor or specialist does leave your plan you have certain rights and protections that are summarized below:

• Even though our network of providers may change during the year, Medicare requires that we furnish you with uninterrupted access to qualified doctors and specialists.
If you have an emergency, we will talk with the doctors who are giving you emergency care to help manage and follow up on your care. 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 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. See Chapter 4, Section 2.3 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 go to 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 these urgently needed services (for more information about this, see Section 3.2 below).

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

What are “urgently needed services”?
“Urgently needed services” are non-emergency, unforeseen medical illnesses, injuries, or conditions that require immediate medical care. Urgently needed services may be furnished by network providers or by out-of-network providers when network providers are temporarily unavailable or inaccessible. The unforeseen condition could, for example, be an unforeseen flare-up of a known condition that you have.

What if you are in the plan’s service area when you have an urgent need for care?
You should always try to obtain urgently needed services from network providers. However, if providers are temporarily unavailable or inaccessible and it is not reasonable to wait to obtain care from your network provider when the network becomes available, we will cover urgently needed services that you get from an out-of-network provider.

You can find a list of urgent care providers online at UCare.org, or by calling Customer Services at the number on the back cover of this booklet. To find out how to access urgently needed care, you can call your Primary Care Clinic, or you can call the UCare 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 UCare 24/7 nurse line can give you information on how to access care after normal business hours.

What if you are outside the plan’s service area when you have an urgent need for care?
When you are outside the service area and cannot get care from a network provider, our plan will cover urgently needed services that you get from any provider.
cost beyond the benefit limitation will not count toward your out-of-pocket maximum. You can call Customer Services when you want to know how much of your benefit limit you have already used.

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. They test new medical care procedures or drugs by asking for volunteers to help with the study. This kind of study is one of the final stages of a research process that helps doctors and scientists see if a new approach works and if it is safe.

Not all clinical research studies are open to members of our plan. Medicare first needs to approve the research study. 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**.

Once Medicare approves the study, someone who works on the study will contact you to explain more about the study and see 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. 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 a Medicare-approved clinical research study, you do not need to 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, **you do need to tell us before you start participating in a clinical research study**.

If you plan on participating in a clinical research study, contact Customer Services (phone numbers are printed on the back cover of this booklet) to let them know that you will be participating in a clinical trial and to find out more specific details about what your plan will pay.

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

Once you join a Medicare-approved clinical research study, you are covered for 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.
Section 6.2  What care from a religious non-medical health care institution is covered by our plan?

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

- “Non-excepted” medical care or treatment is any medical care or treatment that is voluntary and not required by any federal, state, or local law.

- “Excepted” medical treatment is medical care or treatment that you get that is not voluntary or is required under federal, state, or local law.

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

- The facility providing the care must be certified by Medicare.

- Our plan’s coverage of services you receive is limited to non-religious aspects of care.

- If you get services from this institution that are provided to you in a facility, the following conditions apply:
  - You must have a medical condition that would allow you to receive covered services for inpatient hospital care or skilled nursing facility care.
  - and – you must get approval in advance from our plan before you are admitted to the facility or your stay will not be covered.

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 booklet.

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 the plan, 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. Under certain limited circumstances we will transfer ownership of the DME item to you. Call Customer Services (phone numbers are printed on the back cover of this booklet) to find out about the requirements you must meet and the documentation you need to provide.
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 focuses on your covered services and what you pay for your medical benefits. It includes a Medical Benefits Chart that lists your covered services and shows how much you will pay for each covered service as a member of the plan. 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 the 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 the 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. If you think that you are being asked to pay improperly, contact Customer Services.

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 to how much you have to pay out-of-pocket each year for in-network medical services that are covered under Medicare Part A and Part B (see the Medical Benefits Chart in Section 2, below). This limit is called the maximum out-of-pocket amount for medical services.

As a member of the plan, the most you will have to pay out-of-pocket for in-network covered Part A and Part B services in 2019 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 and for your Part D prescription drugs do not count toward your maximum out-of-pocket amount. In addition, amounts you pay for some services do not count toward your maximum out-of-pocket amount.) If you reach the 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).
SECTION 2  Use the Medical Benefits Chart to find out what is covered for you 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 the plan 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, and equipment) must be medically necessary. "Medically necessary" means that the services, supplies, or drugs are needed for the prevention, diagnosis, or treatment of your medical condition and meet accepted standards of medical practice.

- You receive your care from a network provider. In most cases, care you receive from an out-of-network provider will not be covered. Chapter 3 provides more information about requirements for using network providers and the situations when we will cover services from an out-of-network provider.

- You have a primary care provider (a PCP) who is providing and overseeing your care.

- Some of the services listed in the Medical Benefits Chart are covered only if your doctor or other network provider gets approval in advance (sometimes called “prior authorization”) from us. Covered services that need approval in advance are marked in the Medical Benefits Chart by an asterisk (*). In addition, the following services not listed in the Benefits Chart require prior authorization: inpatient rehabilitation services, genetic molecular diagnosis test, spine surgery, bone growth stimulators, and spinal cord stimulators.

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 2019 Handbook. View it online at https://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.

- Sometimes, Medicare adds coverage under Original Medicare for new services during the year. If Medicare adds coverage for any services during 2019, either Medicare or our plan will cover those services.
<table>
<thead>
<tr>
<th>Services that are covered for you</th>
<th>What you must pay when you get these services In-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Annual physical exam</strong></td>
<td>$0 copayment. Additional copayments or coinsurance may apply to any diagnostic tests performed during your visit, as described for each separate service in this Medical Benefits Chart.</td>
</tr>
</tbody>
</table>
| 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. | |
| **Annual wellness visit**        | There is no coinsurance, copayment, or deductible for the annual wellness visit. |
| If you’ve had Part B for longer than 12 months, you can get an annual wellness visit to develop or update a personalized prevention plan based on your current health and risk factors. This is covered once every 12 months.  
  **Note:** Your first annual wellness visit can’t take place within 12 months of your “Welcome to Medicare” preventive visit. However, you don’t need to have had a “Welcome to Medicare” visit to be covered for annual wellness visits after you’ve had Part B for 12 months. | |
| **Bone mass measurement**        | There is no coinsurance, copayment, or deductible for Medicare-covered 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 the results. | |
| **Breast cancer screening (mammograms)** | There is no coinsurance, copayment, or deductible for covered screening mammograms. |
| Covered services include:  
  - One baseline mammogram between the ages of 35 and 39.  
  - One screening mammogram every 12 months for women 40 and older.  
  - Clinical breast exams once every 24 months. | |
<table>
<thead>
<tr>
<th>Services that are covered for you</th>
<th>What you must pay when you get these services In-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Chiropractic services</strong>*</td>
<td>$0 copayment for each Medicare-covered visit.</td>
</tr>
<tr>
<td>We contract with Fulcrum Health, Inc. to provide chiropractic services. You need to see a ChiroCare provider to have coverage for this benefit.</td>
<td></td>
</tr>
<tr>
<td>To find an in-network chiropractor, go to ucare.org and select Find a Chiropractor. For general chiropractic benefit information, call UCare Customer Services at 612-676-6840 or toll free at 1-877-447-4385, 24 hours a day, 7 days a week. TTY users call 612-676-6810 or 1-800-688-2534.</td>
<td></td>
</tr>
<tr>
<td>Covered services include:</td>
<td></td>
</tr>
<tr>
<td>- We cover only manual manipulation of the spine to correct subluxation.</td>
<td></td>
</tr>
<tr>
<td><strong>Colorectal cancer screening</strong></td>
<td></td>
</tr>
<tr>
<td>For people 50 and older, the following are covered:</td>
<td>There is no coinsurance, copayment, or deductible for a Medicare-covered colorectal cancer screening exam.</td>
</tr>
<tr>
<td>- Flexible sigmoidoscopy (or screening barium enema as an alternative) every 48 months.</td>
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<tr>
<td>One of the following every 12 months:</td>
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<tr>
<td>- Guaiac-based fecal occult blood test (gFOBT)</td>
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<tr>
<td>- Fecal immunochemical test (FIT)</td>
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<tr>
<td>DNA-based colorectal screening every 3 years.</td>
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<tr>
<td>For people at high risk of colorectal cancer, we cover:</td>
<td></td>
</tr>
<tr>
<td>- Screening colonoscopy (or screening barium enema as an alternative) every 24 months.</td>
<td></td>
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<tr>
<td>For people not at high risk of colorectal cancer, we cover:</td>
<td></td>
</tr>
<tr>
<td>- Screening colonoscopy every 10 years (120 months), but not within 48 months of a screening sigmoidoscopy.</td>
<td></td>
</tr>
<tr>
<td>Services that are covered for you</td>
<td>What you must pay when you get these services In-Network</td>
</tr>
<tr>
<td>----------------------------------</td>
<td>--------------------------------------------------------</td>
</tr>
</tbody>
</table>
| **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 Medicare-covered continuous glucose monitor and supplies. No coinsurance 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. |
| **Durable medical equipment (DME) and related supplies**  
(For a definition of “durable medical equipment,” see Chapter 12 of this booklet.) 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 durable medical equipment 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. | 20% coinsurance for Medicare-covered benefits. |
<table>
<thead>
<tr>
<th>Services that are covered for you</th>
<th>What you must pay when you get these services In-Network</th>
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</thead>
<tbody>
<tr>
<td><strong>Health and wellness education programs</strong></td>
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</tr>
<tr>
<td>• <strong>You may choose one of the two fitness options below:</strong></td>
<td>$0 copayment.</td>
</tr>
<tr>
<td><strong>Option 1: SilverSneakers® Fitness Program</strong></td>
<td></td>
</tr>
<tr>
<td>– Free basic fitness membership at participating SilverSneakers locations.</td>
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</tr>
<tr>
<td>– Access to more than 500 participating locations in Minnesota (including the YMCA and Life Time Fitness Gold or Life Time Fitness Bronze locations.) and 13,000 locations across the country.</td>
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</tr>
<tr>
<td>– Group exercise classes, fitness equipment, and amenities at participating locations. (Classes and amenities vary by location.)</td>
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<tr>
<td>– SilverSneakers FLEX®, which brings fitness classes to communities at local parks, recreation centers and more.</td>
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</tr>
<tr>
<td>– Online member website with access to healthy tools and resources, and community support.</td>
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<tr>
<td>– Find participating locations and classes at silversneakers.com.</td>
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</tr>
<tr>
<td>– Present your SilverSneakers card or 16-digit ID number at a participating location to get started.</td>
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</tr>
<tr>
<td>– Use a Steps kit to help you get fit at home or on the go. Call SilverSneakers at 1-888-423-4632 toll free or visit silversneakers.com to order one of several fitness kit options available to you at no charge.</td>
<td></td>
</tr>
<tr>
<td>– Tivity Health, SilverSneakers, and SilverSneakers FLEX are registered trademarks or trademarks of Tivity Health, Inc., and/or its subsidiaries and/or affiliates in the USA and/or other countries. © 2018 Tivity Health, Inc. All rights reserved.</td>
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<tr>
<td>Services that are covered for you</td>
<td>What you must pay when you get these services In-Network</td>
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</tr>
<tr>
<td><strong>HIV screening</strong></td>
<td>- There is no coinsurance, copayment, or deductible for members eligible for Medicare-covered preventive HIV screening.</td>
</tr>
<tr>
<td>For people who ask for an HIV screening test or who are at increased risk for HIV infection, we cover:</td>
<td></td>
</tr>
<tr>
<td>- One screening exam every 12 months.</td>
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<tr>
<td>For women who are pregnant, we cover:</td>
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<tr>
<td>- Up to three screening exams during a pregnancy.</td>
<td></td>
</tr>
<tr>
<td><strong>Home health agency care</strong></td>
<td>- $0 copayment for all home health visits provided by a network home health agency when Medicare criteria are met.</td>
</tr>
<tr>
<td>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.</td>
<td></td>
</tr>
<tr>
<td>Covered services include, but are not limited to:</td>
<td></td>
</tr>
<tr>
<td>- 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).</td>
<td></td>
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<tr>
<td>- Physical therapy, occupational therapy, and speech therapy.</td>
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<tr>
<td>- Medical and social services.</td>
<td></td>
</tr>
<tr>
<td>- Medical equipment and supplies.</td>
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</tr>
<tr>
<td>There is cost-sharing for durable medical equipment and related supplies. Please refer to “Durable medical equipment and related supplies.”</td>
<td></td>
</tr>
<tr>
<td>Services that are covered for you</td>
<td>What you must pay when you get these services In-Network</td>
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</tr>
<tr>
<td><strong>Hospice care (continued)</strong></td>
<td></td>
</tr>
<tr>
<td>For drugs that may be covered by the plan’s Part D benefit: Drugs are never covered by both hospice and our plan at the same time. For more information, please see Chapter 5, Section 9.4 (<em>What if you’re in Medicare-certified hospice</em>).</td>
<td></td>
</tr>
<tr>
<td><strong>Note:</strong> If you need non-hospice care (care that is not related to your terminal prognosis), you should contact us to arrange the services.</td>
<td></td>
</tr>
<tr>
<td>Our plan covers hospice consultation services (one time only) for a terminally ill person who hasn’t elected the hospice benefit.</td>
<td></td>
</tr>
<tr>
<td><strong>Immunizations</strong></td>
<td></td>
</tr>
<tr>
<td>Covered Medicare Part B services include:</td>
<td>There is no coinsurance, copayment, or deductible for the pneumonia, influenza, and Hepatitis B vaccines.</td>
</tr>
<tr>
<td>• Pneumonia vaccine.</td>
<td>Refer to “Medicare Part B prescription drugs” in this Medical Benefits Chart</td>
</tr>
<tr>
<td>• Flu shots, once each flu season in the fall and winter, with additional flu shots if medically necessary.</td>
<td></td>
</tr>
<tr>
<td>• Hepatitis B vaccine if you are at high or intermediate risk of getting Hepatitis B.</td>
<td></td>
</tr>
<tr>
<td>• Other vaccines if you are at risk and they meet Medicare Part B coverage rules.</td>
<td></td>
</tr>
<tr>
<td>We also cover some vaccines under our Part D prescription drug benefit.</td>
<td></td>
</tr>
<tr>
<td>Services that are covered for you</td>
<td>What you must pay when you get these services In-Network</td>
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</tr>
<tr>
<td><strong>Inpatient hospital care (continued)</strong></td>
<td></td>
</tr>
<tr>
<td>• 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 the plan 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.</td>
<td></td>
</tr>
<tr>
<td>• 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.</td>
<td></td>
</tr>
<tr>
<td>• Physician services.</td>
<td></td>
</tr>
<tr>
<td><strong>Note:</strong> 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.</td>
<td></td>
</tr>
<tr>
<td>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 <a href="https://www.medicare.gov/Pubs/pdf/11435.pdf">https://www.medicare.gov/Pubs/pdf/11435.pdf</a> 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.</td>
<td></td>
</tr>
<tr>
<td>Services that are covered for you</td>
<td>What you must pay when you get these services In-Network</td>
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<td>----------------------------------</td>
<td>--------------------------------------------------</td>
</tr>
<tr>
<td><strong>Inpatient stay:</strong> Covered services received in a hospital or SNF during a non-covered inpatient stay (continued)</td>
<td></td>
</tr>
<tr>
<td>• Surgical dressings.</td>
<td>Please refer to “Outpatient diagnostic tests and therapeutic services and supplies.”</td>
</tr>
<tr>
<td>• Splints, casts and other devices used to reduce fractures and dislocations.</td>
<td>Please refer to “Outpatient diagnostic tests and therapeutic services and supplies.”</td>
</tr>
<tr>
<td>• 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.</td>
<td>Please refer to “Prosthetic devices and related supplies.”</td>
</tr>
<tr>
<td>• 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.</td>
<td>Please refer to “Prosthetic devices and related supplies.”</td>
</tr>
<tr>
<td>• Physical therapy, speech therapy, and occupational therapy.</td>
<td>Please refer to “Outpatient rehabilitation services.”</td>
</tr>
</tbody>
</table>

**Medical nutrition therapy**

This benefit is for people with diabetes, renal (kidney) disease (but not on dialysis), or after a kidney transplant when ordered by your doctor.

