UCare Connect + Medicare (HMO D-SNP) *Member Handbook*

January 1, 2026 — December 31, 2026

Your Medicare and Medical Assistance Health, Long-Term Services and Supports, and Drug Coverage under UCare Connect + Medicare

OMB Approval 0938-1444 (Expires: June 30, 2026)
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ucare®

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

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

ያስተውሉ፡ ካለምንም ክፍያ ይህንን ዶኩመንት የሚተረጉምሎ አስተርጓሚ ከፈለጉ ከላይ ወደተጻፈው የስልክ ቁጥር ይደውሉ።

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

သတိ။ ဤစွက်စာတမ်းအားအခမဲ့ဘာသာပြန်ပေးခြင်း အကူအညီလိုအပ်ပါက၊ အထက်ပါဖုန်းနံပါတ်ကိုခေါ်ဆိုပါ။

កំណត់សំគាល់ ។ បើអ្នកត្រូវការជំនួយក្នុងការបកប្រែឯកសារនេះដោយឥតគិតថ្លៃ សូមហៅទូរស័ព្ទតាមលេខខាងលើ ។

請注意，如果您需要免費協助傳譯這份文件，請撥打上面的電話號碼。

Attention. Si vous avez besoin d’une aide gratuite pour interpréter le présent document, veuillez appeler au numéro ci-dessus.

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

ဟ်သူဉ်ဟ်သးဘဉ်တကွ၊်. ဖဲနမ့၊်လိဉ်ဘဉ်တ၊်မၤစၢၤကလီလၢတ၊်ကကျိးထံဝဲဇဉ်လံာ် တီလံာ်မီတခါအံၤန့ဉ်,ကိးဘဉ် လိတဲစိနီ၊်ဂ်၊်လၢထးအံၤန့ဉ်တကွ၊်.

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

ໂປຣດຊາບ. ຖ້າຫາກ ທ່ານຕ້ອງການການຊ່ວຍເຫຼືອໃນການແປເອກະສານນີ້ຟຣີ, ຈົ່ງ ໂທຣໄປທີ່ໝາຍເລກຂ້າງເທິງນີ້.

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

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

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

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

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

Civil Rights Notice

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

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

You have the right to file a discrimination complaint if you believe you were treated in a discriminatory way by UCare. You can file a complaint and ask for help filing a complaint in person or by mail, phone, fax, or email at:
UCare
Attn: Appeals and Grievances
PO Box 52
Minneapolis, MN 55440-0052
Toll Free: 1-800-203-7225
TTY: 1-800-688-2534
Fax: 612-884-2021
Email: cag@ucare.org

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

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

Civil Rights Complaints

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

U.S. Department of Health and Human Services Office for Civil Rights (OCR)
You have the right to file a complaint with the OCR, a federal agency, if you believe you have been discriminated against because of any of the following:

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

Contact the OCR directly to file a complaint:

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

Minnesota Department of Human Rights (MDHR)

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

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

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

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

Minnesota Department of Human Services (DHS)

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

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

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

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

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

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

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

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

NO ENGLISH ☎ 1-800-203-7225 612-676-3200

TRS: 711

ATTENTION: If you speak English, free language assistance services are available to you free of charge and without unnecessary delay. Additionally, appropriate auxiliary aids and services to provide information in accessible formats are available free of charge and in a timely manner. Please call the number above or speak to your provider. English

ማሳሰቢያ፦ አማርኛ ተናጋሪ ከሆኑ ፤ ነጻ የቋንቋ ድጋፍ አገልግሎቶች ካለምንም ክፍያ እና ካለአላስፈላጊ መዘግየት ማግኘት ይችላሉ። በተጨማሪም መረጃን በቀላሉ ለማግኘት በሚያስችል ቅርጸት ለማቅረብ ተገቢ የሆኑ የመስማት ድጋፍ እና አገልግሎቶች ከክፍያ ነጻ በሆነ እና ግዜውን በጠበቀ መልኩ ማግኘት ይችላሉ። እባክዎ ከላይ ባለው ቁጥር ይደውሉ ወይም አቅራቢዎን ያነጋግሩ። Amharic

تنبيه: نقدم لمتحدثي اللغة العربية خدمات مساعدة لغوية مجانية وفورية، بالإضافة إلى وسائل وخدمات مساعدة مناسبة، وبصيغة معلومات سهلة بدون تكلفة وبشكل سريع. يرجى التواصل على الرقم الموضح أعلاه أو مراجعة مقدم الخدمة المباشرة. Arabic

သတိပြုရန် – အကယ်၍ သင်သည် မြန်မာဘာသာစကား ပြောဆိုသူဖြစ်လျှင် အခမဲ့ ဘာသာစကားဆိုင်ရာ ပံ့ပိုးထောက်ပံ့ပေးမှု ဝန်ဆောင်မှုများအား မလိုအပ်သည့် နှောင့်နှေးကြန့်ကြာမှုများ မရှိစေဘဲ သင် အခမဲ့ ရရှိနိုင်မည် ဖြစ်သည်။ ထို့ပြင် အချက်အလက်များအား အလွယ်တကူ ဝင်ရောက်ရယူနိုင်စေသော ဖောမတ်ပုံစံများဖြင့် ထောက်ပံ့ပေးထားသည့် သက်ဆိုင်ရာ ဖြည့်စွက် ထောက်ပံ့မှုများနှင့် ဝန်ဆောင်မှုများကိုလည်း အခမဲ့၊ အချိန်မ ရရှိနိုင်စေရန် စီမံပေးထားပါသည်။ ကျေးဇူးပြုပြီး အထက်ဖော်ပြပါ ဖုန်းနံပါတ်သို့ ခေါ်ဆိုပါ သို့မဟုတ် သင်၏ ထောက်ပံ့သူဖြင့် ပြောဆိုဆွေးနွေးပါ။ မြန်မာဘာသာစကား Burmese

យកចិត្តទុកដាក់៖ ប្រសិនបើអ្នកនិយាយភាសាខ្មែរ (ខ្មែរ) សេវាកម្មជំនួយភាសាឥតគិតថ្លៃមានផ្តល់ជូនអ្នកដោយមិនគិតថ្លៃ និងដោយគ្មានការពន្យារពេលមិនចាំបាច់ឡើយ។ លើសពីនេះ ជំនួយ និងសេវាកម្មដែលសមស្របក្នុងការផ្តល់ព័ត៌មានក្នុង ទម្រង់ដែលអាចចូលប្រើបានគឺអាចរកបានដោយឥតគិតថ្លៃ និងទាន់ពេលវេលា។ សូមហៅទូរសព្ទទៅលេខខាងលើ ឬនិយាយជាមួយអ្នកផ្តល់សេវារបស់អ្នក។ ភាសាខ្មែរ (ខ្មែរ) Cambodian (Khmer)

注意：如果您說簡體中文，您可以免費獲得語言協助服務，且不會有不必要的延誤。此外，還能免費及時獲取以無障礙格式提供資訊的適當輔助工具和服務。請撥打上面的電話號碼，或與您的服務提供商溝通。 Cantonese (Traditional Chinese)

ATTENTION : Si vous parlez français, des services d'assistance linguistique gratuits sont à votre disposition, sans frais et sans délai. En outre, des aides et services auxiliaires appropriés pouvant fournir des informations dans des formats accessibles sont disponibles gratuitement et rapidement. Veuillez appeler le numéro ci-dessus ou contacter votre fournisseur. French

CEEB TOOM: Yog koj hais lus Hmoob, muaj kev pab txhais lus dawb rau koj siv. Koj tsis tas them nqi thiab yuav tsis qeeb. Kuj muaj cuab yeej thiab kev pab los pab koj nyeem cov ntaub ntawv kom yooj yim nkag siab. Koj hu tau rau tus xov tooj saum toj no lossis nrog koj tus kws kho mob tham. Hmong

NO ENGLISH  1-800-203-7225 612-676-3200

TRS: 711

ဟ်သူဉ်ဟ်သး– နမ့်ကတိၤကညီကျိာ်အဃိ, နမၤန့်, ကျိာ်တ၊်ဆီဉ်ထွဲမၤစ၊ၤ လ၊တလာ်ဘူဉ်လာ်စ့ၤ ဒီးတအိဉ်ဒီး တ၊်မၤယံာ်မၤနီ၊်သးဘဉ်နၣ်လီၤ. အါန့်အနၣ်, တ၊်အိဉ်စ့၊်ကီးဒီး တ၊်မၤစ၊ၤတ၊်နှ၊်ဟူဒီး တ၊်မၤစ၊ၤတ၊်မၤတဖဉ် လ၊ကဟ့ဉ်တ၊်ဂ့၊်တ၊်ကျိၤ လ၊ပှၤအါဂၤန၊်ပ၊်အီၤသ့ လ၊တအိဉ်ဒီးအဘူးအလဲ ဒီးချူးဆ၊ချူးကတိၤနၣ်လီၤ. ဝံသးစူၤ ကိးနိဉ်ဂံ၊်လ၊ထး မ့တမ့၊် တဲသကိးတ၊်ဒီး ပှၤလ၊အဟ့ဉ်နၤတ၊်မၤစ၊ၤ တက့၊်. ကညီကျိာ် Karen

안내: 한국어를 사용하시는 분께는 언어 지원 서비스를 무료로, 지체 없이 제공해 드립니다. 또한, 정보 접근성을 위한 적절한 보조 기구 및 서비스가 무료로, 시의적절하게 제공됩니다. 위에 있는 번호로 전화하시거나 담당자에게 말씀해 주십시오. Korean

ໝາຍເຫດ: ຖ້າທ່ານເວົ້າພາສາລາວ, ທ່ານຈະໄດ້ຮັບບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາໂດຍບໍ່ເສຍຄ່າ ແລະ ບໍ່ມີການຊັກຊ້າ ທີ່ບໍ່ຈຳເປັນ. ນອກຈາກນັ້ນ, ເຄື່ອງມືຊ່ວຍເຫຼືອແລະ ບໍລິການເສີມທີ່ເໝາະສົມເພື່ອໃຫ້ຂໍ້ມູນໃນຮູບແບບທີ່ເຂົ້າເຖິງໄດ້ ໂດຍບໍ່ເສຍຄ່າໃຊ້ຈ່າຍ ແລະ ທັນເວລາ. ກະລຸນາໂທຫາເບີໂທລະສັບຂ້າງເທິງ ຫຼື ສົນທະນາກັບຜູ້ໃຫ້ບໍລິການຂອງທ່ານ. Lao

HUBADHAA: Yoo Afaan Oromoo dubbattu ta’e, tajaajila gargaarsa turjumaana afaanii biliisaan akkasumas turtii barbaachisaa hin taane hambisu danda’u isiniif dhihaatee jira. Dabalataanis, odeeffannoo haala salphaan argamuu danda’an dhiyeessuuf gargaarsa fi tajaajiloota deeggarsaa qama midhamtootaaf mijatoo ta’an, kaffaltii tokko malee fi yeroo isaa eeggatee kennamu dhihaatee jira. Odeeffanno dabalataaf lakkoofsa armaan oliitti fayyadamuun namoota gargaarsa kana isiniif kennan qunnamaa. Oromo

ВНИМАНИЕ: Если вы разговариваете на русском языке, воспользуйтесь услугами языковой поддержки бесплатно и без лишних проволочек. Также бесплатно и незамедлительно предоставляются соответствующие вспомогательные средства и услуги по обеспечению информацией в доступных форматах. Позвоните по указанному выше номеру или обратитесь к своему поставщику услуг. Russian

FIIRO GAAR AH: Haddii aad ku hadasho Soomaali, waxaa si bilaash ah kuugu diyaar ah adeegyada caawinada luuqadeed oo aan lahayn daahitaan aan munaasib ahayn. Intaas waxaa dheer, waxaa la heli karaa adeegyada iyo kaabitaanka naafada ee haboon si macluumaadka loogu bixiyo qaabab la adeegsan karo oo bilaash ah laguna bixinayo waqqigeeda. Fadlan wac lambarka kore ama la hadal adeegbixiyahaaga. Somali

ATENCIÓN: si habla español, tiene a su disposición los servicios gratuitos de traducción sin costo alguno y sin demoras innecesarias. Además, se encuentran disponibles de forma gratuita y oportuna ayuda y servicios auxiliares adecuados con el fin de brindarle información en formatos accesibles. Llame al número indicado anteriormente o hable con su proveedor. Spanish

LƯU Ý: Nếu bạn nói tiếng Việt, bạn có thể được hỗ trợ ngôn ngữ miễn phí mà không phải chờ đợi lâu. Ngoài ra, các thiết bị hỗ trợ và dịch vụ phù hợp để cung cấp thông tin ở định dạng dễ tiếp cận cũng có sẵn miễn phí và kịp thời. Vui lòng gọi số điện thoại phía trên hoặc trao đổi với nhân viên y tế của bạn. Vietnamese

Member Handbook Introduction

This *Member Handbook,* otherwise known as the *Evidence of Coverage,* tells you about your coverage under our plan through 12/31/2026. It explains health care services, behavioral health (mental health and substance use disorder) services, drug coverage, and long-term services and supports. Key terms and their definitions appear in alphabetical order in **Chapter 12** of this *Member Handbook*.

This is an important legal document. Keep it in a safe place.

When this *Member Handbook* says “we”, “us”, “our”, or "our plan", it means UCare Connect + Medicare.

You can get this document for free in other formats, such as large print, braille, and/or audio by calling Customer Service at the number at the bottom of this page. The call is free.

- To make or change a standing request to get this document, now and in the future, in a language other than English or in an alternate format, call Customer Service at the numbers at the bottom of this page.

We have free interpreter services to answer any questions that you may have about our health or drug plan. To get an interpreter just call us at the numbers at the bottom of the page. Someone that speaks your language can help you. This is a free service.

Disclaimers

- UCare is an HMO D-SNP health plan that contracts with both Medicare and the Minnesota Medical Assistance (Medicaid) program to provide benefits of both programs to enrollees. Enrollment in UCare depends on contract renewal.
- Benefits and/or copays may change on January 1, 2027.
- Our covered drugs, pharmacy network, and/or provider network may change at any time. You’ll get a notice about any changes that may affect you at least 30 days in advance.

Chapter 1: Getting started as a member

Introduction

This chapter includes information about UCare Connect + Medicare, a health plan that covers all of your Medicare and Medical Assistance services, and your membership in it. It also tells you what to expect and what other information you'll get from us. Key terms and their definitions appear in alphabetical order in the last chapter of this *Member Handbook*.

Table of Contents

A. Welcome to our plan

Our plan provides Medicare and Medical Assistance services to individuals who are eligible for both programs. Our plan includes doctors, hospitals, pharmacies, providers of long-term services and supports, behavioral health providers, and other providers. We also have care coordinators and care teams to help you manage your providers and services. They all work together to provide the care you need.

B. Information about Medicare and Medical Assistance

B1. Medicare

Medicare is the federal health insurance program for:

- people 65 years of age or over,
- some people under age 65 with certain disabilities, **and**
- people with end-stage renal disease (kidney failure).

B2. Medical Assistance

Medical Assistance is the name of Minnesota's Medicaid program. Medical Assistance is run by the state and is paid for by the state and the federal government. Medical Assistance helps people with limited incomes and resources pay for Long-Term Services and Supports (LTSS) and medical costs. It covers extra services and drugs not covered by Medicare.

Each state decides:

- what counts as income and resources,
- who is eligible,
- what services are covered, **and**
- the cost for services.

States can decide how to run their programs, as long as they follow the federal rules.

Medicare and the state of Minnesota approved our plan. You can get Medicare and Medical Assistance program services through our plan as long as:

- we choose to offer the plan, **and**

- Medicare and the state of Minnesota allow us to continue to offer this plan.

Even if our plan stops operating in the future, your eligibility for Medicare and Medical Assistance services isn't affected.

C. Advantages of our plan

You'll now get all your covered Medicare and Medical Assistance services from our plan, including drugs. **You don't pay extra to join this health plan.**

We help make your Medicare and Medical Assistance benefits work better together and work better for you. Some of the advantages include:

- You can work with us for **most** of your health care needs.
- You have a care team that you help put together. Your care team may include yourself, your caregiver, doctors, nurses, counselors, or other health professionals.
- You have access to a care coordinator. This is a person who works with you, with our plan, and with your care team to help make a support plan.
- You're able to direct your own care with help from your care team and care coordinator.
- Your care team and care coordinator work with you to make a support plan designed to meet **your** health needs. The care team helps coordinate the services you need. For example, this means that your care team makes sure:
  - Your doctors know about all the medicines you take so they can make sure you're taking the right medicines and can reduce any side effects that you may have from the medicines.
  - Your test results are shared with all of your doctors and other providers, as appropriate.

D. Our plan's service area

Our service area includes these counties in Minnesota: Anoka, Benton, Carver, Chisago, Dakota, Hennepin, Isanti, Mille Lacs, Ramsey, Scott, Sherburne, Stearns, Washington, and Wright.

Only people who live in our service area can join our plan.

You can't stay in our plan if you move outside of our service area. Refer to **Chapter 8** of this *Member Handbook* for more information about the effects of moving out of our service area.

E. What makes you eligible to be a plan member

You're eligible for our plan as long as you:

- live in our service area (incarcerated individuals aren't considered living in the service area even if they're physically located in it), **and**
- have both Medicare Part A and Medicare Part B, **and**
- are a United States citizen or are lawfully present in the United States, **and**
- are currently eligible for Medical Assistance.
- are age 18-64
- have a certified disability through the Social Security Administration or the State Medical Review Team

If you lose eligibility but can be expected to regain it within three months then you're still eligible for our plan.

Call Customer Service for more information.

F. What to expect when you first join our health plan

When you first join our plan, you get a health risk assessment (HRA) within 60 days before or after your enrollment effective date.

We must complete an HRA for you. This HRA is the basis for developing your support plan. The HRA includes questions to identify your medical, behavioral health, and functional needs.

We reach out to you to complete the HRA. We can complete the HRA by an in-person visit, telephone call, or mail.

We'll send you more information about this HRA.

If UCare Connect + Medicare is new for you, you can keep using the doctors you use now for up to 120 days for certain reasons. For more information, refer to **Chapter 3** of this *Member Handbook*.

After 120 days you will need to use doctors and other providers in the UCare Connect + Medicare network.

A network provider is a provider who works with the health plan. Refer to **Chapter 3** of this *Member Handbook* for more information on getting care.

G. Your care team and support plan

G1. Care team

A care team can help you keep getting the care you need. A care team may include your doctor, a care coordinator, or other health person that you choose.

A care coordinator is a person trained to help you manage the care you need. You get a care coordinator when you enroll in our plan. This person also refers you to other community resources that our plan may not provide and will work with your care team to help coordinate your care. Call us at the numbers at the bottom of the page for more information about your care coordinator and care team.

G2. Support plan

Your care team works with you to make a support plan. A support plan tells you and your doctors what services you need and how to get them. It includes your medical, behavioral health, and LTSS or other services.

Your support plan includes:

- preventive and maintenance health care service goals,
- coordination of health care services needs,
- your health care goals, **and**
- a timeline for getting the services you need.

Your care team meets with you after your HRA. They ask you about services you need. They also tell you about services you may want to think about getting. Your support plan is created based on your needs and goals. Your care team works with you to update your support plan at least every year.

H. Summary of important costs

Our plan has no premium. Your costs may include the following:

- Monthly Medicare Part B Premium (**Section H1**)
- Medicare Prescription Payment Plan Amount (**Section H2**)

H1. Monthly Medicare Part B Premium

Many members are required to pay other Medicare premiums

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

Your Medicare Part B premium is either automatically taken from your monthly Social Security check or you are billed directly. While you're a member of this UCare plan, we'll pay up to $1.90 of your Medicare Part B premium. You don't have to do anything to get this benefit. It could take a few months for this benefit to process.

- If your Medicare Part B premium is automatically taken from your monthly Social Security check, your monthly Social Security check will go up by $1.90. Any missed increases will be added to your next check once the process is complete.
- If you are billed directly for your Medicare Part B premium, your monthly premium bill will decrease by $1.90. Any missed reductions will be reduced from your next bill once the process is complete.

If you leave this plan, your Medicare Part B premium reduction benefit will end on your last day as a member. Please note that it may take a few of months for this to process. Any premium reductions you get after you leave this plan will eventually be taken from your Social Security check if you are receiving Social Security or be added to your Part B Premium bill if you are billed directly.

If Medical Assistance isn't paying your Medicare premiums for you, you must continue to pay your Medicare premiums to stay a member of our plan. This includes your premium for Medicare Part B. You may also pay a premium for Medicare Part A if you aren't eligible for

premium-free Medicare Part A. **In addition, please contact Customer Service or your care coordinator and inform them of this change.**

H2. Medicare Prescription Payment Amount

If you're participating in the Medicare Prescription Payment Plan, you'll get a bill from your plan for your drugs (instead of paying the pharmacy). Your monthly bill is based on what you owe for any prescriptions you get, plus your previous month's balance, divided by the number of months left in the year.

Chapter 2 tells more about the Medicare Prescription Payment Plan. If you disagree with the amount billed as part of this payment option, you can follow the steps in **Chapter 9** to make a complaint or appeal.

I. This *Member Handbook*

This *Member Handbook* is part of our contract with you. This means that we must follow all rules in this document. If you think we've done something that goes against these rules, you may be able to appeal our decision. For information about appeals, refer to **Chapter 9** of this *Member Handbook* or call 1-800-MEDICARE (1-800-633-4227).

You can ask for a *Member Handbook* by calling Customer Service at the numbers at the bottom of the page. You can also refer to the *Member Handbook* found on our website at the web address at the bottom of the page.

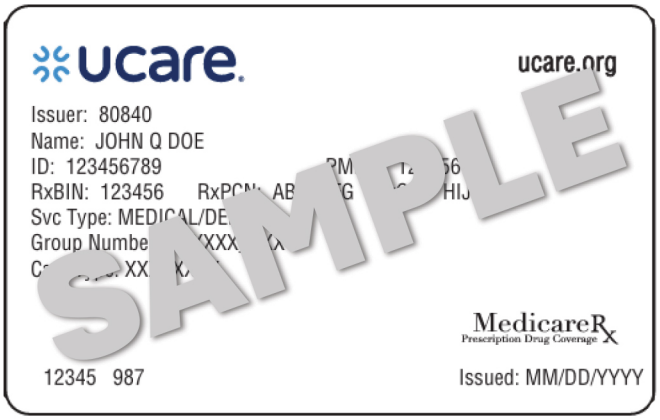
The contract is in effect for the months you're enrolled in our plan between January 1, 2026 and December 31, 2026.

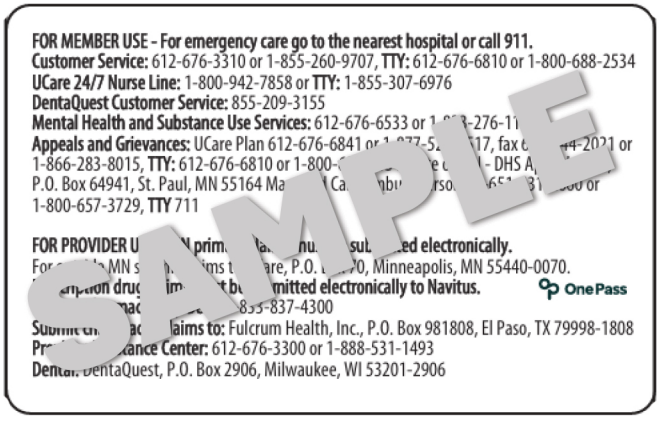
J. Other important information you get from us

Other important information we provide to you includes your Member ID Card, information about how to access a *Provider and Pharmacy Directory*, and information about how to access a *List of Covered Drugs*, also known as a *Drug List* or *Formulary*.

J1. Your Member ID card

Under our plan, you have one card for your Medicare and Medical Assistance services, including LTSS, certain behavioral health services, and prescriptions. You show this card when you get any services or prescriptions. Here is a sample Member ID Card:





If your Member ID Card is damaged, lost, or stolen, call Customer Service at the number at the bottom of the page right away. We'll send you a new card.

As long as you're a member of our plan, you don't need to use your red, white, and blue Medicare card or your Medical Assistance card to get most services. Keep those cards in a safe place, in case you need them later. If you show your Medicare card instead of your Member ID Card, the provider may bill Medicare instead of our plan, and you may get a bill. You may be asked to show your Medicare card if you need hospital services, hospice services, or participate in Medicare-approved clinical research studies (also called clinical trials). Refer to **Chapter 7** of this *Member Handbook* to find out what to do if you get a bill from a provider.

For benefits covered outside of our plan you may need to use your Medical Assistance card. Refer to **Chapter 4**, **Section E**.

J2. *Provider and Pharmacy Directory*

The *Provider and Pharmacy Directory* lists the providers and pharmacies in our plan's network. While you're a member of our plan, you must use network providers to get covered services.

You can ask for a *Provider and Pharmacy Directory* (electronically or in hard copy form) by calling Customer Service at the numbers at the bottom of the page. Requests for hard copy Provider and Pharmacy Directories will be mailed to you within three business days. You can also refer to the *Provider and Pharmacy Directory* at the web address at the bottom of the page.

? **If you have questions**, please call UCare Connect + Medicare at 612-676-3310 or 1-855-260-9707 (this call is free), TTY 612-676-6810 or 1-800-688-2534 (this call is free), 8 am – 8 pm, seven days a week. **For more information, visit ucare.org.**

Both Customer Service and the website can give you the most up-to-date information about changes in our network pharmacies and providers. You can find names, addresses and phone numbers for network doctors, clinics, pharmacies, hospitals and more. You can also get other details about providers such as qualifications, specialty, medical school attended, residency completed and board certification status.

Definition of network providers

- Our network providers include:
  - doctors, nurses, and other health care professionals that you can use as a member of our plan;
  - clinics, hospitals, nursing facilities, and other places that provide health services in our plan; **and**
  - LTSS, behavioral health services, home health agencies, durable medical equipment (DME) suppliers, and others who provide goods and services that you get through Medicare or Medical Assistance.

Network providers agree to accept payment from our plan for covered services as payment in full.

Definition of network pharmacies

- Network pharmacies are pharmacies that agree to fill prescriptions for our plan members. Use the *Provider and Pharmacy Directory* to find the network pharmacy you want to use.
- Except during an emergency, you must fill your prescriptions at one of our network pharmacies if you want our plan to help you pay for them.

Call Customer Service at the numbers at the bottom of the page for more information. Both Customer Service and our website can give you the most up-to-date information about changes to our network pharmacies and providers.

J3. *List of Covered Drugs*

Our plan has a *List of Covered Drugs*. We call it the *Drug List* for short. It tells you which drugs our plan covers. The drugs on this list are selected by our plan with the help of doctors and pharmacists. The *Drug List* must meet Medicare's requirements. Drugs with negotiated prices under the Medicare Drug Price Negotiation Program will be included on your *Drug List* unless they have been removed and replaced as described in **Chapter 5, Section E**. Medicare approved the UCare Connect + Medicare *Drug List*.

The *Drug List* also tells you if there are any rules or restrictions on any drugs, such as a limit on the amount you can get. Refer to **Chapter 5** of this *Member Handbook* for more information.

Each year, we send you information about how to access the *Drug List*, but some changes may occur during the year. To get the most up-to-date information about which drugs are covered, call Customer Service or visit our website at the address at the bottom of the page.

J4. The *Explanation of Benefits*

When you use your Medicare Part D drug benefits, we send you a summary to help you understand and keep track of payments for your Medicare Part D drugs. This summary is called the *Explanation of Benefits* (EOB).

The EOB tells you the total amount you, or others on your behalf, spent on your Medicare Part D drugs and the total amount we paid for each of your Medicare Part D drugs during the month. This EOB isn't a bill. The EOB has more information about the drugs you take such as increases in price and other drugs with lower cost-sharing that may be available. You can talk to your prescriber about these lower cost options. **Chapter 6** of this *Member Handbook* gives more information about the EOB and how it helps you track your drug coverage.

You can also ask for an EOB. To get a copy, contact Customer Service at the numbers at the bottom of the page.

You may view your 2026 Part D *Explanation of Benefits* (Part D EOB) by logging into your online member account at **member.ucare.org** and going to the Documents library. You may also request to stop receiving a paper copy of your Part D EOB by calling Customer Service to learn more.

K. Keeping your membership record up to date

You can keep your membership record up to date by telling us when your information changes.

We need this information to make sure that we have your correct information in our records. The doctors, hospitals, pharmacists, and other providers in our plan's network use your membership record to know what services and drugs are covered and your cost-sharing amounts. Because of this, it's very important to help us keep your information up to date.

Tell us right away about the following:

- changes to your name, address, or phone number;
- changes to any other health insurance coverage, such as from your employer, your spouse’s employer, or your domestic partner’s employer, or workers’ compensation;

- any liability claims, such as claims from an automobile accident;
- admission to a nursing facility or hospital;
- care from a hospital or emergency room;
- changes in your caregiver (or anyone responsible for you); **and**
- participation in a clinical research study. (**Note:** You're not required to tell us about a clinical research study you intend to participate in, but we encourage you to do so.)

If any information changes, call Customer Service at the numbers at the bottom of the page. You may update your address, phone number, and email communication preferences by logging in to your online member account at **member.ucare.org**. Using your online member account, you can also send us a message to request that we update your Primary Care Clinic selection.

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

- Name or address changes
- Admission to a nursing home
- Addition or loss of a household member
- Lost or stolen Minnesota Health Care Program ID Card
- New insurance
- New job or change in income

K1. Privacy of personal health information (PHI)

Information in your membership record may include personal health information (PHI). Federal and state laws require that we keep your PHI private. We protect your PHI. For more details about how we protect your PHI, refer to **Chapter 8** Section C of this *Member Handbook*.

Chapter 2: Important phone numbers and resources

Introduction

This chapter gives you contact information for important resources that can help you answer your questions about our plan and your health care benefits. You can also use this chapter to get information about how to contact your care coordinator and others to advocate on your behalf. Key terms and their definitions appear in alphabetical order in the last chapter of this *Member Handbook*.

Table of Contents

A. Customer Service

Contact Customer Service to get help with:

- questions about the plan
- questions about claims or billing

Method	Customer Service
CALL	612-676-3310 or 1-855-260-9707 (this call is free) 8 am – 8 pm, seven days a week We have free interpreter services for people who don't speak English.
TTY	612-676-6810 or 1-800-688-2534 (this call is free) 8 am – 8 pm, seven days a week This number is for people who have difficulty with hearing or speaking. You must have special equipment to call it.
FAX	612-676-6501 1-866-457-7145
WRITE	**Attn: Customer Service** UCare PO Box 52 Minneapolis, MN 55440-0052
WEBSITE	**ucare.org**

? **If you have questions**, please call UCare Connect + Medicare at 612-676-3310 or 1-855-260-9707 (this call is free), TTY 612-676-6810 or 1-800-688-2534 (this call is free), 8 am – 8 pm, seven days a week. **For more information, visit ucare.org.**

- coverage decisions about your health care
  - A coverage decision about your health care is a decision about:
    - your benefits and covered services **or**
    - the amount we pay for your health services.
  - Call us if you have questions about a coverage decision about your health care.
  - To learn more about coverage decisions, refer to **Chapter 9** of this *Member Handbook*.

Method	Coverage Decisions for Health Care
CALL	**For coverage decisions** **Customer Service** 612-676-3310 1-855-260-9707 (this call is free) 8 am – 8 pm, seven days a week
TTY	612-676-6810 1-800-688-2534 (this call is free) 8 am – 8 pm, seven days a week These numbers are for people who have difficulty with hearing or speaking. You must have special equipment to call them
FAX	612-884-2021 1-866-283-8015 **Attn: Appeals and Grievances**
WRITE	**For coverage decisions** **Attn: Standard Review** UCare PO Box 52 Minneapolis, MN 55440-0052
WEBSITE	**ucare.org**

- appeals about your health care
  - An appeal is a formal way of asking us to review a decision we made about your coverage and asking us to change it if you think we made a mistake or disagree with the decision.
  - To learn more about making an appeal, refer to **Chapter 9** of this *Member Handbook* or contact Customer Service.

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

- complaints about your health care
  - You can make a complaint about us or any provider (including a non-network or network provider). A network provider is a provider who works with our plan. You can also make a complaint to us or to the Quality Improvement Organization (QIO) about the quality of the care you received (refer to **Section D).**
  - You can call us and explain your complaint at the numbers at the bottom of the page.
  - If your complaint is about a coverage decision about your health care, you can make an appeal (refer to the section below).
  - You can send a complaint about our plan to Medicare. You can use an online form at www.medicare.gov/my/medicare-complaint. Or you can call 1-800-MEDICARE (1-800-633-4227) to ask for help.
  - To learn more about making a complaint about your health care, refer to **Chapter 9** of this *Member Handbook*.

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

- coverage decisions about your drugs
  - A coverage decision about your drugs is a decision about:
    - your benefits and covered drugs **or**
    - the amount we pay for your drugs.
  - This applies to your Medicare Part D drugs, Medical Assistance program prescription drugs and over-the-counter (OTC) drugs.
  - For more on coverage decisions about your drugs, refer to **Chapter 9** of this *Member Handbook*.

Method	Coverage Decisions for Medicare Part D Prescription Drugs
CALL	**Customer Service** 612-676-3310 1-855-260-9707 (this call is free) 8 am – 8 pm, seven days a week
TTY	612-676-6810 1-800-688-2534 (this call is free) 8 am – 8 pm, seven days a week These numbers are for people who have difficulty with hearing or speaking. You must have special equipment to call them
FAX	1-855-668-8552
WRITE	**Attn: Medicare Reviews** Navitus Health Solutions PO Box 1039 Appleton, WI 54912-1039

- appeals about your drugs
  - An appeal is a way to ask us to change a coverage decision.
  - For more on making an appeal about your drugs, refer to **Chapter 9** of this *Member Handbook*.

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

- complaints about your drugs
  - You can make a complaint about us or any pharmacy. This includes a complaint about your drugs.
  - If your complaint is about a coverage decision about your drugs, you can make an appeal. (Refer to the section below.)
  - You can send a complaint about our plan right to Medicare. You can use an online form at www.medicare.gov/my/medicare-complaint. Or you can call 1-800-MEDICARE (1-800-633-4227) to ask for help.
  - For more on making a complaint about your drugs, refer to **Chapter 9** of this *Member Handbook*.

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

- payment for health care or drugs you already paid for
  - We don't allow UCare Connect + Medicare providers to bill you for services. We pay our providers directly, and we protect you from any charges. The exception is if you pay for Medicare Part D drugs. If you paid for a service that you think we should've covered, contact Customer Service at the numbers at the bottom of the page.
  - For more on how to ask us to pay you back, or to pay a bill you got, refer to **Chapter 7** of this *Member Handbook*.
  - If you ask us to pay a bill and we deny any part of your request, you can appeal our decision. Refer to **Chapter 9** of this *Member Handbook*.

Method	Payment Requests for Medical Care or Part D Prescription Drugs
CALL	**Customer Service** 612-676-3310 1-855-260-9707 (this call is free) 8 am – 8 pm, seven days a week
TTY	612-676-6810 1-800-688-2534 (this call is free) 8 am – 8 pm, seven days a week These numbers are for people who have difficulty with hearing or speaking. You must have special equipment to call them
FAX	**For medical claims only:** 612-884-2021 1-866-283-8015 **For prescription drug claims only (Navitus Health Solutions):** 1-855-668-8550

Method	Payment Requests for Medical Care or Part D Prescription Drugs
WRITE	**For medical claims**, submit to UCare's Direct Member Reimbursement Department (DMR): **Attn: DMR Department** UCare PO Box 52 Minneapolis, MN 55440-0052 **For prescription drug claims**, submit to Navitus Health Solutions: Navitus Health Solutions Manual Claims PO Box 1039 Appleton, WI 54912-1039
WEBSITE	**ucare.org**

B. Your Care Coordinator

When you first join the plan, you're automatically assigned a care coordinator. Your care coordinator's job is to help you understand your benefits and get the most out of your benefits with the least amount of hassle and paperwork. You, your doctors, and others providing your care will all work together with your care coordinator. Your care coordinator will send you their contact information within 10 days of enrollment. If you don't remember the name or number of your care coordinator, you can call Customer Service at the numbers shown below.