We cover 3 hours of one-on-one counseling services during your first year that you receive medical nutrition therapy services under Medicare (this includes our plan, any other Medicare Advantage Plan, or Original Medicare), and 2 hours each year after that. If your condition, treatment, or diagnosis changes, you may be able to receive more hours of treatment with a physician’s order. A physician must prescribe these services and renew their order yearly if your treatment is needed into the next calendar year.

There is no coinsurance, copayment, or deductible for members eligible for Medicare-covered medical nutrition therapy services.
<table>
<thead>
<tr>
<th>Services that are covered for you</th>
<th>What you must pay when you get these services In-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td><em><em>Medicare Part B prescription drugs</em> (continued)</em>*</td>
<td></td>
</tr>
<tr>
<td>Chapter 5 explains the Part D prescription drug benefit, including rules you must follow to have prescriptions covered. What you pay for your Part D prescription drugs through our plan is explained in Chapter 6.</td>
<td></td>
</tr>
<tr>
<td><strong>Obesity screening and therapy to promote sustained weight loss</strong></td>
<td></td>
</tr>
<tr>
<td>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.</td>
<td>There is no coinsurance, copayment, or deductible for preventive obesity screening and therapy.</td>
</tr>
<tr>
<td><strong>Outpatient diagnostic tests and therapeutic services and supplies</strong></td>
<td></td>
</tr>
<tr>
<td>Covered services include, but are not limited to:</td>
<td></td>
</tr>
<tr>
<td>• X-rays.</td>
<td>$0 copayment for each Medicare-covered standard X-ray service in a primary care or specialist office; $25 copayment for each Medicare-covered X-ray service in other facilities (e.g., ambulatory surgical center or outpatient hospital).</td>
</tr>
<tr>
<td>• Radiation (radium and isotope) therapy including technician materials and supplies.</td>
<td>$0 copayment for each Medicare-covered radiation (radium and isotope) therapy service, including technician materials and supplies in a primary care or specialist office; $25 copayment for each Medicare-covered radiation therapy service in other facilities (e.g., ambulatory surgical center or outpatient hospital).</td>
</tr>
<tr>
<td>• Surgical supplies, such as dressings.</td>
<td>$0 copayment for each Medicare-covered medical supply.</td>
</tr>
<tr>
<td>Services that are covered for you</td>
<td>What you must pay when you get these services In-Network</td>
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</tr>
<tr>
<td><strong>Outpatient hospital services (continued)</strong></td>
<td></td>
</tr>
<tr>
<td>- Mental health care, including care in a partial-hospitalization program*, if a doctor certifies that inpatient treatment would be required without it.</td>
<td>“Outpatient mental health care” or “Partial hospitalization services.”</td>
</tr>
<tr>
<td>- X-rays and other radiology services billed by the hospital.</td>
<td>“Outpatient diagnostic tests and therapeutic services and supplies.”</td>
</tr>
<tr>
<td>- Medical supplies such as splints and casts.</td>
<td>“Outpatient diagnostic tests and therapeutic services and supplies.”</td>
</tr>
<tr>
<td>- Certain drugs and biologicals that you can’t give yourself.</td>
<td>“Medicare Part B prescription drugs.”</td>
</tr>
</tbody>
</table>

**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/Pubs/pdf/11435.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.

<table>
<thead>
<tr>
<th><strong>Outpatient mental health care</strong></th>
<th>$30 copayment for each Medicare-covered visit.</th>
</tr>
</thead>
<tbody>
<tr>
<td>UCare uses a comprehensive network of mental health care providers.</td>
<td></td>
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<tr>
<td>Covered services include:</td>
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</tr>
<tr>
<td>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.</td>
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</tr>
<tr>
<td>Services that are covered for you</td>
<td>What you must pay when you get these services In-Network</td>
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</tr>
<tr>
<td>Physician/Practitioner services, including doctor’s office visits</td>
<td>$15 copayment for medical care furnished by a primary care physician. Or, under certain circumstances, by a nurse practitioner or physician’s assistant or other non-physician health care professionals (as permitted under Medicare rules).</td>
</tr>
<tr>
<td>Covered services include:</td>
<td>For applicable copayments or coinsurance amounts for surgery or procedures furnished in a certified ambulatory surgical center or hospital outpatient setting, see the “Outpatient surgery, including services provided at outpatient hospital facilities and ambulatory surgical centers” and/or the “Outpatient hospital services” section in this benefits chart.</td>
</tr>
<tr>
<td>• Medically-necessary medical care or surgery services furnished in a physician’s office, certified ambulatory surgical center, hospital outpatient department, or any other location.</td>
<td>$30 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).</td>
</tr>
<tr>
<td>• Consultation, diagnosis, and treatment by a specialist</td>
<td></td>
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<tr>
<td>Services that are covered for you</td>
<td>What you must pay when you get these services In-Network</td>
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</tr>
<tr>
<td><strong>Prostate cancer screening exams</strong>&lt;br&gt;For men age 50 and older, covered services include the following – once every 12 months:&lt;br&gt;• Digital rectal exam.&lt;br&gt;• Prostate Specific Antigen (PSA) test.</td>
<td>There is no coinsurance, copayment, or deductible for an annual digital rectal exam and PSA test.</td>
</tr>
<tr>
<td><strong>Prosthetic devices and related supplies</strong>&lt;br&gt;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 – see “Vision Care” later in this section for more detail.</td>
<td>$0 copayment for Medicare-covered prosthetic and orthotic devices, including repair and/or replacement.&lt;br&gt;$0 copayment for Medicare-covered supplies.</td>
</tr>
<tr>
<td><strong>Pulmonary rehabilitation services</strong>&lt;br&gt;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.</td>
<td>$30 copayment for each Medicare-covered visit.</td>
</tr>
<tr>
<td><strong>Screening and counseling to reduce alcohol misuse</strong>&lt;br&gt;We cover one alcohol misuse screening for adults with Medicare (including pregnant women) who misuse alcohol, but aren’t alcohol dependent.&lt;br&gt;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.</td>
<td>There is no coinsurance, copayment, or deductible for the Medicare-covered screening and counseling to reduce alcohol misuse preventive benefit.</td>
</tr>
<tr>
<td>Services that are covered for you</td>
<td>What you must pay when you get these services In-Network</td>
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</tr>
<tr>
<td><strong>Services to treat kidney disease</strong></td>
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<tr>
<td>Covered services include:</td>
<td>$0 copayment for Medicare-covered benefits.</td>
</tr>
<tr>
<td>• 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.</td>
<td>$0 copayment 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.</td>
</tr>
<tr>
<td>• Outpatient dialysis treatments (including dialysis treatments when temporarily out of the service area, as explained in Chapter 3).</td>
<td>Please refer to the “Inpatient hospital care” section found in this Medical Benefits Chart.</td>
</tr>
<tr>
<td>• Inpatient dialysis treatments (if you are admitted as an inpatient to a hospital for special care).</td>
<td>$0 copayment for Medicare-covered benefits.</td>
</tr>
<tr>
<td>• Self-dialysis training (includes training for you and anyone helping you with your home dialysis treatments).</td>
<td>$0 copayment for Medicare-covered benefits.</td>
</tr>
<tr>
<td>• Home dialysis equipment and supplies.</td>
<td>$0 copayment for Medicare-covered benefits.</td>
</tr>
<tr>
<td>• 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).</td>
<td>$0 copayment for Medicare-covered benefits.</td>
</tr>
<tr>
<td>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.”</td>
<td></td>
</tr>
<tr>
<td>Services that are covered for you</td>
<td>What you must pay when you get these services In-Network</td>
</tr>
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</tbody>
</table>
| **Smoking and tobacco use cessation**  
  (counseling to stop smoking or tobacco use) | There is no coinsurance, copayment, or deductible for the Medicare-covered smoking and tobacco use cessation preventive benefits. |
<p>| 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. | |
| <strong>Resources to Stop Using Tobacco:</strong> | $0 copayment. |
| UCare members can get free help to quit smoking or chewing tobacco with the <strong>tobacco quit line</strong>. Call the tobacco quit line at 1-855-260-9713 (toll free) to get started today. TTY users should call 711 (toll free). | |</p>
<table>
<thead>
<tr>
<th>Services that are covered for you</th>
<th>What you must pay when you get these services In-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Urgently needed services</strong></td>
<td>$35 copayment per visit.</td>
</tr>
<tr>
<td>Urgently needed services are provided to treat a non-emergency, unforeseen medical illness, injury, or condition that requires immediate medical care. Urgently needed services may be furnished by network providers or by out-of-network providers when network providers are temporarily unavailable or inaccessible. Cost-sharing for necessary urgently needed services furnished out-of-network is the same as for such services furnished in-network. <strong>Worldwide urgent care:</strong> 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.</td>
<td>$75 copayment for each worldwide urgent care visit.</td>
</tr>
<tr>
<td><strong>Vision care</strong></td>
<td>$0 copayment for each Medicare-covered visit.</td>
</tr>
<tr>
<td>Covered services include:</td>
<td>$0 copayment for one routine vision exam and up to two refractions annually. $0 copayment for each Medicare-covered glaucoma screening.</td>
</tr>
<tr>
<td>• 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. • One routine vision (eye) examination and up to two refractions annually. • For people who are at high risk of glaucoma, we will cover one glaucoma screening each year. People at high risk of glaucoma include people with a family history of glaucoma, people with diabetes, African-Americans who are age 50 and older and Hispanic Americans who are 65 or older. • For people with diabetes, screening for diabetic retinopathy is covered once per year.</td>
<td>$0 copayment for each Medicare-covered diabetic retinopathy exam.</td>
</tr>
</tbody>
</table>
Section 2.2 Extra “optional supplemental” benefits you can buy

Our plan offers some extra benefits that are not covered by Original Medicare and not included in your benefits package as a plan member. These extra benefits are called “Optional Supplemental Benefits.” If you want these optional supplemental benefits, you must sign up for them and you may have to pay an additional premium for them. The optional supplemental benefits described in this section are subject to the same appeals process as any other benefits.

As a member of the plan, you have the option of purchasing the Classic Choice Dental benefit package. You may select this option (a) upon your initial enrollment into the plan, (b) within the first 30 days of enrollment into the plan, or (c) during the Medicare Annual Enrollment Period each year. The monthly premium in 2019 is $21. This is in addition to your monthly UCare Medicare Group Plans premium and your Medicare Parts A and/or B premium, if applicable. The deductible and coinsurance for these covered services do not apply toward your out-of-pocket maximum described in this Chapter 4. Dental services are administered by Delta Dental of Minnesota (Delta Dental) (“administrator”).

The following coverage information applies if you purchase Classic Choice Dental.

A. Selecting Your Dentist. You should select a Delta Dental Medicare Advantage network dental provider from the provider 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 licensed dental professional. For more information about whether your dentist is contracted with the administrator, call Delta Dental customer service at 1-855-648-1416 (toll free) or 651-768-1416 (local), Monday through Friday, from 7 a.m. to 7 p.m., or call the TTY line at 711 (toll free). You can also call UCare Customer Services. (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 Medicare Advantage network. However, services must be obtained within the United States and its territories. Services rendered by dentists who have opted out or been excluded from Medicare are not eligible for reimbursement. 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 Section D 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 330
Minneapolis, MN 55440-0330

Reimbursement may be delayed if submitted without the required documentation listed above.
<table>
<thead>
<tr>
<th>Services that are covered for you – BASIC SERVICES</th>
<th>What you must pay when you get these services – OPTIONAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Emergency treatment for pain relief (minor procedures).</td>
<td>20% coinsurance on the UCare dental fee schedule.</td>
</tr>
<tr>
<td>• Restoration of lost tooth structure as a result of tooth decay or fracture, when restored with amalgams (silver fillings) or resins (white fillings).</td>
<td></td>
</tr>
<tr>
<td>– 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. <strong>Limitation:</strong> Coverage for the replacement of restorations is provided only after a two (2) year period has elapsed, measured from the last date the covered dental service was performed.</td>
<td></td>
</tr>
<tr>
<td>• Consultation, by a provider other than your current provider, as needed for diagnosis and recommending a treatment plan (such as a second opinion).</td>
<td></td>
</tr>
<tr>
<td>• General anesthesia or intravenous sedation is a separate covered dental service in conjunction with a complex surgical dental covered service.</td>
<td></td>
</tr>
</tbody>
</table>

**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. 20% coinsurance on the UCare dental fee schedule.
<table>
<thead>
<tr>
<th>Services that are covered for you – MAJOR SERVICES</th>
<th>What you must pay when you get these services – OPTIONAL</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Major restorative services</strong></td>
<td>50% coinsurance on the UCare dental fee schedule.</td>
</tr>
<tr>
<td>• Emergency services – major procedures.</td>
<td></td>
</tr>
<tr>
<td>• Crowns. <strong>Limitation:</strong> Benefit for the replacement of a crown or an onlay will be provided only after a five (5) year period, measured from the last date the covered dental service was performed.</td>
<td></td>
</tr>
<tr>
<td>• Cast onlays for treatment of severe carious lesions and severe fracture. <strong>Limitation:</strong> Benefits for the replacement of a crown or an onlay will be provided only after a five (5) year period, measured from the last date the covered dental service was performed.</td>
<td></td>
</tr>
<tr>
<td><strong>Prosthetics: Removable and fixed</strong></td>
<td>50% coinsurance on the UCare dental fee schedule.</td>
</tr>
<tr>
<td>• Bridges, standard partial dentures, and full dentures for the replacement of extracted permanent teeth.</td>
<td></td>
</tr>
<tr>
<td><strong>Exclusion:</strong> Coverage is <strong>not</strong> provided for the following:</td>
<td></td>
</tr>
<tr>
<td>– Replacement of misplaced, lost, or stolen dental prosthetic appliances.</td>
<td></td>
</tr>
<tr>
<td>– Initial installation of a bridge or denture to replace teeth missing prior to coverage.</td>
<td></td>
</tr>
<tr>
<td>– Replacement of teeth congenitally missing.</td>
<td></td>
</tr>
<tr>
<td>• Replacement benefit for prosthetic services: A prosthetic appliance (i.e., bridge or denture) for the purpose of replacing an existing appliance will be covered only after five (5) years, measured from the last date the covered dental service was performed and then only in the event that the existing appliance is not and cannot be made satisfactory. Services necessary to make an appliance satisfactory are covered.</td>
<td></td>
</tr>
</tbody>
</table>
E. Exclusions. While some of the exclusions shown below may be covered services under the terms of the Evidence of Coverage for non-dental services, the following are not covered dental services under this comprehensive dental benefit package:

1. Services rendered by dentists who have opted out or been excluded from Medicare are not eligible for reimbursement.

2. Dental services that are not necessary or specifically covered.

3. Hospitalization or other facility charges.

4. Prescription drugs.

5. Any dental procedure performed solely as a cosmetic procedure.

6. Charges for dental procedures completed prior to your effective date of coverage.

7. Anesthesiologist services.

8. 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.

9. Direct diagnostic surgical or non-surgical treatment procedures applied to jaw joints or muscles, except as provided under Oral Surgery in Section D.

10. Artificial material implanted or grafted into soft tissue, including surgical removal of implants, with exceptions.

11. Oral hygiene instruction and periodontal exam.

12. Services for teeth retained in relation to an overdenture. Overdenture appliances are limited to an allowance for a standard full denture.

13. Any oral surgery that includes surgical endodontics (apicoectomy, retrograde filling) other than that listed under Oral Surgery in Section D.


15. Removable unilateral dentures.


17. Splinting.

18. Consultations by the treating provider and office visits.

19. 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 Classic Choice Dental for more than 24 months.

20. Occlusal analysis, occlusal guards (night guards), and occlusal adjustments (limited and complete).

21. Veneers (bonding of coverings to the teeth).

22. Orthodontic treatment procedures.
Section 2.3  Point-of-Service benefit

Coverage is available for certain covered services provided by out-of-network physicians 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 11 for more information about provider opt-out).

You do not need a referral from your Primary Care Provider before getting services under the Point-of-Service benefit. However, your provider may need to obtain approval in advance from us for those services marked with an asterisk (*) in the Medical Benefits Chart and listed at the beginning of Section 2.1.

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. Therefore, when dialysis services are received outside the service area, the Point-of-Service benefit coinsurance does not apply. 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 out-of-pocket and plan benefit maximum

Under the Point-of-Service benefit, you will pay 20% coinsurance on charges. There is a $10,000 annual member out-of-pocket cost maximum. There is also a $100,000 plan benefit maximum under the Point-of-Service benefit. After you reach this $100,000 plan benefit maximum, you are responsible for any charges for benefits received from out-of-network providers.

These outpatient benefits have the same cost-sharing out-of-network as in-network:

- Primary Care Physician Services
- Occupational Therapy Services
- Physician Specialist Services
- Mental Health Specialty Services
- Podiatry Services
- Psychiatric Services
- Physical Therapy and Speech Therapy Services

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. Non-participating providers can charge more than the Medicare-approved amount, but there is a limit called the “limiting charge” the provider can only charge you up to 15% over the amount that non-participating providers are paid.
<table>
<thead>
<tr>
<th>Services not covered by Medicare</th>
<th>Not covered under any condition</th>
<th>Covered only under specific conditions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Services considered not reasonable and necessary, according to the standards of Original Medicare.</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>Experimental medical and surgical procedures, equipment and medications.</td>
<td></td>
<td>✓</td>
</tr>
<tr>
<td>Experimental procedures and items are those items and procedures determined by our plan and Original Medicare to not be generally accepted by the medical community.</td>
<td></td>
<td>May be covered by Original Medicare under a Medicare-approved clinical research study or by our plan. (See Chapter 3, Section 5 for more information on clinical research studies.)</td>
</tr>
<tr>
<td>Private room in a hospital.</td>
<td></td>
<td>✓</td>
</tr>
<tr>
<td>Personal items in your room at a hospital or a skilled nursing facility, such as a telephone or a television.</td>
<td>✓</td>
<td>Covered only when medically necessary.</td>
</tr>
<tr>
<td>Full-time nursing care in your home.</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>**Custodial care is care provided in a nursing home, hospice, or other facility setting when you do not require skilled medical care or skilled nursing care.</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>Homemaker services include basic household assistance, including light housekeeping or light meal preparation.</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>Fees charged for care by your immediate relatives or members of your household.</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>Services not covered by Medicare</td>
<td>Not covered under any condition</td>
<td>Covered only under specific conditions</td>
</tr>
<tr>
<td>---------------------------------</td>
<td>---------------------------------</td>
<td>--------------------------------------</td>
</tr>
<tr>
<td>Non-routine dental care.</td>
<td></td>
<td>✓ Dental care required to treat illness or injury may be covered as inpatient or outpatient care.</td>
</tr>
<tr>
<td>Routine chiropractic care.</td>
<td></td>
<td>✓ Manual manipulation of the spine to correct a subluxation is covered.</td>
</tr>
<tr>
<td>Routine foot care.</td>
<td></td>
<td>✓ Some limited coverage provided according to Medicare guidelines, e.g., if you have diabetes.</td>
</tr>
<tr>
<td>Home-delivered meals.</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>Orthopedic shoes.</td>
<td></td>
<td>✓ If shoes are part of a leg brace and are included in the cost of the brace, or the shoes are for a person with diabetic foot disease.</td>
</tr>
<tr>
<td>Supportive devices for the feet.</td>
<td></td>
<td>✓ Orthopedic or therapeutic shoes for people with diabetic foot disease.</td>
</tr>
<tr>
<td>Hearing aids, or exams to fit hearing aids.</td>
<td></td>
<td>✓ $500 benefit allowance every 36 months (combined in- and out-of-network). The benefit allowance does not accrue.</td>
</tr>
<tr>
<td>Radial keratotomy, LASIK surgery, and other low vision aids.</td>
<td>✓</td>
<td></td>
</tr>
</tbody>
</table>
CHAPTER 5

Using the plan's coverage for your Part D prescription drugs
SECTION 7
What types of drugs are not covered by the plan? .......................... 121
Section 7.1 Types of drugs we do not cover .............................. 121

SECTION 8
Show your plan membership card when you fill a prescription .......... 122
Section 8.1 Show your membership card .................................. 122
Section 8.2 What if you don’t have your membership card with you? .. 122

SECTION 9
Part D drug coverage in special situations ................................. 122
Section 9.1 What if you’re in a hospital or a skilled nursing facility for a stay that is covered by the plan? ............................... 122
Section 9.2 What if you’re a resident in a long-term care (LTC) facility? .................. 123
Section 9.3 What if you’re also getting drug coverage from an employer or retiree group plan? ........................................... 123
Section 9.4 What if you’re in Medicare-certified hospice? .................. 124

SECTION 10
Programs on drug safety and managing medications .................. 124
Section 10.1 Programs to help members use drugs safely ................. 124
Section 10.2 Drug Management Program (DMP) to help members safely use their opioid medications ...................................... 125
Section 10.3 Medication Therapy Management (MTM) and other programs to help members manage their medications .................. 125
Section 1.2 Basic rules for the plan’s Part D drug coverage

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

- You must have a provider (a doctor, dentist or other prescriber) write your prescription.

- Your prescriber must either accept Medicare or file documentation with CMS showing that he or she is qualified to write prescriptions, or your Part D claim will be denied. You should ask your prescribers the next time you call or visit if they meet this condition. If not, please be aware it takes time for your prescriber to submit the necessary paperwork to be processed.

- You generally must use a network pharmacy to fill your prescription. (See Section 2, Fill your prescriptions at a network pharmacy or through the plan’s mail-order service.)

- Your drug must be on the plan’s List of Covered Drugs (Formulary) (we call it the “Drug List” for short). (See Section 3, Your drugs need to be on the plan’s “Drug List.”)

- Your drug must be used for a medically accepted indication. A “medically accepted indication” is a use of the drug that is either approved by the Food and Drug Administration or supported by certain reference books. (See Section 3 for more information about a medically accepted indication.)

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

Section 2.1 To have your prescription covered, use a network pharmacy

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

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

Our network includes pharmacies that offer standard cost-sharing and pharmacies that offer preferred cost-sharing. You may go to either type of network pharmacy to receive your covered prescription drugs. Your cost-sharing may be less at pharmacies with preferred cost-sharing.

Section 2.2 Finding network pharmacies

How do you find a network pharmacy in your area?

To find a network pharmacy, you can look in your Pharmacy Directory, visit our website (ucare.org), or call Customer Services (phone numbers are printed on the back cover of this booklet).

You may go to any of our network pharmacies. However, your costs may be even less for your covered drugs if you use a network pharmacy that offers preferred cost-sharing rather than a network pharmacy that offers standard cost-sharing. The Pharmacy Directory will tell you which of the network pharmacies
Section 2.3    Using the plan’s mail-order services

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

To get information about filling your prescriptions by mail, call Customer Services.

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

**New prescriptions the pharmacy receives directly from your doctor’s office.** The pharmacy will automatically fill and deliver new prescriptions it receives from health care providers, without checking with you first, if either:

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

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

If you used mail-order in the past and do not want the pharmacy to automatically fill and ship each new prescription, please contact us by calling 1-877-567-6320. TTY users call 1-800-716-3231.

If you have never used our mail-order delivery and/or decide to stop automatic fills of new prescriptions, the pharmacy will contact you each time it gets a new prescription from a health care provider to see if you want the medication filled and shipped immediately. This will give you an opportunity to make sure that the pharmacy is delivering the correct drug (including strength, amount, and form) and, if necessary, allow you to cancel or delay the order before you are billed and it is shipped. It is important that you respond each time you are contacted by the pharmacy, to let them know what to do with the new prescription and to prevent any delays in shipping.

To opt out of automatic deliveries of new prescriptions received directly from your health care provider’s office, please contact us by calling Express Scripts Mail Order Pharmacy at 1-877-567-6320. TTY users call 1-800-716-3231. You may also login to www.express-scripts.com.

**Refills on mail order prescriptions.** For refills, please contact your pharmacy 30 days before you think the drugs you have on hand will run out to make sure your next order is shipped to you in time.

So the pharmacy can reach you to confirm your order before shipping, please make sure to let the pharmacy know the best ways to contact you by calling Express Scripts Customer Service at 1-877-567-6320. TTY users call 1-800-716-3231. You may also login to www.express-scripts.com.
In these situations, please check first with Customer Services to see if there is a network pharmacy nearby. (Phone numbers for Customer Services are printed on the back cover of this booklet.) You may be required to pay the difference between what you pay for the drug at the out-of-network pharmacy and the cost that we would cover at an in-network pharmacy.

How do you ask for reimbursement from the plan?

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

SECTION 3 Your drugs need to be on the plan’s “Drug List”

Section 3.1 The “Drug List” tells which Part D drugs are covered

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

The drugs on this list are selected by the plan with the help of a team of doctors and pharmacists. The list must meet requirements set by Medicare. Medicare has approved the plan’s Drug List.

The drugs on the Drug List are only those covered under Medicare Part D (earlier in this chapter, Section 1.1 explains about Part D drugs).

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

- approved by the Food and Drug Administration. (That is, the Food and Drug Administration has approved the drug for the diagnosis or condition for which it is being prescribed.)
- or — supported by certain reference books. (These reference books are the American Hospital Formulary Service Drug Information; the DRUGDEX Information System; and the USPDI or its successor; and, for cancer, the National Comprehensive Cancer Network and Clinical Pharmacology or their successors.)

The Drug List includes both brand-name and generic drugs

A generic drug is a prescription drug that has the same active ingredients as the brand-name drug. Generally, it works just as well as the brand-name drug and usually costs less. There are generic drug substitutes available for many brand-name drugs.
SECTION 4  There are restrictions on coverage for some drugs

Section 4.1  Why do some drugs have restrictions?

For certain prescription drugs, special rules restrict how and when the plan covers them. A team of doctors and pharmacists developed these rules to help our members use drugs in the most effective ways. These special rules also help control overall drug costs, which keeps your drug coverage more affordable.

In general, our rules encourage you to get a drug that works for your medical condition and is safe and effective. Whenever a safe, lower-cost drug will work just as well medically as a higher-cost drug, the plan’s rules are designed to encourage you and your provider to use that lower-cost option. We also need to comply with Medicare’s rules and regulations for drug coverage and cost-sharing.

If there is a restriction for your drug, it usually means that you or your provider will have to take extra steps in order for us to cover the drug. If you want us to waive the restriction for you, you will need to use the coverage decision process and ask us to make an exception. We may or may not agree to waive the restriction for you. (See Chapter 9, Section 6.2 for information about asking for exceptions.)

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

Section 4.2  What kinds of restrictions?

Our plan uses different types of restrictions to help our members use drugs in the most effective ways. The sections below tell you more about the types of restrictions we use for certain drugs.

Restricting brand name drugs when a generic version is available

Generally, a “generic” drug works the same as a brand name drug and usually costs less. In most cases, when a generic version of a brand name drug is available, our network pharmacies will provide you the generic version. We usually will not cover the brand name drug when a generic version is available. However, if your provider has told us the medical reason that neither the generic drug nor other covered drugs that treat the same condition will work for you, then we will cover the brand name drug. (Your share of the cost may be greater for the brand name drug than for the generic drug.)

Getting plan approval in advance

For certain drugs, you or your provider need to get approval from the plan before we will agree to cover the drug for you. This is called “prior authorization.” Sometimes the requirement for getting approval in advance helps guide appropriate use of certain drugs. If you do not get this approval, your drug might not be covered by the plan.

Trying a different drug first

This requirement encourages you to try less costly but just as effective drugs before the plan covers another drug. For example, if Drug A and Drug B treat the same medical condition, the plan may
There are things you can do if your drug is not covered in the way that you’d like it to be covered. Your options depend on what type of problem you have:

- If your drug is not on the Drug List or if your drug is restricted, go to Section 5.2 to learn what you can do.

- If your drug is in a cost-sharing tier that makes your cost more expensive than you think it should be, go to Section 5.3 to learn what you can do.

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

If your drug is not on the Drug List or is restricted, here are things you can do:

- You may be able to get a temporary supply of the drug (only members in certain situations can get a temporary supply). This will give you and your provider time to change to another drug or to file a request to have the drug covered.

- You can change to another drug.

- You can request an exception and ask the plan to cover the drug or remove restrictions from the drug.

**You may be able to get a temporary supply**

Under certain circumstances, the plan can offer a temporary supply of a drug to you when your drug is not on the Drug List or when it is restricted in some way. Doing this gives you time to talk with your provider about the change in coverage and figure out what to do.

To be eligible for a temporary supply, you must meet the two requirements below:

1. **The change to your drug coverage must be one of the following types of changes:**
   
   - The drug you have been taking is no longer on the plan’s Drug List.
   
   - Or – the drug you have been taking is now restricted in some way (Section 4 in this chapter tells about restrictions).

2. **You must be in one of the situations described below:**

   - For those members who are new or who were in the plan last year:

     We will cover a temporary supply of your drug **during the first 90 days of your membership in the plan if you were new and during the first 90 days of the calendar year if you were in the plan last year**. This temporary supply will be for a maximum of 30 days at a retail pharmacy and 31 days from a long-term care (LTC) facility. If your prescription is written for fewer days, we will allow multiple fills to provide up to a maximum of 30 days at a retail pharmacy and 31 days of medication from a long-term care (LTC) facility. The prescription must be filled at a network pharmacy. (Please note that the long-term care pharmacy may provide the drug in smaller amounts at a time to prevent waste.)
You can ask for an exception

For drugs in Tiers 2 and 3, you and your provider can ask the plan to make an exception in the cost-sharing tier for the drug so that you pay less for it. If your provider says that you have medical reasons that justify asking us for an exception, your provider can help you request an exception to the rule.

If you and your provider want to ask for an exception, Chapter 9, Section 6.4 tells what to do. It explains the procedures and deadlines that have been set by Medicare to make sure your request is handled promptly and fairly.

Drugs in our Tier 4 – Specialty Tier are not eligible for this type of exception. We do not lower the cost-sharing amount for drugs in this tier.

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

Section 6.1  The Drug List can change during the year

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

- **Add or remove drugs from the Drug List.** New drugs become available, including new generic drugs. Perhaps the government has given approval to a new use for an existing drug. Sometimes, a drug gets recalled and we decide not to cover it. Or we might remove a drug from the list because it has been found to be ineffective.

- **Move a drug to a higher or lower cost-sharing tier.**

- **Add or remove a restriction on coverage for a drug** (for more information about restrictions to coverage, see Section 4 in this chapter).