Method	Customer Service
CALL	612-676-3310 or 1-855-260-9707 (this call is free) 8 am – 8 pm, seven days a week We have free interpreter services for people who don't speak English.
TTY	612-676-6810 or 1-800-688-2534 (this call is free) 8 am – 8 pm, seven days a week This number is for people who have difficulty with hearing or speaking. You must have special equipment to call it.
FAX	612-676-6501 1-866-457-7145
WRITE	**Attn: Customer Service** UCare PO Box 52 Minneapolis, MN 55440-0052
WEBSITE	**ucare.org**

Contact your care coordinator for help with:

- questions about your health care
- questions about getting behavioral health (mental health and substance use disorder) services
- questions about transportation

? **If you have questions**, please call UCare Connect + Medicare at 612-676-3310 or 1-855-260-9707 (this call is free), TTY 612-676-6810 or 1-800-688-2534 (this call is free), 8 am – 8 pm, seven days a week. **For more information, visit ucare.org.**

C. Senior LinkAge Line®

The State Health Insurance Assistance Program (SHIP) is a government program with trained counselors in every state that offers free help, information, and answers to your Medicare questions. In Minnesota, the SHIP is called Senior LinkAge Line®.

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

Method	Senior LinkAge Line® (Minnesota SHIP)
CALL	1-800-333-2433 (this call is free) Monday - Friday 8:00 a.m. to 4:30 p.m.
TTY	Call the Minnesota Relay Service at 711 or use your preferred relay service. The call is free.
WRITE	Minnesota Board on Aging PO Box 64976 St. Paul, MN 55164-0976
EMAIL	Senior.linkage@state.mn.us
WEBSITE	www.mn. gov/senior-linkage-line

Contact Senior LinkAge Line® for help with:

- questions about Medicare
- Senior LinkAge Line® counselors can answer your questions about changing to a new plan and help you:
  - understand your rights,
  - understand your plan choices,
  - answer questions about switching plans,
  - make complaints about your health care or treatment, **and**
  - straighten out problems with your bills.

D. Quality Improvement Organization (QIO)

Our state has an organization called Commence Health. This is a group of doctors and other health care professionals who help improve the quality of care for people with Medicare. Commence Health is an independent organization. It's not connected with our plan.

Method	Commence Health (Minnesota's Quality Improvement Organization) – Contact Information
CALL	1-888-524-9900 (this call is free) Monday through Friday, 9:00 am - 5:00 pm Weekend and Holidays, 10:00 am - 4:00 pm 24-hour voicemail is available
TTY	1-888-985-8775 (this call is free) This number is for people who have difficulty with hearing or speaking . You must have special telephone equipment to call it. Or 711 or use your referred relay service These calls are free
WRITE	Commence Health, BFCC-QIO Program 10820 Guilford Road, Suite 202 Annapolis Junction, MD 20701-1105
WEBSITE	https://www.livantaqio.cms.gov/

Contact Commence Health for help with:

- questions about your health care rights
- making a complaint about the care you got if you:
  - have a problem with the quality of care such as getting the wrong medication, unnecessary tests or procedures, or a misdiagnosis,
  - think your hospital stay is ending too soon, **or**
  - think your home health care, skilled nursing facility care, or comprehensive outpatient rehabilitation facility (CORF) services are ending too soon.

E. Medicare

Medicare is the federal health insurance program for people 65 years of age or over, 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, or CMS. This agency contracts with Medicare Advantage organizations including our plan.

Method	Medicare
CALL	1-800-MEDICARE (1-800-633-4227) Calls to this number are free, 24 hours a day, 7 days a week
TTY	1-877-486-2048 (this call is free) This number is for people who have difficulty with hearing or speaking. You must have special telephone equipment to call it.
CHAT LIVE	Chat live at www.medicare.gov/talk-to-someone
WRITE	Write to Medicare at PO Box 1270, Lawrence, KS 66044

Method	Medicare
WEBSITE	www.medicare.gov • Get information about the Medicare health and drug plans in your area, including what they cost and what services they provide. • Find Medicare-participating doctors or other health care providers and suppliers. • Find out what Medicare covers, including preventive services (like screenings, shots, or vaccines, and yearly "wellness" visits). • Get Medicare appeals information and forms. • Get information about the quality of care provided by plans, nursing homes, hospitals, doctors, home health agencies, dialysis facilities, hospice centers, inpatient rehabilitation facilities, and long-term care hospitals. • Look up helpful websites and phone numbers. To submit a complaint to Medicare, go to www.medicare.gov/my/medicare-complaint. Medicare takes your complaints seriously and will use this information to help improve the quality of the Medicare program.

F. Medical Assistance

Medical Assistance helps with medical and long-term services and supports costs for people with limited incomes and resources.

You're enrolled in Medicare and in Medical Assistance. If you have questions about the help you get from Medical Assistance, call the Minnesota Department of Human Services.

Method	**Minnesota Department of Human Services (Minnesota's Medical Assistance (Medicaid) program)**
CALL	Health Care Consumer Support (HCCS) 1-651-297-3862 Or 1-800-657-3672. This call is free. Monday through Friday, 8:00 a.m. - 4:30 p.m.
TTY	711 or use your preferred relay service These calls are free.
WRITE	Department of Human Services 444 Lafayette Road St. Paul, MN 55155
EMAIL	DHS.info@state.mn.us
WEBSITE	https://mn.gov/dhs/people-we-serve/adults/health-care/health-care-programs/programs-and-services/medical-assistance.jsp

G. Ombudsperson for Public Managed Health Care Program

The Ombudsperson for Public Managed Health Care Program works as an advocate on your behalf. They can answer questions if you have a problem or complaint and can help you understand what to do. The Ombudsperson for Public Managed Health Care Program also helps you with service or billing problems. They aren't connected with our plan or with any insurance company or health plan. Their services are free.

Method	Ombudsperson for Public Managed Health Care Programs
CALL	1-651-431-2660 Or 1-800-657-3729 (this call is free) Monday through Friday, 8:00 a.m. - 4:30 p.m.
TTY	1-800-627-3529 Or 711 or use your preferred relay service These calls are free.
WRITE	MN Department of Human Services Ombudsperson for Public Managed Health Care Programs PO Box 64249 St. Paul, MN 55164-0249
EMAIL	dhsombudsperson@state.mn.us
WEBSITE	mn.gov/dhs/managedcareombudsman

H. Office of Ombudsman for Long-Term Care (OOLTC)

The OOLTC helps people get information about nursing homes and resolve problems between nursing homes and residents or their families.

The OOLTC isn't connected with our plan or any insurance company or health plan.

Method	Minnesota Office of Ombudsman for Long-Term Care
CALL	1-651-431-2555 Or 1-800-657-3591 (this call is free) Monday through Friday, 8:00 a.m. - 4:30 p.m.
TTY	1-800-627-3529 This number is for people who have difficulty with hearing or speaking. You must have special telephone equipment to call it. Or 711 or use your preferred relay service These calls are free.
WRITE	Minnesota Office of Ombudsman for Long-Term Care PO Box 64971 St. Paul, MN 55164-0971
EMAIL	mba.ooltc@state.mn.us
WEBSITE	www.mn.gov/ooltc

I. Programs to Help People Pay for Drugs

The Medicare website (www.medicare.gov/basics/costs/help/drug-costs) provides information on how to lower your drug costs. For people with limited incomes, there are also other programs to assist, as described below.

I1. Extra Help from Medicare

Because you're eligible for Medicaid, you qualify for and are getting "Extra Help" from Medicare to pay for your drug plan costs. You don't need to do anything to get this "Extra Help."

Method	Medicare
CALL	1-800-MEDICARE (1-800-633-4227) Calls to this number are free, 24 hours a day, 7 days a week
TTY	1-877-486-2048 (this call is free) This number is for people who have difficulty with hearing or speaking. You must have special telephone equipment to call it.
WEBSITE	www.medicare.gov

If you think you're paying an incorrect amount for your prescription at a pharmacy, our plan has a process to help get evidence of your correct copayment amount. If you already have evidence of the right amount, we can help you share this evidence with us.

- First, contact Customer Service. We'll help you identify what documentation must be sent to us. Upon receipt of your documentation, we'll review it and determine if it meets Medicare requirements. If the documentation meets Medicare requirements, we'll correct your cost-sharing amount. If the documentation does not support a change in your cost-sharing amount, we'll notify you.
- When we get the evidence showing the right copayment level, we'll update our system so you can pay the right copayment amount when you get your next prescription. If you overpay your copayment, we'll pay you back either by check or a future copayment credit. If the pharmacy didn't collect your copayment and you owe them a debt, we may make the payment directly to the pharmacy. If a state paid on your behalf, we may make payment directly to the state. Call Customer Service at the number at the bottom of the page if you have questions.

I2. AIDS Drug Assistance Program (ADAP)

ADAP helps ADAP-eligible people living with HIV/AIDS have access to life-saving HIV drugs. Medicare Part D drugs that are also on the ADAP formulary qualify for prescription cost-sharing help. For information, call the Minnesota Department of Human Services at 651-431-2414 or 1-800-657-3761, (TTY 711).

Note: To be eligible for the ADAP in your state, people must meet certain criteria, including proof of the state residence and HIV status, low income as defined by the state, and uninsured/under-insured status. If you change plans, notify your local ADAP enrollment worker so you can continue to receive assistance for information on eligibility criteria, covered drugs, or how to enroll in the program, please call the Minnesota Department of Human Services at 651-431-2414 or 1-800-657-3761, (TTY 711).

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

I3. The Medicare Prescription Payment Plan

The Medicare Prescription Payment Plan is a payment option that works with your current drug coverage to help you manage your out-of-pocket costs for drugs covered by our plan by spreading them across the calendar year (January-December). Anyone with a Medicare drug plan or Medicare health plan with drug coverage (like a Medicare Advantage plan with drug

coverage) can use this payment option. **This payment option might help you manage your expenses, but it doesn't save you money or lower your drug costs. If you're participating in the Medicare Prescription Payment Plan and stay in the same plan, you don't need to do anything to continue this option**. "Extra Help" from Medicare and help from your ADAP, for those who qualify, is more advantageous than participation in this payment option, no matter your income level, and plans with drug coverage must offer this payment option. To learn more about this payment option, call Member Services at the phone number at the bottom of the page or visit www.medicare.gov.

J. Social Security

Social Security determines Medicare eligibility and handles Medicare enrollment.

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

Method	Social Security
CALL	1-800-772-1213 (this call is free) Available 8:00 am to 7:00 pm, Monday through Friday. You can use their automated telephone services to get recorded information and conduct some business 24 hours a day.
TTY	1-800-325-0778 This number is for people who have difficulty with hearing or speaking. You must have special telephone equipment to call it.
WEBSITE	www.ssa.gov

K. Railroad Retirement Board (RRB)

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

Method	Railroad Retirement Board
CALL	1-877-772-5772 (this call is free) Press "0" to speak with a RRB representative from 9:00 am to 3:30 pm, Monday, Tuesday, Thursday, and Friday, and from 9:00 am to 12:00 pm on Wednesday. Press "1" to access the automated RRB Help Line and get recorded information 24 hours a day, including weekends and holidays.
TTY	1-312-751-4701 This number is for people who have difficulty with hearing or speaking. You must have special telephone equipment to call it. Calls to this number aren't free.
WEBSITE	rrb.gov

L. Other resources

L1. Disability Hub MN™

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

Method	Disability Hub MN™
CALL	1-866-333-2466 (this call is free) Monday through Friday from 8:30 a.m. to 5:00 p.m.
TTY	Call the Minnesota Relay Services at 711 or use your preferred relay service. Calls to this number are free.
WRITE	Disability Hub MN™ PO Box 64967 St. Paul, MN 55164-0976
WEBSITE	www.disabilityhubmn.org

L2. Help with Mental Health and Substance Use Disorder

Method	Integrated Care Management Triage Line
CALL	612-676-6533 or 1-833-276-1185 (this call is free) 8 am – 5 pm, Monday – Friday We have free interpreter services for people who do not speak English.
TTY	612-676-6810 or 1-800-688-2534 (this call is free) 8 am – 5 pm, Monday – Friday You need special telephone equipment to call these numbers.

L3. How to contact the UCare 24/7 Nurse Line

The UCare 24/7 Nurse Line is a telephone service that provides members with reliable health information 24 hours a day, seven days a week. The nurses can offer health advice or answer health questions.

Method	24/7 Nurse Line
CALL	1-800-942-7858 (this call is free) 24 hours a day, seven days a week We have free interpreter services for people who do not speak English.
TTY	1-855-307-6976 (this call is free) 24 hours a day, seven days a week You need special telephone equipment to call this number.

Chapter 3: Using our plan's coverage for your health care and other covered services

Introduction

This chapter has specific terms and rules you need to know to get health care and other covered services with our plan. It also tells you about your care coordinator, how to get care from different kinds of providers and under certain special circumstances (including from out-of-network providers or pharmacies), what to do if you're billed directly for services we cover, and the rules for owning Durable Medical Equipment (DME). Key terms and their definitions appear in alphabetical order in the last chapter of this *Member Handbook*.

Table of Contents

A. Information about services and providers

Services are health care, long-term services and supports (LTSS), supplies, behavioral health services, prescription and over-the-counter drugs, equipment and other services. **Covered services** are any of these services that our plan pays for. Covered health care, behavioral health, and LTSS are in **Chapter 4** of this *Member Handbook.* Your covered services for prescription and over-the-counter drugs are in **Chapter 5** of this *Member Handbook*.

Providers are doctors, nurses, and other people who give you services and care and are licensed by the state, as appropriate. Providers also include hospitals, home health agencies, clinics, and other places that give you health care services, behavioral health services, medical equipment, and certain LTSS.

Network providers are providers who work with our plan. These providers agree to accept our payment and your cost-sharing amount as full payment. We arranged for these providers to deliver covered services to you. Network providers bill us directly for care they give you. When you use a network provider, you usually pay only your share of the cost for covered services.

B. Rules for getting services our plan covers

Our plan covers all services covered by Medicare and Medical Assistance. This includes behavioral health and LTSS.

Our plan will generally pay for health care services, behavioral health services, and LTSS you get when you follow our rules. To be covered by our plan:

- The care you get must be included in our Medical Benefits Chart in **Chapter 4** of this *Member Handbook*.
- Medically necessary care is appropriate for your condition. This includes care related to physical conditions and mental health. It includes the kind and level of services. It includes the number of treatments. It also includes where you get the services and how long they continue. Medically necessary services must:
  - be the services that other providers would usually order
  - help you get better or stay as well as you are
  - help stop your condition from getting worse
  - help prevent and find health problems

- For medical services, you must have a network **primary care provider (PCP)** providing and overseeing your care. As a plan member, you must choose a network provider to be your PCP (for more information, go to **Section D1** of this chapter).
  - You don't need referrals from your PCP for emergency care or urgently needed care or to use a woman's health provider. You can get other kinds of care without having a referral from your PCP (for more information, go to **Section D1** in this chapter).
- **You must get your care from network providers** (for more information, go to **Section D** in this chapter). Usually, we won't cover care from a provider who doesn't work with our health plan. This means that you'll have to pay the provider in full for services you get. Here are some cases when this rule doesn't apply:
  - We cover emergency or urgently needed care from an out-of-network provider (for more information, go to **Section I** in this chapter).
  - If you need care that our plan covers and our network providers can't give it to you, you can get care from an out-of-network provider. You must obtain a prior authorization from us prior to seeking care. In this situation, we cover the care as if you got it from a network provider. For information about getting approval to use an out-of-network provider, go to **Section D4** in this chapter.
  - We cover kidney dialysis services when you're outside our plan's service area for a short time or when your provider is temporarily unavailable or not accessible.
- When you first join the plan, you can continue using the providers you use now for up to 120 days for the following reasons:
  - An acute condition.
  - A life-threatening mental or physical illness.
  - A physical or mental disability defined as an inability to engage in one or more major life activities. This applies to a disability that has lasted or is expected to last at least one year, or is likely to result in death.
  - A disabling or chronic condition that's in an acute phase.
  - You're receiving culturally appropriate health care services (excluding transportation services) and the plan doesn't have a network provider with special expertise in the delivery of those culturally appropriate health care services.
  - You don't speak English and the plan doesn't have a network provider who can communicate with you, either directly or through an interpreter.

If your qualified health care provider certifies that you have an expected lifetime of 180 days or less, you may be able to continue to use services for the rest of your life from a provider who is no longer part of our network.

An exception is made for family planning, which is an open access service covered by us through Medical Assistance. Federal and state laws let you choose any provider, even if not in our network, to get certain family planning services. This means by any doctor, clinic, hospital, pharmacy, or family planning office. For more information refer to the "Family Planning Services" section of the Benefits Chart in **Chapter 4**.

C. Your care coordinator

C1. What a care coordinator is

A care coordinator is a person who develops and coordinates supports and services stated in the support plan.

C2. How you can contact your care coordinator

When you first join the plan, you are automatically assigned a care coordinator. Your care coordinator will send you their contact information within 10 days of enrollment. If you don't remember the name or number of your care coordinator, you can call Customer Service at the numbers shown at the bottom of the page.

C3. How you can change your care coordinator

It is possible to change your care coordinator if, for some reason, you are not satisfied with your current care coordinator. You can call Customer Service at the numbers shown at the bottom of the page.

D. Care from providers

D1. Care from a primary care provider (PCP)

You must choose a primary care provider (PCP) to provide and manage your care.

Definition of a PCP and what a PCP does do for you

A PCP is a provider who knows you and your medical history. Your PCP is trained to give you basic medical care. When you become a member of the plan, you must choose a Primary Care Clinic. A Primary Care Clinic (PCC) is a clinic within UCare's network. You can see any PCP at this clinic. The types of providers that can act as a PCP are family medicine doctors, general practitioners, internists, geriatricians, doctors in obstetrics/gynecology, nurse midwives, physician assistants and nurse practitioners, or a specialist who is your primary physician. You can get your routine or basic care from your PCP who will also coordinate the rest of the covered services you get as a plan member.

This includes but is not limited to:

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

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

Your choice of PCP

When you are a member or become a member of UCare Connect + Medicare, you chose or were assigned a PCC and PCP. You can change your PCC and PCP at any time.

Option to change your PCP

You can change your PCP for any reason, at any time. It's also possible that your PCP may leave our plan's network. If your PCP leaves our network, we can help you find a new PCP in our network. If we are notified that your provider is leaving the network, we will notify you in writing.

You only need to change your PCP if you are changing your PCC. You may change your clinic at any time during the month, effective the first of the next month. To change your clinic, call Customer Service. 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.

Services you can get without approval from your PCP

In most cases, you need approval from your PCP before using other providers. This approval is called a **referral**. You can get services like the ones listed below without getting approval from your PCP first:

- Emergency services from network providers or out-of-network providers
- Urgently needed care are covered services that require immediate medical attention (but not an emergency) if you're either temporarily outside our plan's service area, or if it's unreasonable given your time, place, and circumstances to get this service from network providers. Examples of urgently needed services are unforeseen medical illnesses and injuries or unexpected flare-ups of existing conditions. Medically necessary routine provider visits (like annual checkups) aren't considered urgently needed even if you're outside our plan's service area or our network is temporarily unavailable.
- Kidney dialysis services that you get at a Medicare-certified dialysis facility when you're outside our plan's service area. Call Customer Service before you leave the service area. We can help you get dialysis while you're away.
- Flu shots and COVID-19 vaccines as well as hepatitis B vaccines and pneumonia vaccines as long as you get them from a network provider.
- Routine women's health care and family planning services. This includes breast exams, screening mammograms (X-rays of the breast), Pap tests, and pelvic exams.
- Additionally, if you're eligible to get services from Indian health providers, you may use these providers without a referral.

D2. Care from specialists and other network providers

A specialist is a doctor who provides health care for a specific disease or part of the body. There are many kinds of specialists, such as:

- Oncologists care for patients with cancer.
- Cardiologists care for patients with heart problems.
- Orthopedists care for patients with bone, joint, or muscle problems.

You can use any specialist in the network on your own without a referral. To use an out-of-network doctor or specialist, you or your provider must obtain a prior authorization from us in order for those services to be covered. Some services require your provider to get a prior authorization from us.

Refer to "Our plan's Benefits Chart" in **Chapter 4** for more information.

If we're unable to find you a qualified plan network provider, we must give you a standing prior authorization for a qualified specialist for any of these conditions:

- a chronic (ongoing) condition;
- a life-threatening mental or physical illness;
- a degenerative disease or disability;
- any other condition or disease that's serious or complex enough to require treatment by a specialist.

If you don't get a prior authorization from us when needed, the bill may not be paid. For more information, call Customer Service at the phone numbers printed at the bottom of this page.

D3. When a provider leaves our plan

A network provider you use may leave our plan. If one of your providers leaves our plan, you have these rights and protections that are summarized below:

- Even if our network of providers change during the year, we must give you uninterrupted access to qualified providers.
- We'll notify you that your provider is leaving our plan so that you have time to select a new provider.
  - If your primary care or behavioral health provider leaves our plan, we'll notify you if you visited that provider within the past three years.
  - If any of your other providers leave our plan, we'll notify you if you're assigned to the provider, currently get care from them, or visited them within the past three months.
- We help you select a new qualified in-network provider to continue managing your health care needs.

- If you're currently undergoing medical treatment or therapies with your current provider, you have the right to ask to continue getting medically necessary treatment or therapies. We'll work with you so you can continue to get care.
- We'll give you information about available enrollment periods and options you may have for changing plans.
- If we can't find a qualified network specialist accessible to you, we must arrange an out-of-network specialist to provide your care when an in-network provider or benefit is unavailable or inadequate to meet your medical needs. You must obtain a prior authorization from us prior to seeking care. In this situation, we will cover the care as if you got it from a network provider.
- If you find out one of your providers is leaving our plan, contact us. We can help you choose a new provider to manage your care. Call Customer Service at the phone numbers printed at the bottom of this page.
- If you think we haven't replaced your previous provider with a qualified provider or that we aren't managing your care well, you have the right to file a quality of care complaint to the Quality Improvement Organization (QIO), a quality of care grievance, or both. (Refer to **Chapter 9** for more information.)

D4. Out-of-network providers

To use an out-of-network doctor or specialist, you or your PCP must obtain a prior authorization from us in order for those services to be covered. Some services require your provider to get a prior authorization from us. Refer to **Chapter 4** for more information.

If you don't get a prior authorization from us when needed, the bill may not be paid. For more information, call Customer Service at the phone numbers at the bottom of the page.

If you use an out-of-network provider, the provider must be eligible to participate in Medicare and/or Medical Assistance.

- We can't pay a provider who isn't eligible to participate in Medicare and/or Medical Assistance.
- If you use a provider who isn't eligible to participate in Medicare, you must pay the full cost of the services you get.
- Providers must tell you if they aren't eligible to participate in Medicare.

E. Long-term services and supports (LTSS)

Long-term services and supports (LTSS) are services that help people who need assistance doing everyday tasks like taking a bath, getting dressed, making food, and taking medicine. Most of these services help you stay in your home so you don't need to move to a nursing home or hospital.

When a member receives his or her face-to-face health risk assessment (HRA), the care coordinator evaluates at that time whether or not the member is in need of LTSS and if he or she meets nursing facility level of care criteria to qualify. If so, then the care coordinator will assist the member in completing required forms and sending them to the member's financial worker at the member's county of residence. After the member's financial worker determines if the member qualifies financially, the member's care coordinator will arrange for LTSS at that time.

F. Behavioral health (mental health and substance use disorder) services

UCare has an Integrated Care Management triage line to assist members with any questions about how to get care from a mental health specialist, substance use disorder specialist or other network providers. Our triage line is available by phone 8 am – 5 pm, Monday – Friday at 612-676-6533 or 1-833-276-1185 (this call is free), TTY at 612-676-6810 or 1-800-688-2534 (this call is free) to support the mental health or substance use disorder needs of our members.

You can find a list of mental health and substance use disorder providers in your *Provider and Pharmacy Directory*, online at **ucare.org/searchnetwork** or by calling the Integrated Care Management triage line at 612-676-6533 or 1-833-276-1185 (this call is free), TTY at 612-676-6810 or 1-800-688-2534 (this call is free). Members can also call the UCare 24/7 Nurse Line at 1-800-942-7858 (this call is free), TTY 1-855-307-6976 (this call is free) for assistance with finding provider information.

G. Transportation services

If you need transportation to and from health services that we cover, call HealthRide at 612-676-6830 or 1-800-864-2157 (this call is free), TTY at 612-676-6810 or 1-800-688-2534 (this call is free). We'll provide the most appropriate and cost-effective transportation. We aren't required to provide transportation to your Primary Care Clinic if it's over 30 miles from your

home or if you choose a specialty provider that's more than 60 miles from your home. Call Customer Service at 612-676-3310 or 1-855-260-9707 (this call is free), TTY at 612-676-6810 or 1-800-688-2534 (this call is free) if you don't have a Primary Care Clinic that's available within 30 miles of your home and/or if it's over 60 miles to your specialty provider.

UCare requires two business days notice when booking rides to help ensure provider availability.

H. Covered services in a medical emergency, when urgently needed, or during a disaster

H1. Care in a medical emergency

A medical emergency is a medical condition with symptoms such as illness, severe pain, serious injury or a medical condition that's quickly getting worse. The condition is so serious that, if it doesn't get immediate medical attention, you or anyone with an average knowledge of health and medicine could expect it to result in:

- serious risk to your life and, if you're pregnant, loss of an unborn child; **or**
- loss of or serious harm to bodily functions; **or**
- loss of a limb or function of a limb; **or**
- In the case of a pregnant woman in active labor, when:
  - There isn't enough time to safely transfer you to another hospital before delivery.
  - A transfer to another hospital may pose a threat to your health or safety or to that of your unborn child.

If you have a medical emergency:

- **Get help as fast as possible**. Call 911 or use the nearest emergency room or hospital. Call for an ambulance if you need it. You **don't** need approval or a referral from your PCP. You don't need to use a network provider. You can get covered emergency medical care whenever you need it, anywhere in the U.S. or its territories from any provider with an appropriate state license even if they're not part of our network.

Covered services in a medical emergency

Our plan covers ambulance services in situations where getting to the emergency room in any other way could endanger your health. We also cover medical services during the emergency. To learn more, refer to the Benefits Chart in **Chapter 4** of this *Member Handbook*.

The providers who give you emergency care decide when your condition is stable and the medical emergency is over. They'll continue to treat you and will contact us to make plans if you need follow-up care to get better.

Our plan covers your follow-up care. If you get your emergency care from out-of-network providers, we'll try to get network providers to take over your care as soon as possible.

Getting emergency care if it wasn't an emergency

Sometimes it can be hard to know if you have a medical or behavioral health emergency. You may go in for emergency care and the doctor says it wasn't really an emergency. As long as you reasonably thought your health was in serious danger, we cover your care.

However, after the doctor says it wasn't an emergency, we cover your additional care only if:

- You use a network provider, or
- The additional care you get is considered "urgently needed care" and you follow the rules for getting it. Refer to the next section.

H2. Urgently needed care

Urgently needed care is care you get for a situation that isn't an emergency but needs care right away. For example, you might have a flare-up of an existing condition or an unforeseen illness or injury.

Urgently needed care in our plan's service area

In most cases, we cover urgently needed care only if:

- You get this care from a network provider **and**
- You follow the rules described in this chapter.

If it isn't possible or reasonable to get to a network provider given your time, place or circumstances, we cover urgently needed care you get from an out-of-network provider.

You can find a list of urgent care providers in your *Provider and Pharmacy Directory*, online at **ucare.org/searchnetwork**, or by calling Customer Service at the number on the bottom of this page.

To find out how to access urgently needed care, you can call your PCP, 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.

Urgently needed care when outside our plan's service area

When you're outside our plan's service area, you may not be able to get care from a network provider. In that case, our plan covers urgently needed care you get from any provider. However, medically necessary routine provider visits, such as annual checkups, aren't considered urgently needed even if you're outside our plan's service area or our plan network is temporarily unavailable.

Our plan doesn't cover urgently needed care or any other care that you get outside the United States and its territories.

H3. Care during a disaster

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

Visit our website for information on how to get care you need during a declared disaster: **ucare.org/important-coverage-information**.

During a declared disaster, if you can't use a network provider, you can get care from out-of-network providers at the in-network cost-sharing rate. If you can't use a network pharmacy during a declared disaster, you can fill your drugs at an out-of-network pharmacy. Refer to **Chapter 5** of this *Member Handbook* for more information.

I. What if you're billed directly for covered services

We don't allow UCare Connect + Medicare providers to bill you for these services. We pay our providers directly, and we protect you from any charges.

If you paid for your covered services or if you got a bill for covered medical services, refer to **Chapter 7** of this *Member Handbook* to find out what to do.

You shouldn't pay the bill yourself. If you do, we may not be able to pay you back.

I1. What to do if our plan doesn't cover services

Our plan covers all services:

- that are determined medically necessary, **and**
- that are listed in our plan's Benefits Chart (refer to **Chapter 4** of this *Member Handbook*), **and**
- that you get by following plan rules.

If you get services that our plan doesn't cover, **you pay the full cost yourself.**

If you want to know if we pay for any medical service or care, you have the right to ask us. You also have the right to ask for this in writing. If we say we won't pay for your services, you have the right to appeal our decision.

Chapter 9 of this *Member Handbook* explains what to do if you want us to cover a medical service or item. It also tells you how to appeal our coverage decision. Call Customer Service to learn more about your appeal rights.

We pay for some services up to a certain limit. If you go over the limit, you pay the full cost to get more of that type of service. Refer to **Chapter 4** for specific benefit limits. Call Customer Service to find out what the benefit limits are and how much of your benefits you've used.

J. Coverage of health care services in a clinical research study

J1. Definition of a clinical research study

A clinical research study (also called a clinical trial) is a way doctors test new types of health care or drugs. A clinical research study approved by Medicare typically asks for volunteers to be in the study.

When you're in a clinical research study, you can stay enrolled in our plan and continue to get the rest of your care (care that's not related to the study) through our plan.

If you want to take part in any Medicare-approved clinical research study, you **don't** need to tell us or get approval from us or your primary care provider. Providers that give you care as part of the study **don't** need to be network providers. This doesn't apply to covered benefits that require a clinical trial or registry to assess the benefit, including certain benefits requiring coverage with evidence development (NCDs-CED) and investigational device exemption (IDE) studies. These benefits may also be subject to prior authorization and other plan rules.

We encourage you to tell us before you take part in a clinical research study.

If you plan to be in a clinical research study, covered for enrollees by Original Medicare, we encourage you or your care coordinator to contact Customer Service to let us know you'll take part in a clinical trial.

J2. Payment for services when you're in a clinical research study

If you volunteer for a clinical research study that Medicare approves, you pay nothing for the services covered under the study. Medicare pays for services covered under the study as well as routine costs associated with your care. Once you join a Medicare-approved clinical research study, you're covered for most services and items you get as part of the study. This includes:

- 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 that's part of the research study
- treatment of any side effects and complications of the new care

If you're part of a study that Medicare **hasn't** approved, you pay any costs for being in the study.

J3. More about clinical research studies

You can learn more about joining a clinical research study by reading "Medicare & Clinical Research Studies" on the Medicare website (www.medicare.gov/sites/default/files/2019-09/02226-medicare-and-clinical-research-studies.pdf). You can also call 1-800-MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048.

K. How your health care services are covered in a religious non-medical health care institution

K1. Definition of a religious non-medical health care institution

A religious non-medical health care institution is a place that provides care you would normally get in a hospital or skilled nursing facility. If getting care in a hospital or a skilled nursing facility is against your religious beliefs, we cover care in a religious non-medical health care institution.

This benefit is only for Medicare Part A inpatient services (non-medical health care services).

K2. Care from a religious non-medical health care institution

To get care from a religious non-medical health care institution, you must sign a legal document that says you're against getting medical treatment that's "non-excepted."

- "Non-excepted" medical treatment is any care or treatment that's **voluntary and not required** by any federal, state, or local law.
- "Excepted" medical treatment is any care or treatment that's **not voluntary and 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 only covers non-religious aspects of care.
- If you get services from this institution provided to you in a facility:
  - You must have a medical condition that would allow you to get covered services for inpatient hospital care or skilled nursing facility care.
  - You must get approval from us before you're admitted to the facility, or your stay **won't** be covered.

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

L. Durable medical equipment (DME)

L1. DME as a member of our plan

DME includes certain medically necessary items ordered by a provider, such as wheelchairs, crutches, powered mattress systems, diabetic supplies, hospital beds ordered by a provider for use in the home, intravenous (IV) infusion pumps, speech generating devices, oxygen equipment and supplies, nebulizers, and walkers.

You always own some DME items, such as prosthetics.

Other types of DME you must rent. As a member of our plan, you usually **won't** own the rented DME items, no matter how long you rent it.

In some limited situations, we transfer ownership of the DME item to you. Call Customer Service at the phone number at the bottom of the page for more information.

Even if you had DME for up to 12 months in a row under Medicare before you joined our plan, you **won't** own the equipment.

L2. DME ownership if you switch to Original Medicare

In the Original Medicare program, people who rent certain types of DME own it after 13 months. In a Medicare Advantage (MA) plan, the plan can set the number of months people must rent certain types of DME before they own it.

You'll have to make 13 payments in a row under Original Medicare, or you'll have to make the number of payments in a row set by the MA plan, to own the DME item if:

- you didn't become the owner of the DME item while you were in our plan, **and**
- you leave our plan and get your Medicare benefits outside of any health plan in the Original Medicare program or a MA plan.

If you made payments for the DME item under Original Medicare or an MA plan before you joined our plan, **those Original Medicare or MA plan payments don't count toward the payments you need to make after leaving our plan.**

- You'll have to make 13 new payments in a row under Original Medicare or a number of new payments in a row set by the MA plan to own the DME item.
- There are no exceptions to this when you return to Original Medicare or an MA plan.

L3. Oxygen equipment benefits as a member of our plan

If you qualify for oxygen equipment covered by Medicare, we cover:

- rental of oxygen equipment
- delivery of oxygen and oxygen contents
- tubing and related accessories for the delivery of oxygen and oxygen contents
- maintenance and repairs of oxygen equipment

Oxygen equipment must be returned when it's no longer medically necessary for you or if you leave our plan.

L4. Oxygen equipment when you switch to Original Medicare or another Medicare Advantage (MA) plan

When oxygen equipment is medically necessary and **you leave our plan and switch to Original Medicare**, you rent it from a supplier for 36 months. Your monthly rental payments cover the oxygen equipment and the supplies and services listed above.

If oxygen equipment is medically necessary **after you rent it for 36 months** your supplier must provide:

- oxygen equipment, supplies, and services for another 24 months
- oxygen equipment and supplies for up to 5 years if medically necessary

If oxygen equipment is still medically necessary **at the end of the 5-year period**:

- Your supplier no longer has to provide it, and you may choose to get replacement equipment from any supplier.
- A new 5-year period begins.
- You rent from a supplier for 36 months.
- Your supplier then provides the oxygen equipment, supplies, and services for another 24 months.
- A new cycle begins every 5 years as long as oxygen equipment is medically necessary.

When oxygen equipment is medically necessary and **you leave our plan and switch to another MA plan**, the plan will cover at least what Original Medicare covers. You can ask your new MA plan what oxygen equipment and supplies it covers and what your costs will be.

Chapter 4: Benefits chart

Introduction

This chapter tells you about the services our plan covers and any restrictions or limits on those services. It also tells you about benefits not covered under our plan. Key terms and their definitions appear in alphabetical order in the last chapter of this *Member Handbook*.

Table of Contents

A. Your covered services

This chapter tells you about services our plan covers. You can also learn about services that aren't covered. Information about drug benefits is in **Chapter 5** of this *Member Handbook*. This chapter also explains limits on some services.

Because you get help from Medical Assistance, you pay nothing for your covered services as long as you follow our plan's rules. Refer to **Chapter 3** of this *Member Handbook* for details about our plan's rules.

If you need help understanding what services are covered, call your care coordinator and/or Customer Service at 612-676-3310 or 1-855-260-9707 (this call is free), TTY 612-676-6810 or 1-800-688-2534 (this call is free), 8 am – 8 pm, seven days a week.

B. Rules against providers charging you for services

We don't allow our providers to bill you for in-network covered services. We pay our providers directly, and we protect you from any charges. This is true even if we pay the provider less than the provider charges for a service.

You should never get a bill from a provider for covered services. If you do, refer to **Chapter 7** of this *Member Handbook* or call Customer Service.

C. About our plan's Benefits Chart

The Benefits Chart tells you the services our plan pays for. It lists covered services in alphabetical order and explains them.

We pay for the services listed in the Benefits Chart when the following rules are met. You **don't** pay anything for the services listed in the Benefits Chart, as long as you meet the requirements described below.

- We provide covered Medicare and Medical Assistance covered services according to the rules set by Medicare and Medical Assistance.
- The services (including medical care, behavioral health and substance use services, long-term services and supports, supplies, equipment, and drugs) must be "medically necessary." Medically necessary describes services, supplies, or drugs you need to prevent, diagnose, or treat a medical condition or to maintain your current health status.

This includes care that keeps you from going into a hospital or nursing facility. It also means the services, supplies, or drugs meet accepted standards of medical practice.

  - Medically necessary care is appropriate for your condition. This includes care related to physical conditions and behavioral health (including Mental Health and Substance Use Disorder). It includes the kind and level of services. It includes the number of treatments. It also includes where you get the services and how long they continue. Medically necessary services must:
    - be the services, supplies, and drugs other providers would usually order.
    - help you get better or stay as well as you are.
    - help stop your condition from getting worse.
    - help prevent and find health problems.

- For new members for the first 90 days we may not require you to get approval in advance for any active course of treatment, even if the course of treatment was for a service that began with an out-of-network provider.
- You get your care from a network provider. A network provider is a provider who works with us. In most cases, care you get from an out-of-network provider won't be covered unless it's an emergency or urgently needed care, or unless your plan or a network provider gave you a referral. **Chapter 3** of this *Member Handbook* has more information about using network and out-of-network providers.
- UCare or designated approval authority may continue an authorization previously approved with an out-of-network provider beyond the first 120 days.
- If a provider you choose is no longer in our plan network, you must choose another plan network provider. You may be able to continue to use services from a provider who is no longer a part of our plan network for up to 120 days for the following reasons:
  - An acute condition
  - A life-threatening mental or physical illness.
  - A physical or mental disability defined as an inability to engage in one or more major life activities. This applies to a disability that has lasted or is expected to last at least one year, or is likely to result in death.
  - A disabling or chronic condition that's in an acute phase.
  - If your qualified health provider certifies that you have an expected lifetime of 180 days or less, you may be able to continue to use services for the rest of your life from a provider who is no longer part of our network.

- We cover some services listed in the Benefits Chart only if your doctor or other network provider gets our approval first. This is called prior authorization (PA). We mark covered services in the Benefits Chart that need PA with an asterisk (*). In addition, you must get PA for the following services not listed in the Benefits Chart: inpatient rehabilitation services, spine surgery, bone growth stimulators, spinal cord stimulators, and molecular/genetic testing (for example, screening for cancer or testing to predict heart disease). If we provide approval of a PA request for a course of treatment, the approval must be valid for as long as medically reasonable and necessary to avoid disruptions in care based on coverage criteria, your medical history, and the treating provider's recommendations.

Important Benefit Information for Members with Certain Chronic Conditions.

- If you have any of the chronic condition(s) listed below and meet certain medical criteria, you may be eligible for additional benefits:
  - ADHD
  - Autism
  - Anxiety
  - Depression
  - Diabetes
  - Hypertension
  - Lipid disorders
- Refer to the Help with Certain Chronic Conditions row in the Benefits Chart for more information.
- Contact us for additional information.

All preventive services are free. This apple shows the preventive services in the Benefits Chart. You will find an asterisk (*) next to services that may require a prior authorization.

Restricted Recipient Program

- The Restricted Recipient Program is for members who've misused health services. This includes getting health services that members didn't need, using them in a way that costs more than they should, or using them in a way that may be dangerous to a member's health. UCare will notify members if they're placed in the Restricted Recipient Program.

- If you're in the Restricted Recipient Program, you must get health services from one designated primary care provider, one clinic, one hospital used by the primary care provider, and one pharmacy. UCare may designate other health care providers. You may also be assigned to a home health agency. You won't be allowed to use the personal care assistance choice or flexible use options or consumer directed services. You won't be able to use the Community First Services and Supports (CFSS) budget model.
- You'll be restricted to these designated health care providers for at least 24 months of eligibility for Minnesota Health Care Programs (MHCP). All referrals to specialists must be from your primary care provider, and received by the UCare Restricted Recipient Program. Restricted recipients may not pay out-of-pocket to use a non-designated provider who is the same provider type as one of their designated providers.
- Placement in the program will stay with you if you change health plans. Placement in the program will also stay with you if you change to MHCP fee-for-service. You won't lose eligibility for MHCP because of placement in the program.
- At the end of the 24 months, your use of health care services will be reviewed. If you still misused health services, you'll be placed in the program for an additional 36 months of eligibility.
- You have the right to appeal placement in the Restricted Recipient Program. You must file an appeal within 60 days from the date on the notice from us. You must appeal within 30 days to prevent the restriction from being implemented during your appeal. You may request a State Appeal (Fair Hearing with the State) after receiving our decision that we have decided to enforce the restriction. Refer to **Chapter 9**, Section F3 of this *Member Handbook*, for more information about your right to appeal.
- The Restricted Recipient Program doesn't apply to Medicare-covered services. If you use opioid medications that you get from several doctors or pharmacies, we may talk to your doctors to make sure your use is appropriate and medically necessary. Working with your doctors, if we decide your use of prescription opioid or benzodiazepine medications isn't safe, we may limit how you can get those medications. Refer to **Chapter 5**, **Section G3** of this *Member Handbook* for more information.

D. Our plan's Benefits Chart

Covered Service	What you pay
Abdominal aortic aneurysm screening We will pay for a one-time ultrasound screening for people at risk. Our plan only covers this screening if you have certain risk factors and if you get a referral for it from your physician, physician assistant, nurse practitioner, or clinical nurse specialist. We may cover additional screenings if medically necessary.	$0
Acupuncture Acupuncture services are covered when provided by a licensed acupuncturist or by another Minnesota licensed practitioner with acupuncture training and credentialing. We will pay for up to 12 acupuncture visits in 90 days if you have chronic low back pain, defined as: • lasting 12 weeks or longer; • not specific (having no systemic cause that can be identified, such as not associated with metastatic, inflammatory, or infectious disease); • not associated with surgery; **and** • not associated with pregnancy. In addition, we pay for an additional eight sessions of acupuncture for chronic low back pain if you show improvement. You may not get more than 20 acupuncture treatments for chronic low back pain each year. **This benefit is continued on the next page**	$0

Covered Service	What you pay
Acupuncture (continued) Acupuncture treatments must be stopped if you don't get better or if you get worse. In addition, we'll pay for up to 20 units of acupuncture services per calendar year without authorization. Ask for prior authorization if additional units are needed. Acupuncture services are covered for the following: • acute and chronic pain • depression • anxiety • schizophrenia • post-traumatic stress syndrome • insomnia • smoking cessation • restless legs syndrome • menstrual disorders • xerostomia (dry mouth) associated with the following: – Sjogren's syndrome – radiation therapy • nausea and vomiting associated with the following: – post-operative procedures – pregnancy – cancer care Provider Requirements: **This benefit is continued on the next page**	

Covered Service	What you pay
Acupuncture (continued) Physicians (as defined in 1861(r)(1) of the Social Security Act (the Act)) may furnish acupuncture in accordance with applicable state requirements. Physician assistants (PAs), nurse practitioners (NPs)/clinical nurse specialists (CNSs) (as identified in 1861(aa) (5) of (the Act)), and auxiliary personnel may furnish acupuncture if they meet all applicable state requirements and have: • a master's or doctoral level degree in acupuncture or Oriental Medicine from a school accredited by the Accreditation Commission on Acupuncture and Oriental Medicine (ACAOM); and, • a current, full, active, and unrestricted license to practice acupuncture in a State, Territory, or Commonwealth (i.e., Puerto Rico) of the United States, or District of Columbia. Auxiliary personnel furnishing acupuncture must be under the appropriate level of supervision of a physician, PA, or NP/CNS required by our regulations at 42 CFR §§ 410.26 and 410.27.	
Alcohol misuse screening and counseling We will pay for one alcohol-misuse screening for adults who misuse alcohol but aren't alcohol dependent. This includes pregnant women. If you screen positive for alcohol misuse, you can get up to four brief, face-to-face counseling sessions each year (if you're able and alert during counseling) with a qualified **This benefit is continued on the next page**	$0

Covered Service	What you pay
Alcohol misuse screening and counseling (continued) primary care provider (PCP) or practitioner in a primary care setting (refer to the "Outpatient substance use disorder services" section of this chart for additional covered benefits).	
Ambulance services Covered ambulance services, whether for an emergency or non-emergency situation, include ground and air (airplane and helicopter), and ambulance services. The ambulance will take you to the nearest place that can give you care. Your condition must be serious enough that other ways of getting to a place of care could risk your health or life. Ambulance services for other cases (non-emergency) must be approved by us. In cases that aren't emergencies, we may pay for an ambulance. Your condition must be serious enough that other ways of getting to a place of care could risk your life or health.	$0
Annual wellness visit You can get an annual checkup. This is to make or update a prevention plan based on your current risk factors. We pay for this once every 12 months. **Note:** Your first annual wellness visit can't take place within 12 months of your **Welcome to Medicare** visit. However, you don't need to have had a **Welcome to Medicare** visit to get annual wellness visits after you've had Part B for 12 months.	$0

Covered Service	What you pay
Bone mass measurement We pay for certain procedures for members who qualify (usually, someone at risk of losing bone mass or at risk of osteoporosis). These procedures identify bone mass, find bone loss, or find out bone quality. We pay for the services once every 24 months or more often if medically necessary. We also pay for a doctor to look at and comment on the results.	$0
Breast cancer screening (mammograms) We pay for the following services: • one baseline mammogram between the ages of 35 and 39 • one screening mammogram every 12 months for women aged 40 and over • clinical breast exams once every 24 months	$0
Cardiac (heart) rehabilitation services We pay for cardiac rehabilitation services such as exercise, education, and counseling. Members must meet certain conditions and have a doctor's order. We also cover intensive cardiac rehabilitation programs, which are more intense than cardiac rehabilitation programs.	$0

Covered Service	What you pay
Cardiovascular (heart) disease risk reduction visit (therapy for heart disease) We pay for one visit a year, or more if medically necessary, with your primary care provider (PCP) to help lower your risk for heart disease. During the visit or visits, your doctor may: • discuss aspirin use, • check your blood pressure, **and/or** • give you tips to make sure you're eating well.	$0
Cardiovascular (heart) disease screening tests We pay for blood tests to check for cardiovascular disease once every five years (60 months). These blood tests also check for defects due to high risk of heart disease.	$0
Care coordination You're assigned a care coordinator who will help connect you to the services and resources you need to get the best possible care. Care coordinators can also help you learn more about your health, any health conditions you have, and help you follow your support plan. Care coordinators and UCare Connect + Medicare Customer Service staff are available to answer questions about UCare Connect + Medicare and the SNBC program. Your care coordination team will contact you to offer a health risk assessment to determine care coordination needs. **This benefit is continued on the next page**	$0

Covered Service	What you pay
Care coordination (continued) Care coordination is always available for you. You can stop using this service at any time by telling your care coordinator or by contacting UCare Connect + Medicare. If you want to change your care coordinator, call Customer Service at the number at the bottom of the page. We pay for the following services: • an assessment to identify how the care coordinator can help you with health care, housing, food security, and other needs • help with scheduling, coordinating, and receiving assessments or tests and health care services such as dental, behavioral health, rehabilitative, and primary care • creation and updating of your support plan, based on your unique needs and working with the people you choose • with your permission, our care coordinators can communicate with agencies and people who can help meet your needs • work together with you and others you choose when you have a change in your health care needs or a hospitalization • help you find resources you need in your community. • work together with your Home and Community Based Services waiver case managers or other case managers **This benefit is continued on the next page**	

Covered Service	What you pay
Care coordination (continued) • with your participation, our care coordinators also do the following: – help you set goals for your health and well-being and work with you to reach them – communicate or meet with you regularly to discuss your health and well-being – remind you when you need preventive services, tests, or appointments that are part of your support plan	
Cervical and vaginal cancer screening We pay for the following services: • for all women: Pap tests and pelvic exams once every 24 months • for women who are at high risk of cervical or vaginal cancer: one Pap test every 12 months • for women who have had an abnormal Pap test within the last three years and are of childbearing age: one Pap test every 12 months	$0
Child and Teen Checkups (C&TC) These preventive well-child visits look at growth, development, and overall health. According to the Minnesota C&TC Schedule of Age-Related Screening Standards (edocs.dhs.state.mn.us/lfserver/public/DHS-3379-ENG) these checkups are meant to keep kids healthy by finding **This benefit is continued on the next page**	$0

Covered Service	What you pay
Child and Teen Checkups (C&TC) (continued)	
any health concerns or problems early. Finding health concerns early prevents them from becoming bigger problems later. Keeping healthy means you're more likely to grow into a healthy adult. Depending on age, these visits may include: • head-to-toe exam • immunizations and lab tests as needed • checks on development and growth • health history including nutrition • health education • hearing and vision checks • information on good physical and mental health • time to ask questions and get answers about health, behavior, and development and talk about learning, feelings, relationships, parenting, and caregiver well-being • fluoride varnish to keep teeth healthy and dental referrals C&TC is a health care benefit promoting health visits for children members under 21 years old. Each visit may include one-on-one time with the health care provider. This gives time for young adults to ask questions privately and learn to manage their own health. Members under age 21 should contact their Primary Care Clinic to schedule C&TC preventive health visits.	

Covered Service	What you pay
Chiropractic services*	
For members under age 21, we pay for the following services: • adjustments of the spine to correct alignment • one evaluation or exam per calendar year • manual manipulation (adjustment) of the spine to treat subluxation of the spine – up to 24 treatments per calendar year, limited to six per month. Treatments exceeding 24 per calendar year or six per month require a prior authorization.* • x-rays when needed to support a diagnosis of subluxation of the spine For members age 21 and older: Manual manipulation of the spine to correct subluxation. **Note:** Our plan doesn't cover other adjustments, vitamins, medical supplies, therapies, or equipment from a chiropractor. We also offer a supplemental chiropractic benefit per year for members with musculoskeletal disorders. Coverage includes additional services beyond what is listed above or not covered by Medical Assistance. Additional coverage limits may apply. These services include the following: • Up to 12 additional routine chiropractic visits per year, including exams and adjustment of extremities	$0

Covered Service	What you pay
Chronic pain management and treatment services Covered monthly services for people living with chronic pain (persistent or recurring pain lasting longer than 3 months). Services may include pain assessment, medication management, and care coordination and planning.	$0
Colorectal cancer screening We pay for the following services: • Colonoscopy has no minimum or maximum age limitation and is covered once every 120 months (10 years) for patients not at high risk, or 48 months after a previous flexible sigmoidoscopy for patients who aren't at high risk for colorectal cancer, and once every 24 months for high risk patients after a previous screening colonoscopy. • Computed tomography colonography for patients 45 years and older who aren't at high risk of colorectal cancer is covered when at least 59 months have passed following the month in which the last screening computed tomography colonography was performed, or when 47 months have passed following the month in which the last screening flexible sigmoidoscopy or screening colonoscopy was performed. For patients at high risk for colorectal cancer, payment may be made for a screening computed tomography colonography performed after at least 23 months have passed following the month in which the last screening computed tomography colonography or the last screening colonoscopy was performed. • Flexible sigmoidoscopy for patients 45 year and older. Once every 120 months for patients not at high risk after **This benefit is continued on the next page**	$0

Covered Service	What you pay
Colorectal cancer screening (continued) the patient got a screening colonoscopy. Once every 48 months for high risk patients from the last flexible sigmoidoscopy or computed tomography colonography. • Screening fecal-occult blood tests for patients 45 years and older. Once every 12 months. • Multitarget stool DNA for patients 45 to 85 years of age and not meeting high risk criteria. Once every 3 years. • Blood-based Biomarker Tests for patients 45 to 85 years of age and not meeting high risk criteria. Once every 3 years. • Colorectal cancer screening tests include a follow-up screening colonoscopy after a Medicare covered non-invasive stool-based colorectal cancer screening test returns a positive result. • Colorectal cancer screening tests include a planned screening, flexible sigmoidoscopy, or screening colonoscopy that involves the removal of tissue or other matter, or other procedure furnished in connection with, as a result of, and in the same clinical encounter as the screening test.	
Dental services Certain dental services, including cleanings, fillings, and dentures, are available through the Medical Assistance Dental Program. IMPORTANT: This isn't a comprehensive list. Specific coverage isn't guaranteed. **This benefit is continued on the next page**	$0

Covered Service	What you pay
Dental services (continued) Service limits may apply to services listed in the following dental section. Some services may or may not require prior authorization due to medical necessity. To find out more about these services, contact Customer Service at the number at the bottom of the page. We pay for the following services: Diagnostic services: • exam and oral evaluation • imaging services, which include: – bitewing – single X-rays for diagnosis of problems – panoramic – full mouth x-rays Preventive services: • cavity arresting treatment • dental cleanings • fluoride varnish • sealants • oral hygiene instruction Restorative services: • fillings • sedative fillings for relief of pain • individual crowns, restricted to resin and stainless steel **This benefit is continued on the next page**	

Covered Service	What you pay
Dental services (continued)	
Endodontics (root canals)	
Oral Surgery • tooth extractions	
Orthodontics (with prior authorization)	
Periodontics: • gross removal of plaque and tartar • scaling and root planing – follow-up procedures (periodontal maintenance) for two years following scaling and root planing	
Prosthodontics: • removable appliances (dentures, partials, overdentures) (one appliance every 3 years per dental arch); (partials always require a prior authorization) • adjustments, modifications, relines, repairs, and rebases of removable appliances (dentures and partials) • replacement of appliances that are lost, stolen, or damaged beyond repair under certain circumstances • replacement of partial appliances if the existing partial can't be altered to meet dental needs • tissue conditioning liners • precision attachments and repairs	
Additional general dental services: • emergency treatment of dental pain	
This benefit is continued on the next page	

Covered Service	What you pay
Dental services (continued) • general anesthesia, deep sedation • extended care facility/house call in certain institutional settings including: nursing facilities, skilled nursing facilities, boarding care homes, Institutions for Mental Diseases (IMD), Intermediate Care Facilities for Persons with Developmental Disabilities (ICF/DDs), Hospices, Minnesota Extended Treatment Options (METO), and swing beds (a nursing facility bed in a hospital) • behavioral management when necessary to ensure that a covered dental service is correctly and safely performed • medications (only when medically necessary for very limited conditions) • nitrous oxide • oral bite adjustments • oral or IV sedation **Notes:** If you choose to get dental benefits from a federally qualified health center (FQHC) or a state-operated dental clinic, you'll have the same benefits that you're entitled to under Medical Assistance. If you're new to our health plan and have already started a dental service treatment plan, contact us for coordination of care. If you begin orthodontia services, we won't require completion of the treatment plan to pay the provider for services received. **This benefit is continued on the next page**	

Covered Service	What you pay
Dental services (continued) We pay for some dental services when the service is an integral part of specific treatment of a person's primary medical condition. Examples include reconstruction of the jaw after a fracture or injury, tooth extractions done in preparation for radiation treatment for cancer involving the jaw, or oral exams prior to organ transplantation. We also offer a supplemental dental benefit per year for certain additional services beyond what is listed above or not covered by Medical Assistance. Additional coverage limits may apply. These services include: • One comprehensive oral evaluation per year • One panoramic x-ray once each year • One full mouth series x-ray per year • One porcelain fused to high noble metal crown per calendar year • One dental crown repair per calendar year	$0
Depression screening We pay for one depression screening each year. The screening must be done in a primary care setting that can give follow-up treatment and/or referrals. We may cover additional screenings if medically necessary.	$0

Covered Service	What you pay
Diabetes screening We pay for this screening (includes fasting glucose tests) if you have any of the following risk factors: • high blood pressure (hypertension) • history of abnormal cholesterol and triglyceride levels (dyslipidemia) • obesity • history of high blood sugar (glucose) Tests may be covered in some other cases, such as if you're overweight and have a family history of diabetes. You may qualify for up to two diabetes screenings every 12 months following the date of your most recent diabetes screening test. We may cover additional screenings if medically necessary.	$0
Diabetes self-management training, services and supplies We pay for the following services for all people who have diabetes (whether they use insulin or not): • Supplies to monitor your blood glucose, including the following: – a blood glucose monitor – blood glucose test strips – lancet devices and lancets **This benefit is continued on the next page**	$0

Covered Service	What you pay
Diabetes self-management training, services and supplies (continued) – glucose-control solutions for checking the accuracy of test strips and monitors • For people with diabetes who have severe diabetic foot disease, we pay for the following: – one pair of therapeutic custom-molded shoes (including inserts), including the fitting, and two extra pairs of inserts each calendar year, **or** – one pair of depth shoes, including the fitting, and three pairs of inserts each year (not including the non-customized removable inserts provided with such shoes) • In some cases we pay for training to help you manage your diabetes. To find out more, contact Customer Service.	
Durable medical equipment (DME) and related supplies* Refer to **Chapter 12** of this *Member Handbook* for a definition of "Durable medical equipment (DME)." We cover the following items: • wheelchairs • crutches • powered mattress systems **This benefit is continued on the next page**	$0

Covered Service	What you pay
Durable medical equipment (DME) and related supplies* (continued) • diabetic supplies (For diabetic supplies refer to the "Diabetic self-management training, services, and supplies" section in this benefit chart.) • hospital beds ordered by a provider for use in the home • intravenous (IV) infusion pumps and pole • speech generating devices • oxygen equipment and supplies • nebulizers • walkers • standard curved handle or quad cane and replacement supplies • cervical traction (over the door) • bone stimulator • dialysis care equipment We cover additional items, including: • repairs of medical equipment • batteries for medical equipment • airway clearance devices • medical supplies you need to take care of your illness, injury or disability • incontinence products • nutritional/enteral products when specific conditions are met **This benefit is continued on the next page**	

Covered Service	What you pay
Durable medical equipment (DME) and related supplies* (continued) • family planning supplies (refer to the "Family planning services" section of this chart for more information) • augmentative communication devices, including electronic tablets • seizure detection devices Other items may be covered. We pay for all medically necessary DME that Medicare and Medical Assistance usually pay for. If our supplier in your area doesn't carry a particular brand or maker, you may ask them if they can special order it for you.	
Early Intensive Developmental and Behavioral Intervention (EIDBI) Services* (for members under age 21) The purpose of the EIDBI benefit is to provide medically necessary, early and intensive intervention for people with Autism Spectrum Disorder (ASD) and related conditions. Families can learn more about EIDBI by taking the pathlore.dhs.mn.gov/Courseware/DisabilityServices/EIDBI/EIDBI101_F/index.html online training. Families can learn more about autism, as well as resources and supports, by visiting the Minnesota Autism Resource Portal (mn.gov/autism/). The benefit is also intended to: • educate, train and support parents and families **This benefit is continued on the next page**	$0

Covered Service	What you pay
Early Intensive Developmental and Behavioral Intervention (EIDBI) Services* (for members under age 21) **(continued)** • promote people's independence and participation in family, school and community life • improve long-term outcomes and the quality of life for people and their families. EIDBI services are provided by enrolled EIDBI providers who have expertise in the approved modalities which include: • Applied Behavior Analysis (ABA) • Developmental, Individual Difference, Relationship-Based (DIR)/Floortime model • Early Start Denver Model (ESDM) • PLAY Project • Relationship Development Intervention (RDI) • Early Social Interaction (ESI). http://www.dhs.state.mn.us/EIDBI-TreatmentModalities Covered services: • Comprehensive Multi-Disciplinary Evaluation (CMDE) which is needed to determine eligibility and medical necessity for EIDBI services (www.dhs.state.mn.us/CMDE). • Individual Treatment Plan (ITP) Development (Initial) **This benefit is continued on the next page**	

Covered Service	What you pay
Early Intensive Developmental and Behavioral Intervention (EIDBI) Services* (for members under age 21) **(continued)** – Individual Treatment Plan (ITP) Development and Progress Monitoring (www.dhs.state.mn.us/ITP) • Direct Intervention: Individual, Group, and/or higher intensity (www.dhs.state.mn.us/EIDBI-DirectIntervention) • Intervention Observation and Direction (www.dhs.state.mn.us/EIDBI-ObservationandDirection) • Family/Caregiver Training and Counseling: Individual and/or Group (www.dhs.state.mn.us/EIDBI-CaregiverTrainingandCounseling) • Coordinated Care Conference (www.dhs.state.mn.us/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION&RevisionSelectionMethod=LatestReleased&dDocName=dhs16_195209) • Travel time	
Emergency care Emergency care means services that are: • given by a provider trained to give emergency services, **and** • needed to evaluate or treat a medical emergency. A medical emergency is an illness, injury, severe pain or medical condition that's quickly getting worse. The condition is so serious that, if it doesn't get immediate **This benefit is continued on the next page**	$0 If you get emergency care at an out-of-network hospital and need inpatient care after your emergency is stabilized, you must move to a network hospital for your care to continue to be paid for. You

Covered Service	What you pay
Emergency care (continued)	
medical attention, anyone with an average knowledge of health and medicine could expect it to result in: • serious risk to your life or to that of your unborn child; **or** • serious harm to bodily functions; **or** • loss of a limb, or loss of function of a limb. • In the case of a pregnant woman in active labor, when: – There isn't enough time to safely transfer you to another hospital before delivery. – A transfer to another hospital may pose a threat to your health or safety or to that of your unborn child. This coverage is only available within the U.S. and its territories.	can stay in the out-of-network hospital for your inpatient care only if our plan approves your stay.
E-visits We cover E-visits as a convenient way to receive online diagnosis and treatment for minor conditions. These services are available 24/7, without an appointment, through virtuwell® at virtuwell.com and other UCare network care systems that offer E-visits. Please see Chapter 12 for a definition of E-visit.	$0

Covered Service	What you pay
Family planning services The law lets you choose any provider — whether a network provider or out-of-network provider — for certain family planning services. These are called open access services. This means any doctor, clinic, hospital, pharmacy or family planning office. We pay for the following services: • family planning exam and medical treatment • family planning lab and diagnostic tests • family planning methods (birth control pills, patch, ring, Intrauterine Device (IUD), injections, implants) • family planning supplies with prescription (condom, sponge, foam, film, diaphragm, cap) • counseling and diagnosis of infertility and related services • counseling and testing for sexually transmitted diseases (STDs), AIDS, and other HIV-related conditions • treatment for sexually transmitted diseases (STDs) • voluntary sterilization: you must be age 21 or over to choose this method of family planning. You must sign a federal sterilization consent form at least 30 days, but not more than 180 days before the date of surgery. • genetic counseling We also pay for some other family planning services. However, you must use a provider in our provider network for the following services: **This benefit is continued on the next page**	$0

Covered Service	What you pay
Family planning services (continued) • treatment for medical conditions of infertility (This service doesn't include artificial ways to become pregnant.) • treatment for AIDS and other HIV-related conditions • genetic testing	
Health and wellness education programs For eligible members, UCare offers the following programs and devices to improve your health and wellbeing. To learn more log in or create an online member account at **member.ucare.org**. Call Customer Service or talk to your care coordinator for more details. • Food access referrals – UCare partners with Second Harvest Heartland to connect members with local food resources. Members can call or email to receive help with applying for SNAP benefits and/or finding food resources in their community including the food shelf, Fare for All, and more. For more information, contact Second Harvest Heartland by calling 651-401-1411,1-866-844-FOOD (this call is free) or email SHHCareCenter@2harvest.org. • Medication Toolkit to help make taking your medication easier – If you're interested in getting a Medication Toolkit, contact your care coordinator to order the kit for you. You must be an eligible UCare member at the time of the order. Limit one kit per year per **This benefit is continued on the next page**	$0

Covered Service	What you pay
Health and wellness education programs (continued) member. Kit contents may be subject to change. Please allow 4 – 6 weeks for delivery. • Connect to Wellness Kit to help reduce stress and improve health and wellness. These kits are available to members with a diagnosis of hypertension, diabetes, lipid disorders, depression, or anxiety. – Contact your care coordinator to find out if you're eligible and which kit may be right for you. You must be an eligible UCare member at the time of the order. Limit one kit per year per member. Kit contents and availability may be subject to change. Please allow 4 – 6 weeks for delivery. • ADHD and Autism Support Kit to help improve your health and wellness. These kits are available to members with an ADHD or autism diagnosis on file with UCare. – Contact your care coordinator to find out if you're eligible and which kit may be right for you. You must be an eligible UCare member at the time of the order. Limit one kit per year per member. Kit contents and availability may be subject to change. Please allow 4 – 6 weeks for delivery. • One Pass, a complete fitness solution that gives you access to participating fitness locations nationwide plus: – On-demand and live-streaming fitness classes – Workout builders to create your own workouts and walk you through each exercise – Home Fitness Kits available to members upon request (one kit per year) **This benefit is continued on the next page**	

Covered Service	What you pay
Health and wellness education programs (continued) – Personalized, online brain training program to help improve memory, attention and focus – Social activities, community classes, and events available for online or in-person participation. To learn more, go to **ucare.org/onepass** or call 1-877-504-6830 (this call is free) or for TTY use 711, (this call is free) 8 am – 9 pm, Monday – Friday. • Breast pumps and resources to help with breastfeeding for new mothers • Car seat and car seat safety education through our Seats, Education, And Travel Safety (SEATS) Program • Childbirth, breastfeeding, and pregnancy-related education classes • Management of Maternity Services (MOMS) program to help expectant mothers stay healthy during and after pregnancy • 24/7 Nurse Line – Access to medical and health information 24 hours a day, seven days a week, including weekends and holidays. Call 1-800-942-7858 (this call is free) (TTY: 1-855-307-6976 (this call is free). The UCare Healthy Benefits+ Visa® card is a flexible and convenient way to access your eligible allowances, discounts, and rewards. You will not get a new card each year. The card is valid until it expires or you are no longer a UCare member. The card will not work once you leave the plan. Allowance amounts and expiration dates vary by plan **This benefit is continued on the next page**	

Covered Service	What you pay
Health and wellness education programs (continued) and program. To learn more, check your card balance or request a replacement card, visit healthybenefitsplus.com/ucare or call 1-833-862-8276 (this call is free); TTY 711 (this call is free). This phone number is also on the back of your UCare Healthy Benefits+ Visa® card. • $55 quarterly Over-the-Counter (OTC) benefit on your UCare Healthy Benefits+ Visa® card. The allowance can be used to purchase eligible items like cough drops, first aid supplies, pain relief, sinus medications, toothpaste and more at participating retailers. The allowance expires at the end of each quarter or upon plan termination • Grocery discounts on healthy foods like milk, whole-grain bread, lean meat, eggs, yogurt, fruits, vegetables and more at participating grocery stores. Weekly discounts are loaded onto your UCare Healthy Benefits+ Visa® card. Scan your Healthy Benefits+ card when paying to access your discount. • Earn rewards for taking care of your health. To see what rewards you're eligible for, call Customer Service at the number on the back of your member ID card.	
Health services We pay for the following services: • Advanced Practice Nurse services: services provided by a nurse practitioner, nurse anesthetist, nurse midwife, or clinical nurse specialist **This benefit is continued on the next page**	$0

Covered Service	What you pay
Health services (continued) • allergy immunotherapy and allergy testing • Behavioral Health Home: coordination of primary care, mental health services and social services • Clinical trial coverage: Routine care that is: – provided as part of the protocol treatment of a clinical trial; – usual, customary and appropriate to your condition; and – would be typically provided outside of a clinical trial. This includes services and items needed for the treatment of effects and complications of the protocol treatment. For more information, please refer to **Chapter 3** of this *Member Handbook*. • community health worker care coordination and patient education services • Community Medical Emergency Technician (CMET) services – post-hospital/post-nursing home discharge visits ordered by your primary care provider – safety evaluation visits ordered by your primary care provider • Community Paramedic: certain services provided by a community paramedic. The services must be a part of a support plan ordered by your primary care provider. The services may include: – health assessments **This benefit is continued on the next page**	

Covered Service	What you pay
Health services (continued) – chronic disease monitoring and education – help with medications – immunizations and vaccinations – collecting lab specimens – follow-up care after being treated at a hospital – other minor medical procedures • Enhanced asthma care services (for eligible members under the age of 21 who are diagnosed as having poorly controlled asthma, when specific criteria are met) • home visits to determine if there are asthma-triggers in the member's home. Visit must be provided by a registered environmental health specialist, healthy homes specialist, and lead risk assessor. Your local public health agency can help you find one of these health care professionals to help you or you can contact Customer Service. • Hospital In-Reach Community-Based Service Coordination (IRSC): coordination of services targeted at reducing hospital emergency room (ER) use under certain circumstances. This service addresses health, social, economic, and other needs of members to help reduce usage of ER and other health care services. • Services of a certified public health nurse or a registered nurse practicing in a public health nursing clinic under a governmental unit • Telemonitoring: use of technology to provide care and support to a member's complex health needs from a remote location such as in a member's home. **This benefit is continued on the next page**	

Covered Service	What you pay
Health services (continued) Telemonitoring can track a member's vital signs using a device or equipment that sends the data electronically to their provider for review. Examples of vital signs that can be monitored remotely include heart rate, blood pressure, and blood glucose levels • Tuberculosis care management and direct observation of drug intake	
Hearing services We pay for hearing and balance tests done by your provider. These tests tell you whether you need medical treatment. They're covered as outpatient care when you get them from a physician, audiologist, or other qualified provider. We cover additional items and services, including: • hearing aids and batteries • repair and replacement of hearing aids due to normal wear and tear, with limits	$0
Help with certain chronic conditions* • Connect to Wellness Kit to help reduce stress and improve health and wellness. These kits are available to members with a diagnosis of hypertension, diabetes, lipid disorders, depression, or anxiety. – Contact your care coordinator to find out if you're eligible and which kit may be right for you. You must be an eligible UCare member at the time of the order. Limit one kit per year per member. Kit **This benefit is continued on the next page**	$0

Covered Service	What you pay
Help with certain chronic conditions* (continued) contents and availability may be subject to change. Please allow 4 – 6 weeks for delivery. • ADHD and Autism Support Kit to help improve your health and wellness. These kits are available to members with an ADHD or autism diagnosis on file with UCare. – Contact your care coordinator to find out if you're eligible and which kit may be right for you. You must be an eligible UCare member at the time of the order. Limit one kit per year per member. Kit contents and availability may be subject to change. Please allow 4 – 6 weeks for delivery.	
HIV screening We pay for one HIV screening exam every 12 months for people who: • ask for an HIV screening test, **or** • are at increased risk for HIV infection. If you're pregnant, we pay for up to three HIV screening tests during a pregnancy. Additional benefits may be covered by us.	$0
Home and Community Based Service Information Your SNBC care coordinator will give you information about community services. A county worker will help you find services to stay in your home or community, and help you find services to move out of a nursing home or other **This benefit is continued on the next page**	$0

Covered Service	What you pay
Home and Community Based Service Information (continued) facility. This information can be given to you by mail, phone, or in person. If you choose to have a visit, you have the right to have friends or family present. You can designate a representative to help you make decisions. You can decide what your needs are and where you want to live. You can ask for services to best meet your needs. You can make the final decisions about your plan for services and help. You can choose who you want to provide the services and supports from those providers available from our Plan's network. After the visit, your SNBC care coordinator will send you a letter that recommends services that best meet your needs. You will be sent a copy of the service or support plan you helped put together. If you're currently on the Community Access for Disability Inclusion (CADI), Community Alternative Care (CAC), Brain Injury (BI), or the Developmental Disability (DD) waiver, your county case manager will coordinate home health agency services with your SNBC care coordinator. If you need transition planning and coordination services to help you move to the community, you may be eligible to get Relocation Service Coordination.	
Home health agency care* Before you can get home health services, a doctor must tell us you need them, and they must be provided by a home **This benefit is continued on the next page**	$0

Covered Service	What you pay
Home health agency care* (continued) health agency. You must be homebound, which means leaving home is a major effort. We pay for the following services, and maybe other services not listed here: • part-time or intermittent skilled nursing and home health aide services* (To be covered under the home health care benefit, your skilled nursing and home health aide services combined must total fewer than 8 hours per day and 35 hours per week.) • physical therapy, occupational therapy, and speech therapy • medical and social services • medical equipment and supplies* • respiratory therapy • Home Care Nursing (HCN)*	
Home infusion therapy We pay for home infusion therapy, defined as drugs or biological substances administered into a vein or applied under the skin and provided to you at home. The following are needed to perform home infusion: • the drug or biological substance, such as an antiviral or immune globulin; • equipment, such as a pump; **and** • supplies, such as tubing or a catheter. **This benefit is continued on the next page**	$0

Covered Service	What you pay
Home infusion therapy (continued) We cover home infusion services that include but aren't limited to: • professional services, including nursing services, provided in accordance with your support plan; • member training and education not already included in the DME benefit; • remote monitoring; **and** • monitoring services for the provision of home infusion therapy and home infusion drugs furnished by a qualified home infusion therapy supplier.	
Hospice care You have the right to elect hospice if your provider and hospice medical director determine you have a terminal prognosis. This means you have a terminal illness and are expected to have six months or less to live. You can get care from any hospice program certified by Medicare. Our plan must help you find Medicare-certified hospice programs in the plan's service area, including programs we own, control, or have a financial interest in. Your hospice doctor can be a network provider or an out-of-network provider. Covered services include: • drugs to treat symptoms and pain • short-term respite care • home care **This benefit is continued on the next page**	$0

Covered Service	What you pay
Hospice care (continued) **For hospice services and services covered by Medicare Part A or Medicare Part B that relate to your terminal prognosis are billed to Medicare:** • Original Medicare (rather than our plan) will pay your hospice provider for your hospice services and any Part A or B services related to your terminal illness. While you're in the hospice program, your hospice provider will bill Original Medicare for the services Original Medicare pays for. **For services covered by our plan but not covered by Medicare Part A or Medicare Part B:** • We cover services not covered under Medicare Part A or Medicare Part B. We cover the services whether or not they relate to your terminal prognosis. You pay nothing for these services. **For drugs that may be covered by our plan's Medicare Part D benefit:** • Drugs are never covered by both hospice and our plan at the same time. For more information, please refer to **Chapter 5** of this *Member Handbook*. **Note:** If you need non-hospice care, call your care coordinator and/or Customer Service to arrange the services. Non-hospice care is care that **isn't** related to your terminal prognosis. We cover hospice consultation services (one time only) for a terminally ill member who has not chosen the hospice benefit.	