- **Replace a brand-name drug with a generic drug.**

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

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

**Information on changes to drug coverage**

When changes to the Drug List occur during the year, we post information on our website about those changes. We will update our online Drug List on a regularly scheduled basis to include any changes that have occurred after the last update. Below we point out the times that you would get direct notice if changes are made to a drug that you are then taking. You can also call Customer Services for more information (phone numbers are printed on the back cover of this booklet).

**Do changes to your drug coverage affect you right away?**

Changes that can affect you this year: In the below cases, you will be affected by the coverage changes during the current year:
If any of these changes happen for a drug you are taking (but not because of a market withdrawal, a generic drug replacing a brand name drug, or other change noted in the sections above), then the change won’t affect your use or what you pay as your share of the cost until January 1 of the next year. Until that date, you probably won’t see any increase in your payments or any added restriction to your use of the drug. You will not get direct notice this year about changes that do not affect you. However, on January 1 of the next year, the changes will affect you, and it is important to check the new year’s Drug List for any changes to drugs.

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

Section 7.1  Types of drugs we do not cover

This section tells you what kinds of prescription drugs are “excluded.” This means Medicare does not pay for these drugs.

If you get drugs that are excluded, you must pay for them yourself. We won’t pay for the drugs that are listed in this section. The only exception: If the requested drug is found upon appeal to be a drug that is not excluded under Part D and we should have paid for or covered it because of your specific situation. (For information about appealing a decision we have made to not cover a drug, go to Chapter 9, Section 6.5 in this booklet.)

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

- Our plan’s Part D drug coverage cannot cover a drug that would be covered under Medicare Part A or Part B.

- Our plan cannot cover a drug purchased outside the United States and its territories.

- Our plan usually cannot cover off-label use. “Off-label use” is any use of the drug other than those indicated on a drug’s label as approved by the Food and Drug Administration.

  - Generally, coverage for “off-label use” is allowed only when the use is supported by certain reference books. These reference books are the American Hospital Formulary Service Drug Information, the DRUGDEX Information System, for cancer, the National Comprehensive Cancer Network and Clinical Pharmacology, or their successors. If the use is not supported by any of these reference books, then our plan cannot cover its “off-label use.”

Also, by law, these categories of drugs are not covered by Medicare drug plans:

- Non-prescription drugs (also called over-the-counter drugs).

- Drugs when used to promote fertility.

- Drugs when used for the relief of cough or cold symptoms.

- Drugs when used for cosmetic purposes or to promote hair growth.

- Prescription vitamins and mineral products, except prenatal vitamins and fluoride preparations.

- Drugs when used for the treatment of sexual or erectile dysfunction.
Please note: When you enter, live in, or leave a skilled nursing facility, you are entitled to a Special Enrollment Period. During this time period, you can switch plans or change your coverage. (Chapter 10, *Ending your membership in the plan*, tells when you can leave our plan and join a different Medicare plan.)

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

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

Check your *Pharmacy Directory* to find out if your long-term care facility’s pharmacy is part of our network. If it isn’t, or if you need more information, please contact Customer Services (phone numbers are printed on the back cover of this booklet).

**What if you’re a resident in a long-term care (LTC) facility and become a new member of the plan?**

If you need a drug that is not on our Drug List or is restricted in some way, the plan will cover a temporary supply of your drug during the first 90 days of your membership. The total supply will be for a maximum of 31 days, or less if your prescription is written for fewer days. (Please note that the long-term care (LTC) pharmacy may provide the drug in smaller amounts at a time to prevent waste.) If you have been a member of the plan for more than 90 days and need a drug that is not on our Drug List or if the plan has any restriction on the drug’s coverage, we will cover one 31-day supply, or less if your prescription is written for fewer days.

During the time when you are getting a temporary supply of a drug, you should talk with your provider to decide what to do when your temporary supply runs out. Perhaps there is a different drug covered by the plan that might work just as well for you. Or you and your provider can ask the plan to make an exception for you and cover the drug in the way you would like it to be covered. If you and your provider want to ask for an exception, Chapter 9, Section 6.4 tells what to do.

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

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

In general, if you are currently employed, the prescription drug coverage you get from us will be secondary to your employer or retiree group coverage. That means your group coverage would pay first.

**Special note about ‘creditable coverage’:**

Each year your employer or retiree group should send you a notice that tells if your prescription drug coverage for the next calendar year is “creditable” and the choices you have for drug coverage.
• Prescriptions written for drugs that have ingredients you are allergic to.

• Possible errors in the amount (dosage) of a drug you are taking.

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

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

We have a program that can help make sure our members safely use their prescription opioid medications, or other medications that are frequently abused. This program is called a Drug Management Program (DMP). If you use opioid medications that you get from several doctors or pharmacies, we may talk to your doctors to make sure your use is appropriate and medically necessary. Working with your doctors, if we decide you are at risk for misusing or abusing your opioid or benzodiazepine medications, we may limit how you can get those medications. The limitations may be:

• Requiring you to get all your prescriptions for opioid or benzodiazepine medications from one pharmacy

• Requiring you to get all your prescriptions for opioid or benzodiazepine medications from one doctor

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

If we decide that one or more of these limitations should apply to you, we will send you a letter in advance. The letter will have information explaining the terms of the limitations we think should apply to you. You will also have an opportunity to tell us which doctors or pharmacies you prefer to use. If you think we made a mistake or you disagree with our determination that you are at-risk for prescription drug abuse or the limitation, you and your prescriber have the right to ask us for an appeal. See Chapter 9 for information about how to ask for an appeal.

The DMP may not apply to you if you have certain medical conditions, such as cancer, or you are receiving hospice care or live in a long-term care facility.

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

We have programs that can help our members with complex health needs. For example, some members have several medical conditions, take different drugs at the same time, and have high drug costs.

These programs are voluntary and free to members. A team of pharmacists and doctors developed the programs for us. The programs can help make sure that our members get the most benefit from the drugs they take. One program is called a Medication Therapy Management (MTM) program. Some members who take medications for different medical conditions may be able to get services through an MTM program. A pharmacist or other health professional will give you a comprehensive review of all your medications. You can talk about how best to take your medications, your costs, and any problems or questions you have about your prescription and over-the-counter medications. You’ll get a written summary of this discussion. The summary has a medication action plan that recommends what you can do to make the best use of your medications, with space for you to take notes or write down any follow-up questions. You’ll also get a personal medication list that will include all the medications you’re taking and why you take them.
CHAPTER 6

What you pay for your Part D prescription drugs
SECTION 7  During the Catastrophic Coverage Stage, the plan pays most of the cost for your drugs ................................................................. 141

Section 7.1 Once you are in the Catastrophic Coverage Stage, you will stay in this stage for the rest of the year................................................................. 141

SECTION 8  What you pay for vaccinations covered by Part D depends on how and where you get them................................................................. 141

Section 8.1 Our plan may have separate coverage for the Part D vaccine medication itself and for the cost of giving you the vaccine ......................... 141

Section 8.2 You may want to call us at Customer Services before you get a vaccination ..... 143
• **Chapter 5 of this booklet.** Chapter 5 gives the details about your prescription drug coverage, including rules you need to follow when you get your covered drugs. Chapter 5 also tells which types of prescription drugs are not covered by our plan.

• **The plan’s Pharmacy Directory.** In most situations you must use a network pharmacy to get your covered drugs (see Chapter 5 for the details). The *Pharmacy Directory* has a list of pharmacies in the plan’s network. It also tells you which pharmacies in our network can give you a long-term supply of a drug (such as filling a prescription for a three-month’s supply).

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

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. The amount that you pay for a drug is called “cost-sharing” and there are three ways you may be asked to pay.

• The **deductible** is the amount you must pay for drugs before our plan begins to pay its share.

• **Copayment** means that you pay a fixed amount each time you fill a prescription.

• **Coinsurance** means that you pay a percent of the total cost of the drug each time you fill a prescription.
SECTION 3  We send you reports that explain payments for your drugs and which payment stage you are in

Section 3.1  We send you a monthly report called the “Part D Explanation of Benefits” (the “Part D EOB”)

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

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

Our plan will prepare a written report called the Part D Explanation of Benefits (it is sometimes called the “Part D EOB”) when you have had one or more prescriptions filled through the plan during the previous month. It includes:

- **Information for that month.** This report gives the payment details about the prescriptions you have filled during the previous month. It shows the total drug costs, what the plan paid, and what you and others on your behalf paid.

- **Totals for the year since January 1.** This is called “year-to-date” information. It shows you the total drug costs and total payments for your drugs since the year began.

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

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

- **Show your membership card when you get a prescription filled.** To make sure we know about the prescriptions you are filling and what you are paying, show your plan membership card every time you get a prescription filled.

- **Make sure we have the information we need.** There are times you may pay for prescription drugs when we will not automatically get the information we need to keep track of your out-of-pocket costs. To help us keep track of your out-of-pocket costs, you may give us copies of receipts for drugs that you have purchased. (If you are billed for a covered drug, you can ask our plan to pay our share of the cost. For instructions on how to do this, go to Chapter 7, Section 2 of this booklet.) Here are some types of situations when you may want to give us copies of your drug receipts to be sure we have a complete record of what you have spent for your drugs:
  - When you purchase a covered drug at a network pharmacy at a special price or using a discount card that is not part of our plan’s benefit.
  - When you made a copayment for drugs that are provided under a drug manufacturer patient assistance program.
SECTION 5  During the Initial Coverage Stage, the plan pays its share of your drug costs and you pay your share

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

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

The plan has four cost-sharing tiers
Every drug on the plan’s Drug List is in one of four cost-sharing tiers. In general, the higher the cost-sharing tier number, the higher your cost for the drug:

- Cost-sharing Tier 1 – Generic drugs (lowest tier)
- Cost-sharing Tier 2 – Preferred brand drugs
- Cost-sharing Tier 3 – Non-preferred drugs
- Cost-sharing Tier 4 – Specialty Tier (highest tier)

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

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

- A network retail pharmacy that offers standard cost-sharing
- A network retail pharmacy that offers preferred cost-sharing
- A pharmacy that is not in the plan’s network
- The plan’s mail-order pharmacy

For more information about these pharmacy choices and filling your prescriptions, see Chapter 5 in this booklet and the plan’s Pharmacy Directory.

Generally, we will cover your prescriptions only if they are filled at one of our network pharmacies. Some of our network pharmacies also offer preferred cost-sharing. You may go to either network pharmacies that offer preferred cost-sharing or other network pharmacies that offer standard cost-sharing to receive your covered prescription drugs. Your costs may be less at pharmacies that offer preferred cost-sharing.
Section 5.3  If your doctor prescribes less than a full month's supply, you may not have to pay the cost of the entire month's supply

Typically, the amount you pay for a prescription drug covers a full month's supply of a covered drug. However, your doctor can prescribe less than a month's supply of drugs. There may be times when you want to ask your doctor about prescribing less than a month's supply of a drug (for example, when you are trying a medication for the first time that is known to have serious side effects). If your doctor prescribes less than a full month's supply, you will not have to pay for the full month's supply for certain drugs.

The amount you pay when you get less than a full month's supply will depend on whether you are responsible for paying coinsurance (a percentage of the total cost) or a copayment (a flat dollar amount).

- If you are responsible for coinsurance, you pay a percentage of the total cost of the drug. You pay the same percentage regardless of whether the prescription is for a full month's supply or for fewer days. However, because the entire drug cost will be lower if you get less than a full month's supply, the amount you pay will be less.

- If you are responsible for a copayment for the drug, your copay will be based on the number of days of the drug that you receive. We will calculate the amount you pay per day for your drug (the "daily cost-sharing rate") and multiply it by the number of days of the drug you receive.

  - Here's an example: Let's say the copay for your drug for a full month's supply (a 30-day supply) is $30. This means that the amount you pay per day for your drug is $1. If you receive a 7 days' supply of the drug, your payment will be $1 per day multiplied by 7 days, for a total payment of $7.

Daily cost-sharing allows you to make sure a drug works for you before you have to pay for an entire month's supply. You can also ask your doctor to prescribe, and your pharmacist to dispense, less than a full month's supply of a drug or drugs, if this will help you better plan refill dates for different prescriptions so that you can take fewer trips to the pharmacy. The amount you pay will depend upon the days' supply you receive.

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

For some drugs, you can get a long-term supply (also called an "extended supply") when you fill your prescription. A long-term supply is up to a 90-day supply. (For details on where and how to get a long-term supply of a drug, see Chapter 5, Section 2.4.)

The table below shows what you pay when you get a long-term up to a 90-day supply of a drug.

- Please note: If your covered drug costs are less than the copayment amount listed in the chart, you will pay that lower price for the drug. You pay either the full price of the drug or the copayment amount, whichever is lower.
SECTION 6  During the Coverage Gap Stage, you receive a discount on brand-name drugs and pay no more than 37% of the costs of generic drugs

Section 6.1  You stay in the Coverage Gap Stage until your out-of-pocket costs reach $5,100

When you are in the Coverage Gap Stage, the Medicare Coverage Gap Discount Program provides manufacturer discounts on brand-name drugs. You pay 25% of the negotiated price and a portion of the dispensing fee for brand-name drugs. Both the amount you pay and the amount discounted by the manufacturer count toward your out-of-pocket costs as if you had paid them and moves you through the coverage gap.

You also receive some coverage for generic drugs. You pay no more than 37% of the cost for Tier 4 generic drugs and the plan pays the rest. For generic drugs, the amount paid by the plan (63%) does not count toward your out-of-pocket costs. Only the amount you pay counts and moves you through the coverage gap.

You continue paying the discounted price for brand-name drugs and no more than 37% of the costs of generic drugs until your yearly out-of-pocket payments reach a maximum amount that Medicare has set. In 2019, that amount is $5,100.

Medicare has rules about what counts and what does not count as your out-of-pocket costs. When you reach an out-of-pocket limit of $5,100, you leave the Coverage Gap Stage and move on to the Catastrophic Coverage Stage.

Section 6.2  How Medicare calculates your out-of-pocket costs for prescription drugs

Here are Medicare’s rules that we must follow when we keep track of your out-of-pocket costs for your drugs.

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

When you add up your out-of-pocket costs, you can include the payments listed below (as long as they are for Part D covered drugs and you followed the rules for drug coverage that are explained in Chapter 5 of this booklet):

- The amount you pay for drugs when you are in any of the following drug payment stages:
  - The Deductible Stage
  - The Initial Coverage Stage
  - The Coverage Gap Stage
- Any payments you made during this calendar year as a member of a different Medicare prescription drug plan before you joined our plan.
• When you reach a total of $5,100 in out-of-pocket costs for the year, this report will tell you that you have left the Coverage Gap Stage and have moved on to the Catastrophic Coverage Stage.

• **Make sure we have the information we need.** Section 3.2 tells what you can do to help make sure that our records of what you have spent are complete and up to date.

**SECTION 7  During the Catastrophic Coverage Stage, the plan pays most of the cost for your drugs**

**Section 7.1** Once you are in the Catastrophic Coverage Stage, you will stay in this stage for the rest of the year

You qualify for the Catastrophic Coverage Stage when your out-of-pocket costs have reached the $5,100 limit for the calendar year. Once you are in the Catastrophic Coverage Stage, you will stay in this payment stage until the end of the calendar year.

During this stage, the plan will pay most of the cost for your drugs.

• **Your share** of the cost for a covered drug will be either coinsurance or a copayment, whichever is the *larger* amount:
  
  – either – coinsurance of 5% of the cost of the drug
  
  – or – $3.40 for a generic drug or a drug that is treated like a generic and $8.50 for all other drugs.

• **Our plan pays the rest** of the cost.