Covered Service	What you pay
Housing stabilization services*	
We pay for the following services for members eligible for Housing Stabilization Services: • Housing consultation services to develop a person-centered plan for people without Medical Assistance case management services • Housing transition services to help you plan for, find, and move into housing – Housing transition — moving expenses up to $3000 per year for people leaving a Medical Assistance funded institution or provider-controlled setting who are moving into their own home. Moving expenses include: – applications, security deposits, and the cost of securing documentation that's required to get a lease on an apartment or home – essential household furnishings including furniture, window coverings, food preparation items, and bed/bath linens – setup fees or deposits for utilities including telephone, electricity, heating and water – services necessary for the individual's health and safety such as pest removal and one time cleaning before moving in – necessary home accessibility adaptations • Housing sustaining services to help you keep your housing • Transportation for Housing Stabilization Services when a provider is discussing housing-related need with the **This benefit is continued on the next page**	$0

Covered Service	What you pay
Housing stabilization services* (continued) member while driving. This time is billed as transition/sustaining units. Mileage isn't reimbursed. You must have an assessment done to find out if you qualify for Housing Stabilization Services. If you have a targeted case manager or waiver case manager or senior care coordinator, you can ask for their help to find out if you qualify for Housing Stabilization Services. You can also contact a Housing Stabilization Services provider to help you. Department of Human Services (DHS) staff will review the assessment to decide whether you qualify for Housing Stabilization Services. DHS will send you a letter about whether you qualify for Housing Stabilization Services. If you qualify, the letter will say services are approved. If you don't qualify, the letter will say services are denied. Work with your provider if you need help with moving expenses. If you're approved for moving expenses, your provider must send us the receipt for each moving expense.	
Immunizations We pay for the following services: • pneumonia vaccines • flu/influenza shots, once each flu/influenza season in the fall and winter, with additional flu/influenza shots if medically necessary • hepatitis B vaccines if you're at high or intermediate risk of getting hepatitis B **This benefit is continued on the next page**	$0

Covered Service	What you pay
Immunizations (continued) • COVID-19 vaccines • other vaccines if you're at risk and they meet Medicare Part B coverage rules We pay for other vaccines that meet the Medicare Part D coverage rules. Refer to **Chapter 6** of this *Member Handbook* to learn more.	
Inpatient hospital care* Includes inpatient acute, inpatient rehabilitation, long-term care hospitals and other types of inpatient hospital services. Inpatient hospital care starts the day you're formally admitted to the hospital with a doctor's order. The day before you're discharged is your last inpatient day. We pay for the following services and other medically necessary services not listed here: • semi-private room (or a private room if it is medically necessary) • meals, including special diets • regular nursing services • costs of special care units, such as intensive care or coronary care units • drugs and medications • lab tests • X-rays and other radiology services • needed surgical and medical supplies **This benefit is continued on the next page**	$0 You must get approval from our plan to get inpatient care at an out-of-network hospital after your emergency is stabilized.

Covered Service	What you pay
Inpatient hospital care* (continued) • appliances, such as wheelchairs • operating and recovery room services • physical, occupational, and speech therapy • inpatient substance use disorder services • in some cases, the following types of transplants: corneal, kidney, kidney/pancreas, heart, liver, lung, heart/lung, bone marrow, stem cell, and intestinal/multivisceral. For heart transplants this also includes a Ventricular Assist Device inserted as a bridge or as a destination therapy treatment. If you need a transplant, a Medicare-approved transplant center will review your case and decide if you're a candidate for a transplant. Transplant providers may be local or outside of the service area. If local transplant providers are willing to accept the Medicare rate, then you can get your transplant services locally or outside the pattern of care for your community. If our plan provides transplant services outside the pattern of care for our community and you choose to get your transplant there, we arrange or pay for lodging and travel costs for you and one other person. • blood, including storage and administration • physician services **Note:** To be an inpatient, your provider must write an order to admit you formally as an inpatient of the hospital. Even if you stay in the hospital overnight, you might still be considered an "outpatient." If you're not sure if you're an inpatient or an outpatient, ask the hospital staff. **This benefit is continued on the next page**	

Covered Service	What you pay
Inpatient hospital care* (continued) Get more information in the Medicare fact sheet *Medicare Hospital Benefits*. This fact sheet is available at Medicare.gov/publications/11435-Medicare-Hospital-Benefits.pdf or by calling 1-800-MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048.	
Inpatient services in a psychiatric hospital We pay for mental health care services that require a hospital stay including extended inpatient psychiatric hospital stays. Covered services include mental health care services that require a hospital stay. There is a 190-day lifetime limit for inpatient services in a psychiatric hospital. The 190-day lifetime limit doesn't apply to inpatient mental health services provided in a psychiatric unit of a general hospital.	$0
Interpreter services The plan will pay for the following services: • spoken language interpreter services • sign language interpreter services	$0
Kidney disease services and supplies We pay for the following services: • Kidney disease education services to teach kidney care and help you make good decisions about your care. You must have stage IV chronic kidney disease, and your **This benefit is continued on the next page**	$0

Covered Service	What you pay
Kidney disease services and supplies (continued) doctor must refer you. We cover up to six sessions of kidney disease education services. • Outpatient dialysis treatments, including dialysis treatments when temporarily out of the service area, as explained in **Chapter 3** of this *Member Handbook*, or when your provider for this service is temporarily unavailable or inaccessible. • Inpatient dialysis treatments if you're admitted as an inpatient to a hospital for special care • Self-dialysis training, including training for you and anyone helping you with your home dialysis treatments • Home dialysis equipment and supplies • Certain home support services, such as necessary visits by trained dialysis workers to check on your home dialysis, to help in emergencies, and to check your dialysis equipment and water supply Medicare Part B pays for some drugs for dialysis**.** For information, refer to "Medicare Part B drugs" in this chart.	
Lung cancer screening with low dose computed tomography (LDCT) We pay for lung cancer screening every 12 months if you: • are aged 50-77, **and** • have a counseling and shared decision-making visit with your doctor or other qualified provider, **and** **This benefit is continued on the next page**	$0

Covered Service	What you pay
Lung cancer screening with low dose computed tomography (LDCT) (continued) • have smoked at least 1 pack a day for 20 years with no signs or symptoms of lung cancer or smoke now or have quit within the last 15 years After the first screening, we pay for another screening each year with a written order from your doctor or other qualified provider. If a provider elects to provide a lung cancer screening, counseling, and shared decision-making visit for lung cancer screenings, the visit must meet the Medicare criteria for such visits.	

Covered Service	What you pay
Lutheran Social Services Healthy Transitions Program Individualized support, education and resources for UCare Connect + Medicare members during the first critical 30 days after a stay at the hospital or short-term rehabilitation center. The member returning home is paired with a specially trained and certified Community Health Worker (CHW) who provides a series of four touch-point (two in-home and two telephone) visits during which several topics are reviewed: – Discharge documentation – Home safety and fall risks – Nutrition – Medications – Socialization – Appointment setting and transportation – Short-term goal setting – Resources and referrals to other providers The Community Health Worker collaborates with your UCare Connect + Medicare care coordinator and you to ensure that all needs are being met. To learn more and see if you are eligible, contact your UCare Connect + Medicare care coordinator.	$0
Medical Assistance covered drugs We'll cover some drugs under Medical Assistance that aren't covered by Medicare Part B and Medicare Part D. **This benefit is continued on the next page**	$0

Covered Service	What you pay
Medical Assistance covered drugs (continued) These include some over-the-counter products, some prescription cough and cold medicines and some vitamins. The drug must be on our *List of Covered Drugs* (*Drug List*). We'll cover a drug not on the *Drug List* if your doctor shows us that: • the drug that's normally covered has caused a harmful reaction to you; or • there's a reason to believe the drug that's normally covered would cause a harmful reaction; or • the drug prescribed by your doctor is more effective for you than the drug that's normally covered. The drug must be in a class of drugs that's covered. If pharmacy staff tells you the drug isn't covered and asks you to pay, ask them to call your doctor. We can't pay you back if you pay for it. There may be another drug that'll work that's covered by our plan. If the pharmacy won't call your doctor, you can. You can also call Customer Service at the number at the bottom of this page.	
Medical nutrition therapy This benefit is for people with diabetes or kidney disease without dialysis. It's also for after a kidney transplant when ordered by your doctor. We pay for three hours of one-on-one counselling services during the first year you get medical nutrition therapy **This benefit is continued on the next page**	$0

Covered Service	What you pay
Medical nutrition therapy (continued) services under Medicare. We may approve additional services if medically necessary. We pay for two hours of one-on-one counseling services each year after that. If your condition, treatment, or diagnosis changes, you may be able to get more hours of treatment with a doctor's order. A doctor must prescribe these services and renew the order each year if you need treatment in the next calendar year. We may approve additional services if medically necessary. We may cover additional benefits if medically necessary.	
Medicare Diabetes Prevention Program (MDPP) We pay for MDPP services for eligible people. MDPP is designed to help you increase healthy behavior. It provides practical training in: • long-term dietary change, **and** • increased physical activity, **and** • ways to maintain weight loss and a healthy lifestyle.	$0
Medicare Part B drugs* These drugs are covered under Part B of Medicare. We pay for the following drugs: • drugs you don't usually give yourself and are injected or infused while you get doctor, hospital outpatient, or ambulatory surgery center services **This benefit is continued on the next page**	$0

Covered Service	What you pay
Medicare Part B drugs* (continued) • insulin furnished through an item of durable medical equipment (such as a medically necessary insulin pump) • other drugs you take using durable medical equipment (such as nebulizers) that our plan authorized • the Alzheimer's drug Leqembi® (generic lecanemab), which is given intravenously (IV) • clotting factors you give yourself by injection if you have hemophilia • transplant/immunosuppressive drugs: Medicare covers transplant drug therapy if Medicare paid for your organ transplant. You must have Part A at the time of the covered transplant, and you must have Part B at the time you get immunosuppressive drugs. Medicare Part D covers immunosuppressive drugs if Part B doesn't cover them. • osteoporosis drugs that are injected. We pay for these drugs if you're homebound, have a bone fracture that a doctor certifies was related to post-menopausal osteoporosis, and can't inject the drug yourself. • some antigens: Medicare covers antigens if a doctor prepares them and a properly instructed person (who could be you, the patient) gives them under appropriate supervision. • certain oral anti-cancer drugs: Medicare covers some oral cancer drugs you take by mouth if the same drug is available in injectable form or the drug is a prodrug (an oral form of a drug that, when ingested, breaks down into the same active ingredient found in the injectable drug). As new oral cancer drugs become available, Part **This benefit is continued on the next page**	

Covered Service	What you pay
Medicare Part B drugs* (continued) B may cover them. If Part B doesn't cover them, Part D does • oral anti-nausea drugs: Medicare covers oral anti-nausea drugs you use as part of an anti-cancer chemotherapeutic regimen if they're administered before, at, or within 48 hours of chemotherapy or are used as a full therapeutic replacement for an intravenous anti-nausea drug • certain oral End-Stage Renal Disease (ESRD) drugs covered under Medicare Part B • calcimimetic and phosphate binder medications under the ESRD payment system, including the intravenous medication Parsabiv®, and the oral medication Sensipar • certain drugs for home dialysis, including heparin, the antidote for heparin (when medically necessary) and topical anesthetics • erythropoiesis-stimulating agents: Medicare covers erythropoietin by injection if you have ESRD or you need this drug to treat anemia related to certain other conditions (such as such as Epogen®, Procrit®, Reatacrit®, Epoetin Alfa, Aranesp®, Darbepoetin Alfa®, Mircera®, or Methoxy polyethylene glycol-epotin beta) • IV immune globulin for the home treatment of primary immune deficiency diseases • parenteral and enteral nutrition (IV and tube feeding) The following link takes you to a list of Medicare Part B Drugs that may be subject to Step Therapy: **ucare.org/dsnp-druglist**. **This benefit is continued on the next page**	

Covered Service	What you pay
Medicare Part B drugs* (continued) We also cover some vaccines under our Medicare Part B and most adult vaccines under our Medicare Part D drug benefit. **Chapter 5** of this *Member Handbook* explains our drug benefit. It explains rules you must follow to have prescriptions covered. **Chapter 6** of this *Member Handbook* explains what you pay for your drugs through our plan.	
Mental health services Refer to the following sections for covered mental health services: • depression screening • inpatient services in a psychiatric hospital • outpatient mental health care • partial hospitalization services and Intensive outpatient services	$0
Nursing facility care* We are responsible for paying a total of 100 days of nursing home room and board. This includes custodial care. If you need continued nursing home care beyond the 100 days, the Minnesota Department of Human Services (DHS) will pay directly for your care. **This benefit is continued on the next page**	$0

Covered Service	What you pay
Nursing facility care* (continued) If DHS is currently paying for your care in the nursing home, DHS, not our plan, will continue to pay for your care. Refer to the "Skilled nursing facility (SNF) care" section of this chart for more information about the additional nursing home coverage our plan provides. A nursing facility (NF) is a place that provides care for people who can't get care at home but who don't need to be in a hospital. Services that we pay for include, but are not limited to, the following: • semiprivate room (or a private room if medically necessary) • meals, including special diets • nursing services • physical therapy, occupational therapy, and speech therapy • respiratory therapy • drugs given to you as part of your plan of care. (This includes substances that are naturally present in the body, such as blood-clotting factors.) • blood, including storage and administration • medical and surgical supplies usually given by nursing facilities • lab tests usually given by nursing facilities **This benefit is continued on the next page**	

Covered Service	What you pay
Nursing facility care* (continued) • X-rays and other radiology services usually given by nursing facilities • use of appliances, such as wheelchairs usually given by nursing facilities • physician/practitioner services • durable medical equipment • dental services, including dentures • vision benefits • hearing exams • chiropractic care • podiatry services You usually get your care from network facilities. However, you may be able to get your care from a facility not in our network. You can get care from the following places if they accept our plan's amounts for payment: • a nursing facility or continuing care retirement community where you were living right before you went to the hospital (as long as it provides nursing facility care). • a nursing facility where your spouse or domestic partner is living at the time you leave the hospital.	
Obesity screening and therapy to keep weight down If you have a body mass index of 30 or more, we pay for counseling to help you lose weight. You must get the counseling in a primary care setting. That way, it can be **This benefit is continued on the next page**	$0

Covered Service	What you pay
Obesity screening and therapy to keep weight down (continued) managed with your full prevention plan. Talk to your primary care provider to find out more. We may cover additional benefits if medically necessary.	
Obstetrics and Gynecology (OB/GYN) Services Covered Services: • prenatal, delivery, and postpartum care • planned home births • childbirth classes • HIV counseling and testing for pregnant people — open access service • treatment for HIV-positive pregnant people • testing and treatment of sexually transmitted diseases (STDs) — open access service • pregnancy-related services received in connection with an abortion (doesn't include abortion-related services) • doula services by a certified doula • services provided by a licensed health professional at licensed birth centers, including services of certified nurse midwives and licensed traditional midwives Not Covered Services: • Abortion: This service isn't covered under the Plan. It may be covered by the State. Call DHS Health **This benefit is continued on the next page**	$0

Covered Service	What you pay
Obstetrics and Gynecology (OB/GYN) Services (continued) Care Consumer Support (HCCS) at 651-297-3862 or 1-800-657-3672 (this call is free) or 711 (TTY) (this call is free) or use your preferred relay service for coverage information. You have "direct access" to OB-GYN providers without a referral for the following services: annual preventive health exam, including follow-up exams that your qualified health care provider says are necessary; maternity care; evaluation and treatment for gynecologic conditions or emergencies. To get the direct access services, you must go to a provider in the Plan network. For services labeled as open access, you can go to any qualified health care provider, clinic, hospital, pharmacy, or family planning agency.	
Opioid treatment program (OTP) services We pay for the following services to treat opioid use disorder (OUD) through an OTP which includes the following services: • intake activities • periodic assessments • medications approved by the FDA and, if applicable, managing and giving you these medications • substance use counseling • individual and group therapy • testing for drugs or chemicals in your body (toxicology testing)	$0

Covered Service	What you pay
Outpatient diagnostic tests and therapeutic services and supplies	
We pay for the following services and other medically necessary services not listed here: • X-rays • radiation (radium and isotope) therapy, including technician materials and supplies • surgical supplies, such as dressings • splints, casts, and other devices used for fractures and dislocations • lab tests • blood including storage and administration • diagnostic non-laboratory tests such as CT scans, MRIs, EKGs, and PET scans when your doctor or other health care provider orders them to treat a medical condition • other outpatient diagnostic tests	$0

Covered Service	What you pay
Outpatient hospital observation We pay for outpatient hospital observation services to determine if you need to be admitted as an inpatient or can be discharged. The services must meet Medicare criteria and be considered reasonable and necessary. Observation services are covered only when provided by the order of a physician or another person authorized by state law and hospital staff bylaws to admit patients to the hospital or order outpatient tests. **Note**: Unless the provider has written an order to admit you as an inpatient to the hospital, you're an outpatient. Even if you stay in the hospital overnight, you might still be considered an outpatient. If you aren't sure if you're an outpatient, ask hospital staff. Get more information in the Medicare fact sheet *Medicare Hospital Benefits*. This fact sheet is available at Medicare.gov/publications/11435-Medicare-Hospital-Benefits.pdf.	$0
Outpatient hospital services We pay for medically necessary services you get in the outpatient department of a hospital for diagnosis or treatment of an illness or injury, such as: • Services in an emergency department or outpatient clinic, such as outpatient surgery or observation services – Observation services help your doctor know if you need to be admitted to the hospital as "inpatient." – Sometimes you can be in the hospital overnight and still be "outpatient." **This benefit is continued on the next page**	$0

Covered Service	What you pay
Outpatient hospital services (continued) – You can get more information about being inpatient or outpatient in this fact sheet: es.medicare.gov/publications/11435-Medicare-Hospital-Benefits.pdf • Labs and diagnostic tests billed by the hospital • Mental health care, including care in a partial-hospitalization program, if a doctor certifies that inpatient treatment would be needed without it • X-rays and other radiology services billed by the hospital • Medical supplies, such as splints and casts • Preventive screenings and services listed throughout the Benefits Chart • Some drugs that you can't give yourself*	
Outpatient mental health care We will pay for the following services, and maybe other services not listed here: • Certified Community Behavioral Health Clinic (CCBHC) • Children's Intensive Behavorial Health Services (CIBHS) (for members under age 21) • Clinical care consultation • Crisis response services including screening, assessment, intervention, stabilization (including residential stabilization), and community intervention **This benefit is continued on the next page**	$0

Covered Service	What you pay
Outpatient mental health care (continued) • Diagnostic assessments including screening for presence of co-occurring mental illness and substance use disorders • Dialectical Behavioral Therapy (DBT) Intensive Outpatient Program (IOP) • Forensic Assertive Community Treatment (FACT) • Mental Health provider travel time • Mental Health Targeted Case Management (MH-TCM) • Outpatient mental health services, including explanation of findings, family psychoeducation services (for members under age 21), mental health medication management, neuropsychological services, psychotherapy (patient and/or family, family, crisis and group), and psychological testing • Physician Mental Health Services, including health and behavioral assessment/intervention, inpatient visits, psychiatric consultations to primary care providers, and physician consultation, evaluation, and management • Rehabilitative Mental Health Services, including – Assertive Community Treatment (ACT), – Adult day treatment, – Adult Rehabilitative Mental Health Services (ARMHS), – Certified Peer Specialist (CPS) support services in limited situations, – Certified family peer specialists, (for members under 21) **This benefit is continued on the next page**	

Covered Service	What you pay
Outpatient mental health care (continued) – Children's mental health residential treatment services (for members under age 21) – Children's Therapeutic Services and Supports (CTSS) including Children's Day Treatment (for members under age 21), – Family psychoeducation services (for members under age 21) – Intensive Residential Treatment Services (IRTS), – Intensive Treatment Foster Care Services (for members under age 21), – Youth Assertive Community Treatment (Youth ACT): intensive non-residential rehabilitative mental health services (for members ages 18 through 20), – Partial Hospitalization Program (PHP) • Psychiatric Residential Treatment Facility (PRTF) (for members ages 18 through 20) • Telehealth If we decide no structured mental health treatment is necessary, you may get a second opinion. For the second opinion, we must allow you to use any qualified health professional that isn't in the plan network. We'll pay for this. We must consider the second opinion, but we have the right to disagree with the second opinion. You have the right to appeal our decision. **This benefit is continued on the next page**	

Covered Service	What you pay
Outpatient mental health care (continued) We won't determine medical necessity for court-ordered mental health services. Use a plan network provider for your court-ordered mental health assessment. The following services aren't covered under the plan but may be available through your county. Call your county for information. • Treatment at Rule 36 facilities that aren't licensed as Intensive Residential Treatment Services (IRTS) • Room and board associated with Intensive Residential Treatment Services (IRTS) • Treatment and room and board services at certain children's residential mental health treatment facilities in bordering states	
Outpatient rehabilitation services* We pay for physical therapy, occupational therapy, and speech therapy. You can get outpatient rehabilitation services from hospital outpatient departments, independent therapist offices, comprehensive outpatient rehabilitation facilities (CORFs), and other facilities.	$0
Outpatient substance use disorder services We pay for the following services, and maybe other services not listed here: **This benefit is continued on the next page**	$0

Covered Service	What you pay
Outpatient substance use disorder services (continued) • screening/assessment/diagnosis including Screening Brief Intervention Referral to Treatment (SBIRT) authorized services • outpatient treatment • outpatient medication assisted treatment • substance use disorder treatment coordination • peer recovery support • detoxification (only when inpatient hospitalization is medically necessary because of conditions resulting from injury or accident or medical complications during detoxification) • withdrawal management A qualified professional who is part of our network will make recommendations for substance use disorder services for you. You may elect up to the highest level of care recommended by the qualified professional. You may receive an additional assessment at any point throughout your care, if you don't agree with the recommended services. If you agree with the second assessment, you may access services according to substance use disorder standards and the second assessment You have the right to appeal. Refer to **Chapter 9** of your *Member Handbook*.	
Outpatient surgery* We pay for outpatient surgery and services at hospital outpatient facilities and ambulatory surgical centers.	$0

This benefit is continued on the next page

Covered Service	What you pay
Outpatient surgery* (continued) **Note**: If you're having surgery in a hospital facility, you should check with your provider about whether you'll be an inpatient or outpatient. Unless the provider writes an order to admit you as an inpatient to the hospital, you're an outpatient. Even if you stay in the hospital overnight, you might still be considered an outpatient.	
Partial hospitalization services and Intensive outpatient services **Partial hospitalization** is a structured program of active psychiatric treatment. It's offered as a hospital outpatient service or by a community mental health center that's more intense than the care you get in your doctor's, therapist's, licensed marriage and family therapist's (LMFT), or licensed professional counselor's office. It can help keep you from having to stay in the hospital. **Intensive outpatient service** is a structured program of active behavioral (mental) health therapy treatment provided as a hospital outpatient service, in a community mental health center, in a federally qualified health center, or in a rural health clinic that's more intense than care you get in your doctor's, therapist's, LMFT's, or licensed professional counselor's office but less intense than partial hospitalization.	$0

Covered Service	What you pay
Physician/provider services, including doctor's office visits We pay for the following services: • medically necessary health care or surgery services given in places such as: • physician's office • certified ambulatory surgical center • hospital outpatient department • consultation, diagnosis, and treatment by a specialist • basic hearing and balance exams given by your primary care provider **or** specialist, if your doctor orders them to find out whether you need treatment • Certain telehealth services, including those for: – Medicare-approved services, including urgently needed services, primary care provider and specialist visits, individual and group mental health sessions, podiatry services, diagnostic procedures and tests, dialysis services, kidney disease education services and eye exams. – You have the option of getting these services through an in-person visit or by telehealth. If you choose to get one of these services by telehealth, you must use a network provider who offers the service by telehealth. • telehealth services for monthly end-stage renal disease (ESRD) related visits for home dialysis members in a hospital-based or critical access hospital-based renal dialysis center, renal dialysis facility, or at home **This benefit is continued on the next page**	$0

Covered Service	What you pay
Physician/provider services, including doctor's office visits (continued) • telehealth services to diagnose, evaluate, or treat symptoms of a stroke • telehealth services for members with a substance use disorder or co-occurring mental health disorder • telehealth services for diagnosis, evaluation, and treatment of mental health disorders if: – You have an in-person visit within 6 months prior to your first telehealth visit – You have an in-person visit every 12 months while receiving these telehealth services – Exceptions can be made to the above for certain circumstances • telehealth services for mental health visits provided by rural health clinics and federally qualified health centers • virtual check-ins (for example, by phone or video chat) with your doctor for 5-10 minutes **if**: – you're not a new patient **and** – the check-in isn't related to an office visit in the past 7 days **and** – the check-in doesn't lead to an office visit within 24 hours or the soonest available appointment • Evaluation of video and/or images you send to your doctor and interpretation and follow-up by your doctor within 24 hours **if**: – you're not a new patient and **This benefit is continued on the next page**	

Covered Service	What you pay
Physician/provider services, including doctor's office visits (continued) – the evaluation isn't related to an office visit in the past 7 days **and** – the evaluation doesn't lead to an office visit within 24 hours or the soonest available appointment • Consultation your doctor has with other doctors by phone, the internet, or electronic health record if you're not a new patient • Second opinion by another network provider before surgery • Preventive and physical exams • Family planning services. For more information, refer to the "Family planning services" section of this chart. • Out-of-network services related to the diagnosis, monitoring and treatment of a rare disease or condition	
Podiatry services We pay for the following services: • diagnosis and medical or surgical treatment of injuries and diseases of the foot (such as hammer toe or heel spurs) • routine foot care for members with conditions affecting the legs, such as diabetes • other non-routine foot care such as debridement of toenails and infected corns and calluses	$0

Covered Service	What you pay
Pre-exposure prophylaxis (PrEP) for HIV prevention If you don't have HIV, but your doctor or other health care practitioner determines you're at an increased risk for HIV, we cover pre-exposure prophylaxis (PrEP) medication and related services. If you qualify, covered services include: • FDA-approved oral or injectable PrEP medication. If you're getting an injectable drug, we also cover the fee for injecting the drug. • Up to 8 individual counseling sessions (including HIV risk assessment, HIV risk reduction, and medication adherence) every 12 months. • Up to 8 HIV screenings every 12 months. • A one-time hepatitis B virus screening.	$0
Post-discharge meals We offer post-discharge meals, up to two meals a day for up to 14 days following a discharge from an inpatient facility. **Note**: Members aren't required to use this service. If you choose to use this service, you keep all your rights. Your health plan can't deny access to any services just because you were offered, are using, or have used this service before.	$0
Post-discharge medication reconciliation Medication reconciliation is an important part of post-discharge care if you take prescription medications. **This benefit is continued on the next page**	$0

Covered Service	What you pay
Post-discharge medication reconciliation (continued) We offer post-discharge medication reconciliation given by a pharmacist after discharge from an inpatient facility. They will review discharge instructions and medications with you to make sure you understand. They will also coordinate your discharge medications with the medications you were taking before your inpatient stay.	
Prostate cancer screening exams For men aged 50 and over, we pay for the following services once every 12 months: • a digital rectal exam • a prostate specific antigen (PSA) test	$0
Prosthetic and orthotic devices and related supplies Prosthetic devices replace all or part of a body part or function. These include but aren't limited to: • testing, fitting, or training in the use of prosthetic and orthotic devices • colostomy bags and supplies related to colostomy care • pacemakers • braces • prosthetic shoes • artificial arms and legs • breast prostheses (including a surgical brassiere after a mastectomy) **This benefit is continued on the next page**	$0

Covered Service	What you pay
Prosthetic and orthotic devices and related supplies (continued) • wigs for people with hair loss due to any medical condition • some shoes when a part of a leg brace or when custom molded We pay for some supplies related to prosthetic and orthotic devices. We also pay to repair or replace prosthetic and orthotic devices. We offer some coverage after cataract removal or cataract surgery. Refer to "Vision care" later in this chart for details.	
Pulmonary rehabilitation services We pay for pulmonary rehabilitation programs for members who have moderate to very severe chronic obstructive pulmonary disease (COPD). You must have an order for pulmonary rehabilitation from the doctor or provider treating the COPD.	$0
Recuperative care Recuperative care helps qualified members avoid being readmitted to the hospital. It provides short-term lodging, medical care and support for up to sixty (60) days for those who are recovering from an illness and are unhoused. This care is for members who need help to recover, but don't need to stay in the hospital. We pay for the following services: • basic nursing care, like checking health and pain **This benefit is continued on the next page**	$0

Covered Service	What you pay
Recuperative care (continued) • wound care • help with taking medicine • teaching about health • checking and updating shots (immunizations) • planning for recovery and going home • checking and planning for medical, emotional, and social needs • creating and following a care plan • helping with legal issues, finding a place to live, getting rides, and other community services • helping with health care and other benefits • following up on care plans • providing medical, social, and emotional support, like counseling • community health worker services We don't pay for the following services: • services related to a member's emotional health needs that exceed those a provider can support • services related to Activities of Daily Living (ADL) that a member can't perform on their own, such as standing up or using the bathroom • payment for room and board associated with recuperative care services is the responsibility of the Minnesota Department of Human Services	

Covered Service	What you pay
Screening for Hepatitis C virus infection We cover one Hepatitis C screening if your primary care doctor or other qualified health care provider orders one and you meet one of these conditions: • You're at high risk because you use or have used illicit injection drugs. • You had a blood transfusion before 1992. • You were born between 1945-1965. If you were born between 1945-1965 and aren't considered high risk, we pay for a screening once. If you're at high risk (for example, you've continued to use illicit injection drugs since your previous negative Hepatitis C screening test), we cover yearly screenings.	$0
Sexually transmitted infections (STIs) screening and counseling We pay for screenings for chlamydia, gonorrhea, syphilis, and hepatitis B. These screenings are covered for pregnant women and for some people who are at increased risk for an STI. A primary care provider must order the tests. We cover these tests once every 12 months or at certain times during pregnancy. We also pay for up to two face-to-face, high intensity behavioral counseling sessions each year for sexually active adults at increased risk for STIs. Each session can be 20 to 30 minutes long. We pay for these counseling sessions as a preventive service only if given by a primary care provider. The sessions must be in a primary care setting, such as a doctor's office.	$0

Covered Service	What you pay
Skilled nursing facility (SNF) care*	
For additional nursing home services covered by us, refer to the "Nursing facility care" section.	$0
For a definition of skilled nursing facility care, go to **Chapter 12.**	
We pay for the following services, and maybe other services not listed here: • a semi-private room, or a private room if it is medically necessary • meals, including special diets • skilled nursing services • physical therapy, occupational therapy, and speech therapy • drugs you get as part of your plan or care, including substances that are naturally in the body, such as blood-clotting factors • blood, including storage and administration • medical and surgical supplies given by SNFs • lab tests given by SNFs • X-ray and other radiology services given by nursing facilities • appliances, such as wheelchairs, usually given by nursing facilities • physician/provider services	
You usually get SNF care from network facilities. Under certain conditions you may be able to get your care from a facility not in our network. You can get care from the	
This benefit is continued on the next page	

Covered Service	What you pay
Skilled nursing facility (SNF) care* (continued) following places if they accept our plan's amounts for payment: • a nursing facility or continuing care retirement community where you lived before you went to the hospital (as long as it provides nursing facility care) • a nursing facility where your spouse or domestic partner lives at the time you leave the hospital	
Smoking and tobacco use cessation (counseling to stop smoking or tobacco use) Smoking and tobacco use cessation counseling is covered for outpatient and hospitalized patients who meet these criteria: • use tobacco, regardless of whether they exhibit signs or symptoms of tobacco-related disease • are competent and alert during counseling • a qualified physician or other Medicare-recognized practitioner provides counseling We pay for two cessation attempts per year (each attempt may include a maximum of four intermediate or intensive sessions, with up to eight sessions per year). We pay for the following services: • In-Person Counseling: You can get help with quitting tobacco or nicotine through individual or group sessions led by trained health care practitioners. **This benefit is continued on the next page**	$0

Covered Service	What you pay
Smoking and tobacco use cessation (counseling to stop smoking or tobacco use) (continued) • Telephone Counseling: You can call the Tobacco and Nicotine Quit Line for support. This service can be accessed by phone and does not require video. – Call the Tobacco and Nicotine Quit Line toll-free 1-855-260-9713 (TTY 711), available 24 hours a day, seven days a week. – Visit ucare.org/quit • Medications: You can get both prescription and over-the-counter medications approved by the FDA to help you quit smoking or using nicotine. • Telemedicine: Services can also be provided through telemedicine (video calls or online). • No Limits: There are no limits on how often you can use these services or how many times you can receive counseling or medications for tobacco and nicotine cessation services. • Multiple Services: You can use different types of support at the same time, like counseling and medications.	
Supervised exercise therapy (SET) We pay for SET for members with symptomatic peripheral artery disease (PAD). Our plan pays for: **This benefit is continued on the next page**	$0

Covered Service	What you pay
Supervised exercise therapy (SET) (continued) • up to 36 sessions during a 12-week period if all SET requirements are met • an additional 36 sessions over time if deemed medically necessary by a health care provider The SET program must be: • 30 to 60-minute sessions of a therapeutic exercise-training program for PAD in members with leg cramping due to poor blood flow (claudication) • in a hospital outpatient setting or in a physician's office • delivered by qualified personnel who make sure benefit exceeds harm and who are trained in exercise therapy for PAD • under the direct supervision of a physician, physician assistant, or nurse practitioner/clinical nurse specialist trained in both basic and advanced life support techniques	
Support for Caregivers The plan covers training and support for caregivers of members who do not have access to coverage through Medical Assistance. Ask your care coordinator for more information about this service.	$0
Transportation If you need transportation to and from health services that we cover, call HealthRide at 612-676-6830 or 1-800-864-2157 (this call is free). TTY at 612-676-6810 or **This benefit is continued on the next page**	$0

Covered Service	What you pay
Transportation (continued) 1-800-688-2534 (this call is free). We'll provide the most appropriate and cost-effective transportation. Our plan isn't required to provide transportation to your Primary Care Clinic if it's over 30 miles from your home or if you choose a specialty provider that's more than 60 miles from your home. Call Customer Service 612-676-3310 or 1-855-260-9707 (this call is free), TTY at 612-676-6810 or 1-800-688-2534 (this call is free) if you don't have a Primary Care Clinic that's available within 30 miles of your home and/or you don't have a specialty provider that's available within 60 miles of your home. • non-emergency ambulance • volunteer driver transport • unassisted transport (taxi or public transportation) • assisted transportation • lift-equipped/ramp transport • protected transportation • stretcher transport **Note:** Our plan doesn't cover mileage reimbursement (for example, when you use your own car), meals, lodging, and parking, also including out of state travel. These services aren't covered under the plan but may be available through the local county or tribal agency. Call your local county or tribal agency for more information.	
Urgently needed care Urgently needed care is care given to treat: **This benefit is continued on the next page**	$0

Covered Service	What you pay
Urgently needed care (continued) • a non-emergency that requires immediate medical care, **or** • an unforeseen illness, **or** • an injury, **or** • a condition that needs care right away. If you require urgently needed care, you should first try to get it from a network provider. However, you can use out-of-network providers when you can't get to a network provider because given your time, place or circumstances, it's not possible, or it's unreasonable, to get this service from network providers (for example, when you're outside the plan's service area and you require medically needed immediate services for an unseen condition but it's not a medical emergency). This coverage is only available within the U.S. and its territories.	
Vision care We pay for outpatient doctor services for the diagnosis and treatment of diseases and injuries of the eye. For example, treatment for age-related macular degeneration. For people at high risk of glaucoma, we pay for one glaucoma screening each year. People at high risk of glaucoma include: • people with a family history of glaucoma • people with diabetes, **This benefit is continued on the next page**	$0

Covered Service	What you pay
Vision care (continued) • African Americans who are 50 and over • Hispanic Americans who are 65 and over For people with diabetes, we pay for screening for diabetic retinopathy once per year. We pay for one pair of glasses or contact lenses after each cataract surgery when the doctor inserts an intraocular lens. If you have two separate cataract surgeries, you must get one pair of glasses after each surgery. You can't get two pairs of glasses after the second surgery, even if you didn't get a pair of glasses after the first surgery. We also cover the following: • eye exams • initial eyeglasses, when medically necessary (eyeglass frame selection may be limited) • replacement eyeglasses, when medically necessary. Identical replacement of covered eyeglasses for loss, theft, or damage beyond repair. • repairs to frames and lenses for eyeglasses covered under the plan • tinted, photochromatic (such as Transitions®) lenses, or polarized lenses, when medically necessary • contact lenses, when medically necessary under certain circumstances We also offer a supplemental benefit of: • Anti-glare lens coating, once per year **This benefit is continued on the next page**	

Covered Service	What you pay
Vision care (continued) • Photochromic ("transition") lens tinting, once per year • Progressive (no-line) lenses, once per year **Note:** Our plan doesn't cover an extra pair of glasses, protective coating for plastic lenses, or contact lens supplies.	
"Welcome to Medicare" preventive visit We cover the one-time "Welcome to Medicare" preventive visit. The visit includes: • a review of your health, • education and counseling about preventive services you need (including screenings and shots), **and** • referrals for other care if you need it. **Note:** We cover the "Welcome to Medicare" preventive visit only during the first 12 months that you have Medicare Part B. When you make your appointment, tell your doctor's office you want to schedule your "Welcome to Medicare" preventive visit.	$0

E. Benefits covered outside of our plan

We don't cover the following services, but they're available through Medicare or Medical Assistance.

E1. Other Services

The following services aren't covered by us under the plan but may be available through another source, such as the state, county, federal government, or tribe. To find out more about these services, call DHS Health Care Consumer Support (HCCS) at 1-651-297-3862 or 1-800-657-3672 or 711 (TTY) or use your preferred relay service. This call is free.

- Case management for people with developmental disabilities
- Child welfare targeted case management
- Consumer Support Grant (CG)
- HIV services under the Ryan White Act
- Home Care Nursing
- Personal Care Assistant (PCA) services (Community First Services and Supports (CFSS))
- Relocation Service Coordination (RSC)
- Waiver services provided under Home and Community-Based Services waivers
- Intermediate care facility for people who have a developmental disability (ICF/DD)
- Treatment at Rule 36 facilities that aren't licensed as Intensive Residential Treatment Services (IRTS)
- Room and board associated with Intensive Residential Treatment Services (IRTS)
- Services provided by a state regional treatment center or a state-owned long-term care facility unless approved by us or the service is ordered by a court under conditions specified in law
- Services provided by federal institutions
- Job training and educational services
- Day training and habilitation
- Mileage reimbursement (for example, when you use your own car), meals, lodging, and parking. Contact your county for more information.
- Nursing home stays for which our plan isn't otherwise responsible. (Refer to the "Nursing facility care" and the "Skilled nursing facility (SNF) care" sections in the Benefits Chart for additional information.)
- Vulnerable Adult Protective Services

- Medical Assistance covered services provided by federally qualified health centers (FQHC)

F. Benefits not covered by our plan, Medicare, or Medical Assistance

This section tells you about benefits excluded by our plan. "Excluded" means that we don't pay for these benefits. Medicare and Medical Assistance don't pay for them either.

The list below describes some services and items not covered by us under any conditions and some excluded by us only in some cases.

We don't pay for excluded medical benefits listed in this section (or anywhere else in this *Member Handbook*) except under specific conditions listed. Even if you get the services at an emergency facility, the plan won't pay for the services. If you think that our plan should pay for a service that isn't covered, you can request an appeal. For information about appeals, refer to **Chapter 9** of this *Member Handbook*.

In addition to any exclusions or limitations described in the Benefits Chart, our plan doesn't cover the following items and services**:**

- services considered not “reasonable and medically necessary”, according to Medicare and Medical Assistance standards, unless we list these as covered services.
- experimental medical and surgical treatments, items, and drugs, unless Medicare, a Medicare-approved clinical research study, or our plan covers them. Refer to **Chapter 3** of this *Member Handbook* for more information on clinical research studies. Experimental treatment and items are those that aren't generally accepted by the medical community.
- surgical treatment for morbid obesity, except when medically necessary and Medicare or Medical Assistance pays for it.
- a private room in a hospital, except when medically necessary.
- personal items in your room at a hospital or a nursing facility, such as a telephone or television.
- fees charged by your immediate relatives or members of your household.
- elective or voluntary enhancement procedures or services (including weight loss, hair growth, sexual performance, athletic performance, cosmetic purposes, anti-aging and mental performance), except when medically necessary.

- cosmetic surgery or other cosmetic work, unless it's needed because of an accidental injury or to improve a part of the body that isn't shaped right. However, we pay for reconstruction of a breast after a mastectomy and for treating the other breast to match it.
- routine foot care, except as described in Podiatry services in the Benefits Chart in **Section D**
- radial keratotomy, LASIK surgery, and other low-vision aids.
- reversal of sterilization procedures and non-prescription contraceptive supplies.
- naturopath services (the use of natural or alternative treatments).
- services provided to veterans in Veterans Affairs (VA) facilities. However, when a veteran gets emergency services at a VA hospital and the VA cost-sharing is more than the cost-sharing under our plan, we'll reimburse the veteran for the difference. You're still responsible for your cost-sharing amounts.

Chapter 5: Getting your outpatient drugs

Introduction

This chapter explains rules for getting your outpatient drugs. These are drugs that your provider orders for you that you get from a pharmacy or by mail order. They include drugs covered under Medicare Part D and Medical Assistance. Key terms and their definitions appear in alphabetical order in the last chapter of this *Member Handbook*.

We also cover the following drugs, although they're not discussed in this chapter:

- **Drugs covered by Medicare Part A**. These generally include drugs given to you while you're in a hospital or nursing facility.
- **Drugs covered by Medicare Part B**. These include some chemotherapy drugs, some drug injections given to you during an office visit with a doctor or other provider, and drugs you're given at a dialysis clinic. To learn more about what Medicare Part B drugs are covered, refer to the Benefits Chart in **Chapter 4** of this *Member Handbook*.
- In addition to the plan's Medicare Part D and medical benefits coverage, your drugs may be covered by Original Medicare if you're in Medicare hospice. For more information, please refer to **Chapter 5**, Section F3 "In a Medicare-certified hospice program."

Rules for our plan's outpatient drug coverage

We usually cover your drugs as long as you follow the rules in this section. If a drug is a Part D drug, it can't be covered under the Medical Assistance benefit. Some prescription and over-the-counter drugs are covered under Medical Assistance. These drugs are included in the *Drug List*.

You must have a provider (doctor, dentist, or other prescriber) write your prescription, which must be valid under applicable state law. This person often is your primary care provider (PCP). It could also be another provider if your PCP has referred you for care.

Your prescriber must **not** be on Medicare's Exclusion or Preclusion Lists or any similar Medical Assistance lists.

You generally must use a network pharmacy to fill your prescription. Refer to **Section A1** for more information. Or, you can fill your prescription through the plan's mail-order service

Your prescribed drug must be on our plan's *List of Covered Drugs*. We call it the *Drug List* for short (Refer to Section B of this chapter).

- If it isn't on the *Drug List*, we may be able to cover it by giving you an exception.
- Refer to **Chapter 9** to learn about asking for an exception.

Your drug must be used for a medically accepted indication. This means that use of the drug is

either approved by the Food and Drug Administration (FDA) or supported by certain medical references. Your prescriber may be able to help identify medical references to support the requested use of the prescribed drug.

Your drug may require approval from our plan based on certain criteria before we'll cover it (refer to **Section C** in this chapter).

Table of Contents

A. Getting your prescriptions filled

A1. Filling your prescriptions at a network pharmacy

In most cases, we will pay for prescriptions only when filled at any of our network pharmacies. A network pharmacy is a drug store that agrees to fill prescriptions for our plan members. You may use any of our network pharmacies. Refer to **Section A8** for information about when we cover prescriptions filled at out-of-network pharmacies.

To find a network pharmacy, refer to the *Provider and Pharmacy Directory*, visit our website or contact Customer Service or your care coordinator.

A2. Using your Member ID Card when you fill a prescription

To fill your prescription, **show your Member ID Card** at your network pharmacy. The network pharmacy bills us for our share of the cost of your covered drug. You may need to pay the pharmacy a copay when you pick up your prescription.

If you don't have your Member ID Card with you when you fill your prescription, ask the pharmacy to call us to get the necessary information, or you can ask the pharmacy to look up your plan enrollment information.

If the pharmacy can't get the necessary information, you may have to pay the full cost of the prescription when you pick it up. Then you can ask us to pay you back for our share. **If you can't pay for the drug, contact Customer Service right away.** We'll do everything we can to help.

- To ask us to pay you back, refer to **Chapter 7** of this *Member Handbook*.
- If you need help getting a prescription filled, contact Customer Service or your care coordinator.

A3. What to do if you change your network pharmacy

If you change pharmacies and need a prescription refill, you can either ask to have a new prescription written by a provider or ask your pharmacy to transfer the prescription to the new pharmacy if there are any refills left.

If you need help changing your network pharmacy, contact Customer Service or your care coordinator.

A4. What to do if your pharmacy leaves the network

If the pharmacy you use leaves our plan's network, you need to find a new network pharmacy.

To find a new network pharmacy, refer to the *Provider and Pharmacy Directory*, visit our website, or contact Customer Service or your care coordinator.

A5. Using a specialized pharmacy

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

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

  Please refer to your *Provider and Pharmacy Directory* to find a home infusion pharmacy provider in your area. For more information, contact Customer Service.
- Pharmacies that supply drugs for residents of a long-term care facility, such as a nursing facility.
  - Usually, long-term care facilities have their own pharmacies. If you're a resident of a long-term care facility, we make sure you can get the drugs you need at the facility's pharmacy.
  - If your long-term care facility's pharmacy is not in our network or you have difficulty getting your drugs in a long-term care facility, contact Customer Service.
- Pharmacies that serve the Indian Health Service/Tribal/Urban Indian Health Program. Except in emergencies, only Native Americans or Alaska Natives may use these pharmacies.
- Pharmacies that dispense drugs restricted by the FDA to certain locations or that require special handling, provider coordination, or education on their use. (Note: This scenario should happen rarely.)

To find a specialized pharmacy, refer to the *Provider and Pharmacy Directory*, visit our website, or contact Customer Service or your care coordinator.

A6. Using mail-order services to get your drugs

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

Our plan's mail-order service allows you to order up to a 100-day supply. A 100-day supply has the same copay as a one-month supply.

Filling prescriptions by mail

To get order forms and information about filling your prescriptions by mail call Customer Service or contact Costco Mail Order Pharmacy at 1-800-607-6861 (this call is free). TTY users call 711 (this call is free). You may also visit rx.costco.com and click on "Get Started" to set up an account and complete the patient profile to begin filling prescriptions. If you use a mail-order pharmacy that is not in the plan network, your prescription will not be covered.

Usually, a mail-order prescription arrives within 14 business days. However, sometimes mail-order may be delayed. If your mail-order is delayed, call Customer Service to find out how to fill your prescription.

Mail-order processes

Mail-order service has different procedures for new prescriptions it gets from you, new prescriptions it gets directly from your provider's office, and refills on your mail-order prescriptions.

1. New prescriptions the pharmacy gets from you

The pharmacy automatically fills and delivers new prescriptions it gets from you.

2. New prescriptions the pharmacy gets from your provider's office

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

- You used mail-order services with this plan in the past and the copay does not exceed $150 **or**
- You sign up for automatic delivery of all new prescriptions you get directly from health care providers. You may ask for automatic delivery of all new prescriptions now or at any time by

calling Costco Mail Order Pharmacy at 1-800-607-6861 (this call is free). TTY users call 711 (this call is free). You may also visit rx.costco.com.

If you used mail order in the past and don't want the pharmacy to automatically fill and ship each new prescription, contact Costco Mail Order Pharmacy at 1-800-607-6861 (this call is free). TTY users call 711 (this call is free). You may also visit rx.costco.com.

If you get a prescription automatically by mail that you don't want, and you weren't contacted to find out if you wanted it before it shipped, you may be eligible for a refund.

If you never used our mail-order delivery and/or decide to stop automatic fills of new prescriptions, the pharmacy contacts you each time it gets a new prescription from a health care provider to find out if you want the medication filled and shipped immediately.

- This gives you an opportunity to make sure the pharmacy is delivering the correct drug (including strength, amount, and form) and, if necessary, allows you to cancel or delay the order before you're billed and it's shipped.
- Respond each time the pharmacy contacts you, 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 you get directly from your health care provider's office, contact Costco Mail Order Pharmacy at 1-800-607-6861 (this call is free). TTY users call 711 (this call is free). You may also visit rx.costco.com.

3. Refills on mail-order prescriptions

For refills of your drugs, you have the option to sign up for an automatic refill program. Under this program we start to process your next refill automatically when our records show you should be close to running out of your drug.

- The pharmacy contacts you before shipping each refill to make sure you need more medication, and you can cancel scheduled refills if you have enough medication or your medication has changed.
- If you choose not to use our auto refill program, contact your pharmacy 21 days before your current prescription will run out to make sure your next order is shipped to you in time.

To opt out of our program that automatically prepares mail-order refills, contact Costco Mail Order Pharmacy at 1-800-607-6861 (this call is free). TTY users call 711 (this call is free). You may also visit rx.costco.com.

Let the pharmacy know the best ways to contact you so they can reach you to confirm your order before shipping. Call Costco Mail Order Pharmacy Customer Service at 1-800-607-6861

(this call is free). TTY users call 711 (this call is free). You may also visit rx.costco.com and click on "Get Started" to set up an account and complete the patient profile to begin filling prescriptions.

A7. Getting a long-term supply of drugs

You can get a long-term supply of maintenance drugs on our plan's *Drug List*. Maintenance drugs are drugs you take on a regular basis, for a chronic or long-term medical condition. When you get a long-term supply of a drug, your copay may be lower.

Some network pharmacies allow you to get a long-term supply of maintenance drugs. A 100-day supply has the same copay as a one-month supply. The *Provider and Pharmacy Directory* tells you which pharmacies can give you a long-term supply of maintenance drugs. You can also call your care coordinator or Customer Service for more information.

For certain kinds of drugs, you can use our plan's network mail-order services to get a long-term supply of maintenance drugs. Refer to **Section A6** of this chapter to learn about mail-order services.

A8. Using a pharmacy not in our plan's network

Generally, we pay for drugs filled at an out-of-network pharmacy only when you're not able to use a network pharmacy. We have network pharmacies outside of our service area where you can get prescriptions filled as a member of our plan. In these cases, check with your care coordinator or Customer Service first to find out if there's a network pharmacy nearby.

We pay for prescriptions filled at an out-of-network pharmacy in the following cases:

1. In case of a medical emergency.

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

2. Other situations.

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

- If you are unable to get a covered drug in a timely manner within our service area because there are no network pharmacies within a reasonable driving distance that provide 24-hour service.

- If you are trying to fill a covered prescription drug that's not regularly stocked at an eligible network retail or mail-order pharmacy. (These drugs include orphan drugs or other specialty pharmaceuticals.)
- If you are traveling within the U.S., but outside the service area, and you become ill, lose or run out of your prescription drugs, we will cover prescriptions that are filled at an out-of-network pharmacy if you follow all other coverage rules and a network pharmacy is not available. We can't pay for any prescriptions that are filled outside the U.S., even for a medical emergency.

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

A9. Paying you back for a prescription

If you must use an out-of-network pharmacy, you must generally pay the full cost instead of a copay when you get your prescription. You can ask us to pay you back for our share of the cost. UCare is not allowed to reimburse members for Medical Assistance covered drugs. You may be required to pay the difference between what you pay for the drug at the out-of-network pharmacy and the cost we would cover at an in-network pharmacy.

To learn more about this, refer to **Chapter 7** of this *Member Handbook*.

Note: If the drug is covered by Medical Assistance (Medicaid), we don't allow UCare Connect + Medicare providers to bill you for these drugs. We pay our providers directly, and we protect you from any charges. This is true even if we pay the provider less than the provider charges. If you paid for a drug that you think we should've covered, contact Customer Service at the number at the bottom of this page.

B. Our plan's *Drug List*

We have a *List of Covered Drugs*. We call it the *Drug List* for short.

We select the drugs on the *Drug List* with the help of a team of doctors and pharmacists. The *Drug List* also tells you the rules you need to follow to get your drugs.

We generally cover a drug on our plan's *Drug List* when you follow the rules we explain in this chapter.

B1. Drugs on our *Drug List*

Our *Drug List* includes drugs covered under Medicare Part D and some prescription and over-the-counter (OTC) drugs and products covered under Medical Assistance.

Our *Drug List* includes brand name drugs, generic drugs, and biological products (which may include biosimilars).

A brand name drug is a prescription drug sold under a trademarked name owned by the drug manufacturer. Biological products are drugs that are more complex than typical drugs. On our *Drug List*, when we refer to "drugs" this could mean a drug or a biological product.

Generic drugs have the same active ingredients as brand name drugs. Biological products have alternatives called biosimilars. Generally, generic drugs and biosimilars work just as well as brand name drugs or original biological products and usually cost less. There are generic drug substitutes available for many brand name drugs and biosimilar alternatives for some original biological products. Some biosimilars are interchangeable biosimilars and, depending on state law, may be substituted for the original biological product at the pharmacy without needing a new prescription, just like generic drugs can be substituted for brand name drugs.

Refer to **Chapter 12** for definitions of the types of drugs that may be on the *Drug List*.

Our plan also covers certain OTC drugs and products. Some OTC drugs cost less than prescription drugs and work just as well. For more information, call Customer Service.

B2. How to find a drug on our *Drug List*

To find out if a drug you take is on our *Drug List*, you can:

- Visit our plan's website at **ucare.org/dsnp-druglist**. The *Drug List* on our website is always the most current one.
- Call Customer Service to find out if a drug is on our *Drug List* or to ask for a copy of the list.
- Use our "Real Time Benefit Tool" by logging in to your UCare Member Online Account at **member.ucare.org** and selecting Pharmacy Benefits to search for drugs on the *Drug List* to get an estimate of what you'll pay and if there are alternative drugs on the *Drug List* that could treat the same condition. You can also call your care coordinator or Customer Service.

B3. Drugs not on our *Drug List*

We don't cover all drugs.

- Some drugs aren't on our *Drug List* because the law doesn't allow us to cover those drugs.
- In other cases, we decided not to include a drug on our *Drug List*.
- In some cases, you may be able to get a drug that isn't on our *Drug List.* For more information refer to **Chapter 9**.

Our plan doesn't pay for the kinds of drugs described in this section. These are called **excluded drugs**. If you get a prescription for an excluded drug, you may need to pay for it yourself. If you think we should pay for an excluded drug because of your case, you can make an appeal. Refer to **Chapter 9** of this *Member Handbook* for more information about appeals.

Here are three general rules for excluded drugs:

1. Our plan's outpatient drug coverage (which includes Medicare Part D and Medical Assistance program drugs) can't pay for a drug that Medicare Part A or Medicare Part B already covers. Our plan covers drugs covered under Medicare Part A or Medicare Part B for free, but these drugs aren't considered part of your outpatient drug benefits.
2. Our plan can't cover a drug purchased outside the United States and its territories.
3. Use of the drug must be approved by the FDA or supported by certain medical references as a treatment for your condition. Your doctor or other provider may prescribe a certain drug to treat your condition, even though it wasn't approved to treat the condition. This is called "off-label use." Our plan usually doesn't cover drugs prescribed for off-label use.

Also, by law, Medicare or Medical Assistance can't cover the types of drugs listed below.

- Drugs used to promote fertility
- Drugs used for cosmetic purposes or to promote hair growth
- Drugs used for the treatment of sexual or erectile dysfunction
- Outpatient drugs made by a company that says you must have tests or services done only by them

B4. *Drug List* cost sharing tiers

Every drug on our *Drug List* is in a tier. A tier is a group of drugs of generally the same type (for example, brand name, generic, or OTC drugs).

To find out which tier your drug is in, refer to the drug on our *Drug List*.

Chapter 6 of your *Member Handbook* tells the amount you pay for drugs in each tier.

C. Limits on some drugs

For certain drugs, special rules limit how and when our plan covers them. Generally, our rules encourage you to get a drug that works for your medical condition and is safe and effective. When a safe, lower-cost drug works just as well as a higher-cost drug, we expect your provider to prescribe the lower-cost drug.

Note that sometimes a drug may appear more than once in our *Drug List*. This is because the same drugs can differ based on the strength, amount, or form of the drug prescribed by your provider, and different restrictions may apply to the different versions of the drugs (for example, 10 mg versus 100 mg; one per day versus two per day; tablet versus liquid.)

If there's a special rule for your drug, it usually means that you or your provider must take extra steps for us to cover the drug. For example, your provider may have to tell us your diagnosis or provide results of blood tests first. If you or your provider thinks our rule shouldn't apply to your situation, ask us to use the coverage decision process to make an exception. We may or may not agree to let you use the drug without taking extra steps.

To learn more about asking for exceptions, refer to **Chapter 9** of this *Member Handbook*.

1. **Limiting use of a brand name drug or original biological products when, respectively, a generic or interchangeable biosimilar version is available**

   Generally, a generic drug or interchangeable biosimilar works the same as a brand name drug or original biological product and usually costs less. In most cases, if there's a generic or interchangeable biosimilar version of a brand name drug or original biological product available, our network pharmacies give you, respectively, the generic or interchangeable biosimilar version.

   - We usually don't pay for the brand name drug or original biological product when there's an available generic version.
   - However, if your provider told us the medical reason that the generic drug or interchangeable biosimilar won't work for you **or** wrote "No substitutions" on your prescription for a brand name drug or original biological product **or** told us the medical reason that the generic drug, interchangeable biosimilar, or other covered drugs that treat the same condition won't work for you, then we cover the brand name drug.

- Your copay may be greater for the brand name drug or original biological product than for the generic drug or interchangeable biosimilar.

2. **Getting plan approval in advance**

   For some drugs, you or your prescriber must get approval from our plan before you fill your prescription. This is called prior authorization. This is put in place to ensure medication safety and help guide appropriate use of certain drugs. If you don't get approval, we may not cover the drug. Call Customer Service at the number at the bottom of the page or on our website at **ucare.org/dsnp-druglist** for more information about prior authorization.

3. **Trying a different drug first**

   In general, we want you to try lower-cost drugs that are as effective before we cover drugs that cost more. For example, if Drug A and Drug B treat the same medical condition, and Drug A costs less than Drug B, we may require you to try Drug A first.

   If Drug A **doesn't** work for you, then we cover Drug B. This is called step therapy. Call Customer Service at the number at the bottom of the page or on our website at **ucare.org/dsnp-druglist** for more information about step therapy.

4. **Quantity limits**

   For some drugs, we limit the amount of the drug you can have. This is called a quantity limit. For example, if it's normally considered safe to take only one pill per day for a certain drug, we might limit how much of a drug you can get each time you fill your prescription.

To find out if any of the rules above apply to a drug you take or want to take, check our *Drug List*. For the most up-to-date information, call Customer Service or check our website at **ucare.org/dsnp-druglist**. If you disagree with our coverage decision based on any of the above reasons you may request an appeal. Please refer to **Chapter 9** of this *Member Handbook*.

D. Reasons your drug might not be covered

We try to make your drug coverage work well for you, but sometimes a drug may not be covered in the way that you like. For example:

- Our plan doesn't cover the drug you want to take. The drug may not be on our *Drug List*. We may cover a generic version of the drug but not the brand name version you want to take. A drug may be new, and we haven't reviewed it for safety and effectiveness yet.

- Our plan covers the drug, but there are special rules or limits on coverage. As explained in the section above, Section C, some drugs our plan covers have rules that limit their use. In some cases, you or your prescriber may want to ask us for an exception.

There are things you can do if we don't cover a drug the way you want us to cover it.

D1. Getting a temporary supply

In some cases, we can give you a temporary supply of a drug when the drug isn't on our *Drug List* or is limited in some way. This gives you time to talk with your provider about getting a different drug or to ask us to cover the drug.

To get a temporary supply of a drug, you must meet the two rules below:

1. The drug you've been taking:
   - is no longer on our *Drug List* **or**
   - was never on our *Drug List* **or**
   - is now limited in some way.
2. You must be in one of these situations:
   - You were in our plan last year.
     - We cover a temporary supply of your drug **during the first 90 days of the calendar year.**
     - This temporary supply is for up to 30 days.
     - If your prescription is written for fewer days, we allow multiple refills to provide up to a maximum of 30 days of medication. You must fill the prescription at a network pharmacy.
     - Long-term care pharmacies may provide your drug in small amounts at a time to prevent waste.
   - You're new to our plan.
     - We cover a temporary supply of your drug **during the first 90 days of your membership in our plan.**
     - This temporary supply is for up to 30 days.
     - If your prescription is written for fewer days, we allow multiple refills to provide up to a maximum of 30 days of medication. You must fill the prescription at a network pharmacy.

  - Long-term care pharmacies may provide your drug in small amounts at a time to prevent waste.

- You've been in our plan for more than 90 days, live in a long-term care facility, and need a supply right away.
  - We cover one 31-day supply, or less if your prescription is written for fewer days. This is in addition to the temporary supply above.
  - **For those who are a current member of the plan and transitioning to a different level of care:** We'll cover one 31-day supply, or less if your prescription is written for fewer days. If you're a current member, admitted or discharged from a long-term care facility, you'll be allowed "refill-too-soon" overrides to ensure that you have access to an adequate supply of your medications.

D2. Asking for a temporary supply

To ask for a temporary supply of a drug, call Customer Service.

When you get a temporary supply of a drug, talk with your provider as soon as possible to decide what to do when your supply runs out. Here are your choices:

- Change to another drug.

  Our plan may cover a different drug that works for you. Call Customer Service to ask for a list of drugs we cover that treat the same medical condition. The list can help your provider find a covered drug that may work for you.

  OR

- Ask for an exception.

  You and your provider can ask us to make an exception. For example, you can ask us to cover a drug that is not on our *Drug List* or ask us to cover the drug without limits. If your provider says you have a good medical reason for an exception, they can help you ask for one.

E. Coverage changes for your drugs

Most changes in drug coverage happen on January 1, but we may add or remove drugs on our *Drug List* during the year. We may also change our rules about drugs. For example, we may:

- Decide to require or not require prior approval (PA) for a drug (permission from us before you can get a drug).
- Add or change the amount of a drug you can get (quantity limits).
- Add or change step therapy restrictions on a drug (you must try one drug before we cover another drug).
- Replace an original biological product with an interchangeable biosimilar version of the biological product.

We must follow Medicare requirements before we change our plan's *Drug List*. For more information on these drug rules, refer to **Section C**.

If you take a drug that we covered at the **beginning** of the year, we generally won't remove or change coverage of that drug **during the rest of the year** unless:

- a new, cheaper drug comes on the market that works as well as a drug on our *Drug List* now, **or**
- we learn that a drug isn't safe, **or**
- a drug is removed from the market.

What happens if coverage changes for a drug you're taking?

To get more information on what happens when our *Drug List* changes, you can always:

- Check our current *Drug List* online at **ucare.org/dsnp-druglist or**
- Call Customer Service at the numbers at the bottom of the page to check our current *Drug List*.

Changes we may make to the *Drug List* that affect you during the current plan year

Some changes to the *Drug List* will happen immediately. For example:

- A new generic drug becomes available. Sometimes, a new generic drug or biosimilar comes on the market that works as well as a brand name drug or original biological

product on the *Drug List* now. When that happens, we may remove the brand name drug and add the new generic drug, but your cost for the new drug will stay the same.

When we add the new generic drug, we may also decide to keep the brand name drug on the list but change its coverage rules or limits.

- We may not tell you before we make this change, but we'll send you information about the specific change we made once it happens.
- You or your provider can ask for an "exception" from these changes. We'll send you a notice with the steps you can take to ask for an exception. Please refer to **Chapter 9** of this handbook for more information on exceptions.

Removing unsafe drugs and other drugs that are taken off the market. Sometimes a drug may be found unsafe or taken off the market for another reason. If this happens, we may immediately take it off our *Drug List*. If you're taking the drug, we'll send you a notice after we make the change. When this happens, you should talk to your doctor or other prescriber. He or she can help you decide if there is a similar drug on the *Drug List* you can take instead.

We may make other changes that affect the drugs you take. We tell you in advance about these other changes to our *Drug List*. These changes might happen if:

- The FDA provides new guidance or there are new clinical guidelines about a drug.

When these changes happen, we:

- Tell you at least 30 days before we make the change to our *Drug List* **or**
- Let you know and give you a 30-day supply of the drug after you ask for a refill.

This gives you time to talk to your doctor or other prescriber. They can help you decide:

- If there's a similar drug on our *Drug List* you can take instead **or**
- If you should ask for an exception from these changes to continue covering the drug or the version of the drug you've been taking. To learn more about asking for exceptions, refer to **Chapter 9** of this *Member Handbook*.

Changes to the *Drug List* that don't affect you during this plan year

We may make changes to drugs you take that aren't described above and don't affect you now. For such changes, if you're taking a drug we covered at the **beginning** of the year, we generally don't remove or change coverage of that drug **during the rest of the year**.

For example, if we remove a drug you're taking or limit its use, then the change doesn't affect your use of the drug for the rest of the year.

If any of these changes happen for a drug you're taking (except for the changes noted in the section above), the change won't affect your use until January 1 of the next year.

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

F. Drug coverage in special cases

F1. In a hospital or a skilled nursing facility for a stay that our plan covers

If you're admitted to a hospital or skilled nursing facility for a stay our plan covers, we generally cover the cost of your drugs during your stay. You won't pay a copay. Once you leave the hospital or skilled nursing facility, we cover your drugs as long as the drugs meet all of our coverage rules.

To learn more about drug coverage and what you pay, refer to **Chapter 6** of this *Member Handbook*.

F2. In a long-term care facility

Usually, a long-term care facility, such as a nursing facility, has its own pharmacy or a pharmacy that supplies drugs for all of their residents. If you live in a long-term care facility, you may get your drugs through the facility's pharmacy if it's part of our network.

Check your *Provider and 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, contact Customer Service.

F3. In a Medicare-certified hospice program

Drugs are never covered by both hospice and our plan at the same time.

- You may be enrolled in a Medicare hospice and require certain drugs (e.g., pain medication, anti-nausea drugs, laxatives, or anti-anxiety drugs) that your hospice doesn't cover because it isn't related to your terminal prognosis and conditions. In that case, our plan must get notification from the prescriber or your hospice provider that the drug is unrelated before we can cover the drug.

- To prevent delays in getting any unrelated drugs that our plan should cover, you can ask your hospice provider or prescriber to make sure we have the notification that the drug is unrelated before you ask a pharmacy to fill your prescription.

If you leave hospice, our plan covers all of your drugs. To prevent any delays at a pharmacy when your Medicare hospice benefit ends, take documentation to the pharmacy to verify that you left hospice.

Refer to earlier parts of this chapter that tell about drugs our plan covers. Refer to **Chapter 4** of this *Member Handbook* for more information about the hospice benefit.

G. Programs on drug safety and managing drugs

G1. Programs to help you use drugs safely

Each time you fill a prescription, we look for possible problems, such as drug errors or drugs that:

- may not be needed because you take another, similar drug that does the same thing
- may not be safe for your age or gender
- could harm you if you take them at the same time
- have ingredients that you are or may be allergic to
- may have an error in the amount (dosage)
- have unsafe amounts of opioid pain medications

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

G2. Programs to help you manage your drugs

Our plan has a program to help members with complex health needs. In such cases, you may be eligible to get services, at no cost to you, through a medication therapy management (MTM) program. This program is voluntary and free. This program helps you and your provider make sure that your medications are working to improve your health. If you qualify for the program, a pharmacist or other health professional will give you a comprehensive review of all of your medications and talk with you about:

- how to get the most benefit from the drugs you take

- any concerns you have, like medication costs and drug reactions
- how best to take your medications
- any questions or problems you have about your prescription and over-the-counter medication

Then, they'll give you:

- A written summary of this discussion. The summary has a medication action plan that recommends what you can do for the best use of your medications.
- A personal medication list that includes all medications you take, how much you take, and when and why you take them.
- Information about safe disposal of prescription medications that are controlled substances.

It's a good idea to talk to your prescriber about your action plan and medication list.

- Take your action plan and medication list to your visit or anytime you talk with your doctors, pharmacists, and other health care providers.
- Take your medication list with you if you go to the hospital or emergency room.

MTM programs are voluntary and free to members who qualify. If we have a program that fits your needs, we enroll you in the program and send you information. If you don't want to be in the program, let us know, and we'll take you out of it.

If you have questions about these programs, contact Customer Service or your care coordinator.

G3. Drug management program (DMP) to help members safely use opioid medications

We have a program that helps make sure members safely use prescription opioids and other frequently abused medications. This program is called a Drug Management Program (DMP).

If you use opioid medications that you get from several prescribers or pharmacies or if you had a recent opioid overdose, we may talk to your prescribers to make sure your use of opioid medications is appropriate and medically necessary. Working with your prescribers, if we decide your use of prescription opioid or benzodiazepine medications may not be safe, we may

limit how you can get those medications. If we place you in our DMP, the limitations may include:

- Requiring you to get all prescriptions for opioid or benzodiazepine medications from a certain pharmacy
- Requiring you to get all your prescriptions for opioid or benzodiazepine medications from a certain prescriber
- Limiting the amount of opioid or benzodiazepine medications we'll cover for you

If we plan on limiting how you get these medications or how much you can get, we'll send you a letter in advance. The letter will tell you if we'll limit coverage of these drugs for you, or if you'll be required to get the prescriptions for these drugs only from a specific provider or pharmacy.

You'll have a chance to tell us which prescribers or pharmacies you prefer to use and any information you think is important for us to know. After you've had the opportunity to respond, if we decide to limit your coverage for these medications, we'll send you another letter that confirms the limitations.

If you think we made a mistake, you disagree with our decision or the limitation, you and your prescriber can make an appeal. If you appeal, we'll review your case and give you a new decision. If we continue to deny any part of your appeal related to limitations that apply to your access to medications, we'll automatically send your case to an Independent Review Organization (IRO). (To learn more about appeals and the IRO, refer to **Chapter 9** of this *Member Handbook*.)

The DMP may not apply to you if you:

- have certain medical conditions, such as cancer or sickle cell disease,
- are getting hospice, palliative, or end-of-life care, **or**
- live in a long-term care facility.

Chapter 6: What you pay for your Medicare and Medical Assistance drugs

Introduction

This chapter tells what you pay for your outpatient drugs. By "drugs," we mean:

- Medicare Part D drugs, **and**
- Drugs and items covered under Medical Assistance, **and**
- Drugs and items covered by our plan as additional benefits.

Because you're eligible for Medical Assistance, you get Extra Help from Medicare to help pay for your Medicare Part D prescription drugs. We sent you a separate insert, called the *Member Handbook Rider for People Who Get Extra Help Paying for Prescription Drugs* (also known as the "Low Income Subsidy Rider" or the "LIS Rider"), which tells you about your drug coverage. If you don't have this insert, please call Customer Service and ask for the "LIS Rider."

Extra Help is a Medicare program that helps people with limited incomes and resources reduce Medicare Part D drug costs, such as premiums, deductibles, and copays. Extra Help is also called the "Low-Income Subsidy," or "LIS."

Other key terms and their definitions appear in alphabetical order in the last chapter of this *Member Handbook*.

To learn more about drugs, you can look in these places:

- Our *List of Covered Drugs*.
  - We call this the *Drug List*. It tells you:
    - Which drugs we pay for
    - Which of the tiers each drug is in
    - If there are any limits on the drugs
  - If you need a copy of our *Drug List*, call Customer Service. You can also find the most current copy of our *Drug List* on our website at **ucare.org/dsnp-druglist**.
- **Chapter 5** of this *Member Handbook*.
  - It tells how to get your outpatient drugs through our plan.