**SECTION 8  What you pay for vaccinations covered by Part D depends on how and where you get them**

**Section 8.1** Our plan may have separate coverage for the Part D vaccine medication itself and for the cost of giving you the vaccine

Our plan provides coverage for a number of Part D vaccines. We also cover vaccines that are considered medical benefits. You can find out about coverage of these vaccines by going to the Medical Benefits Chart in Chapter 4, Section 2.1.

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

• The first part of coverage is the cost of the vaccine medication itself. The vaccine is a prescription medication.

• The second part of coverage is for the cost of giving you the vaccine. (This is sometimes called the “administration” of the vaccine.)
Situation 3: You buy the Part D vaccine at your pharmacy, and then take it to your doctor’s office where they give you the vaccine.

- You will have to pay the pharmacy the amount of your coinsurance or copayment for the vaccine itself.
- When your doctor gives you the vaccine, you will pay the entire cost for this service. You can then ask our plan to pay our share of the cost by using the procedures described in Chapter 7 of this booklet.
- You will be reimbursed the amount charged by the doctor for administering the vaccine less any difference between the amount the doctor charges and what we normally pay. (If you get “Extra Help,” we will reimburse you for this difference.)

Section 8.2 You may want to call us at Customer Services before you get a vaccination

The rules for coverage of vaccinations are complicated. We are here to help. We recommend that you call us first at Customer Services whenever you are planning to get a vaccination. (Phone numbers for Customer Services are printed on the back cover of this booklet.)

- We can tell you about how your vaccination is covered by our plan and explain your share of the cost.
- We can tell you how to keep your own cost down by using providers and pharmacies in our network.
- If you are not able to use a network provider and pharmacy, we can tell you what you need to do to get payment from us for our share of the cost.
CHAPTER 7

Asking us to pay our share of a bill you have received for covered medical services or drugs
SECTION 1 Situations in which you should ask us to pay our share of the cost of your covered services or drugs

Section 1.1 If you pay our plan’s share of the cost of your covered services or drugs, or if you receive a bill, you can ask us for payment

Sometimes when you get medical care or a prescription drug, you may need to pay the full cost right away. Other times, you may find that you have paid more than you expected under the coverage rules of the plan. In either case, you can ask our plan to pay you back (paying you back is often called “reimbursing” you). It is your right to be paid back by our plan whenever you’ve paid more than your share of the cost for medical services or drugs that are covered by our plan.

There may also be times when you get a bill from a provider for the full cost of medical care you have received. In many cases, you should send this 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.

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 services from any provider, whether or not the provider is a part of our network. When you receive emergency or urgently needed services from a provider who is not part of our network, you are only responsible for paying your share of the cost, not for the entire cost. You should ask the provider to bill the plan for our share of the cost.

   • If you pay the entire amount yourself at the time you receive the care, you need to 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.

   • At times 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 services covered by our plan. 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. For more information about “balance billing,” go to Chapter 4, Section 1.3.
7. When you are asking us to pay our share of the cost for eyewear

UCare will pay for part of the cost for some types of eyewear, the benefit limits are explained in the Medical Benefits Chart in Chapter 4. After you pay the entire purchase amount for your eyewear, send us a copy of your receipt and ask us to pay you back for our share of the cost.

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 9 of this booklet (*What to do if you have a problem or complaint (coverage decisions, appeals, complaints)*) 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

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Section 2.1  How and where to send us your request for payment

Send us your request for payment, along with 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.

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](http://ucare.org)) or call Customer Services and ask for the form. (Phone numbers for Customer Services are printed on the back cover of this booklet.)

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

For medical payment requests:

UCare  
**Attn: DMR Department**  
P.O. Box 52  
Minneapolis, MN 55440-0052

For prescription drug payment requests:

Express Scripts  
**Attn: Medicare Part D**  
P.O. Box 14718  
Lexington, KY 40512-4718

Contact Customer Services if you have any questions (phone numbers are printed on the back cover of this booklet). If you don’t know what you should have paid, or you receive bills and you don’t know what to do about those bills, we can help. You can also call if you want to give us more information about a request for payment you have already sent to us.
SECTION 4 Other situations in which you should save your receipts and send copies to us

Section 4.1 In some cases, you should send copies of your receipts to us to help us track your out-of-pocket drug costs

There are some situations when you should let us know about payments you have made for your drugs. In these cases, you are not asking us for payment. Instead, you are telling us about your payments so that we can calculate your out-of-pocket costs correctly. This may help you to qualify for the Catastrophic Coverage Stage more quickly.

Here are two situations when you should send us copies of receipts to let us know about payments you have made for your drugs:

1. **When you buy the drug for a price that is lower than our price**

   Sometimes when you are in the Deductible Stage and Coverage Gap Stage you can buy your drug at a network pharmacy for a price that is lower than our price.

   - For example, a pharmacy might offer a special price on the drug. Or you may have a discount card that is outside our benefit that offers a lower price.

   - Unless special conditions apply, you must use a network pharmacy in these situations and your drug must be on our Drug List.

   - Save your receipt and send a copy to us so that we can have your out-of-pocket expenses count toward qualifying you for the Catastrophic Coverage Stage.

   - **Please note:** If you are in the Deductible Stage and Coverage Gap Stage, we may not pay for any share of these drug costs. But sending a copy of the receipt allows us to calculate your out-of-pocket costs correctly and may help you qualify for the Catastrophic Coverage Stage more quickly.

2. **When you get a drug through a patient assistance program offered by a drug manufacturer**

   Some members are enrolled in a patient assistance program offered by a drug manufacturer that is outside the plan benefits. If you get any drugs through a program offered by a drug manufacturer, you may pay a copayment to the patient assistance program.

   - Save your receipt and send a copy to us so that we can have your out-of-pocket expenses count toward qualifying you for the Catastrophic Coverage Stage.

   - **Please note:** Because you are getting your drug through the patient assistance program and not through the plan’s benefits, we will not pay for any share of these drug costs. But sending a copy of the receipt allows us to calculate your out-of-pocket costs correctly and may help you qualify for the Catastrophic Coverage Stage more quickly.

Since you are not asking for payment in the two cases described above, these situations are not considered coverage decisions. Therefore, you cannot make an appeal if you disagree with our decision.
CHAPTER 8

Your rights and responsibilities
SECTION 1 Our plan must honor your rights as a member of the plan

Section 1.1 We must provide information in a way that works for you
(in languages other than English, in Braille, in large print,
or other alternate formats, etc.)

To get information from us in a way that works for you, please call Customer Services (phone numbers are printed on the back cover of this booklet).

Our plan has people and free interpreter services available to answer questions from disabled and 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 Services (phone numbers are printed on the back cover of this booklet) or contact our Civil Rights Coordinator.

If you have any trouble getting information from our plan in a format that is accessible and appropriate for you, please call to file a grievance with Customer Services. 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. Contact information is included in this Evidence of Coverage or with this mailing, or you may contact Customer Services for additional information.

Section 1.2 We must treat you with fairness and respect at all times

Our plan must obey laws that protect you from discrimination or unfair treatment. We do not discriminate based on a person’s race, ethnicity, national origin, religion, gender, age, mental or physical disability, health status, claims experience, medical history, genetic information, evidence of insurability, or geographic location within the service area.

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.

If you have a disability and need help with access to care, please call us at Customer Services (phone numbers are printed on the back cover of this booklet). If you have a complaint, such as a problem with wheelchair access, Customer Services can help.

Section 1.3 We must ensure that you get timely access to your covered services and drugs

As a member of our plan, you have the right to choose a primary care provider (PCP) in the plan’s network to provide and arrange for your covered services (Chapter 3 explains more about this). Call Customer Services to learn which doctors are accepting new patients (phone numbers are printed on the back cover of this booklet). We do not require you to get referrals to go to network providers.

As a plan member, 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
Section 1.5  We must give you information about the plan, its network of providers, and your covered services

As a member of our plan, you have the right to get several kinds of information from us. (As explained above in Section 1.1, you have the right to get information from us in a way that works for you. This includes getting the information in languages other than English and in large print or other alternate formats.)

If you want any of the following kinds of information, please call Customer Services (phone numbers are printed on the back cover of this booklet):

• **Information about our plan.** This includes, for example, information about the plan’s financial condition. It also includes information about the number of appeals made by members and the plan’s performance ratings, including how it has been rated by plan members and how it compares to other Medicare health plans.

• **Information about our network providers including our network pharmacies.**
  - For example, you have the right to get information from us about the qualifications of the providers and pharmacies in our network and how we pay the providers in our network.
  - For a list of the providers in the plan’s network, see the Provider Directory.
  - For a list of the pharmacies in the plan’s network, see the Pharmacy Directory.
  - For more detailed information about our providers or pharmacies, you can call Customer Services (phone numbers are printed on the back cover of this booklet) or visit our website at ucare.org.

• **Information about your coverage and the rules you must follow when using your coverage.**
  - In Chapters 3 and 4 of this booklet, we explain what medical services are covered for you, any restrictions to your coverage, and what rules you must follow to get your covered medical services.
  - To get the details on your Part D prescription drug coverage, see Chapters 5 and 6 of this booklet plus the plan’s List of Covered Drugs (Formulary). These chapters, together with the List of Covered Drugs (Formulary), tell you what drugs are covered and explain the rules you must follow and the restrictions to your coverage for certain drugs.
  - If you have questions about the rules or restrictions, please call Customer Services (phone numbers are printed on the back cover of this booklet).

• **Information about why something is not covered and what you can do about it.**
  - If a medical service or Part D drug is not covered for you, or if your coverage is restricted in some way, you can ask us for a written explanation. You have the right to this explanation even if you received the medical service or drug from an out-of-network provider or pharmacy.
  - If you are not happy or if you disagree with a decision we make about what medical care or Part D drug 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 9 of this booklet. It gives you the details about how to make an appeal if you want us to change our decision. (Chapter 9 also tells about how to make a complaint about quality of care, waiting times, and other concerns.)
The legal documents that you can use to give your directions in advance in these situations are called "advance directives." There are different types of advance directives and different names for them. Documents called "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.** If you want to have an advance directive, you can get a 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. You can also contact Customer Services to ask for the forms (phone numbers are printed on the back cover of this booklet).

- **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 as the one to make decisions for you if you can’t. You may want to give copies to close friends or family members as well. Be sure to 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.**

- If you are admitted to the hospital, they 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 toll free 1-800-369-7994.

If you believe that a health plan did not follow the advance directive requirements, you may file a complaint with the Minnesota Health Information Clearinghouse at 651-201-5178 or 1-800-657-3793.

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Section 1.7 You have the right to make complaints and to ask us to reconsider decisions we have made

If you have any problems or concerns about your covered services or care, Chapter 9 of this booklet tells what you can do. It gives the details about how to deal with all types of problems and complaints. What you need to do to follow up on a problem or concern depends on the situation. You might need to ask our plan to make a coverage decision for you, make an appeal to us to change a coverage decision, or make a complaint. Whatever you do – ask for a coverage decision, make an appeal, or make a complaint – we are required to treat you fairly.
• Get familiar with your covered services and the rules you must follow to get these covered services. Use this Evidence of Coverage booklet 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, including what is covered, what is not covered, rules to follow, and what you pay.
  
  – Chapters 5 and 6 give the details about your coverage for Part D prescription drugs.

• If you have any other health insurance coverage or prescription drug coverage in addition to our plan, you are required to tell us. Please call Customer Services to let us know (phone numbers are printed on the back cover of this booklet).
  
  – We are required to follow rules set by Medicare to make sure that you are using all of your coverage in combination when you get your covered services from our plan. This is called “coordination of benefits” because it involves coordinating the health and drug benefits you get from our plan with any other health and drug benefits available to you. We’ll help you coordinate your benefits. (For more information about coordination of benefits, go to Chapter 1, Section 10.)

• 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 or Part D prescription drugs.

• Help your doctors and other providers help you by giving them information, asking questions, and following through on your care.
  
  – To help your doctors and other health providers give you the best care, learn as much as you are able to about your health problems and give them the information they need about you and your health. Follow the treatment plans and instructions that you and your doctors agree upon.
  
  – 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. Your doctors and other health care providers are supposed to explain things in a way you can understand. If you ask a question and you don’t understand the answer you are given, ask again.

• 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 to continue being a member of our plan.
  
  – In order to be eligible for our plan, you must have Medicare Part A and Medicare Part B. Some plan members must pay a premium for Medicare Part A. Most plan members must pay a premium for Medicare Part B to remain a member of the plan.
  
  – For most of your medical services or drugs covered by the plan, you must pay your share of the cost when you get the service or drug. This will be a copayment (a fixed amount) or coinsurance (a percentage of the total cost). Chapter 4 tells what you must pay for your medical services. Chapter 6 tells what you must pay for your Part D prescription drugs.
CHAPTER 9

What to do if you have a problem or complaint (coverage decisions, appeals, complaints)
Section 6.2  What is an exception? ................................................................. 180
Section 6.3  Important things to know about asking for exceptions .......... 182
Section 6.4  Step-by-step: How to ask for a coverage decision, including an exception.............. 182
Section 6.5  Step-by-step: How to make a Level 1 Appeal (how to ask for a review of a coverage decision made by our plan) ................. 185
Section 6.6  Step-by-step: How to make a Level 2 Appeal ......................... 187

SECTION 7  How to ask us to cover a longer inpatient hospital stay if you think the doctor is discharging you too soon ................................................. 189
Section 7.1  During your inpatient hospital stay, you will get a written notice from Medicare that tells about your rights ................................................. 190
Section 7.2  Step-by-step: How to make a Level 1 Appeal to change your hospital discharge date ................................................................. 191
Section 7.3  Step-by-step: How to make a Level 2 Appeal to change your hospital discharge date ................................................................. 193
Section 7.4  What if you miss the deadline for making your Level 1 Appeal? ........ 194

SECTION 8  How to ask us to keep covering certain medical services if you think your coverage is ending too soon ..................................................... 196
Section 8.1  This section is about three services only: Home health care, skilled nursing facility care, and Comprehensive Outpatient Rehabilitation Facility (CORF) services ................................. 196
Section 8.2  We will tell you in advance when your coverage will be ending ................................................................. 197
Section 8.3  Step-by-step: How to make a Level 1 Appeal to have our plan cover your care for a longer time ................................................................. 197
Section 8.4  Step-by-step: How to make a Level 2 Appeal to have our plan cover your care for a longer time ................................................................. 199
Section 8.5  What if you miss the deadline for making your Level 1 Appeal? ........ 200

SECTION 9  Taking your appeal to Level 3 and beyond ................................................. 203
Section 9.1  Levels of Appeal 3, 4, and 5 for Medical Service Appeals ................. 203
Section 9.2  Levels of Appeal 3, 4, and 5 for Part D Drug Appeals ...................... 204

MAKING COMPLAINTS ................................................................................. 206

SECTION 10  How to make a complaint about quality of care, waiting times, customer service, or other concerns ............................................................. 206
Section 10.1  What kinds of problems are handled by the complaint process? ........ 206
Section 10.2  The formal name for “making a complaint” is “filing a grievance” .......... 207
Section 10.3  Step-by-step: Making a complaint ............................................... 207
Section 10.4  You can also make complaints about quality of care to the Quality Improvement Organization ................................................................. 209
Section 10.5  You can also tell Medicare about your complaint ......................... 210
Get help from an independent government organization

We are always available to help you. But in some situations you may also want help or guidance from someone who is not connected with us. You can always contact your State Health Insurance Assistance Program (SHIP). This government program has trained counselors in every state. 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 in Chapter 2, Section 3 of this booklet.

You can also get help and information from Medicare

For more information and help in handling a problem, you can also contact Medicare. Here are two ways to get information directly from 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 visit the Medicare website (https://www.medicare.gov).

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

Section 3.1  Should you use the process for coverage decisions and appeals?  Or should you use the process for making complaints?

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.

To figure out which part of this chapter will help with your specific problem or concern, START HERE:

Is your problem or concern about your benefits or coverage?

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

Yes. My problem is about benefits or coverage.

Go on to the next section of this chapter, Section 4, “A guide to the basics of coverage decisions and appeals.”

No. My problem is not about benefits or coverage.

Skip ahead to Section 10 at the end of this chapter: “How to make a complaint about quality of care, waiting times, customer service or other concerns.”
- To get free help from an independent organization that is not connected with our plan, contact your State Health Insurance Assistance Program (see Section 2 of this chapter).

- Your doctor can make a request for you.
  - For medical care, 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. To request any appeal after Level 2, your doctor must be appointed as your representative.
  - For Part D prescription drugs, your doctor or other prescriber can request a coverage decision or a Level 1 or Level 2 Appeal on your behalf. To request any appeal after Level 2, your doctor or other prescriber must be appointed as your representative.

- 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.
  - There may be someone who is already legally authorized to act as your representative under State law.
  - If you want a friend, relative, your doctor or other provider, or other person to be your representative, call Customer Services (phone numbers are printed on the back cover of this booklet) and ask for the “Appointment of Representative” form. (The form is also available on Medicare’s website at https://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/downloads/cms1696.pdf. 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.

- You also have the right to hire a lawyer to act for you. 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 four different types of situations that involve coverage decisions and appeals. Since each situation has different rules and deadlines, we give the details for each one in a separate section:

- Section 5 of this chapter: “Your medical care: How to ask for a coverage decision or make an appeal”

- Section 6 of this chapter: “Your Part D prescription drugs: How to ask for a coverage decision or make an appeal”

- Section 7 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 8 of this chapter: “How to ask us to keep covering certain medical services if you think your coverage is ending too soon” (Applies to these services only: home health care, skilled nursing facility care, and Comprehensive Outpatient Rehabilitation Facility (CORF) services)

If you’re not sure which section you should be using, please call Customer Services (phone numbers are printed on the back cover of this booklet). You can also get help or information from government
Which of these situations are you in?

<table>
<thead>
<tr>
<th>If you are in this situation:</th>
<th>This is what you can do:</th>
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<tbody>
<tr>
<td>Do you want to find out whether we will cover the medical care or services you want?</td>
<td>You can ask us to make a coverage decision for you. Go to the next section of this chapter, Section 5.2.</td>
</tr>
<tr>
<td>Have we already told you that we will not cover or pay for a medical service in the way that you want it to be covered or paid for?</td>
<td>You can make an appeal. (This means you are asking us to reconsider.) Skip ahead to Section 5.3 of this chapter.</td>
</tr>
<tr>
<td>Do you want to ask us to pay you back for medical care or services you have already received and paid for?</td>
<td>You can send us the bill. Skip ahead to Section 5.5 of this chapter.</td>
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Section 5.2   Step-by-step: How to ask for a coverage decision (how to ask our plan to authorize or provide the medical care coverage you want)

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<tr>
<th>Legal Terms</th>
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<tr>
<td>When a coverage decision involves your medical care, it is called an “organization determination.”</td>
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Step 1: You ask our plan to make a coverage decision on the medical care you are requesting. If your health requires a quick response, you should ask us to make a “fast coverage decision.”

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<th>Legal Terms</th>
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<tr>
<td>A “fast coverage decision” is called an “expedited determination.”</td>
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</table>

How to request coverage for the medical care you want

- 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.

- For the details on how to contact us, go to Chapter 2, Section 1 and look for the section called, How to contact us when you are asking for a coverage decision about your medical care.

Generally we use the standard deadlines for giving you our decision

When we give you our decision, we will use the “standard” deadlines unless we have agreed to use the “fast” deadlines. A standard coverage decision means we will give you an answer within 14 calendar days after we receive your request.
If you believe we should not take extra days, you can file a “fast complaint” about our decision to take extra days. When you file a fast complaint, we will give you an answer to your complaint within 24 hours. (For more information about the process for making complaints, including fast complaints, see Section 10 of this chapter.)

If we do not give you our answer within 72 hours (or if there is an extended time period, by the end of that period), you have the right to appeal. Section 5.3 below tells how to make an appeal.

- **If our answer is yes to part or all of what you requested**, we must authorize or provide the medical care coverage we have agreed to provide within 72 hours after we received your request. If we extended the time needed to make our coverage decision, we will authorize or provide the coverage by the end of that extended period.

- **If our answer is no to part or all of what you requested**, we will send you a detailed written explanation as to why we said no.

**Deadlines for a “standard coverage decision”**

- Generally, for a standard coverage decision, we will give you our answer within 14 calendar days of receiving your request.
  - We can take up to 14 more calendar days (“an extended time period”) under certain circumstances. If we decide to take extra days to make the coverage decision, we will tell you in writing.
  - If you believe we should not take extra days, you can file a “fast complaint” about our decision to take extra days. When you file a fast complaint, we will give you an answer to your complaint within 24 hours. (For more information about the process for making complaints, including fast complaints, see Section 10 of this chapter.)
  - If we do not give you our answer within 14 calendar days (or if there is an extended time period, by the end of that period), you have the right to appeal. Section 5.3 below tells how to make an appeal.

- **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 14 calendar days after we received your request. If we extended the time needed to make our coverage decision, we will authorize or provide the coverage by the end of that extended period.

- **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 3: If we say no to your request for coverage for medical care, you decide if you want to make an appeal.**

- If we say no, you have the right to ask us to reconsider – and perhaps change – this decision by making an appeal. Making an appeal means making another try to get the medical care coverage you want.

- If you decide to make an appeal, it means you are going on to Level 1 of the appeals process (see Section 5.3 below).
If your health requires it, ask for a “fast appeal” (you can make a request by calling us).

<table>
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<th>Legal Terms</th>
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<tr>
<td>A “fast appeal” is also called an “expedited reconsideration.”</td>
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- If you are appealing a decision we made about coverage for care you have not yet received, you and/or your doctor will need to decide if you need a “fast appeal.”

- The requirements and procedures for getting a “fast appeal” are the same as those for getting a “fast coverage decision.” To ask for a fast appeal, follow the instructions for asking for a fast coverage decision. (These instructions are given earlier in this section.)

- If your doctor tells us that your health requires a “fast appeal,” we will give you a fast appeal.

**Step 2: We consider your appeal and we give you our answer.**

- When our plan is reviewing your appeal, we take another careful look at all of the information about your request for coverage of medical care. We check to see if we were following all the rules when we said no to your request.

- We will gather more information if we need it. We may contact you or your doctor to get more information.

**Deadlines for a “fast appeal”**

- When we are using the fast deadlines, 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 do so.

  - However, if you ask for more time, or if we need to gather more information that may benefit you, we **can take up to 14 more calendar days.** If we decide to take extra days to make the decision, we will tell you in writing.

  - 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 organization. Later in this section, we tell you about this organization and explain what happens at Level 2 of the appeals 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 automatically send your appeal to the Independent Review Organization for a Level 2 Appeal.

**Deadlines for a “standard appeal”**

- If we are using the standard deadlines, we must give you our answer **within 30 calendar days** after we receive your appeal if your appeal is about coverage for services you have not yet received. We will give you our decision sooner if your health condition requires us to.
• 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*

• If you had a fast appeal to our plan at Level 1, you will automatically receive a fast appeal at Level 2. The review organization must give you an answer to your Level 2 Appeal **within 72 hours** of when it receives your appeal.

• However, if the Independent Review Organization needs to gather more information that may benefit you, it can take up to **14 more calendar days**.

*If you had a “standard appeal” at Level 1, you will also have a “standard appeal” at Level 2*

• If you had a standard appeal to our plan at Level 1, you will automatically receive a standard appeal at Level 2. The review organization must give you an answer to your Level 2 Appeal **within 30 calendar days** of when it receives your appeal.

• However, if the Independent Review Organization needs to gather more information that may benefit you, it can take up to **14 more calendar days**.

**Step 2: The Independent Review Organization gives you their answer.**

The Independent Review Organization will tell you its decision in writing and explain the reasons for it.

• **If the review organization says yes to part or all of what you requested**, 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 or within 72 hours from the date the plan receives the decision from the review organization for expedited requests.

• **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.” It is also called “turning down your appeal.”)

  - If the Independent Review Organization “upholds the decision” you have the right to a Level 3 Appeal. However, to make another appeal at Level 3, the dollar value of the medical care coverage you are requesting must meet a certain minimum. If the dollar value of the coverage you are requesting is too low, you cannot make another appeal, which means that the decision at Level 2 is final. The written notice you get from the Independent Review Organization will tell you how to find out the dollar amount to continue the appeals process.

**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 your Level 2 Appeal is turned down and you meet the requirements to continue with the appeals process, you must decide whether you want to go on to Level 3 and make a third appeal. The details on how to do this are in the written notice you got after your Level 2 Appeal.
SECTION 6  Your Part D prescription drugs: How to ask for a coverage decision or make an appeal

? Have you read Section 4 of this chapter (A guide to “the basics” of coverage decisions and appeals)? If not, you may want to read it before you start this section.

Section 6.1  This section tells you what to do if you have problems getting a Part D drug or you want us to pay you back for a Part D drug

Your benefits as a member of our plan include coverage for many prescription drugs. Please refer to our plan’s List of Covered Drugs (Formulary). To be covered, the drug must be used for a medically accepted indication. (A “medically accepted indication” is a use of the drug that is either approved by the Food and Drug Administration or supported by certain reference books. See Chapter 5, Section 3 for more information about a medically accepted indication.)

- **This section is about your Part D drugs only.** To keep things simple, we generally say “drug” in the rest of this section, instead of repeating “covered outpatient prescription drug” or “Part D drug” every time.

- For details about what we mean by Part D drugs, the List of Covered Drugs (Formulary), rules and restrictions on coverage, and cost information, see Chapter 5 (Using our plan’s coverage for your Part D prescription drugs) and Chapter 6 (What you pay for your Part D prescription drugs).

**Part D coverage decisions and appeals**

As discussed in Section 4 of this chapter, a coverage decision is a decision we make about your benefits and coverage or about the amount we will pay for your drugs.

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<tr>
<td>An initial coverage decision about your Part D drugs is called a <strong>coverage determination.</strong></td>
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Here are examples of coverage decisions you ask us to make about your Part D drugs:

- You ask us to make an exception, including:
  - Asking us to cover a Part D drug that is not on the plan’s List of Covered Drugs (Formulary)
  - Asking us to waive a restriction on the plan’s coverage for a drug (such as limits on the amount of the drug you can get)
  - Asking to pay a lower cost-sharing amount for a covered drug on a higher cost-sharing tier

- You ask us whether a drug is covered for you and whether you satisfy any applicable coverage rules. (For example, when your drug is on the plan’s List of Covered Drugs (Formulary) but we require you to get approval from us before we will cover it for you.)
  
  - **Please note:** If your pharmacy tells you that your prescription cannot be filled as written, you will get a written notice explaining how to contact us to ask for a coverage decision.
• If we agree to make an exception and cover a drug that is not on the Drug List, you will need to pay the cost-sharing amount that applies to drugs in Tier 3 for non-preferred drugs or Tier 1 for generic drugs. You cannot ask for an exception to the copayment or coinsurance amount we require you to pay for the drug.

2. **Removing a restriction on our coverage for a covered drug.** There are extra rules or restrictions that apply to certain drugs on our List of Covered Drugs (Formulary) (for more information, go to Chapter 5 and look for Section 4).

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<td>Asking for removal of a restriction on coverage for a drug is sometimes called asking for a “formulary exception.”</td>
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• The extra rules and restrictions on coverage for certain drugs include:
  
  - *Getting plan approval in advance* before we will agree to cover the drug for you. (This is sometimes called “prior authorization.”)
  
  - *Being required to try a different drug first* before we will agree to cover the drug you are asking for. (This is sometimes called “step therapy.”)
  
  - *Quantity limits.* For some drugs, there are restrictions on the amount of the drug you can have.

• If we agree to make an exception and waive a restriction for you, you can ask for an exception to the copayment or coinsurance amount we require you to pay for the drug.

3. **Changing coverage of a drug to a lower cost-sharing tier.** Every drug on our Drug List is in one of four cost-sharing tiers. In general, the lower the cost-sharing tier number, the less you will pay as your share of the cost of the drug.

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<td>Asking to pay a lower price for a covered non-preferred drug is sometimes called asking for a “tiering exception.”</td>
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• If our drug list contains alternative drug(s) for treating your medical condition that are in a lower cost-sharing tier than your drug, you can ask us to cover your drug at the cost-sharing amount that applies to the alternative drug(s). This would lower your share of the cost for the drug.
  
  - If the drug you’re taking is a biological product you can ask us to cover your drug at the cost-sharing amount that applies to the lowest tier that contains biological product alternatives for treating your condition.

  - If the drug you’re taking is a brand name drug you can ask us to cover your drug at the cost-sharing amount that applies to the lowest tier that contains brand name alternatives for treating your condition.
• You or your doctor or someone else who is acting on your behalf can ask for a coverage decision. Section 4 of this chapter tells how you can give written permission to someone else to act as your representative. You can also have a lawyer act on your behalf.

• If you want to ask us to pay you back for a drug, start by reading Chapter 7 of this booklet: Asking us to pay our share of a bill you have received for covered medical services or drugs. Chapter 7 describes the situations in which you may need to ask for reimbursement. It also tells how to send us the paperwork that asks us to pay you back for your share of the cost of a drug you have paid for.

• If you are requesting an exception, provide the “supporting statement.” Your doctor or other prescriber must give us the medical reasons for the drug exception you are requesting. (We call this the “supporting statement.”) Your doctor or other prescriber can fax or mail the statement to us. Or your doctor or other prescriber can tell us on the phone and follow up by faxing or mailing a written statement if necessary. See Sections 6.2 and 6.3 for more information about exception requests.

• We must accept any written request, including a request submitted on the CMS Model Coverage Determination Request Form or on our plan’s form, which are available on our website.

   ![Legal Terms Table]

   A “fast coverage decision” is called an “expedited coverage determination.”

**If your health requires it, ask us to give you a “fast coverage decision”**

• When we give you our decision, we will use the “standard” deadlines unless we have agreed to use the “fast” deadlines. A standard coverage decision means we will give you an answer within 72 hours after we receive your doctor’s statement. A fast coverage decision means we will answer within 24 hours after we receive your doctor’s statement.

• To get a fast coverage decision, you must meet two requirements:

  - You can get a fast coverage decision only if you are asking for a drug you have not yet received. (You cannot get a fast coverage decision if you are asking us to pay you back for a drug you have already bought.)

  - You can get a fast coverage decision only if using the standard deadlines could cause serious harm to your health or hurt your ability to function.

• If your doctor or other prescriber 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 or other prescriber’s support), we will decide whether your health requires that we give you a fast coverage decision.

  - If we decide that your medical condition does not meet the requirements for a fast coverage decision, we will send you a letter that says so (and we will use the standard deadlines instead).

  - This letter will tell you that if your doctor or other prescriber asks for the fast coverage decision, we will automatically give a fast coverage decision.
If our answer is yes to part or all of what you requested, we are also required to make payment to you within 14 calendar days after we receive your request.

If our answer is no to part or all of what you requested, we will send you a written statement that explains why we said no. We will also tell you how to appeal.

**Step 3: If we say no to your coverage request, you decide if you want to make an appeal.**

- If we say no, you have the right to request an appeal. Requesting an appeal means asking us to reconsider – and possibly change – the decision we made.