  - It includes rules you need to follow. It also tells which types of drugs our plan doesn't cover.
  - When you use the plan's "Real Time Benefit Tool" to look up drug coverage (refer to **Chapter 5**, **Section B2**), the cost shown is an estimate of the out-of-pocket costs you're expected to pay. You can call your care coordinator or Customer Service for more information.

- Our *Provider and Pharmacy Directory*.
  - In most cases, you must use a network pharmacy to get your covered drugs. Network pharmacies are pharmacies that agree to work with us.
  - The *Provider and Pharmacy Directory* lists our network pharmacies. Refer to **Chapter 5** of this *Member Handbook* for more information about network pharmacies.

Table of Contents

A. The *Explanation of Benefits* (EOB)

Our plan keeps track of your drug costs and the payments you make when you get prescriptions at the pharmacy. We track two types of costs:

- Your **out-of-pocket costs**. This is the amount of money you, or others on your behalf, pay for your prescriptions. This includes what you paid when you get a covered Part D drug, any payments for your drugs made by family or friends, any payments made for your drugs by Extra Help from Medicare, employer or union health plans, Indian Health Service, AIDS drug assistance programs, charities, and most State Pharmaceutical Assistance Programs (SPAPs).
- Your **total drug costs.** This is the total of all payments made for your covered Part D drugs. It includes what our plan paid, and what other programs or organizations paid for your covered Part D drugs.

When you get drugs through our plan, we send you a summary called the *Explanation of Benefits*. We call it the EOB for short. The EOB isn't a bill. The EOB has more information about the drugs you take such as increases in price and other drugs with lower cost sharing that may be available. You can talk to your prescriber about these lower cost options. The EOB includes:

- **Information for the month.** The summary tells what drugs you got for the previous month. It shows the total drug costs, what we paid, and what you and others paid for you.
- **Totals for the year since January 1.** This shows the total drug costs and total payments for your drugs since the year began.
- **Drug price information.** This is the total price of the drug and changes in the drug prices since the first fill for each prescription claim of the same quantity.
- **Lower cost alternatives.** When applicable, information about other available drugs with lower cost sharing for each prescription.

We offer coverage of drugs not covered under Medicare.

- Payments made for these drugs don't count towards your total out-of-pocket costs.
- To find out which drugs our plan covers, refer to our *Drug List*. In addition to the drugs covered under Medicare, some prescription and over-the-counter drugs are covered under Medical Assistance. These drugs are included in the *Drug List*.

B. How to keep track of your drug costs

To keep track of your drug costs and the payments you make, we use records we get from you and from your pharmacy. Here is how you can help us:

1. **Use your Member ID Card.**

   Show your Member ID Card every time you get a prescription filled. This helps us know what prescriptions you fill and what you pay.

2. **Make sure we have the information we need.**

   Give us copies of receipts for covered drugs that you paid for. You can ask us to pay you back for our share of the cost of the drug.

   Here are examples of when you should give us copies of your receipts:

   - When you buy a covered drug at a network pharmacy at a special price or use a discount card that isn't part of our plan's benefit
   - When you pay a copay for drugs that you get under a drug maker's patient assistance program
   - When you buy covered drugs at an out-of-network pharmacy
   - When you pay the full price for a covered drug under special circumstances

   For more information about asking us to pay you back for our share of the cost of a drug, refer to **Chapter 7** of this *Member Handbook*.

3. **Send us information about payments others make for you.**

   Payments made by certain other people and organizations also count toward your out-of-pocket costs. For example, payments made by an AIDS drug assistance program (ADAP), the Indian Health Service, and most charities count toward your out-of-pocket costs.

4. **Check the EOBs we send you.**

   When you get an EOB in the mail, make sure it's complete and correct.

   - **Do you recognize the name of each pharmacy?** Check the dates. Did you get drugs that day?
   - **Did you get the drugs listed?** Do they match those listed on your receipts? Do the drugs match what your doctor prescribed?

What if you find mistakes on this summary?

If something is confusing or doesn't seem right on this EOB, please call UCare Connect + Medicare's Customer Service. You can also find answers to many questions on our website: **ucare.org**.

What about possible fraud?

If this summary shows drugs you're not taking or anything else that seems suspicious to you, please contact us.

- Call UCare's Compliance/Fraud Hotline at 1-877-826-6847 (this call is free), 24 hours per day, 7 days per week; TTY users call 612-676-6810 or 1-800-688-2534 (this call is free); 8 am – 8 pm, 7 days per week; or email compliance@ucare.org. You may remain anonymous.
- Or call Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048. You can call these numbers for free.

If you think something is wrong or missing, or if you have any questions, call Customer Service. You may also review your Part D EOB by logging into your online member account at **member.ucare.org** and viewing your monthly Part D EOB in the Document library. Keep these EOBs. They're an important record of your drug expenses.

C. Drug Payment Stages for Medicare Part D drugs

There are two payment stages for your Medicare Part D drug coverage under our plan. How much you pay for each prescription depends on which stage you're in when you get a prescription filled or refilled. These are the two stages:

Stage 1: Initial Coverage Stage	Stage 2: Catastrophic Coverage Stage
During this stage, we pay part of the costs of your drugs, and you pay your share. Your share is called the copay. You begin in this stage when you fill your first prescription of the year.	During this stage, we pay all of the costs of your drugs through December 31, 2026. You begin this stage when you've paid a certain amount of out-of-pocket costs.

D. Stage 1: The Initial Coverage Stage

During the Initial Coverage Stage, we pay a share of the cost of your covered drugs, and you pay your share. Your share is called the copay. The copay depends on what cost-sharing tier the drug is in and where you get it.

Cost sharing tier levels are groups of drugs with the same copay. To find the cost-sharing tiers for your drugs, refer to our *Drug List*.

- Tier 1 Generic drugs have the lowest copay. The copay is from $0 to $5.10, depending on your income and level of Medical Assistance eligibility.
- Tier 1 Brand name drugs have a higher copay. The copay is from $0 to $12.65, depending on your income and level of Medical Assistance eligibility.
- OTCs have a $0 copay.

D1. Your pharmacy choices

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

- A network retail pharmacy **or**
- An out-of-network pharmacy.

  In limited cases, we cover prescriptions filled at out-of-network pharmacies. Refer to **Chapter 5** of this *Member Handbook* to find out when we will do that.

- Our plan's mail-order pharmacy.

To learn more about these choices, refer to **Chapter 5** of this *Member Handbook* and to our *Provider and Pharmacy Directory*.

D2. Getting a long-term 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 100-day supply. It costs you the same as a one-month supply.

For details on where and how to get a long-term supply of a drug, refer to **Chapter 5** of this *Member Handbook* or our plan's *Provider and Pharmacy Directory*.

D3. What you pay

During the Initial Coverage Stage, you may pay a copay each time you fill a prescription. If your covered drug costs less than the copay, you pay the lower price.

Contact Customer Service to find out how much your copay is for any covered drug.

Your share of the cost when you get a one-month or long-term supply of a covered drug from:

	A network pharmacy A one-month supply or up to a 30-day supply or long-term 100-day supply	**Our plan's mail-order service** A one-month or up to a 30-day supply or long-term 100-day supply covered generic drugs	**A network long-term care pharmacy** Up to a 31-day supply	**An out-of-network pharmacy** Up to a 29-day supply. Coverage is limited to certain cases. Refer to **Chapter 5** of your *Member Handbook* for details.
Cost Sharing Tier 1 (Covered generic drugs)	$0/$1.60/$5.10 copay depending on your income, institutional status, or if you are receiving Home and Community Based Services (Elderly Waiver or disability waiver).	$0/$1.60/$5.10 depending on your income, institutional status, or if you are receiving Home and Community Based Services (disability waiver).	$0 depending on your income, institutional status, or if you are receiving Home and Community Based Services (disability waiver).	$0/$1.60/$5.10 depending on your income, institutional status, or if you are receiving Home and Community Based Services (disability waiver).
Cost Sharing Tier 2 (Covered brand drugs)	$0/$4.90/$12.65 copay for prescription drugs may vary based on the level of Extra Help you receive. Please contact the plan for more details.	$0/$4.90/$12.65 depending on your income, institutional status, or if you are receiving Home and Community Based Services (disability waiver).	$0 depending on your income, institutional status, or if you are receiving Home and Community Based Services (disability waiver).	$0/$4.90/$12.65 depending on your income, institutional status, or if you are receiving Home and Community Based Services (disability waiver).

For information about which pharmacies can give you long-term supplies, refer to our *Provider and Pharmacy Directory.*

D4. End of the Initial Coverage Stage

The Initial Coverage Stage ends when your total out-of-pocket costs reach $2,100. At that point, the Catastrophic Coverage Stage begins. The plan covers all of your drug costs from then until the end of the year.

Your EOB helps you keep track of how much you've paid for your drugs during the year. We let you know if you reach the $2,100 limit. Many people don't reach it in a year.

E. Stage 2: The Catastrophic Coverage Stage

When you reach the out-of-pocket limit of $2,100 for your drugs, the Catastrophic Coverage Stage begins. You stay in the Catastrophic Coverage Stage until the end of the calendar year. During this stage, you pay nothing for your Part D covered drugs.

F. Your drug costs if your doctor prescribes less than a full month's supply

Usually, you pay a copay to cover 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're trying a drug for the first time).
- If your doctor agrees, you don't pay for the full month’s supply for certain drugs.

When you get less than a month’s supply of a drug, the amount you pay is based on the number of days of the drug that you get. We 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 get.

- Here’s an example: Let’s say the copay for your drug for a full month’s supply (a 30-day supply) is $1.60. This means that the amount you pay for your drug is less than $0.06 per day. If you get a 7 days’ supply of the drug, your payment is less than $0.06 per day multiplied by 7 days, for a total payment of $0.42.

- Daily cost sharing allows you to make sure a drug works for you before you pay for an entire month's supply.
- You can also ask your provider to prescribe less than a full month's supply of a drug to help you:
  - Better plan when to refill your drugs,
  - Coordinate refills with other drugs you take, **and**
  - Take fewer trips to the pharmacy.

G. What you pay for Part D vaccines

Important message about what you pay for vaccines: Some vaccines are considered medical benefits and are covered under Medicare Part B. Other vaccines are considered Medicare Part D drugs. You can find these vaccines listed in our *Drug List*. Our plan covers most adult Medicare Part D vaccines at no cost to you. Refer to your plan's *Drug List* or contact Customer Service for coverage and cost-sharing details about specific vaccines.

There are two parts to our coverage of Medicare Part D vaccines:

1. The first part is for the cost of the vaccine itself.
2. The second part is for the cost of giving you the vaccine. For example, sometimes you may get the vaccine as a shot given to you by your doctor.

G1. What you need to know before you get a vaccine

We recommend that you call Customer Service if you plan to get a vaccine.

- We can tell you about how our plan covers your vaccine.
- If you paid for a Medicare Part D vaccine that you think we should have covered, contact Customer Service at the number at the bottom of this page.

Chapter 7: Asking us to pay our share of a bill you got for covered services or drugs

Introduction

This chapter tells you how and when to send us a bill to ask for payment. It also tells you how to make an appeal if you don't agree with a coverage decision. Key terms and their definitions appear in alphabetical order in the last chapter of this *Member Handbook*.

Table of Contents

A. Asking us to pay for your services or drugs

Our network providers must bill the plan for your covered services and drugs after you get them. A network provider is a provider who works with the health plan.

We don't allow UCare Connect + Medicare providers to bill you for these services. We pay our providers directly, and we protect you from any charges.

If you get a bill for the full cost of health care or drugs, don't pay the bill and send the bill to us. To send us a bill, refer to **Section B** of this chapter.

- If we cover the services or drugs, we'll pay the provider directly.
- If we cover the services or drugs and you already paid more than your share of the cost, it's your right to be paid back.
  - If you paid for services covered by Medicare, we'll pay you back.
  - If you paid for services covered by Medical Assistance we can't pay you back, but the provider will. Customer Service or your care coordinator can help you contact the provider's office. Refer to the bottom of the page for the Customer Service phone number.
- If we don't cover the services or drugs, we'll tell you.

Contact Customer Service or your care coordinator if you have any questions. If you don't know what you should've paid, or if you get a bill and you don't know what to do about it, we can help. You can also call if you want to tell us information about a request for payment you already sent to us.

Examples of times when you may need to ask us to pay you back or to pay a bill you got include:

NOTE: If a service is covered by Medical Assistance, we don't allow UCare Connect + Medicare providers to bill you for these services. We pay our providers directly, and we protect you from any charges. This is true even if we pay the provider less than the provider charges. If you paid for a service that you think we should've covered, contact Customer Service at the number at the bottom of this page.

1. **When you get emergency or urgently needed health care from an out-of-network provider**

   Ask the provider to bill us.

- If you pay the full amount when you get the care, ask us to pay you back for our share of the cost. Send us the bill and proof of any payment you made.
- You may get a bill from the provider asking for payment that you think you don't owe. Send us the bill and proof of any payment you made.
  - If the provider should be paid, we'll pay the provider directly.
  - If you already paid more than your share of the cost for the Medicare service, we'll pay you back for our share of the cost.

2. When a network provider sends you a bill

Network providers must always bill us. It's important to show your Member ID Card when you get any services or prescriptions. But sometimes they make mistakes and ask you to pay for your services or more than your share of the costs. **Call Customer Service or your care coordinator** at the number at the bottom of this page **if you get any bills.**

- As a plan member, you only pay the copay when you get services we cover. We don't allow providers to bill you more than this amount. This is true even if we pay the provider less than the provider charged for a service. Even if we decide not to pay for some charges, you still don't pay them.
- Whenever you get a bill from a network provider that you think is more than you should pay, send us the bill. We'll contact the provider directly and take care of the problem.
- If you already paid a bill from a network provider for Medicare-covered services but feel that you paid too much, send us the bill and proof of any payment you made. We'll pay you back for the difference between the amount you paid and the amount you owed under our plan.

3. If you're retroactively enrolled in our plan

Sometimes your enrollment in the plan can be retroactive. (This means that the first day of your enrollment has passed. It may have even been last year.)

- If you were enrolled retroactively and paid a bill after the enrollment date, you can ask us to pay you back.
- Send us the bill and proof of any payment you made.

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

If you use an out-of-network pharmacy, you pay the full cost of your prescription.

- In only a few cases, we'll cover prescriptions filled at out-of-network pharmacies. Send us a copy of your receipt when you ask us to pay you back for our share of the cost.

- Refer to **Chapter 5** of this *Member Handbook* to learn more about out-of-network pharmacies.
- We may not pay you back the difference between what you paid for the drug at the out-of-network pharmacy and the amount that we'd pay at an in-network pharmacy.

5. **When you pay the full prescription cost because you don't have your Member ID Card with you**

   If you don't have your Member ID Card with you, you can ask the pharmacy to call us or refer to your plan enrollment information.

   - If the pharmacy can't get the information right away, you may have to pay the full prescription cost yourself or return to the pharmacy with your Member ID Card.
   - Send us a copy of your receipt when you ask us to pay you back for our share of the cost.
   - We may not pay you back the full cost you paid if the cash price you paid is higher than our negotiated price for the prescription.

6. **When you pay the full prescription cost for a drug that's not covered**

   You may pay the full prescription cost because the drug isn't covered.

   - The drug may not be on our *List of Covered Drugs* (*Drug List*) on our website, or it may have a requirement or restriction that you don't know about or don't think applies to you. If you decide to get the drug, you may need to pay the full cost.
     - If you don't pay for the drug but think we should cover it, you can ask for a coverage decision (refer to **Chapter 9** of this *Member Handbook*).
     - If you and your doctor or other prescriber think you need the drug right away (within 24 hours), you can ask for a fast coverage decision (refer to **Chapter 9** of this *Member Handbook*).
   - Send us a copy of your receipt when you ask us to pay you back. In some cases, we may need to get more information from your doctor or other prescriber to pay you back for our share of the cost of the drug. We may not pay you back the full cost you paid if the price you paid is higher than our negotiated price for the prescription.

When you send us a request for payment, we review it and decide whether the service or drug should be covered. This is called making a "coverage decision." If we decide the service or drug should be covered, we pay for our share of the cost of it.

If we deny your request for payment, you can appeal our decision. To learn how to make an appeal, refer to **Chapter 9** of this *Member Handbook*.

B. Sending us a request for payment

We don't allow UCare Connect + Medicare providers to bill you for services. We pay our providers directly, and we protect you from any charges.

You shouldn't pay the bill yourself. Send us the bill. You can also ask your care coordinator for help. Refer to **Section A** of this chapter or **Chapter 9**, **Section F5.**

Send us your bill and proof of any payment you made for Medicare services. Proof of payment can be a copy of the check you wrote or a receipt from the provider. **It's a good idea to make a copy of your bill and receipts for your records.** You can ask your care coordinator for help. You must send your information to us within 12 months of the date you received the service, item, or drug.

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

For Medical payment requests:

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

For Part D prescription drug payment requests:

Attn: Medicare Part D
Navitus Health Solutions
PO Box 1039
Appleton, WI 54912-1039

C. Coverage decisions

When we get your request for payment, we make a coverage decision. This means that we decide if our plan covers your service, item, or drug. We also decide the amount of money, if any, you must pay.

- We'll let you know if we need more information from you.
- If we decide that our plan covers the service, item, or drug and you followed all the rules for getting it, we'll pay our share of the cost for it. If you already paid for the service or drug, we'll mail you a check for our share of the cost of it. If you paid the full cost of a

drug, you might not be reimbursed the full amount you paid (for example, if you got a drug at an out-of-network pharmacy or if the cash price you paid is higher than our negotiated price). If you haven't paid, we'll pay the provider directly.

Chapter 3 of this *Member Handbook* explains the rules for getting your services covered. **Chapter 5** of this *Member Handbook* explains the rules for getting your Medicare Part D drugs covered.

- If we decide not to pay for our share of cost of the service or drug, we'll send you a letter with the reasons. The letter also explains your rights to make an appeal.
- To learn more about coverage decisions, refer to **Chapter 9** of this *Member Handbook*.

D. Appeals

If you think we made a mistake in turning down your request for payment, you can ask us to change our decision. This is called "making an appeal." You can also make an appeal if you don't agree with the amount we pay.

The formal appeals process has detailed procedures and deadlines. To learn more about appeals, refer to **Chapter 9** of this *Member Handbook*.

- To make an appeal about getting paid back for a health care service, refer to **Chapter 9**, **Section F** of this *Member Handbook*.
- To make an appeal about getting paid back for a drug, refer to **Chapter 9, Section G** of this *Member Handbook*.

Chapter 8: Your rights and responsibilities

Introduction

This chapter includes your rights and responsibilities as a member of our plan. We must honor your rights. Key terms and their definitions appear in alphabetical order in the last chapter of this *Member Handbook*.

Table of Contents

A. Your right to get services and information in a way that meets your needs

We must ensure **all** services, both clinical and non-clinical, are provided to you in a culturally competent and accessible manner including for those with limited English proficiency, limited reading skills, hearing incapacity, or those with diverse cultural and ethnic backgrounds. We must also tell you about our plan's benefits and your rights in a way that you can understand. We must tell you about your rights each year that you're in our plan.

- To get information in a way that you can understand, call your care coordinator or Customer Service. Our plan has free interpreter services available to answer questions in different languages.
- Our plan can also give you materials in formats such as large print, braille, or audio. To get materials in one of these alternative formats, please call Customer Service or write to UCare, PO Box 52, Minneapolis MN 55440-0052.
- To make or change a standing request to get this document, now and in the future, in a language other than English or in an alternate format, call Customer Service at the number at the bottom of this page.

If have trouble getting information from our plan because of language problems or a disability and you want to file a complaint, call:

- Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.
- UCare Connect + Medicare Customer Service at 612-676-3310 or 1-855-260-9707 (this call is free) 8 am – 8 pm, seven days a week. TTY users should call 612-676-6810 or 1-800-688-2534 (this call is free) 8 am – 8 pm, seven days a week.
- Civil Rights Coordinator, Minnesota Department of Human Services, 651-431-3040 or use your preferred relay service.
- Office for Civil Rights at 1-800-368-1019. TTY users should call 1-800-537-7697.

B. Our responsibility for your timely access to covered services and drugs

You have rights as a member of our plan.

- You have the right to choose a primary care provider (PCP) in our network. A network provider is a provider who works with us. You can find more information about what types of providers may act as a PCP and how to choose a PCP in **Chapter 3** of this *Member Handbook*.
  - Call your care coordinator or Customer Service or refer to the *Provider and Pharmacy Directory* to learn more about network providers and which doctors are accepting new patients.
- You have the right to a women's health specialist without getting a referral. A referral is approval from your PCP to use a provider that isn't your PCP.
- You have the right to get covered services from network providers within a reasonable amount of time.
  - This includes the right to get timely services from specialists.
  - If you can't get services within a reasonable amount of time, we must pay for out-of-network care.
- You have the right to get emergency services or care that's urgently needed without prior approval (PA).
- You have the right to get your prescriptions filled at any of our network pharmacies without long delays.
- You have the right to know when you can use an out-of-network provider. To learn about out-of-network providers, refer to **Chapter 3** of this *Member Handbook*.

Chapter 9 of this *Member Handbook* tells what you can do if you think you aren't getting your services or drugs within a reasonable amount of time. It also tells what you can do if we denied coverage for your services or drugs and you don't agree with our decision.

C. Our responsibility to protect your personal health information (PHI)

We protect your PHI as required by federal and state laws.

Your PHI includes the personal information you gave us when you enrolled in our plan. It also includes your medical records and other medical and health information.

You have rights when it comes to your information and controlling how your PHI is used. We give you a written notice that tells about these rights and explains how we protect the privacy of your PHI. The notice is called the "Notice of Privacy Practice."

C1. How we protect your PHI

We make sure that no unauthorized people look at or change your records.

Except for the cases noted below, we don't give your PHI to anyone not providing your care or paying for your care. If we do, we must get written permission from you first. You, or someone legally authorized to make decisions for you, can give written permission.

Sometimes we don't need to get your written permission first. These exceptions are allowed or required by law:

- We must release PHI to government agencies checking on our plan's quality of care.
- We must release PHI by court order.
- We must give Medicare your PHI, including information about your Medicare Part D drugs. If Medicare releases your PHI for research or other uses, they do it according to federal laws.
- We, and the health providers who take care of you, have the right to look at information about our health care. When you enrolled in the Minnesota Health Care Program, you gave your consent for us to do this. We'll keep this information private according to law.

C2. Your right to look at your medical records

- You have the right to look at your medical records and to get a copy of your records.
- You have the right to ask us to update or correct your medical records. If you ask us to do this, we work with your health care provider to decide if changes should be made.
- You have the right to know if and how we share your PHI with others for any purposes that aren't routine.

If you have questions or concerns about the privacy of your PHI, call Customer Service.

Notice of Privacy Practices

Effective Date: July 1, 2013

This Notice describes how medical information about you* may be used and disclosed and how you can get access to this information. Please review it carefully.

*In this Notice, "you" means the member and "we" means UCare.

Questions

If you have questions or want to file a complaint, you may contact our Privacy Officer at Attn: Privacy Officer, UCare, P.O. Box 52, Minneapolis, MN 55440-0052 or by calling our 24-hour Compliance Hotline at 612-676-6525. You may also file a complaint with the Secretary of the U.S. Department of Health & Human Services at the Office for Civil Rights, U.S. Department of Health & Human Services, 233 N. Michigan Ave., Suite 240, Chicago, IL 60601. We will not retaliate against you for filing a complaint.

Why are we telling you this?

UCare believes it is important to keep your health information private. In fact, the law requires us to do so. The law also requires us to tell you about our legal duties and privacy practices. We are required to follow the terms of the Notice currently in effect.

What do we mean by "information?"

In this Notice, when we talk about "information," "medical information," or "health information," we mean information about you that we collect in our business of providing health coverage for you and your family. It is information that identifies you.

What kinds of information do we use?

We receive information about you as part of our work in providing health plan services and health coverage. This information includes your name, address, and date of birth, race, ethnicity, language, sexual orientation, gender identity, telephone numbers, family information, financial information, health records, or other health information. Examples of the kinds of information we collect include: information from enrollment applications, claims, provider information, and customer satisfaction or health surveys; information you give us when you call us about a question or when you file a complaint or appeal; information we need to answer your question or decide your appeal; and information you provide us to help us obtain payment for premiums.

What do we do with this information?

We use your information to provide health plan services to members and to operate our health plan. These routine uses involve coordination of care, preventive health, and case management programs. For example, we may use your information to talk with your doctor to coordinate a referral to a specialist.

We also use your information for coordination of benefits, enrollment and eligibility status, benefits management, utilization management, premium billing, claims issues, and coverage decisions. For example, we may use your information to pay your health care claims.

Other uses include customer service activities, complaints or appeals, health promotion, quality activities, health survey information, underwriting, actuarial studies, premium rating, legal and regulatory compliance, risk management, professional peer review, credentialing, accreditation, antifraud activities, as well as business planning and administration. For example, we may use your information to make a decision regarding an appeal filed by you.

We do not use or disclose any genetic information, race, ethnicity, language, sexual orientation or gender identity, for the purpose of underwriting.

In addition, we may use your information to provide you with appointment reminders, information about treatment alternatives, or other health-related benefits and services that may be of interest to you. We may also share information with family members or others you identify as involved with your care, or with the sponsor of a group health plan, as applicable.

We do not sell or rent your information to anyone. We will not use or disclose your information for fundraising without your permission. We will only use or disclose your information for marketing purposes with your authorization. We treat information about former members with the same protection as current members.

Who sees your information?

UCare employees see your information only if necessary to do their jobs. We have procedures and systems to keep personal information secure from people who do not have a right to see it. We may share the information with providers and other companies or persons working with or for us. We have contracts with those companies or persons. In those contracts, we require that they agree to keep your information confidential. This includes our lawyers, accountants, auditors, third party administrators, insurance agents or brokers, information systems companies, marketing companies, disease management companies, or consultants.

We also may share your information as required or permitted by law. Information may be shared with government agencies and their contractors as part of regulatory reports, audits, encounter reports, mandatory reporting such as child abuse, neglect, or domestic violence; or in response to a court or administrative order, subpoena, or discovery request. We may share information with health oversight agencies for licensure, inspections, disciplinary actions, audits, investigations, government program eligibility, government program standards compliance, and for certain civil rights enforcement actions. We also may share information for research, for law enforcement purposes, with coroners to permit identification or determine cause of death, or with funeral directors to allow them to carry out their duties. We may be

required to share information with the Secretary of the Department of Health and Human Services to investigate our compliance efforts. There may be other situations when the law requires or permits us to share information.

We only share your psychotherapy notes with your authorization and in certain other limited circumstances.

Other uses and disclosures not described above will be made only with your written permission. We will also accept the permission of a person with authority to represent you.

In most situations, permissions to represent you may be cancelled at any time. However, the cancellation will not apply to uses or disclosures we made before we received your cancellation. Also, once we have permission to release your information, we cannot promise that the person who receives the information will not share it.

What are your rights?

You have the right to ask that we don't use or share your information in a certain way. Please note that while we will try to honor your request, we are not required to agree to your request.

You have the right to ask us to send information to you at an address you choose or to request that we communicate with you in a certain way. For example, you may request that your mailings be sent to a work address rather than your home address. We may ask that you make your request in writing.

You have the right to look at or get a copy of certain information we have about you. This information includes records we use to make decisions about health coverage, such as payment, enrollment, case, or medical management records. We may ask you to make your request in writing. We may also ask you to provide information we need to answer your request. We have the right to charge a reasonable fee for the cost of making and mailing the copies. In some cases, we may deny your request to inspect or obtain a copy of your information. If we deny your request, we will tell you in writing. We may give you a right to have the decision reviewed. Please let us know if you have any questions about this.

You have the right to ask us to correct or add missing information about you that we have in our records. Your request needs to be in writing. In some cases, we may deny a request if the information is correct and complete, if we did not create it, if we cannot share it, or if it is not part of our records. All denials will be in writing. You may file a written statement of disagreement with us. We have the right to disagree with that statement. Even if we deny your request to change or add to your information, you still have the right to have your written request, our written denial, and your statement of disagreement included with your information.

You have the right to receive a listing of the times when we have shared your information in some cases. Please note that we are not required to provide you with a listing of information shared prior to April 14, 2003; information shared or used for treatment, payment, and health care operations purposes; information shared with you or someone else as a result of your permission; information that is shared as a result of an allowed use or disclosure; or information shared for national security or intelligence purposes. All requests for this list must be in writing. We will need you to provide us specific information so we can answer your request. If you request this list more than once in a 12-month period, we may charge you a reasonable fee. If you have questions about this, please contact us at the address provided at the end of this Notice.

You have the right to receive notifications of breaches of your unsecured protected health information.

You have the right to receive a copy of this Notice from us upon request. This Notice took effect July 1, 2013 and was last revised July 20,2022.

How do we protect your information?

UCare protects all forms of your information, written, electronic and oral. We follow the state and federal laws related to the security and confidentiality of your information. We have many safety procedures in place that physically, electronically and administratively protect your information against loss, destruction or misuse.
These procedures include computer safeguards, secured files and buildings and restriction on who may access your information.

What else do you need to know?

We may change our privacy policy from time to time. As the law requires, we will send you our Notice if you ask us for it. If you have questions about this Notice, please call UCare Customer Service at 612-676-3310 or 1-855-260-9707 (this call is free). TTY users call 612-676-6810 or 1-800-688-2534 (this call is free). This information is also available in other forms to people with disabilities. Please ask us for that information.

D. Our responsibility to give you information

As a member of our plan, you have the right to get information from us about our plan, our network providers, and your covered services.

If you don't speak English, we have interpreter services to answer questions you have about our plan. To get an interpreter, call Customer Service. This is a free service to you. We can also give you information in large print, braille, or audio.

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

- How to choose or change plans
- Our plan, including:
  - financial information
  - how plan members have rated us
  - the number of appeals made by members
  - how to leave our plan
  - the results of an external quality review study from the state
- Our network providers and our network pharmacies, including:
  - how to choose or change primary care providers
  - qualifications of our network providers and pharmacies
  - how we pay providers in our network
  - whether we use a physician incentive plan that affects the use of referral services and details about the plan
- A listing of our network providers and pharmacies. This is available in our online *Provider and Pharmacy Directory* on our website at **ucare.org/searchnetwork** or by calling Customer Service at the number at the bottom of this page for more information and to request a copy of the *Provider and Pharmacy Directory*.
- Covered services and drugs, including:
  - services (refer to **Chapters 3 and 4** of this *Member Handbook*) and drugs (refer to **Chapters 5 and 6** of this *Member Handbook*) covered by our plan
  - limits to your coverage and drugs
  - rules you must follow to get covered services and drugs
- Why something isn't covered and what you can do about it (refer to **Chapter 9** of this *Member Handbook*), including asking us to:
  - put in writing why something isn't covered

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

E. Inability of network providers to bill you directly

Doctors, hospitals, and other providers in our network can't make you pay for covered services. They also can't balance bill or charge you if we pay less than the amount the provider charged us. To learn what to do if a network provider tries to charge you for covered services, refer to **Chapter 7** of this *Member Handbook*.

F. Your right to leave our plan

No one can make you stay in our plan if you don't want to.

- You have the right to get most of your health care services through Original Medicare or another Medicare Advantage (MA) plan.
- You can get your Medicare Part D drug benefits from a drug plan or from another MA plan.
- Refer to **Chapter 10** of this *Member Handbook*:
  - For more information about when you can join a new MA or drug benefit plan.

- For information about how you'll get your Medical Assistance benefits if you leave our plan.

G. Your right to make decisions about your health care

You have the right to full information from your doctors and other health care providers to help you make decisions about your health care.

G1. Your right to know your treatment choices and make decisions

Your providers must explain your condition and your treatment choices in a way that you can understand. You have the right to:

- **Know your choices.** You have the right to be told about all treatment options that are recommended for your condition, no matter what they cost or whether they are covered by our plan.
- **Know the risks.** You have the right to be told about any risks involved. We must tell you in advance if any service or treatment is part of a research experiment. You have the right to refuse experimental treatments.
- **Get a second opinion.** You have the right to use another doctor before deciding on treatment.
- **Say no.** You have the right to refuse any treatment. This includes the right to leave a hospital or other medical facility, even if your doctor advises you not to. You have the right to stop taking a prescribed drug. If you refuse treatment or stop taking a prescribed drug, we won't drop you from our plan. However, if you refuse treatment or stop taking a drug, you accept full responsibility for what happens to you.
- **Ask us to explain why a provider denied care.** You have the right to get an explanation from us if a provider denied care that you think you should get.
- **Ask us to cover a service or drug that we denied or usually don't cover.** This is called a coverage decision. **Chapter 9** of this *Member Handbook* tells how to ask us for a coverage decision.
- **Participate in decision making.** You have the right to participate with your doctors in making decisions about your health care.

G2. Your right to say what you want to happen if you can't make health care decisions for yourself

Sometimes people are unable to make health care decisions for themselves. Before that happens to you, you can:

- Fill out a written form **giving someone the right to make health care decisions for you** if you can't make decisions for yourself.
- **Give your doctors written instructions** about how to handle your health care if you become unable to make decisions for yourself, including care you **don't** want.

The legal document you use to give your directions is called an "advance directive." There are different types of advance directives and different names for them. Examples are a living will and a power of attorney for health care.

You aren't required to have an advance directive, but you can. Here's what to do if you want to use an advance directive:

- **Get the form.** You can get the form from your doctor, a lawyer, a social worker, or some office supply stores. Pharmacies and provider offices often have the forms. You can find a free form online and download it. The Senior LinkAge Line® is an organization that gives people information about Medicare or Medical Assistance, including resources for getting a form at https://mn.gov/adresources. In Minnesota, you can contact the Senior LinkAge Line® at 1-800-333-2433.
- **Fill out the form and sign it.** The form is a legal document. Consider having a lawyer or someone else you trust, such as a family member or your PCP, help you complete it.
- **Give copies of the form to people who need to know.** Give a copy of the form to your doctor. You should also give a copy to the person you name to make decisions for you if you can't. You may want to give copies to close friends or family members. Keep a copy at home.
- If you're being hospitalized and you have a signed advance directive, **take a copy of it to the hospital**.
  - The hospital will ask if you have a signed advance directive form and if you have it with you.
  - If you don't have a signed advance directive form, the hospital has forms and will ask if you want to sign one.

You have the right to:

- Have your advance directive placed in your medical records.
- Change or cancel your advance directive at any time.
- Remember, it's your choice to fill out an advance directive or not.

By law, no one can deny you care or discriminate against you based on whether you signed an advance directive. Call Customer Service for more information.

G3. What to do if your instructions aren't followed

If you signed an advance directive and you think a doctor or hospital didn't follow the instructions in it, you can make a complaint with the Office of Health Facility Complaints at the Minnesota Department of Health at 651-201-4200, or 1-800-369-7994 toll-free.

If you believe that a health plan did not follow the advance directive requirements, you may file a complaint with the Managed Care Section at 651-201-5176 or toll-free at 1-888-657-3916. TTY users call 711.

H. Your right to make complaints and ask us to reconsider our decisions

Chapter 9 of this *Member Handbook* tells you what you can do if you have any problems or concerns about your covered services or care. For example, you can ask us to make a coverage decision, make an appeal to change a coverage decision, or make a complaint.

You have the right to get information about appeals and complaints that other plan members have filed against us. Call Customer Service to get this information.

H1. What to do about unfair treatment or to get more information about your rights

You have the right to be treated with respect and dignity. If you feel you are being treated unfairly or your rights are not being respected, there are actions you can take. If you think we treated you unfairly — and it **isn't** about discrimination for reasons listed in **Chapter 11** of this *Member Handbook* — or you want more information about your rights, you can call:

- Customer Service

- The Senior LinkAge Line® program at 1-800-333-2433. For more details about the Senior LinkAge Line®, refer to **Chapter 2** of this *Member Handbook*.
- The Minnesota Ombudsperson for Public Managed Health Care Programs at 1-800-657-3729. For more details about this program, refer to **Chapter 2** of this *Member Handbook*.
- Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048. (You can also read or download "Medicare Rights & Protections," found on the Medicare website at https://www.medicare.gov/publications/11534-medicare-rights-and-protections.pdf.)

I. Your responsibilities as a plan member

As a plan member, you have a responsibility to do the things that are listed below. If you have any questions, call Customer Service.

- **Read this *Member Handbook*** to learn what our plan covers and the rules to follow to get covered services and drugs. For details about your:
  - Covered services, refer to **Chapters 3 and 4** of this *Member Handbook*. Those chapters tell you what's covered, what isn't covered, what rules you need to follow, and what you pay.
  - Covered drugs, refer to **Chapters 5 and 6** of this *Member Handbook*.
- **Tell us about any other health or drug coverage** you have. We must make sure you use all of your coverage options when you get health care. Call Customer Service if you have other coverage.
- **Tell your doctor and other health care providers** that you're a member of our plan. Show your Member ID Card when you get services or drugs.
- **Help your doctors** and other health care providers give you the best care.
  - Give them information they need about you and your health in order for them to provide you care.
  - Learn as much as you can about your health problems so you can participate in developing mutually agreed-upon treatment goals with your provider.
  - Follow the treatment plans and instructions that you and your providers agree on.

  - Establish a relationship with a plan network primary care doctor before you become ill. This helps you and your primary care doctor understand your total health condition.
  - Make sure your doctors and other providers know about all the drugs you take. This includes prescription drugs, over-the-counter drugs, vitamins, and supplements.
  - Practice preventive health care. Have tests, exams, and shots recommended for you based on your age and gender.
  - Ask any questions you have. Your doctors and other providers must explain things in a way you can understand. If you ask a question and you don't understand the answer, ask again.

- **Be considerate.** We expect all plan members to respect the rights of others. We also expect you to act with respect in your doctor's office, hospitals, and other provider offices.

- **Pay what you owe.** As a plan member, you're responsible for these payments:
  - Medicare Part A and Medicare Part B premiums. For most *UCare Connect + Medicare* members, Medical Assistance pays for your Medicare Part A premium and for your Medicare Part B premium.
  - For some of your drugs covered by our plan, you must pay your share of the cost when you get the drug. This will be a copay (a fixed amount). **Chapter 6** tells what you must pay for your drugs.
  - **If you get any services or drugs that aren't covered by our plan, you must pay the full cost.** (**Note:** If you disagree with our decision to not cover a service or drug, you can make an appeal. Please refer to **Chapter 9** of this *Member Handbook* to learn how to make an appeal.)

- **Tell us if you move.** If you plan to move, tell us right away. Call your care coordinator or Customer Service.
  - **If you move outside of our service area, you can't stay in our plan.** Only people who live in our service area can be members of this plan. **Chapter 1** of this *Member Handbook* refers to our service area.
  - We can help you find out if you're moving outside our service area. During a special enrollment period, you can switch to Original Medicare or enroll in a Medicare health or drug plan in your new location. We can tell you if we have a plan in your new area.

  - Tell Medicare and Medical Assistance your new address when you move. Refer to **Chapter 2** of this *Member Handbook* for phone numbers for Medicare and Medical Assistance.
  - **If you move and stay in our service area, we still need to know.** We need to keep your membership record up to date and know how to contact you.
  - **If you move, tell Social Security (or the Railroad Retirement Board).**
- **Call your care coordinator or Customer Service for help if you have questions or concerns.**

J. Your right to give feedback on the member rights and responsibilities policy

You have the right to make recommendations regarding our member rights and responsibilities. Call Customer Service to provide that information to us. We welcome your feedback. Phone numbers and calling hours are printed on the bottom of this page.

Chapter 9: What to do if you have a problem or complaint (coverage decisions, appeals, complaints)

Introduction

This chapter has information about your rights. Read this chapter to find out what to do if:

- You have a problem with or complaint about your plan.
- You need a service, item, or medication that your plan said it won't pay for.
- You disagree with a decision your plan made about your care.
- You think your covered services are ending too soon.

This chapter is in different sections to help you easily find what you're looking for. **If you have a problem or concern, read the parts of this chapter that apply to your situation.**

If you're having a problem with your care, you can call the Ombudsperson for Public Managed Health Care Programs at 651-431-2660 or 1-800-657-3729 or TTY MN Relay 711 or use your preferred relay service. This call is free. This chapter explains the different options you have for different problems and complaints, but you can always call the Ombudsperson for Public Managed Health Care Programs to help guide you through your problem.

For more information about ombudsperson programs that can help you address your concerns, refer to **Chapter 2** of this *Member Handbook*.

Table of Contents

Table of Contents

A. What to do if you have a problem or concern

This chapter explains how to handle problems and concerns. The process you use depends on the type of problem you have. Use one process for **coverage decisions and appeals** and another for **making complaints** (also called grievances).

To ensure fairness and promptness, each process has a set of rules, procedures, and deadlines that we and you must follow.

A1. About the legal terms

There are legal terms in this chapter for some rules and deadlines. Many of these terms can be hard to understand, so we use simpler words in place of certain legal terms when we can. We use abbreviations as little as possible.

For example, we say:

- “Making a complaint” instead of “filing a grievance”
- “Coverage decision” instead of “organization determination", “benefit determination”, “at risk-determination", or “coverage determination”
- “Fast coverage decision” instead of “expedited determination”
- "Independent Review Organization" (IRO) instead of "Independent Review Entity" (IRE)

Knowing the proper legal terms may help you communicate more clearly, so we provide those too.

B. Where to get help

B1. For more information and help

Sometimes it's confusing to start or follow the process for dealing with a problem. This can be especially true if you don't feel well or have limited energy. Other times, you may not have the information you need to take the next step.

Help from the Senior LinkAge Line®

You can call the Senior LinkAge Line. The Senior LinkAge Line counselors can answer your questions and help you understand what to do about your problem. The Senior LinkAge Line

isn't connected with us or with any insurance company or health plan. The Senior LinkAge Line has trained counselors statewide, and services are free. The Senior LinkAge Line's phone number is 1-800-333-2433 or TTY MN Relay 711, or use your preferred relay service. These calls are free. Visit the Senior LinkAge Line website at www.seniorlinkageline.com.

Help and information from Medicare

For more information and help, you can contact Medicare. Here are two ways to get help from Medicare:

- Call 1-800-MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048.
- Visit the Medicare website (www.medicare.gov).

Help and information from the Ombudsperson for Public Managed Health Care Programs

If you need help, you can always call the Ombudsperson for Public Managed Health Care Programs. The Ombudsperson for Public Managed Health Care Programs can answer your questions and help you understand what to do to handle your problem. Refer to **Chapter 2** of this *Member Handbook* for more information on ombudsperson programs.

The Ombudsperson for Public Managed Health Care Programs isn't connected with us or with any insurance company or health plan. They can help you understand which process to use. The phone number for the Ombudsperson for Public Managed Health Care Programs is 651-431-2660 or 1-800-657-3729 or TTY MN Relay 711 or use your preferred relay service. The services are free.

C. Understanding Medicare and Medical Assistance complaints and appeals in our plan

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

Sometimes Medicare and Medical Assistance processes can't be combined. In those situations, you use one process for a Medicare benefit and another process for a Medical Assistance benefit. **Section F4** explains these situations.

D. Problems with your benefits

If you have a problem or concern, read the parts of this chapter that apply to your situation. The following chart helps you find the right section of this chapter for problems or complaints.

Is your problem or concern about your benefits or coverage? This includes problems about whether particular medical care (medical items, services and/or Part B drugs) are covered or not, the way they're covered, and problems about payment for medical care.	
Yes. My problem is about benefits or coverage. Refer to **Section E**, "Coverage decisions and appeals."	**No.** My problem isn't about benefits or coverage. Refer to **Section K**, "How to make a complaint."

E. Coverage decisions and appeals

The process for asking for a coverage decision and making an appeal deals with problems related to your benefits and coverage for your medical care (services, items and Part B drugs, including payment). To keep things simple, we generally refer to medical items, services, and Part B drugs as **medical care.**

E1. Coverage decisions

A coverage decision is a decision we make about your benefits and coverage or about the amount we pay for your medical services or drugs. For example, if your plan network provider refers you to a medical specialist outside of the network, this referral is considered a favorable decision unless either your network provider can show that you received a standard denial notice for this medical specialist, or the referred service is never covered under any condition (refer to **Chapter 4**, **Section F** of this *Member Handbook)*.

You or your doctor can also contact us and ask for a coverage decision. You or your doctor may be unsure whether we cover a specific medical service or if we may refuse to provide medical

care you think you need. **If you want to know if we'll cover a medical service before you get it, you can ask us to make a coverage decision for you.**

We make a coverage decision whenever we decide what's covered for you and how much we pay. In some cases, we may decide a service or drug isn't covered or is no longer covered for you by Medicare or Medical Assistance. If you disagree with this coverage decision, you can make an appeal.

E2. Appeals

If we make a coverage decision and you aren't satisfied with this decision, you can "appeal" the decision. An appeal is a formal way of asking us to review and change a coverage decision we made.

When you appeal a decision for the first time, this is called a Level 1 Appeal. In this appeal, we review the coverage decision we made to check if we followed all rules properly. Different reviewers than those who made the original unfavorable decision handle your appeal.

When we complete the review, we give you our decision. Under certain circumstances, explained later in this chapter in **Section F2**, you can ask for an expedited or "fast coverage decision" or "fast appeal" of a coverage decision.

If we say **No** to part or all of what you asked for, we'll send you a letter. If your problem is about coverage of Medicare medical care, the letter will tell you that we sent your case to the Independent Review Organization (IRO) for a Level 2 Appeal. If your problem is about coverage of a Medicare Part D or Medical Assistance service or item, the letter will tell you how to file a Level 2 Appeal yourself. Refer to **Section F4** for more information about Level 2 Appeals.

If you aren't satisfied with the Level 2 Appeal decision, you may be able to go through additional levels of appeal.

E3. Help with coverage decisions and appeals

You can ask for help from any of the following:

- **Customer Service** at the numbers at the bottom of the page.
- Call the **State Health Insurance Assistance Program (SHIP)** for free help. The SHIP is an independent organization. It's not connected with this plan. In Minnesota the SHIP is called the Senior LinkAge Line®. The phone number is 1-800-333-2433 or TTY MN Relay 711 or use your preferred relay service. These calls are free.

- Call the **Ombudsperson for Public Managed Health Care Programs** for free help. The Ombudsperson for Public Managed Health Care Programs helps people enrolled in Medical Assistance with service or billing problems. The phone number is 651-431-2660 or 1-800-657-3729 or TTY MN Relay 711 or use your preferred relay service.
- **Your doctor or other provider**. Your doctor or other provider can ask for a coverage decision or appeal on your behalf.
- **A friend or family member**. You can name another person to act for you as your "representative" and ask for a coverage decision or make an appeal.
- **A lawyer**. You have the right to a lawyer, but **you aren't required to have a lawyer** to ask for a coverage decision or make an appeal.
  - Call your own lawyer or get the name of a lawyer from the local bar association or other referral service. Some legal groups will give you free legal services if you qualify.

Fill out the Appointment of Representative form if you want a lawyer or someone else to act as your representative. The form gives someone permission to act for you.

Call Customer Service at the numbers at the bottom of the page and ask for the "Appointment of Representative" form. You can also get the form by visiting https://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/downloads/cms1696.pdf or on our website at **ucare.org/formembers**. **You must give us copy of the signed form.**

E4. Which section of this chapter can help you

There are four situations that involve coverage decisions and appeals. Each situation has different rules and deadlines. We give details for each one in a separate section of this chapter. Refer to the section that applies**:**

- **Section F,** "Medical, behavioral health and long-term care services"
- **Section G,** "Medicare Part D drugs"
- **Section H,** "Asking us to cover a longer hospital stay"
- **Section I,** "Asking us to continue covering certain medical services" (This section only applies to these services: home health care, skilled nursing facility care, and Comprehensive Outpatient Rehabilitation Facility (CORF) services.)

If you're not sure which section to use, call Customer Service at the numbers at the bottom of the page.

If you need other help or information, please call the Ombudsperson for Public Managed Health Care Programs at 651-431-2660 or 1-800-657-3729 or TTY MN Relay 711 or use your preferred relay service.

F. Medical care, behavioral health, and long-term care services

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

This section is about your benefits for medical care that are described in **Chapter 4** of this *Member Handbook* in the benefits chart. In some cases, different rules may apply to a Medicare Part B drug. When they do, we explain how rules for Medicare Part B drugs differ from rules for medical services and items.

F1. Using this section

This section explains what you can do in any of the five following situations:

1. You think we cover medical care you need but aren't getting.

   What you can do: You can ask us to make a coverage decision. Refer to **Section F2**.

2. We didn't approve the medical care your doctor or other health care provider wants to give you, and you think we should.

   What you can do: You can appeal our decision. Refer to **Section F3.**

3. You got medical care that you think we cover, but we won't pay.

   What you can do: You can appeal our decision not to pay. Refer to **Section F5**.

4. You got and paid for medical care you thought we cover, and you want us to pay you back.

   What you can do: You can ask us to pay you back. Refer to **Section F5**.

5. We reduced or stopped your coverage for certain medical care, and you think our decision could harm your health.

   What you can do: You can appeal our decision to reduce or stop the medical care. Refer to **Section F4**.

   - If the coverage is for hospital care, home health care, skilled nursing facility care, or CORF services, special rules apply. Refer to **Section H** or **Section I** to find out more.

- For all other situations involving reducing or stopping your coverage for certain medical care, use this section (**Section F**) as your guide.

F2. Asking for a coverage decision

When a coverage decision involves your medical care, it's called an "**integrated organization determination.**"

You, your doctor, or your representative can ask us for a coverage decision by:

- Calling: 612-676-3310 or 1-855-260-9707 (this call is free); TTY 612-676-6810 or 1-800-688-2534 (this call is free).
- Faxing: 612-884-2021 or 1-866-283-8015, Attn: Appeals and Grievances.
- Writing:

  Attn: Appeals and Grievances
  UCare
  PO Box 52
  Minneapolis, MN 55440-0052

Standard coverage decision

When we give you our decision, we use the "standard" deadlines unless we agree to use the "fast" deadlines. A standard coverage decision means we give you an answer within:

- **7 calendar days** after we get your request **for a medical service or item that is subject to our prior authorization rules**.
- **14 calendar days** after we get your request **for all other medical services or items**.
- **72 hours** after we get your request **for a Medicare Part B drug**.

For a medical item or service, we can take up to 14 more calendar days if you ask for more time or if we need more information that may benefit you (such as medical records from out-of-network providers). If we take extra days to make the decision, we'll tell you in writing. **We can't take extra days if your request is for a Medicare Part B drug**.

If you think we **shouldn't** take extra days, you can make a "fast complaint" about our decision to take extra days. When you make a fast complaint, we give you an answer to your complaint within 24 hours. The process for making a complaint is different from the process for coverage

decisions and appeals. For more information about making a complaint, including a fast complaint, refer to **Section K**.

Fast coverage decision

The legal term for "fast coverage decision" is "**expedited determination.**"

When you ask us to make a coverage decision about your medical care and your health requires a quick response, ask us to make a "fast coverage decision." A fast coverage decision means we'll give you an answer within:

- **72 hours** after we get your request **for a medical service or item**.
- **24 hours** after we get your request **for a Medicare Part B drug**.

For a medical item or service, we can take up to 14 more calendar days if we find information that may benefit you is missing (such as medical records from out-of-network providers) or if you need time to get us information for the review. If we take extra days to make the decision, we'll tell you in writing. **We can't take extra time if your request is for a Medicare Part B drug.**

If you think we **shouldn't** take extra days to make the coverage decision, you can make a "fast complaint" about our decision to take extra days. For more information about making a complaint, including a fast complaint, refer to **Section K**. We'll call you as soon as we make the decision.

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

- You're asking for coverage for medical items and/or services that you **didn't get**. You can't ask for a fast coverage decision about payment for items or services you already got.
- Using the standard deadlines **could cause serious harm to your health** or hurt your ability to function.

We automatically give you a fast coverage decision if your doctor tells us your health requires it. If you ask without your doctor's support, we decide if you get a fast coverage decision.

- If we decide that your health doesn't meet the requirements for a fast coverage decision, we send you a letter that says so and we use the standard deadlines instead. The letter tells you:
  - We automatically give you a fast coverage decision if your doctor asks for it.
  - How you can file a "fast complaint" about our decision to give you a standard coverage decision instead of a fast coverage decision. For more information about making a complaint, including a fast complaint, refer to **Section K**.

If we say No to part or all of your request, we send you a letter explaining the reasons.

- If we say **No**, you have the right to make an appeal. If you think we made a mistake, making an appeal is a formal way of asking us to review our decision and change it.
- If you decide to make an appeal, you'll go on to Level 1 of the appeals process (refer to **Section F3)**.

In limited circumstances we may dismiss your request for a coverage decision, which means we won't review the request. Examples of when a request will be dismissed include:

- if the request is incomplete,
- if someone makes the request on your behalf but isn't legally authorized to do so, **or**
- if you ask for your request to be withdrawn.

If we dismiss a request for a coverage decision, we'll send you a notice explaining why the request was dismissed and how to ask for a review of the dismissal. This review is called an appeal. Appeals are discussed in the next section.

F3. Making a Level 1 Appeal

To start an appeal, you, your doctor, or your representative must contact us. Call us at 612-676-6841 or 1-877-523-1517 (this call is free). TTY 612-676-6810 or 1-800-688-2534 (this call is free) or 1-800-688-2534 (this call is free). You can also contact us in writing at:

Attn: Member Appeals and Grievances,
UCare
PO Box 52
Minneapolis, MN 55440-0052

Ask for a standard appeal or a fast appeal in writing or by calling us at the number at the bottom of the page.

- If your doctor or other prescriber asks to continue a service or item you're already getting during your appeal, you may need to name them as your representative to act on your behalf.
- If someone other than your doctor makes the appeal for you, include an Appointment of Representative form authorizing this person to represent you. You can get the form by visiting www.cms.gov/Medicare/CMS-Forms/CMSForms/downloads/cms1696.pdf or our website at **ucare.org/formembers**.
- We can accept an appeal request without the form, but we can't begin or complete our review until we get it. If we don't get the form before our deadline for making a decision on your appeal:
  - We dismiss your request, and
  - We send you a written notice explaining your right to ask the IRO to review our decision to dismiss your appeal.
- You must ask for an appeal within 65 calendar days from the date on the letter we sent you to tell you our decision.
- If you miss the deadline and have a good reason for missing it, we may give you more time to make your appeal. Examples of good reasons are things like you had a serious illness or we gave you the wrong information about the deadline. Explain the reason why your appeal is late when you make the appeal.
- You have the right to ask us for a free copy of the information about your appeal. You and your doctor may also give us more information to support your appeal.

If your health requires it, ask for a fast appeal.

The legal term for "fast appeal" is "**expedited reconsideration.**"

- If you appeal a decision we made about coverage for care, you and/or your doctor decide if you need a fast appeal.

We automatically give you a fast appeal if your doctor tells us your health requires it. If you ask without your doctor's support, we decide if you get a fast appeal.

- If we decide that your health doesn't meet the requirements for a fast appeal, we send you a letter that says so and we use the standard deadlines instead. The letter tells you:
  - We automatically give you a fast appeal if your doctor asks for it.
  - How you can file a "fast complaint" about our decision to give you a standard appeal instead of a fast appeal. For more information about making a complaint, including a fast complaint, refer to **Section K**.

If we tell you we are stopping or reducing services or items that you already get, you may be able to continue those services or items during your appeal.

- If we decide to change or stop coverage for a service or item that you get, we send you a notice before we take action.
- If you disagree with our decision, you can file a Level 1 Appeal.
- We continue covering the service or item if you ask for a Level 1 Appeal within 10 calendar days of the date on our letter or by the intended effective date of the action, whichever is later.
  - If you meet this deadline, you'll get the service or item with no changes while your Level 1 appeal is pending.
  - You'll also get all other services or items (that aren't the subject of your appeal) with no changes.
  - If you don't appeal before these dates, then your service or item won't be continued while you wait for your appeal decision.

We consider your appeal and give you our answer.

- When we review your appeal, we take another careful look at all information about your request for coverage of medical care.
- We check if we followed all the rules when we said **No** to your request.
- We gather more information if we need it. We may contact you or your doctor to get more information.

There are deadlines for a fast appeal.

- When we use the fast deadlines, we must give you our answer **within 72 hours after we get your appeal**. We'll give you our answer sooner if your health requires it.
- If you ask for more time or if we need more information that may benefit you, we **can take up to 14 more calendar days** if your request is for a medical item or service.

- If we need extra days to make the decision, we tell you in writing.
- If your request is for a Medicare Part B drug, we can't take extra time to make the decision.
- If we don't give you an answer within 72 hours or by the end of the extra days we took, we must send your request to Level 2 of the appeals process. An IRO then reviews it. Later in this chapter in **Section F4**, we tell you about this organization and explain the Level 2 appeals process. If your problem is about coverage of a Medical Assistance service or item, you can file a Level 2—Fair Hearing with the state yourself as soon as the time is up. In Minnesota a Fair Hearing is called a State Appeal.

- **If we say Yes to part or all of your request,** we must authorize or provide the coverage we agreed to provide within 72 hours after we get your appeal.
- **If we say No to part or all of your request,** we send your appeal to the IRO for a Level 2 Appeal.

There are deadlines for a standard appeal.

- When we use the standard deadlines, we must give you our answer **within 30 calendar days** after we get your appeal for coverage for the services you didn't get.
- If your request is for a Medicare Part B drug you didn't get, we give you our answer **within 7 calendar days** after we get your appeal or sooner if your health requires it.
- If you ask for more time or if we need more information that may benefit you, **we can take up to 14 more calendar days** if your request is for a medical item or service.
  - If we need extra days to make the decision, we tell you in writing.
  - If your request is for a Medicare Part B drug, we can't take extra time to make the decision.
  - If you think we should **shouldn't** take extra days, you can file a fast complaint about our decision. When you file a fast complaint, we give you an answer within 24 hours. For more information about making complaints, including fast complaints, refer to **Section K.**
  - If we don't give you an answer by the deadline or by the end of the extra days we took, we must send your request to Level 2 of the appeals process. An IRO then reviews it. Later in this chapter in **Section F4**, we tell you about this organization and explain the Level 2 appeals process. If your problem is about coverage of a Medical Assistance service or item, you can file a Level 2 — Fair Hearing with the

state yourself as soon as the time is up. In Minnesota a Fair Hearing is called a State Appeal.

If we say Yes to part or all of your request, we must authorize or provide the coverage we agreed to provide within 30 calendar days, or **within 7 calendar days** if your request is for a Medicare Part B drug, after we get your appeal.

If we say **No** to part or all of your request, **you have additional appeal rights:**

- If we say **No** to part or all of what you asked for, we send you a letter.
- If your problem is about coverage of a Medicare service or item, the letter tells you that we sent your case to the IRO for a Level 2 Appeal.
- If your problem is about coverage of a Medical Assistance service or item, the letter tells you how to file a Level 2 Appeal yourself.

F4. Making a Level 2 Appeal

If we say **No** to part or all of your Level 1 Appeal, we send you a letter. This letter tells you if Medicare, Medical Assistance, or both programs usually cover the service or item.

- If your problem is about a service or item that Medicare usually covers, we automatically send your case to Level 2 of the appeals process as soon as the Level 1 Appeal is complete.
- If your problem is about a service or item that Medical Assistance usually covers, you can file a Level 2 Appeal yourself. The letter tells you how to do this. We also include more information later in this chapter.
- If your problem is about a service or item that **both Medicare and Medical Assistance** may cover, you automatically get a Level 2 Appeal with the IRO. You can also ask for a Fair Hearing with the state.

If you qualified for continuation of benefits when you filed your Level 1 Appeal, your benefits for the service, item or drug under appeal may also continue during Level 2. Refer to **Section F3** for information about continuing your benefits during Level 1 Appeals.

- If your problem is about a service usually covered only by Medicare, your benefits for that service don't continue during the Level 2 appeals process with the IRO.
- If your problem is about a service usually covered only by Medical Assistance, your benefits for that service continue if you submit a Level 2 Appeal within 10 calendar days after getting our decision letter.

When your problem is about a service or item Medicare usually covers

The IRO reviews your appeal. It's an independent organization hired by Medicare.

The formal name for the "Independent Review Organization" (IRO) is the "**Independent Review Entity",** sometimes called the "**IRE".**

- This organization isn't connected with us and isn't a government agency. Medicare chose the company to be the IRO, and Medicare oversees their work.
- We send information about your appeal (your "case file") to this organization. You have the right to a free copy of your case file.
- You have a right to give the IRO additional information to support your appeal.
- Reviewers at the IRO take a careful look at all information related to your appeal.

If you had a fast appeal at Level 1, you also have a fast appeal at Level 2.

- If you had a fast appeal to us at Level 1, you automatically get a fast appeal at Level 2. The IRO must give you an answer to your Level 2 Appeal **within 72 hours** of getting your appeal.
- If your request is for a medical item or service and the IRO needs to gather more information that may benefit you, **it can take up to 14 more calendar days**. The IRO can't take extra time to make a decision if your request is for a Medicare Part B drug.

If you had a standard appeal at Level 1, you also have a standard appeal at Level 2.

- If you had a standard appeal to us at Level 1, you automatically get a standard appeal at Level 2.
- If your request is for a medical item or service, the IRO must give you an answer to your Level 2 Appeal **within 30 calendar days** of getting your appeal.
- If your request is for a Medicare Part B drug, the IRO must give you an answer to your Level 2 Appeal **within 7 calendar days** of getting your appeal.
- If your request is for a medical item or service and the IRO needs to gather more information that may benefit you, **it can take up to 14 more calendar days**. The IRO can't take extra time to make a decision if your request is for a Medicare Part B drug.

The IRO gives you their answer in writing and explains the reasons.

- **If the IRO says Yes to part or all of a request for a medical item or service,** we must:
  - Authorize the medical care coverage **within 72 hours, or**
  - Provide the service **within 14 calendar days** after we get the IRO's decision for **standard requests, or**
  - Provide the service **within 72 hours** from the date we get the IRO's decision for **expedited requests.**
- **If the IRO says Yes to part or all of a request for a Medicare Part B drug, we must authorize or provide the Medicare Part B drug under dispute:**
  - **within 72 hours** after we get the IRO's decision for **standard requests, or**
  - **within 24 hours** from the date we get the IRO's decision for **expedited requests.**
- **If the IRO says No part or all of your appeal,** it means they agree that we shouldn't approve your request (or part of your request) for coverage for medical care. This is called "upholding the decision" or "turning down your appeal."
  - 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.
  - If your Level 2 Appeal is turned down and you meet the requirements to continue the appeals process, you must decide whether to go on to Level 3 and make a third appeal. The details about how to do this are in the written notice you get after your Level 2 Appeal.
  - An Administrative Law Judge (ALJ) or attorney adjudicator handles a Level 3 Appeal. Refer to **Section J** for more information about Level 3,4, and 5 Appeals.

When your problem is about a service or item Medical Assistance usually covers, or that's covered by both Medicare and Medical Assistance

A Level 2 Appeal for services that Medical Assistance usually covers is a Fair Hearing with the state. In Minnesota a Fair Hearing is called a State Appeal. You must ask for a Fair Hearing in writing or by phone **within 120 calendar days** of the date we sent the decision letter on your Level 1 Appeal. The letter you get from us tells you where to submit your request for a Fair Hearing.

You must ask for a State Appeal within 120 days of the date of the plan's appeal decision.

Mail, fax, or submit your written request to:

Minnesota Department of Human Services
Appeals Office
PO Box 64941
St. Paul, MN 55164-0941
Fax: 651-431-7523

Online Appeal Form:
edocs.dhs.state.mn.us/lfserver/Public/DHS-0033-ENG

A Human Services Judge from the State Appeals Office will hold the hearing. Your meeting will be by telephone unless you ask for a face-to-face meeting. During your hearing, tell the Judge why you disagree with the decision made by the plan. You can ask a friend, relative, advocate, provider, or lawyer to help you.

The process can take between 30 and 90 days. If your hearing is about an urgently needed service and you need an answer faster, tell the State Appeals Office when you file your hearing request. If your hearing is about a medical necessity denial, you may ask for an expert medical opinion from an outside reviewer. There's no cost to you.

If you need help at any point in the process, call the Ombudsperson for Public Managed Health Care Programs at 651-431-2660 or 1-800-657-3729 or TTY MN Relay 711 or use your preferred relay service.

The Fair Hearing office gives you their decision in writing and explains the reasons.

- If the Fair Hearing office says **Yes** to part or all of a request for a medical item or service, we must authorize or provide the service or item **within 72 hours** after we get their decision.

- If the Fair Hearing office says **No** to part or all of your appeal, it means they agree that we shouldn't approve your request (or part of your request) for coverage for medical care. This is called "upholding the decision" or "turning down your appeal."

If the IRO or Fair Hearing office decision is **No** for all or part of your request, you have additional appeal rights.

If your Level 2 Appeal went to the **IRO,** you can appeal again only if the dollar value of the service or item you wants meets a certain minimum amount. An ALJ or attorney adjudicator handles a Level 3 Appeal. **The letter you get from the IRO explains additional appeal rights you may have.**

The letter you get from the Fair Hearing office describes the next appeal option.

Refer to **Section J** for more information about your appeal rights after Level 2.

F5. Payment problems

We don't allow our network providers to bill you for covered services and items. This is true even if we pay the provider less than the provider charges for a covered service or item. You're never required to pay the balance of any bill. The only amount you should be asked to pay is the copay for Part D drugs that require a copay.

We can't reimburse you directly for a Medical Assistance service or item. If you get a bill that's more than your copay for Medical Assistance covered services and items, send the bill to us. Don't pay the bill yourself. We'll contact the provider directly and take care of the problem. If you do pay the bill, you can get a refund from that health care provider if you followed the rules for getting services or items.

If you want us to reimburse you for a **Medicare** service or item or you're asking us to pay a health care provider for a Medical Assistance service or item you paid for, you'll ask us to make this a coverage decision. We'll check if the service or item you paid for is covered and if you followed all the rules for using your coverage. For more information, refer to **Chapter 7** of this *Member Handbook*.

- If the service or item you paid for is covered and you followed all the rules, we'll send your provider our share of the cost for the service or item typically within 30 calendar days, but not later than 60 calendar days after we get your request. Your provider will then send the payment to you.
- If you haven't paid for the service or item yet, we'll send the payment directly to the provider. When we send the payment, it's the same as saying **Yes** to your request for a coverage decision.
- If the service or item isn't covered or you didn't follow all the rules, we'll send you a letter telling you we won't pay for the service or item and explaining why.

If you don't agree with our decision not to pay, **you can make an appeal.** Follow the appeals process described in **Section F3**. When you follow these instructions, note:

- If you make an appeal for us to pay you back, we must give you our answer within 30 calendar days after we get your appeal.

If our answer to your appeal is **No** and **Medicare** usually covers the service or item, we'll send your case to the IRO. We'll send you a letter if this happens.

- If the IRO reverses our decision and says we should pay you, we must send the payment to you or to the provider within 30 calendar days. If the answer to your appeal is **Yes** at any stage of the appeals process after Level 2, we must send the payment to you or to the health care provider within 60 calendar days.
- If the IRO says **No** to your appeal, it means they agree that we shouldn't approve your request. This is called "upholding the decision" or "turning down your appeal." You'll get a letter explaining additional appeal rights you may have. Refer to **Section J** of this *Member Handbook* for more information about additional levels of appeal.

If our answer to your appeal is **No** and Medical Assistance usually covers the service or item, you can file a Level 2 Appeal yourself. Refer to **Section F4** of this *Member Handbook* for more information.

G. Medicare Part D drugs

Your benefits as a member of our plan include coverage for many drugs. Most of these are Medicare Part D drugs. There are a few drugs that Medicare Part D doesn't cover that Medical Assistance may cover. **This section only applies to Medicare Part D drug appeals**. We'll say "drug" in the rest of this section instead of saying "Medicare Part D drug" every time. For drugs covered only by Medical Assistance follow the process in **Section E**.

To be covered, the drug must be used for a medically accepted indication. That means the drug is approved by the Food and Drug Administration (FDA) or supported by certain medical references. Refer to **Chapter 5** of this *Member Handbook* for more information about a medically accepted indication.

G1. Medicare Part D drug coverage decisions and appeals

Here are examples of coverage decisions you ask us to make about your Medicare Part D drugs:

- You ask us to make an exception, including asking us to:
  - cover a Medicare Part D drug that isn't on our plan's *Drug List*
  - set aside a restriction on our coverage for a drug (such as limits on the amount you can get)
- You ask us if a drug is covered for you (such as when your drug is on our plan's *Drug List* but we must approve it for you before we cover it).

NOTE: If your pharmacy tells you that your prescription can't be filled as written, the pharmacy gives you a written notice explaining how to contact us to ask for a coverage decision.

An initial coverage decision about your Medicare Part D drugs is called a "**coverage determination.**"

- You ask us to pay for a drug you already bought. This is asking for a coverage decision about payment.

If you disagree with a coverage decision we made, you can appeal our decision. This section tells you both how to ask for coverage decisions and how to make an appeal. Use the following chart to help you.

Which of these situations are you in?			
You need a drug that isn't on our *Drug List* or need us to set aside a rule or restriction on a drug we cover.	You want us to cover a drug on our *Drug List* and you think you meet plan rules or restrictions (such as getting approval in advance) for the drug you need.	You want to ask us to pay you back for a drug you already got and paid for	We told you that we won't cover or pay for a drug in the way that you want.
You can ask us to make an exception. (This is a type of coverage decision.)	**You can ask us for a coverage decision.**	**You can ask us to pay you back**. (This is a type of coverage decision.)	**You can make an appeal.** (This means you ask us to reconsider.)
Start with **Section G2**, then refer to **Sections G3 and G4**	Refer to **Section G4**	Refer to **Section G4**	Refer to **Section G5**

G2. Medicare Part D exceptions

If we don't cover a drug in the way you would like, you can ask us to make an "exception." If we turn down your request for an exception, you can appeal our decision.

When you ask for an exception, your doctor or other prescriber needs to explain the medical reasons why you need the exception.

> Asking for coverage of a drug not on our *Drug List* or for removal of a restriction on a drug is sometimes called asking for a "**formulary exception.**"

Here are some examples of exceptions that you or your doctor or other prescriber can ask us to make:

1. **Covering a drug that isn't on our *Drug List*.**
   - If we agree to make an exception and cover a drug that isn't on our *Drug List*, you pay the copay that applies to drugs in Tier 1 for brand name drugs or Tier 1 for generic drugs.
   - You can't get an exception to the required copay amount for the drug.
2. **Removing a restriction for a covered drug**
   - Extra rules or restrictions apply to certain drugs on our *Drug List* (refer to **Chapter 5** of this *Member Handbook* for more information).
   - Extra rules and restrictions for certain drugs include:
     - Being required to use the generic version of a drug instead of the brand name drug.
     - Getting our approval in advance before we agree to cover the drug for you. This is sometimes called "prior authorization (PA)."
     - Being required to try a different drug first before we agree to cover the drug you ask for. This is sometimes called "step therapy."
     - Quantity limits. For some drugs, there are restrictions on the amount of the drug you can have.

G3. Important things to know about asking for an exception

Your doctor or other prescriber must tell us the medical reasons.

Your doctor or other prescriber must give us a statement explaining the medical reasons for asking for an exception. For a faster decision, include this medical information from your doctor or other prescriber when you ask for the exception.

Our *Drug List* often includes more than one drug for treating a specific condition. These are called "alternative" drugs. If an alternative drug is just as effective as the drug you ask for and

wouldn't cause more side effects or other health problems, we generally **don't** approve your exception request.

We can say Yes or No to your request.

- If we say **Yes** to your exception request, the exception usually lasts until the end of the calendar year. This is true as long as your doctor continues to prescribe the drug for you and that drug continues to be safe and effective for treating your condition.
- If we say **No** to your exception request, you can make an appeal. Refer to **Section G5** for information on making an appeal if we say **No**.

The next section tells you how to ask for a coverage decision, including an exception.

G4. Asking for a coverage decision, including an exception

Ask for the type of coverage decision you want by calling 612-676-3310 or 1-855-260-9707 (this call is free) TTY use 612-676-6810 or 1-800-688-2534 (this call is free), writing, or faxing us. You, your representative, or your doctor (or other prescriber) can do this. Please include your name, contact information and information about the claim.

- You or your doctor (or other prescriber) or someone else acting on your behalf can ask for a coverage decision. You can also have a lawyer act on your behalf.
- Refer to **Section E3** to find out how to name someone as your representative.
- You don't need to give written permission to your doctor or other prescriber to ask for a coverage decision on your behalf.
- If you want to ask us to pay you back for a drug, refer to **Chapter 7** of this *Member Handbook.*
- If you ask for an exception, give us a "supporting statement." The supporting statement includes your doctor or other prescriber's medical reasons for the exception request.
- Your doctor or other prescriber can fax or mail us the supporting statement. They can also tell us by phone and then fax or mail the statement.
- To submit a coverage determination request electronically, log in to your online member account at **member.ucare.org** and select Pharmacy Benefits. Click on the Coverage Determination Request Form link, complete the form and submit it to begin the request.