---

**Section 6.5**

Step-by-step: How to make a Level 1 Appeal
(how to ask for a review of a coverage decision made by our plan)

---

**Legal Terms**

An appeal to the plan about a Part D drug coverage decision is called a plan “redetermination.”

---

**Step 1: You contact us and make your Level 1 Appeal. If your health requires a quick response, you must ask for a “fast appeal.”**

*What to do*

- To start your appeal, you (or your representative or your doctor or other prescriber) must contact us.
  - For details on how to reach us by phone, fax, or mail, or on our website, for any purpose related to your appeal, go to Chapter 2, Section 1, and look for the section called, *How to contact us when you are making an appeal about your Part D prescription drugs.*

- If you are asking for a standard appeal, make your appeal by submitting a written request. You may also ask for an appeal by calling us at the phone number shown in Chapter 2, Section 1 (*How to contact our plan when you are making an appeal about your Part D prescription drugs*).

- If you are asking for a fast appeal, you may make your appeal in writing or you may call us at the phone number shown in Chapter 2, Section 1 (*How to contact our plan when you are making an appeal about your Part D prescription drugs*).

- We must accept any written request, including a request submitted on the CMS Model Coverage Determination Request Form, which is available on our website.

- You must make your appeal request within 60 calendar days from the date on the written notice we sent to tell you our answer to your request for a coverage decision. If you miss this deadline and have a good reason for missing it, we may give you more time to make your appeal. Examples of good cause for missing the deadline may include if you had 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 in your appeal and add more information.
• If our answer is yes to part or all of what you requested –
  – If we approve a request for coverage, we must **provide the coverage** we have agreed to provide as quickly as your health requires, but **no later than 7 calendar days** after we receive your appeal.
  – If we approve a request to pay you back for a drug you already bought, we are required to **send payment to you within 30 calendar days** after we receive your appeal request.

• If our answer is no to part or all of what you requested, we will send you a written statement that explains why we said no and how to appeal our decision.

• If you are requesting that we pay you back for a drug you have already bought, we must give you our answer **within 14 calendar days** after we receive your request.
  – If we do not give you a decision within 14 calendar days, we are required to send your request on to Level 2 of the appeals process, where it will be reviewed by an independent organization. Later in this section, we talk about this review organization and explain what happens at Appeal Level 2.

• If our answer is yes to part or all of what you requested, we are also required to make payment to you within 30 calendar days after we receive your request.

• If our answer is no to part or all of what you requested, we will send you a written statement that explains why we said no. We will also tell you how to appeal.

**Step 3: If we say no to your appeal, you decide if you want to continue with the appeals process and make another appeal.**

• If we say no to your appeal, you then choose whether to accept this decision or continue by making another appeal.

• If you decide to make another appeal, it means your appeal is going on to Level 2 of the appeals process (see below).

Section 6.6  Step-by-step: How to make a Level 2 Appeal

If we say no to your appeal, you then choose whether to accept this decision or continue by making another appeal. If you decide to go on to a Level 2 Appeal, the **Independent Review Organization** reviews the decision we made when we said no to your first appeal. This organization decides whether the decision we made should be changed.

<table>
<thead>
<tr>
<th>Legal Terms</th>
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<tbody>
<tr>
<td>The formal name for the “Independent Review Organization” is the “<strong>Independent Review Entity</strong>.” It is sometimes called the “IRE.”</td>
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</table>

CHAPTER 9 – What to do if you have a problem or complaint (coverage decisions, appeals, complaints) | 187
2019 Evidence of Coverage – UCare Medicare Group Plans
- If the Independent Review Organization approves a request to pay you back for a drug you already bought, we are required to send payment to you within 30 calendar days after we receive the decision from the review organization.

What if the review organization says no to your appeal?

If this organization says no to your appeal, it means the organization agrees with our decision not to approve your request. (This is called “upholding the decision.” It is also called “turning down your appeal.”)

If the Independent Review Organization “upholds the decision” you have the right to a Level 3 Appeal. However, to make another appeal at Level 3, the dollar value of the drug coverage you are requesting must meet a minimum amount. If the dollar value of the drug coverage you are requesting is too low, you cannot make another appeal and the decision at Level 2 is final. The notice you get from the Independent Review Organization will tell you the dollar value that must be in dispute to continue with the appeals process.

Step 3: If the dollar value of the coverage you are requesting meets the requirement, 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 your Level 2 Appeal is turned down and you meet the requirements to continue with the appeals process, you must decide whether you want to go on to Level 3 and make a third appeal. If you decide to make a third appeal, the details on how to do this are in the written notice you got after your second appeal.

- The Level 3 Appeal is handled by an Administrative Law Judge or attorney adjudicator. Section 9 in this chapter tells more about Levels 3, 4, and 5 of the appeals process.

SECTION 7 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. For more information about our coverage for your hospital care, including any limitations on this coverage, see Chapter 4 of this booklet: Medical Benefits Chart (what is covered and what you pay).

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 also 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 has been decided, your doctor or the hospital staff will let you know.

- 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. This section tells you how to ask.
Section 7.2 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.** Each step in the first two levels of the appeals process is explained below.

- **Meet the deadlines.** The deadlines are important. Be sure that you understand and follow the deadlines that apply to things you must do.

- **Ask for help if you need it.** If you have questions or need help at any time, please call Customer Services (phone numbers are printed on the back cover of this booklet). Or call your State Health Insurance Assistance Program, a government organization that provides personalized assistance (see Section 2 of this chapter).

**During a Level 1 Appeal, the Quality Improvement Organization reviews your appeal.** It checks to see if your planned discharge date is medically appropriate for you.

**Step 1: Contact the Quality Improvement Organization for your state and ask for a “fast review” of your hospital discharge. You must act quickly.**

*What is the Quality Improvement Organization?*

- This organization is a group of doctors and other health care professionals who are paid by the Federal government. These experts are not part of our plan. This organization is paid by Medicare to check on and help improve the quality of care for people with Medicare. This includes reviewing hospital discharge dates for people with Medicare.

*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, Section 4, of this booklet.)

*Act quickly:*

- To make your appeal, you must contact the Quality Improvement Organization *before* you leave the hospital and **no later than your planned discharge date.** (Your “planned discharge date” is the date that has been set for you to leave the hospital.)
  - If you meet this deadline, you are allowed to stay in the hospital *after your discharge date without paying for it* while you wait to get the decision on your appeal 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 about your appeal, you can make your appeal directly to our plan instead. For details about this other way to make your appeal, see Section 7.4.
• 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 turned down 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 7.3 Step-by-step: How to make a Level 2 Appeal to change your hospital discharge date

If the Quality Improvement Organization has turned down your appeal, *and* you stay in the hospital after your planned discharge date, then you can make a Level 2 Appeal. 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 stay after your planned discharge date.

Here are the steps for Level 2 of the appeal process:

**Step 1: You 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 stayed 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 second review, the Quality Improvement Organization 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 and will not change it. This is called “upholding the decision.”
• In this situation, we will use the “fast” deadlines rather than the standard deadlines for giving you the answer to this review.

**Step 3: We give you our decision within 72 hours after you ask for a “fast review” (“fast appeal”).**

- **If we say yes to your fast appeal,** it means we have agreed with you that you still need to be in the hospital after the discharge date, and will keep providing your covered inpatient hospital 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 fast 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 fast appeal, your case will automatically be sent on to the next level of the appeals process.**

- To make sure we were following all the rules when we said no to your fast appeal, we are required to send your appeal to the “Independent Review Organization.” When we do this, it means that you are automatically going on to Level 2 of the appeals process.

**Step-by-Step: Level 2 Alternate Appeal Process**

If we say no to your Level 1 Appeal, your case will automatically be sent on to the next level of the appeals process. During the Level 2 Appeal, an Independent Review Organization reviews the decision we made when we said no to your “fast appeal.” This organization decides whether the decision we made should be changed.

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<thead>
<tr>
<th>Legal Terms</th>
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<tr>
<td>The formal name for the “Independent Review Organization” is the “Independent Review Entity.” It is sometimes called the “IRE.”</td>
</tr>
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</table>

**Step 1: We will automatically forward your case to the Independent Review Organization.**

- We are required to send the information for your Level 2 Appeal to the Independent Review Organization within 24 hours of when we tell you that we are saying no to your first appeal. (If you think we are not meeting this deadline or other deadlines, you can make a complaint. The complaint process is different from the appeal process. Section 10 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.**

- 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
information on your covered services, including your share of the cost and any limitations to coverage that may apply, see Chapter 4 of this booklet: Medical Benefits Chart (what is covered and what you pay).

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 8.2 We will tell you in advance when your coverage will be ending

1. You receive a notice in writing. At least two days before our plan is going to stop covering your care, you will receive a notice.
   - The written notice tells you the date when we will stop covering the care for you.
   - The written notice also tells what you can do if you want to ask our plan to change this decision about when to end your care, and keep covering it for a longer period of time.

   **Legal Terms**

   In telling you what you can do, the written notice is telling 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. (Section 8.3 below tells how you can request a fast-track appeal.)

   The written notice is called the “Notice of Medicare Non-Coverage.” To get a sample copy, call Customer Services (phone numbers are printed on the back cover of this booklet) 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 see a copy online at https://www.cms.gov/Medicare/Medicare-General-Information/BNI/MAEDNotices.html.

2. You must sign the written notice to show that you received it.
   - You or someone who is acting on your behalf must sign the notice. (Section 4 tells how you can give written permission to someone else to act as your representative.)
   - Signing the notice shows only that you have received the information about when your coverage will stop. Signing it does not mean you agree with the plan that it’s time to stop getting the care.

Section 8.3 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. Each step in the first two levels of the appeals process is explained below.

- Meet the deadlines. The deadlines are important. Be sure that you understand and follow the deadlines that apply to things you must do. There are also deadlines our plan must follow. (If you
• By the end of the day the reviewers inform us of your appeal, and you will also get a written notice from us that explains in detail our reasons for ending our coverage for your services.

**Legal Terms**

| This notice of explanation is called the
| “Detailed Explanation of Non-Coverage.” |

**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 to your appeal?**

• 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). In addition, there may be limitations on your covered services (see Chapter 4 of this booklet).

**What happens if the reviewers say no to your appeal?**

• If the reviewers say no to your appeal, then your coverage will end on the date we have told you. We will stop paying our share of the costs of this care on the date listed on the notice.

• 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.

• This first appeal you make is “Level 1” of the appeals process. 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 another appeal.

• Making another appeal means you are going on to “Level 2” of the appeals process.

---

**Section 8.4 Step-by-step: How to make a Level 2 Appeal to have our plan cover your care for a longer time**

If the Quality Improvement Organization has turned down your appeal and you choose to continue getting care after your coverage for the care has ended, then you can make a Level 2 Appeal. 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.

Here are the steps for Level 2 of the appeal process:
Step-by-Step: How to make a Level 1 Alternate Appeal

If you miss the deadline for contacting the Quality Improvement Organization, you can make an appeal to us, asking for a “fast review.” A fast review is an appeal that uses the fast deadlines instead of the standard deadlines.

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<tr>
<th>Legal Terms</th>
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<tbody>
<tr>
<td>A “fast review” (or “fast appeal”) is also called an “expedited appeal.”</td>
</tr>
</tbody>
</table>

Here are the steps for a Level 1 Alternate Appeal:

**Step 1: Contact us and ask for a “fast review.”**
- For details on how to contact us, go to Chapter 2, Section 1 and look for the section called, *How to contact us when you are making an appeal about your medical care.*
- **Be sure to 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.

**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 see if we were following all the rules when we set the date for ending the plan’s coverage for services you were receiving.
- We will use the “fast” deadlines rather than the standard deadlines for giving you the answer to this review.

**Step 3: We give you our decision within 72 hours after you ask for a “fast review” (“fast appeal”).**
- **If we say yes to your fast appeal,** it means we have agreed with you that you need services longer, and 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 fast 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 yourself.

**Step 4: If we say no to your fast appeal, your case will automatically go on to the next level of the appeals process.**
- To make sure we were following all the rules when we said no to your fast appeal, we are required to send your appeal to the “Independent Review Organization.” When we do this, it means that you are automatically going on to Level 2 of the appeals process.
SECTION 9  Taking your appeal to Level 3 and beyond

Section 9.1  Levels of Appeal 3, 4, and 5 for Medical Service Appeals

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. If the dollar value is high enough, the written response you receive to your Level 2 Appeal will explain who to contact and what to do to ask for a Level 3 Appeal.

For most situations that involve appeals, the last three levels of appeal work in much the same way. Here is who handles the review of your appeal at each of these levels.

<table>
<thead>
<tr>
<th>Level 3 Appeal:</th>
<th>A judge (called an Administrative Law Judge) or an attorney adjudicator who works for the Federal government will review your appeal and give you an answer.</th>
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<tbody>
<tr>
<td>• If the Administrative Law Judge or attorney adjudicator says yes to your appeal, the appeals process may or may not be over - We will decide whether to appeal this decision to Level 4. Unlike a decision at Level 2 (Independent Review Organization), we have the right to appeal a Level 3 decision that is favorable to you.</td>
<td></td>
</tr>
<tr>
<td>• If we decide not to appeal the decision, 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.</td>
<td></td>
</tr>
<tr>
<td>• 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.</td>
<td></td>
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<table>
<thead>
<tr>
<th>Level 4 Appeal:</th>
<th>The Medicare Appeals Council (Council) will review your appeal and give you an answer. The Council is part of the Federal government.</th>
</tr>
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<tbody>
<tr>
<td>• 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 - We will decide whether to appeal this decision to Level 5. Unlike a decision at Level 2 (Independent Review Organization), we have the right to appeal a Level 4 decision that is favorable to you.</td>
<td></td>
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<tr>
<td>• 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.</td>
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</table>
Level 4 Appeal: The Medicare Appeals Council (Council) will review your appeal and give you an answer. The Council is part of the Federal government.

- If the answer is yes, the appeals process is over. What you asked for in the appeal has been approved. We must authorize or provide the drug coverage that was approved by the Council within 72 hours (24 hours for expedited appeals) or make payment no later than 30 calendar days after we receive the decision.

- If the answer is no, the appeals process may or may not be over.
  - If you decide to accept this decision that turns down your appeal, the appeals process is over.
  - If you do not want to accept the decision, you might be able to continue to the next level of the review process. If the Council says no to your appeal or denies your request to review the appeal, the notice you get will tell you whether the rules allow you to go on to a Level 5 Appeal. If the rules allow you to go on, the written notice will also tell you who to contact and what to do next if you choose to continue with your appeal.

Level 5 Appeal: A judge at the Federal District Court will review your appeal.

- This is the last step of the appeals process.
<table>
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<tr>
<th>Complaint</th>
<th>Example</th>
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| **Timeliness**  
(These types of complaints are all related to the timeliness of our actions related to coverage decisions and appeals) | The process of asking for a coverage decision and making appeals is explained in Sections 4-9 of this chapter. If you are asking for a decision or making an appeal, you use that process, not the complaint process.  
However, if you have already asked us for a coverage decision or made an appeal, and you think that we are not responding quickly enough, you can also make a complaint about our slowness. Here are examples:  
- If you have asked us to give you a “fast coverage decision” or a “fast appeal,” and we have said we will not, you can make a complaint.  
- If you believe we are not meeting the deadlines for giving you a coverage decision or an answer to an appeal you have made, you can make a complaint.  
- When a coverage decision we made is reviewed and we are told that we must cover or reimburse you for certain medical services or drugs, there are deadlines that apply. If you think we are not meeting these deadlines, you can make a complaint.  
- When we do not give you a decision on time, we are required to forward your case to the Independent Review Organization. If we do not do that within the required deadline, you can make a complaint. |

**Section 10.2**  
The formal name for “making a complaint” is “filing a grievance”

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<th>Legal Terms</th>
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</table>
| - What this section calls a “complaint” is also called a “grievance.”  
- Another term for “making a complaint” is “filing a grievance.”  
- Another way to say “using the process for complaints” is “using the process for filing a grievance.” |

**Section 10.3**  
Step-by-step: Making a complaint

**Step 1: Contact us promptly – either by phone or in writing.**  
- Usually, calling Customer Services is the first step. If there is anything else you need to do, Customer Services will let you know. Call 612-676-6840 or 1-877-447-4385, 24 hours a day, 7 days a week. TTY users call 612-676-6810 or 1-800-688-2534.  
- 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.
• 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 an answer within 24 hours.

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<tr>
<td>What this section calls a “fast complaint” is also called an “expedited grievance.”</td>
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</table>

**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. If your health condition requires us to answer quickly, we will do that.

- **Most complaints are answered in 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 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 let you know. Our response will include our reasons for this answer. We must respond whether we agree with the complaint or not.

---

**Section 10.4 You can also make complaints about quality of care to the Quality Improvement Organization**

You can make your complaint about the quality of care you received to us by using the step-by-step process outlined above.

When your complaint is about *quality of care*, you also have two extra options:

- **You can make your complaint to the Quality Improvement Organization.** If you prefer, you can make your complaint about the quality of care you received directly to this organization (*without* making the complaint to us).
  - 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.
  - To find the name, address, and phone number of the Quality Improvement Organization for your state, look in Chapter 2, Section 4, of this booklet. If you make a complaint to this organization, we will work with them to resolve your complaint.

- **Or you can make your complaint to both at the same time.** If you wish, you can make your complaint about quality of care to us and also to the Quality Improvement Organization.
CHAPTER 10

Ending your membership in the plan
SECTION 1  Introduction

Section 1.1  This chapter focuses on ending your membership in our plan

Ending your membership in the plan 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.
  - There are only certain times during the year, or certain situations, when you may voluntarily end your membership in the plan. Section 2 tells you when you can end your membership in the plan.
  - The process for voluntarily ending your membership varies depending on what type of new coverage you are choosing. Section 3 tells you how to end your membership in each situation.

- There are also limited situations where you do not choose to leave, but 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, you must continue to get your medical care through our plan until your membership ends.

SECTION 2  When can you end your membership in our plan?

You may end your membership in our plan at any time. You will be enrolled until the end of the month.

Please note if you choose to disenroll from your employer group plan you may not be eligible to re-enroll in your employer group plan(s) at a future date.

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.

- When is the Annual Enrollment Period? This happens from October 15 to December 7.

Note: If you’re in a drug management program, you may not be able to change plans. Chapter 5, Section 10 tells more about drug management programs.

- What type of plan can you switch to during the Annual Enrollment Period? You can 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. (You can choose a plan that covers prescription drugs or one that does not cover prescription drugs.)
  - Original Medicare with a separate Medicare prescription drug plan.
  - or – Original Medicare without a separate Medicare prescription drug plan.
Note: If you disenroll from Medicare prescription drug coverage and go without creditable prescription drug coverage for a continuous period of 63 days or more, you may have to pay a Part D late enrollment penalty if you join a Medicare drug plan later. (“Creditable” coverage means the coverage is expected to pay, on average, at least as much as Medicare’s standard prescription drug coverage.) See Chapter 1, Section 5 for more information about the late enrollment penalty.

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

Section 2.3 Where can you get more information about when you can end your membership?

If you have any questions or would like more information on when you can end your membership:

- You can call Customer Services (phone numbers are printed on the back cover of this booklet).

- You can find the information in the Medicare & You 2019 Handbook.
  - Everyone with Medicare receives a copy of Medicare & You each fall. Those new to Medicare receive it within a month after first signing up.
  - You can also download a copy from the Medicare website (https://www.medicare.gov). Or, you can order a printed copy by calling Medicare at the number below.

- You can contact 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 How do you end your membership in our plan?

Section 3.1 Usually, you end your membership by enrolling in another plan

Usually, to end your membership in our plan, you simply enroll in another Medicare plan during one of the enrollment periods (see Section 2 in this chapter for information about the enrollment periods). However, if you want to switch from our plan to Original Medicare without a Medicare prescription drug plan, you must ask to be disenrolled from our plan. There are two ways you can ask to be disenrolled:

- You can make a request in writing to us. Contact Customer Services if you need more information on how to do this (phone numbers are printed on the back cover of this booklet).

- or – You can contact 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.

Note: If you disenroll from Medicare prescription drug coverage and go without creditable prescription drug coverage for a continuous period of 63 days or more, you may have to pay a Part D late enrollment penalty if you join a Medicare drug plan later. (“Creditable” coverage means the coverage is expected to pay, on average, at least as much as Medicare’s standard prescription drug coverage.) See Chapter 1, Section 5 for more information about the late enrollment penalty.
SECTION 4 Until your membership ends, you must keep getting your medical services and drugs through our plan

Section 4.1 Until your membership ends, you are still a member of our plan

If you leave the plan it may take time before your membership ends and your new Medicare coverage goes into effect. (See Section 2 for information on when your new coverage begins.) During this time, you must continue to get your medical care and prescription drugs through our plan.

- You should continue to use our network pharmacies to get your prescriptions filled until your membership in our plan ends. Usually, your prescription drugs are only covered if they are filled at a network pharmacy including through our mail-order pharmacy services.

- If you are hospitalized on the day that your membership ends, your hospital stay will usually be covered by our plan until you are discharged (even if you are discharged after your new health coverage begins).

SECTION 5 We must end your membership in the plan in certain situations

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

We 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, you need to call Customer Services to find out if the place you are moving or traveling to is in our plan’s area. (Phone numbers for Customer Services are printed on the back cover of this booklet.)

- If you become incarcerated (go to prison).

- If you are not a United States citizen or lawfully present in the United States.

- If you lie about or withhold information about other insurance you have that provides prescription drug coverage.

- If you intentionally give us incorrect information when you are enrolling in our plan and that information affects your eligibility for our plan. (We cannot make you leave our plan for this reason unless we get permission from Medicare first.)

- If you continuously behave in a way that is disruptive and makes it difficult for us to provide medical care for you and other members of our plan. (We cannot make you leave our plan for this reason unless we get permission from Medicare first.)
CHAPTER 11
Legal notices
SECTION 1  Notice about governing law

Many laws apply to this Evidence of Coverage and some additional provisions may apply because they are required by law. This may affect your rights and responsibilities even if the laws are not included or explained in this document. The principal law that applies to this 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.

SECTION 2  Notice about non-discrimination

We don’t discriminate based on race, ethnicity, national origin, color, religion, sex, gender, age, mental or physical disability, health status, claims experience, medical history, genetic information, evidence of insurability, or geographic location. 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.

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, our plan, 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 the 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 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 and urgently needed care 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  Quality at UCare

UCare exists to improve the health of our members through innovative services and partnerships across communities. UCare’s quality program is designed to support our mission by accomplishing the following goals:

- Establish effective partnerships with providers, Primary Care Clinics and provider networks committed to quality care.
- Establish and monitor performance in key aspects of care and service.
- Improve clinical and functional outcomes for our members.
- Improve key business processes that result in better service and operational efficiencies.
- Meet or exceed quality standards set by government agencies.

If you would like more information, please call Customer Services.

SECTION 12  Third party liability

If you suffer an injury or illness for which a third party is liable due to a negligent or intentional act or omission causing such illness or injury, you must promptly notify us of the same. We will send you a statement of the reasonable charges for services provided in connection with the injury or illness. If you recover any sums from the responsible third party, we shall be reimbursed out of such recovery from a third party for the services provided, 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 judgment or settlement amount, the recovery is computed as follows:
   a. Determine the ratio of the procurement costs to the total judgment or settlement payment.
   b. Apply the ratio to our payment. The product is our share of procurement costs.
   c. Subtract our share of procurement costs from our payments. The remainder is our recovery amount.
CHAPTER 12
Definitions of important words
**Brand-Name Drug** – A prescription drug that is manufactured and sold by the pharmaceutical company that originally researched and developed the drug. Brand-name drugs have the same active-ingredient formula as the generic version of the drug. However, generic drugs are manufactured and sold by other drug manufacturers and are generally not available until after the patent on the brand-name drug has expired.

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

**Catastrophic Coverage Stage** – The stage in the Part D Drug Benefit where you pay a low copayment or coinsurance for your drugs after you or other qualified parties on your behalf have spent $5,100 in covered drugs during the covered year.

**Centers for Medicare & Medicaid Services (CMS)** – The Federal agency that administers Medicare. Chapter 2 explains how to contact CMS.

**Coinsurance** – An amount you may be required to pay as your share of the cost for services or prescription drugs after you pay any deductibles. Coinsurance is usually a percentage (for example, 20%).

**Complaint** – The formal name for “making a complaint” is “filing a grievance.” The complaint process is used for certain types of problems only. This includes problems related to quality of care, waiting times, and the customer service you receive. See also “Grievance,” in this list of definitions.

**Comprehensive Outpatient Rehabilitation Facility (CORF)** – A facility that mainly provides rehabilitation services after an illness or injury, and provides a variety of services 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 drug. A copayment is a set amount, rather than a percentage. For example, you might pay $10 or $20 for a doctor’s visit or prescription drug.

**Cost-sharing** – Cost-sharing refers to amounts that a member has to pay when services or drugs 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 or drugs are covered; (2) any fixed “copayment” amount that a plan requires when a specific service or drug is received; or (3) any “coinsurance” amount, a percentage of the total amount paid for a service or drug that a plan requires when a specific service or drug is received. A “daily cost-sharing rate” may apply when your doctor prescribes less than a full month’s supply of certain drugs for you and you are required to pay a copayment.

**Cost-Sharing Tier** – Every drug on the list of covered drugs is in one of four cost-sharing tiers. In general, the higher the cost-sharing tier, the higher your cost for the drug.
Dispensing Fee – A fee charged each time a covered drug is dispensed to pay for the cost of filling a prescription. The dispensing fee covers costs such as the pharmacist’s time to prepare and package the prescription.

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, 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.

Emergency Care – Covered services that are: 1) rendered by a provider qualified to furnish emergency services; and 2) needed to treat, evaluate, or stabilize an emergency medical condition.

Endodontic Services – Dental services performed to treat disease of the pulp and root of a tooth.

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.

Exception – A type of coverage determination that, if approved, allows you to get a drug that is not on your plan sponsor’s formulary (a formulary exception), or get a non-preferred drug at a lower cost-sharing level (a tiering exception). You may also request an exception if your plan sponsor requires you to try another drug before receiving the drug you are requesting, or the plan limits the quantity or dosage of the drug you are requesting (a formulary exception).

Extra Help – A Medicare program to help people with limited income and resources pay Medicare prescription drug program costs, such as premiums, deductibles, and coinsurance.

Generic Drug – A prescription drug that is approved by the Food and Drug Administration (FDA) as having the same active ingredient(s) as the brand-name drug. Generally, a “generic” drug works the same as a brand-name drug and usually costs less.

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

Home Health Aide – A home health aide provides services that don’t need the skills of a licensed nurse or therapist, such as help with personal care (e.g., bathing, using the toilet, dressing, or carrying out the prescribed exercises). Home health aides do not have a nursing license or provide therapy.

Hospice – A member who has 6 months or less to live has the right to elect hospice. 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. The hospice will provide special treatment for your state.
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). People with Medicare can get their Medicare health coverage through Original Medicare, a Medicare Cost Plan or a Medicare Advantage Plan.

Medicare Advantage Open Enrollment Period – A set time each year when members in a Medicare Advantage plan can cancel their plan enrollment and switch to Original Medicare or make changes to your Part D coverage. The Open Enrollment Period is from January 1 until March 31, 2019.

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 HMO, PPO, a Private Fee-for-Service (PFFS) plan, or a Medicare Medical Savings Account (MSA) plan. When you are enrolled in a Medicare Advantage Plan, Medicare services are covered through the plan, and are not paid for under Original Medicare. 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. Everyone who has Medicare Part A and Part B is eligible to join any Medicare health plan that is offered in their area, except people with End-Stage Renal Disease (unless certain exceptions apply).

Medicare Cost Plan – A Medicare Cost Plan is a plan operated by a Health Maintenance Organization (HMO) or Competitive Medical Plan (CMP) in accordance with a cost-reimbursed contract under section 1876(h) of the act.

Medicare Coverage Gap Discount Program – A program that provides discounts on most covered Part D brand-name drugs to Part D members who have reached the Coverage Gap Stage and who are not already receiving “Extra Help.” Discounts are based on agreements between the Federal government and certain drug manufacturers. For this reason, most, but not all, brand-name drugs are discounted.

Medicare-Covered Services – Services covered by Medicare Part A and Part B. All Medicare health plans, including our plan, must cover all of the services that are covered by Medicare Part A and B.

Medicare Fee Schedule – A listing of fees used by Original Medicare to pay providers or other suppliers. CMS develops fee schedules for providers, ambulance services, clinical laboratory services, and durable medical equipment, prosthetics, orthotics, and supplies.

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, 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.)
Out-of-Pocket Costs – See the definition for “cost-sharing” above. A member’s cost-sharing requirement to pay for a portion of services or drugs received is also referred to as the member’s “out-of-pocket” cost requirement.

Part C – see “Medicare Advantage (MA) Plan.”

Part D – The voluntary Medicare Prescription Drug Benefit Program. (For ease of reference, we will refer to the prescription drug benefit program as Part D.)

Part D Drugs – Drugs that can be covered under Part D. We may or may not offer all Part D drugs. (See your formulary for a specific list of covered drugs.) Certain categories of drugs were specifically excluded by Congress from being covered as Part D drugs.

Part D Late Enrollment Penalty – An amount added to your monthly premium for Medicare drug coverage if you go without creditable coverage (coverage that is expected to pay, on average, at least as much as standard Medicare prescription drug coverage) for a continuous period of 63 days or more. You pay this higher amount as long as you have a Medicare drug plan. There are some exceptions. For example, if you receive “Extra Help” from Medicare to pay your prescription drug plan costs, you will not pay a late enrollment penalty.

Periodontic Services – Dental services performed to treat tissues surrounding and supporting the teeth.

Point-of-Service Benefit – Coverage for certain covered services provided by out-of-network physicians or providers, within the United States and its territories, at a higher cost-sharing level (out-of-network level). See Chapter 4, Section 2.3 for more information.

Preferred Cost-sharing – Preferred cost-sharing means lower cost-sharing for certain covered Part D drugs at certain network pharmacies.

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 in-network (preferred) and out-of-network (non-preferred) providers.

Premium – The periodic payment to Medicare, an insurance company, or a health care plan for health or prescription drug coverage.

Prescription Drug Benefit Manager – A company under contract with UCare that manages specific delegated aspects of the pharmacy benefit, including claims processing and coverage determinations.

Primary Care Provider (PCP) – Your primary care provider is the doctor or other provider you see first for most health problems. He or she makes sure you get the care you need to keep you healthy. He or she also may talk with other doctors and health care providers about your care and refer you to them. In many Medicare health plans, you must see your primary care provider before you see any other health care provider. See Chapter 3, Section 2.1 for information about Primary Care Providers.
**Step Therapy** – A utilization tool that requires you to first try another drug to treat your medical condition before we will cover the drug your physician may have initially prescribed.

**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.

**Urgently Needed Services** – Urgently needed services are provided to treat a non-emergency, unforeseen medical illness, injury, or condition that requires immediate medical care. Urgently needed services may be furnished by network providers or by out-of-network providers when network providers are temporarily unavailable or inaccessible.