If your health requires it, ask us for a "fast coverage decision."

We use the "standard deadlines" unless we agree to use the "fast deadlines."

- A **standard coverage decision** means we give you an answer within 72 hours after we get your doctor's statement.
- A **fast coverage decision** means we give you an answer within 24 hours after we get your doctor's statement.

> A "fast coverage decision" is called an "**expedited coverage determination.**"

You can get a fast coverage decision if:

- It's for a drug you didn't get. You can't get a fast coverage decision if you're asking us to pay you back for a drug you already bought.
- Your health or ability to function would be seriously harmed if we use the standard deadlines.

If your doctor or other prescriber tells us that your health requires a fast coverage decision, we agree and give it to you. We send you a letter that tells you.

- If you ask for a fast coverage decision without support from your doctor or other prescriber, we decide if you get a fast coverage decision.
- If we decide that your medical condition doesn't meet the requirements for a fast coverage decision, we use the standard deadlines instead.
  - We send you a letter that tells you. The letter also tells you how to make a complaint about our decision.
  - You can file a fast complaint and get a response within 24 hours. For more information about making complaints, including fast complaints, refer to **Section K** .

Deadlines for a fast coverage decision

- If we use the fast deadlines, we must give you our answer within 24 hours after we get your request. If you ask for an exception, we give you our answer within 24 hours after we get your doctor's supporting statement. We give you our answer sooner if your health requires it.
- If we don't meet this deadline, we send your request to Level 2 of the appeals process for review by an IRO. Refer to **Section G6** for more information about a Level 2 Appeal.
- If we say **Yes** to part or all of your request, we give you the coverage within 24 hours after we get your request or your doctor's supporting statement.

- If we say **No** to part or all of your request, we send you a letter with the reasons. The letter also tells you how you can make an appeal.

Deadlines for a standard coverage decision about a drug you didn't get

- If we use the standard deadlines, we must give you our answer within 72 hours after we get your request. If you ask for an exception, we give you our answer within 72 hours after we get your doctor's supporting statement. We give you our answer sooner if your health requires it.
- If we don't meet this deadline, we send your request to Level 2 of the appeals process for review by an IRO.
- If we say **Yes** to part or all of your request, we give you the coverage within 72 hours after we get your request or your doctor's supporting statement for an exception.
- If we say **No** to part or all of your request, we send you a letter with the reasons. The letter also tells you how to make an appeal.

Deadlines for a standard coverage decision about a drug you already bought

- We must give you our answer within 14 calendar days after we get your request.
- If we don't meet this deadline, we send your request to Level 2 of the appeals process for review by an IRO.
- If we say **Yes** to part or all of your request, we pay you back within 14 calendar days.
- If we say **No** to part or all of your request, we send you a letter with the reasons. The letter also tells you how to make an appeal.

G5. Making a Level 1 Appeal

An appeal to our plan about a Medicare Part D drug coverage decision is called a plan **"redetermination."**

- Start your **standard** or **fast appeal** by calling Customer Service at the number at the bottom of the page, writing, or faxing us. You, your representative, or your doctor (or other prescriber) can do this. Please include your name, contact information, and information regarding your appeal.

- You must ask for an appeal **within 65 calendar days** from the date on the letter we sent to tell you our decision.
- If you miss the deadline and have a good reason for missing it, we may give you more time to make your appeal. Examples of good reasons are things like you had a serious illness or we gave you the wrong information about the deadline. Explain the reason why your appeal is late when you make your appeal.
- You have the right to ask us for a free copy of the information about your appeal. You and your doctor may also give us more information to support your appeal.

If your health requires it, ask for a fast appeal.

A fast appeal is also called an "**expedited redetermination.**"

- If you appeal a decision we made about a drug you didn't get, you and your doctor or other prescriber decide if you need a fast appeal.
- Requirements for a fast appeal are the same as those for a fast coverage decision. Refer to **Section G4** for more information.

We consider your appeal and give you our answer.

- We review your appeal and take another careful look at all of the information about your coverage request.
- We check if we followed all the rules when we said **No** to your request.
- We may contact you or your doctor or other prescriber to get more information.

Deadlines for a fast appeal at Level 1

- If we use the fast deadlines, we must give you our answer **within 72 hours** after we get your appeal.
  - We give you our answer sooner if your health requires it.
  - If we don't give you an answer within 72 hours, we must send your request to Level 2 of the appeals process. Then an IRO reviews it. Refer to **Section G6** for information about the review organization and the Level 2 appeals process.
- If we say **Yes** to part or all of your request, we must provide the coverage we agreed to provide within 72 hours after we get your appeal.

- If we say **No** to part or all of your request, we send you a letter that explains the reasons and tells you how you can make an appeal.

Deadlines for a standard appeal at Level 1

- If we use the standard deadlines, we must give you our answer **within 7 calendar days** after we get your appeal for a drug you didn't get.
- We give you our decision sooner if you didn't get the drug and your health condition requires it. If you believe your health requires it, ask for a fast appeal.
  - If we don't give you a decision **within 7 calendar days**, we must send your request to Level 2 of the appeals process. Then an IRO reviews it. Refer to **Section G6** for information about the review organization and the Level 2 appeals process.

If we say **Yes** to part or all of your request:

- We must **provide the coverage** we agreed to provide as quickly as your health requires, but **no later than 7 calendar days** after we get your appeal.
- We must **send payment to you** for a drug you bought **within 30 calendar days** after we get your appeal.

If we say **No** to part or all of your request:

- We send you a letter that explains the reasons and tells you how you can make an appeal.
- We must give you our answer about paying you back for a drug you bought **within 14 calendar days** after we get your appeal.
  - If we don't give you a decision within 14 calendar days, we must send your request to Level 2 of the appeals process. Then an IRO reviews it. Refer to **Section G6** for information about the review organization and the Level 2 appeals process.
- If we say **Yes** to part or all of your request, we must pay you within 30 calendar days after we get your request.
- If we say **No** to part or all of your request, we send you a letter that explains the reasons and tells you how you can make an appeal.

G6. Making a Level 2 Appeal

If we say **No** to your Level 1 Appeal, you can accept our decision or make another appeal. If you decide to make another appeal, you use the Level 2 Appeal process. The **IRO** reviews our decision when we said **No** to your first appeal. This organization decides if we should change our decision.

> The formal name for the "Independent Review Organization" (IRO) is the "**Independent Review Entity**", sometimes called the "**IRE**".

To make a Level 2 Appeal, you, your representative, or your doctor or other prescriber must contact the IRO **in writing** and ask for a review of your case.

- If we say **No** to your Level 1 Appeal, the letter we send you includes **instructions about how to make a Level 2 Appeal** with the IRO. The instructions tell who can make the Level 2 Appeal, what deadlines you must follow, and how to reach the organization.
- When you make an appeal to the IRO, we send the information we have about your appeal to the organization. This information is called your "case file". **You have the right to a free copy of your case file.**
- You have a right to give the IRO other information to support your appeal.

The IRO reviews your Medicare Part D Level 2 Appeal and gives you an answer in writing. Refer to **Section F4** for more information about the IRO.

Deadlines for a fast appeal at Level 2

If your health requires it, ask the IRO for a fast appeal.

- If they agree to a fast appeal, they must give you an answer **within 72 hours** after getting your appeal request.
- If they say **Yes** to part or all of your request, we must provide the approved drug coverage **within 24 hours** after getting the IRO's decision.

Deadlines for standard appeal at Level 2

If you have a standard appeal at Level 2, the IRO must give you an answer:

- **within 7 calendar days** after they get your appeal for a drug you didn't get.
- **within 14 calendar days** after getting your appeal for repayment for a drug you bought.

If the IRO says **Yes** to part or all of your request:

- We must provide the approved drug coverage **within 72 hours** after we get the IRO's decision.
- We must pay you back for a drug you bought **within 30 calendar days** after we get the IRO's decision.
- If the IRO says **No** to your appeal, it means they agree with our decision not to approve your request. This is called "upholding the decision" or "turning down your appeal."

If the IRO says **No** to your Level 2 Appeal, you have the right to a Level 3 Appeal if the dollar value of the drug coverage you ask for meets a minimum dollar value. If the dollar value of the drug coverage you ask for is less than the required minimum, you can't make another appeal. In that case, the Level 2 Appeal decision is final. The IRO sends you a letter that tells you the minimum dollar value needed to continue with a Level 3 Appeal.

If the dollar value of your request meets the requirement, you choose if you want to take your appeal further.

- There are three additional levels in the appeals process after Level 2.
- If the IRO says **No** to your Level 2 Appeal and you meet the requirement to continue the appeals process, you:
  - Decide if you want to make a Level 3 Appeal
  - Refer to the letter the IRO sent you after your Level 2 Appeal for details about how to make a Level 3 Appeal.

An ALJ or attorney adjudicator handles Level 3 Appeals. Refer to **Section J** for information about Level 3, 4, and 5 Appeals.

H. Asking us to cover a longer hospital stay

When you're admitted to a hospital, you have the right to get all hospital services that we cover that are necessary to diagnose and treat your illness or injury. For more information about our plan's hospital coverage, refer to **Chapter 4** of this *Member Handbook*.

During your covered hospital stay, your doctor and the hospital staff work with you to prepare for the day when you leave the hospital. They also help arrange for care you may need after you leave.

- The day you leave the hospital is called your "discharge date."

- Your doctor or the hospital staff will tell you what your discharge date is.

If you think you're being asked to leave the hospital too soon or if you're concerned about your care after you leave the hospital, you can ask for a longer hospital stay. This section tells you how to ask.

H1. Learning about your Medicare rights

Within two days after you're admitted to the hospital, someone at the hospital, such as a nurse or caseworker, will give you a written notice called "An Important Message from Medicare about Your Rights." Everyone with Medicare gets a copy of this notice whenever they're admitted to a hospital.

If you don't get the notice, ask any hospital employee for it. If you need help, call Customer Service at the numbers at the bottom of the page. You can also call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

- **Read the notice** carefully and ask questions if you don't understand. The notice tells you about your rights as a hospital patient, including your rights to:
  - Get Medicare-covered services during and after your hospital stay. You have the right to know what these services are, who will pay for them, and where you can get them.
  - Be a part of any decisions about the length of your hospital stay.
  - Know where to report any concerns you have about the quality of your hospital care.
  - Appeal if you think you're being discharged from the hospital too soon.
- **Sign the notice** to show that you got it and understand your rights.
  - You or someone acting on your behalf can sign the notice.
  - Signing the notice **only** shows that you got the information about your rights. Signing **doesn't** mean you agree to a discharge date your doctor or the hospital staff may have told you.
- **Keep your copy** of the signed notice so you have the information if you need it.

If you sign the notice more than two days before the day you leave the hospital, you'll get another copy before you're discharged.

You can look at a copy of the notice in advance if you:

- Call Customer Service at the numbers at the bottom of the page

- Call Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.
- Visit www.cms.gov/medicare/forms-notices/beneficiary-notices-initiative/ffs-ma-im.

H2. Making a Level 1 Appeal

To ask for us to cover your inpatient hospital services for a longer time, you request an appeal. The Quality Improvement Organization (QIO) reviews the Level 1 Appeal to find out if your planned discharge date is medically appropriate for you.

The QIO is a group of doctors and other health care professionals paid by the federal government. These experts check and help improve the quality for people with Medicare. They aren't part of our plan.

In Minnesota, the (QIO) is Commence Health. Call them at 1-888-524-9900 (TTY: 1-888-985-8775). Contact information is also in the notice, "An Important message from Medicare about Your Rights," and in **Chapter 2**.

Call the QIO before your leave the hospital and no later than your planned discharge date.

- **If you call before you leave,** you can stay in the hospital after your planned discharge date without paying for it while you wait for the QIO's decision about your appeal.
- **If you don't call to appeal,** and you decide to stay in the hospital after your planned discharge date, you may pay all of the costs for hospital care you get after your planned discharge date.

Ask for help if you need it. If you have questions or need help at any time:

- Call Customer Service at the numbers at the bottom of the page.
- Call the Senior LinkAge Line® at 1-800-333-2433 or TTY MN Relay 711.

Ask for a fast review. Act quickly and contact the QIO to ask for a fast review of your hospital discharge.

> The legal term for "fast review" is "**immediate review**" or "**expedited review**."

What happens during fast review

- Reviewers at the QIO ask you or your representative why you think coverage should continue after the planned discharge date. You aren't required to write a statement, but you may.
- Reviewers look at your medical information, talk with your doctor, and review the information that the hospital and our plan gave them.
- By noon of the day after reviewers tell our plan about your appeal, you get a letter with your planned discharge date. The letter also gives reasons why your doctor, the hospital, and we think that's the right discharge date that's medically appropriate for you.

> The legal term for this written explanation is the "**Detailed Notice of Discharge.**" You can get a sample by calling Customer Service at the numbers listed at the bottom of this page or 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. (TTY MN Relay 711 users should call 1-877-486-2048.) You can also refer to a sample notice online at www.cms.gov/medicare/forms-notices/beneficiary-notices-initiative/ffs-ma-im.

Within one full day after getting all of the information it needs, the QIO gives you their answer to your appeal.

If the QIO says **Yes** to your appeal:

- We'll provide your covered inpatient hospital services for as long as the services are medically necessary.

If the QIO says **No** to your appeal:

- They believe your planned discharge date is medically appropriate.
- Our coverage for your inpatient hospital services will end at noon on the day after the QIO gives you their answer to your appeal.
- You may have to pay the full cost of hospital care you get after noon on the day after the QIO gives you their answer to your appeal.
- You can make a Level 2 Appeal if the QIO turns down your Level 1 Appeal **and** you stay in the hospital after your planned discharge date.

H3. Making a Level 2 Appeal

For a Level 2 Appeal, you ask the QIO to take another look at the decision they made on you Level 1 Appeal. Call them at 1-888-524-9900 (TTY: 1-888-985-8775).

You must ask for this review **within 60 calendar days** after the day the QIO said **No** to your Level 1 Appeal. You can ask for this review **only** if you stay in the hospital after the date that your coverage for the care ended.

QIO reviewers will:

- Take another careful look at all of the information related to your appeal.
- Tell you their decision about your Level 2 Appeal within 14 calendar days of receipt of your request for a second review.

If the QIO says **Yes** to your appeal:

- We must pay you back for our share of hospital care costs since noon on the day after the date the QIO turned down your Level 1 Appeal.
- We'll provide your covered inpatient hospital services for as long as the services are medically necessary.

If the QIO says **No** to your appeal:

- They agree with their decision about your Level 1 Appeal and won't change it.
- They give you a letter that tells you what you can do if you want to continue the appeals process and make a Level 3 Appeal.

An ALJ or attorney adjudicator handles Level 3 Appeals. Refer to **Section J** for information about Level 3, 4, and 5 Appeals.

I. Asking us to continue covering certain medical services

This section is only about three types of services you may be getting:

- home health care services
- skilled nursing care in a skilled nursing facility, **and**

- rehabilitation care as an outpatient at a Medicare-approved CORF. This usually means you're getting treatment for an illness or accident or you're recovering from a major operation.

With any of these three types of services, you have the right to get covered services for as long as the doctor says you need them.

When we decide to stop covering any of these, we must tell you **before** your services end. When your coverage for that service ends, we stop paying for it.

If you think we're ending the coverage of your care too soon, **you can appeal our decision**. This section tells you how to ask for an appeal.

I1. Advance notice before your coverage ends

We send you a written notice that you'll get at least two days before we stop paying for your care. This is called the "Notice of Medicare Non-Coverage." The notice tells you the date when we'll stop covering your care and how to appeal our decision.

You or your representative should sign the notice to show that you got it. Signing the notice **only** shows that you got the information. Signing **doesn't** mean you agree with our decision.

I2. Making a Level 1 Appeal

If you think we're ending coverage of your care too soon, you can appeal our decision. This section tells you about the Level 1 Appeal process and what to do.

- **Meet the deadlines.** The deadlines are important. Understand and follow the deadlines that apply to things you must do. Our plan must follow deadlines too. If you think we're not meeting our deadlines, you can file a complaint. Refer to **Section K** for more information about complaints.
- **Ask for help if you need it.** If you have questions or need help at any time
  - Call Customer Service at the number at the bottom of this page.
  - Call the Senior LinkAge Line at 1-800-333-2433 or TTY MN Relay 711.
- **Contact the QIO.**
  - Refer to **Section H2** or refer to **Chapter 2** of this *Member Handbook* for more information about the QIO and how to contact them.
  - Ask them to review your appeal and decide whether to change our plan's decision.

- **Act quickly and ask for a "fast track" appeal.** Ask the QIO if it's medically appropriate for us to end coverage of your medical services.

Your deadline for contacting this organization

- You must contact the QIO to start your appeal by noon of the day before the effective date on the "Notice of Medicare Non-Coverage" we sent you.

The legal term for the written notice is "**Notice of Medicare Non-Coverage".** To get a sample copy, call Customer Service at the numbers at the bottom of the page or call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048. Or get a copy online at

www.cms.gov/Medicare/Medicare-General-Information/BNI/FFS-Expedited-Determination-Notices.

What happens during a fast-track appeal

- Reviewers at the QIO ask you or your representative why you think coverage should continue. You aren't required to write a statement, but you may.
- Reviewers look at your medical information, talk with your doctor, and review information that our plan gave them.
- Our plan also sends you a written notice that explains our reasons for ending coverage of your services. You get the notice by the end of the day the reviewers inform us of your appeal.

The legal term for the notice explanation is **"Detailed Explanation of Non-Coverage."**

- Reviewers tell you their decision within one full day after getting all the information they need.

If the QIO says **Yes** to your appeal:

- We'll provide your covered services for as long as they're medically necessary.

If the QIO says **No** to your appeal:

- Your coverage ends on the date we told you.

- We stop paying our share of the costs of this care on the date in the notice.
- You pay the full cost of this care yourself if you decide to continue the home health care, skilled nursing facility care, or CORF services after the date your coverage ends.
- You decide if you want to continue these services and make a Level 2 Appeal.

I3. Making a Level 2 Appeal

For a Level 2 Appeal, you ask the QIO to take another look at the decision they made on your Level 1 Appeal. Call them at 1-888-524-9900 (TTY: 1-888-985-8775).

You must ask for this review **within 60 calendar days** after the day when the QIO said **No** to your Level 1 Appeal. You can ask for this review **only** if you continue care after the date that your coverage for the care ended.

QIO reviewers will:

- Take another careful look at all of the information related to your appeal.
- Tell you their decision about your Level 2 Appeal within 14 calendar days of receipt of your request for a second review.

If the QIO says **Yes** to your appeal:

- We pay you back for our share of the costs of the care you got since the date when we said your coverage would end.
- We'll provide coverage for the care for as long as it's medically necessary.

If the QIO says **No** to your appeal:

- They agree with our decision to end your care and won't change it.
- They give you a letter that tells you what you can do if you want to continue the appeals process and make a Level 3 Appeal.

An ALJ or attorney adjudicator handles Level 3 Appeals. Refer to **Section J** for information about Level 3, 4, and 5 Appeals.

J. Taking your appeal beyond Level 2

J1. Next steps for Medicare services and items

If you made a Level 1 Appeal and a Level 2 Appeal for Medicare services or items, and both of your appeals were turned down, you may have the right to additional levels of appeal.

If the dollar value of the Medicare service or item you appealed doesn't meet a certain minimum dollar amount, you can't appeal any further. If the dollar value is high enough, you can continue the appeals process. The letter you get from the IRO for your Level 2 Appeal explains who to contact and what to do to ask for a Level 3 Appeal.

Level 3 Appeal

Level 3 of the appeals process is an ALJ hearing. The person who makes the decision is an ALJ or an attorney adjudicator who works for the federal government.

If the ALJ or attorney adjudicator says **Yes** to your appeal, we have the right to appeal a Level 3 decision that's favorable to you.

- If we decide **to appeal** the decision, we send you a copy of the Level 4 Appeal request with any accompanying documents. We may wait for the Level 4 Appeal decision before authorizing or providing the service in dispute.
- If we decide **not to appeal** the decision, we must authorize or provide you with the service within 60 calendar days after getting the ALJ or attorney adjudicator's decision.
  - If the ALJ or attorney adjudicator says **No** to your appeal, the appeals process may not be over.
- If you decide **to accept** this decision that turns down your appeal, the appeals process is over.
- If you decide **not to accept** this decision that turns down your appeal, you can continue to the next level of the review process. The notice you get will tell you what to do for a Level 4 Appeal.

Level 4 Appeal

The Medicare Appeals Council (Council) reviews your appeal and gives you an answer. The Council is part of the federal government.

If the Council says **Yes** to your Level 4 Appeal or denies our request to review a Level 3 Appeal decision favorable to you, we have the right to appeal to Level 5.

- If we decide **to appeal** the decision, we'll tell you in writing.
- If we decide **not to appeal** the decision, we must authorize or provide you with the service within 60 calendar days after getting the Council's decision.

If the Council says **No** or denies our review request, the appeals process may not be over.

- If you decide **to accept** this decision that turns down your appeal, the appeals process is over.
- If you decide **not to accept** this decision that turns down your appeal, you may be able to continue to the next level of the review process. The notice you get will tell you if you can go on to a Level 5 Appeal and what to do.

Level 5 Appeal

- A Federal District Court judge will review your appeal and all of the information and decide **Yes** or **No**. This is the final decision. There are no other appeal levels beyond the Federal District Court.

J2. Additional Medical Assistance appeals

You also have other appeal rights if your appeal is about services or items that Medical Assistance usually covers. The letter you get from the State Appeal office will tell you what to do if you want to continue the appeals process.

If you disagree with the ruling from the State Appeal process, you may appeal to the District Court in your county by calling the county clerk. You have 30 days to file an appeal with District Court.

If you need help at any stage of the process, you can call the Ombudsperson for Public Managed Health Care Programs at 651-431-2660 or 1-800-657-3729 or TTY MN Relay 711 or use your preferred relay service.

J3. Appeal Levels 3, 4 and 5 for Medicare Part D Drug Requests

This section may be right for you if you made a Level 1 Appeal and a Level 2 Appeal, and both of your appeals were turned down.

If the value of the drug you appealed meets a certain dollar amount, you may be able to go on to additional levels of appeal. The written response you get to your Level 2 Appeal explains who to contact and what to do to ask for a Level 3 Appeal.

Level 3 Appeal

Level 3 of the appeals process is an ALJ hearing. The person who makes the decision is an ALJ or an attorney adjudicator who works for the federal government.

If the ALJ or attorney adjudicator says **Yes** to your appeal**:**

- The appeals process is over.
- We must authorize or provide the approved drug coverage within 72 hours (or 24 hours for an expedited appeal) or make payment no later than 30 calendar days after we get the decision.

If the ALJ or attorney adjudicator says **No** to your appeal or if the Council denies the review request, the appeals process may not be over.

- If you decide to **accept** the decision that turns down your appeal, the appeals process is over.
- If you decide **not to accept** this decision that turns down your appeal, you can continue to the next level of the review process. The notice you get will tell you what to do for a Level 4 Appeal.

Level 4 Appeal

The Council reviews your appeal and gives you an answer. The Council is part of the federal government.

If the Council says **Yes** to your appeal:

- The appeals process is over.
- We must authorize or provide the approved drug coverage within 72 hours (or 24 hours for an expedited appeal) or make payment no later than 30 calendar days after we get the decision.

If the Council says **No** to your appeal, the appeals process may not be over.

- If you decide **to accept** this decision that turns down your appeal, the appeals process is over.

- If you decide **not to accept** this decision that turns down your appeal, you may be able to continue to the next level of the review process. The notice you get will tell you if you can go on to a Level 5 Appeal and what to do.

Level 5 Appeal

A Federal District Court judge will review your appeal and all of the information and decide **Yes** or **No**. This is the final decision. There are no other appeal levels beyond the Federal District Court.

K. How to make a complaint

K1. What kinds of problems should be complaints

The complaint process is used for certain types of problems only, such as problems about quality of care, waiting times, coordination of care, and customer service. Here are examples of the kinds of problems handled by the complaint process.

Complaint	Example
Quality of your medical care	• You're unhappy with the quality of care, such as the care you got in the hospital.
Respecting your privacy	• Your think that someone didn't respect your right to privacy or shared confidential information about you.
Disrespect, poor customer service, or other negative behaviors	• A health care provider or staff was rude or disrespectful to you. • Our staff treated you poorly. • You think you're being pushed out of our plan.
Accessibility and language assistance	• You can't physically access the health care services and facilities in a doctor or provider's office.

	• Your doctor or provider doesn't provide an interpreter for the non-English language you speak (such as American Sign Language or Spanish). • Your provider doesn't give you other reasonable accommodations you need and ask for.
Waiting times	• You have trouble getting an appointment or wait too long to get it. • Doctors, pharmacists, or other health professionals, Customer Service, or other plan staff keep you waiting too long.
Cleanliness	• You think the clinic, hospital or doctor's office isn't clean.
Information you get from us	• You think we failed to give you a notice or letter that you should have received. • You think written information we sent you is too difficult to understand.
Timeliness related to coverage decisions or appeals	• You think we don't meet our deadlines for making a coverage decision or answering your appeal. • You think that, after getting a coverage or appeal decision in your favor, we don't meet the deadlines for approving or giving you the service or paying you back for certain medical services. • You don't think we sent your case to the IRO on time.

There are different kinds of complaints. You can make an internal complaint and/or an external complaint. An internal complaint is filed with and reviewed by our plan. An external complaint is filed with and reviewed by an organization not affiliated with our plan. If you need help making an internal and/or external complaint, you can call the Ombudsperson for Public Managed Health Care Programs at 1-651-431-2660 or 1-800-657-3729; TTY MN Relay 711 (use your preferred relay service) or call UCare's Customer Service at 612-676-3310 or 1-855-260-9707 (this call is free) TTY 612-676-6810 or 1-800-688-2534 (this call is free).

The legal term for a "complaint" is a "**grievance**."
The legal term for "making a complaint" is "**filing a grievance**."

K2. Internal complaints

To make an internal complaint, call Customer Service at 612-676-3310 or 1-855-260-9707 (this call is free) TTY 612-676-6810 or 1-800-688-2534 (this call is free). You can make the complaint at any time unless it's about a Medicare Part D drug. If the complaint is about a Medicare Part D drug, you must make it **within 60 calendar days** after you had the problem you want to complain about.

- If there's anything else you need to do, Customer Service will tell you.
- You can also write your complaint and send it to us. If you put your complaint in writing, we'll respond to your complaint in writing.
- Our complaint procedure includes both oral and written complaint processes as described below.

Oral complaint

- If we are not able to resolve your oral complaint right away over the phone, we will look into your complaint and give you a response as quickly as your situation requires based on your health status, but **no later than 10 calendar days** from the date you called us.
- We will call and tell you what we can do about your complaint or tell you our decision. If you request a written response to your oral complaint, we will respond in writing to you.
- We may extend the timeframe for resolving your oral complaint by an additional **14 calendar days** if you request the extension or if we justify a need for additional information and the delay is in your best interest. If we extend the deadline, we must immediately notify you verbally and in writing of the reasons(s) for the delay.

- If we cannot resolve your oral complaint over the phone, or if you do not agree or are dissatisfied with our response, we have a formal procedure for you to file a written complaint.

Written complaint

- You can write us about your complaint. Mail your written complaint letter to:

  Appeals and Grievances
  UCare
  PO Box 52
  Minneapolis, MN 55440-0052
  Or **email** us at cag@ucare.org

- If you prefer to deliver your written complaint to us, our street address is:

  500 Stinson Blvd. NE
  Minneapolis, MN 55413-2615

- You can also fax your written complaint to us at 612-884-2021 or 1-866-283-8015
- We can help you put your complaint in writing. If you need help, call Customer Service at the phone numbers at the bottom of this page.
- We will notify you **within ten (10) calendar days** that we have received your written complaint.
- **Within 30 days** we will send you a letter about our findings or decision.
- We may extend the timeframe for resolving your written complaint by an additional **14 calendar days** if you request the extension or if we justify a need for additional information and the delay is in your best interest. If we extend the deadline, we must immediately notify you verbally and in writing of the reason(s) for the delay.
- If your grievance is about our denial of an expedited reconsideration, organization determination, or coverage determination, we'll give you a decision **within 24 hours**.

The legal term for "fast complaint" is "**expedited grievance.**"

If possible, we 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'll do that.

- We answer most complaints within 30 calendar days. If we don't make a decision within 30 calendar days because we need more information, we will notify you in writing. We also provide a status update and estimated time for you to get the answer.
- If you make a complaint because we denied your request for a "fast coverage decision" or a "fast appeal," we automatically give you a "fast complaint" and respond to your complaint within 24 hours.
- If you make the complaint because we took extra time to make a coverage decision or appeal, we automatically give you a "fast complaint" and respond to your complaint within 24 hours.

If we don't agree with some or all of your complaint, we'll tell you and give you our reasons. We respond whether we agree with the complaint or not.

K3. External complaints

Medicare

You can tell Medicare about your complaint or send it to Medicare. The Medicare Complaint Form is available at: www.medicare.gov/MedicareComplaintForm/home.aspx. You do not need to file a complaint with UCare Connect + Medicare before filing a complaint with Medicare.

Medicare takes your complaints seriously and uses this information to help improve the quality of the Medicare program.

If you have any other feedback or concerns, or if you feel the health plan isn't addressing your problem, you can also call 1-800-MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048. The call is free.

You can tell the Minnesota Department of Health about your complaint

Managed Care Section
PO Box 64975
St. Paul, MN 55164-0975
Phone: 651-201-5100 or 1-800-657-3916, TTY 711

You can also make a complaint at
https://www.health.state.mn.us/facilities/insurance/clearinghouse/complaints.html

Office for Civil Rights (OCR)

You can make a complaint to the Department of Health and Human Services (HHS) OCR if you think you haven't been treated fairly. For example, you can make a complaint about disability access or language assistance. The phone number for the OCR is 1-800-368-1019. TTY users should call 1-800-537-7697. You can also visit www.hhs.gov/ocr for more information.

You may also contact the local OCR office at:

Office of Civil Rights, Midwest Region
233 N. Michigan Ave., Suite 240
Chicago, IL 60601
Call 1-800-368-1019 or fax 1-202-619-3818
Or email ocrmail@hhs.gov

You may also have rights under the Americans with Disability Act (ADA). You can call the Ombudsperson for Public Managed Health Care Programs for assistance. The phone number is 651-431-2660 or 1-800-657-3729 or TTY MN Relay 711.

QIO

When your complaint is about quality of care, you have two choices:

- You can make your complaint about the quality of care directly to the QIO.
- You can make your complaint to the QIO and to our plan. If you make a complaint to the QIO, we work with them to resolve your complaint.

The QIO 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 learn more about the QIO, refer to **Section H2** of this chapter, or **Chapter 2** of this *Member Handbook*.

In Minnesota, the QIO is called Commence Health. The phone number for Commence Health is 1-888-524-9900 (TTY: 1-888-985-8775).

Chapter 10: Ending your membership in the plan

Introduction

This chapter explains how you can end your membership with our plan and your health coverage options after you leave our plan. If you leave our plan, you'll still be in the Medicare and Medical Assistance programs as long as you're eligible. Key terms and their definitions appear in alphabetical order in the last chapter of this *Member Handbook*.

Table of Contents

A. When you can end your membership in our plan

Most people with Medicare can end their membership during certain times of the year. Since you have Medical Assistance, you have some choices to end your membership with our plan any month of the year.

In addition, you may end your membership in our plan during the following periods each year:

- The **Open Enrollment Period**, which lasts from October 15 to December 7. If you choose a new plan during this period, your membership in our plan ends on December 31 and your membership in the new plan starts on January 1.
- The **Medicare Advantage (MA) Open Enrollment Period**, which lasts from January 1 to March 31 and also for new Medicare beneficiaries who are enrolled in a plan, from the month of entitlement to Part A and Part B until the last day of the third month of entitlement. If you choose a new plan during this period, your membership in the new plan starts the first day of the next month.

There may be other situations when you're eligible to make a change to your enrollment. For example, when:

- you move out of our service area,
- your eligibility for Medical Assistance or Extra Help changed, **or**
- if you recently moved into, currently are getting care in, or just moved out of a nursing facility or a long-term care hospital.

Your membership ends on the last day of the month that we get your request to change your plan. For example, if we get your request on January 18, your coverage with our plan ends on January 31. Your new coverage begins the first day of the next month (February 1, in this example).

If you leave our plan, you can get information about your:

- Medicare options in the table in **Section C1** of this chapter.
- Medical Assistance services in **Section C2** of this chapter.

You can get more information about how you can end your membership by calling:

- Customer Service at the number at the bottom of this page. The number for TTY users is listed too.

- Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.
- The State Health Insurance Assistance Program (SHIP) at 1-800-333-2433. TTY MN Relay 711 users should call 711 or use your preferred relay service. These calls are free. In Minnesota, the SHIP is called the Senior LinkAge Line®.

NOTE**:** If you are in a drug management program (DMP), you may not be able to change plans. Refer to **Chapter 5** of this *Member Handbook* for information about drug management programs.

B. How to end your membership in our plan

If you decide to end your membership, you can enroll in another Medicare plan or switch to Original Medicare. However, if you want to switch from our plan to Original Medicare but you haven't selected a separate Medicare 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 Service at the number at the bottom of this page if you need more information on how to do this.
- Call Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users (people who have difficulty with hearing or speaking) should call 1-877-486-2048. When you call 1-800-MEDICARE, you can also enroll in another Medicare health or drug plan. More information on getting your Medicare services when you leave our plan is in the chart in **Section C**.
- **Section C** below includes steps that you can take to enroll in a different plan, which will also end your membership in our plan.

C. How to get Medicare and Medical Assistance services separately

You have choices about getting your Medicare and Medical Assistance services if you choose to leave our plan.

C1. Your Medicare services

You have three options for getting your Medicare services listed below any month of the year. You have an additional option listed below during certain times of the year including the **Open Enrollment Period** and the **Medicare Advantage Open Enrollment Period** or other situations

described in **Section A**. By choosing one of these options, you automatically end your membership in our plan.

1. You can change to: **Another plan that provides your Medicare and most or all of your Medical Assistance benefits and services in one plan, also known as an integrated dual-eligible special needs plan (D-SNP)**	**Here is what to do:** Call Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048. If you need help or more information: • Call the State Health Insurance Assistance Program (SHIP) at 1-800-333-2433 (TTY MN Relay 711 users call 711 or use your preferred relay service). In Minnesota, the SHIP is called the Senior LinkAge Line®. These calls are free. **OR** Enroll in a new integrated D-SNP. You'll automatically be disenrolled from our plan when your new plan's coverage begins.
2. You can change to: **Original Medicare with a separate Medicare drug plan**	**Here is what to do:** Call Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048. If you need help or more information: • Call the State Health Insurance Assistance Program (SHIP) at 1-800-333-2433 (TTY MN Relay 711 users call 711 or use your preferred relay service). In Minnesota, the SHIP is called the Senior LinkAge Line®. These calls are free.

	OR Enroll in a new Medicare drug plan. You'll automatically be disenrolled from our plan when your Original Medicare coverage begins. If you choose to leave our plan, your Medical Assistance will be provided fee-for-service. You can re-enroll in the non-integrated SNBC plan you were enrolled in before UCare Connect + Medicare by filling out a new enrollment form.
3. You can change to: **Original Medicare without a separate Medicare drug plan** **NOTE:** If you switch to Original Medicare and don't enroll in a separate Medicare drug plan, Medicare may enroll you in a drug plan, unless you tell Medicare you don't want to join. You should only drop drug coverage if you have drug coverage from another source, such as an employer or union. If you have questions about whether you need drug coverage, call the Senior LinkAge Line® at 1-800-333-2433 (TTY MN Relay 711 users call 711 or use your preferred relay service). Monday through Friday from 8:00 a.m. to 5:00 p.m. For more information or to find a local office in your area, please visit mn.gov/senior-linkage-line.	**Here is what to do:** Call Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048. If you need help or more information: • Call the State Health Insurance Assistance Program (SHIP) at 1-800-333-2433 (TTY MN Relay 711 users call 711 or use your preferred relay service). In Minnesota, the SHIP is called the Senior LinkAge Line®. These calls are free. You can also visit mn.gov/senior-linkage-line/. You'll automatically be disenrolled from our plan when your Original Medicare coverage begins. If you choose to leave our plan, your Medical Assistance will be provided fee-for-service. You can re-enroll in the non-integrated SNBC plan you were enrolled in before UCare Connect +

	Medicare by filling out a new enrollment form.
4. **You can change to:** **Any Medicare health plan** during certain times of the year including the **Open Enrollment Period** and the **Medicare Advantage Open Enrollment Period** or other situations described in **Section A.**	**Here is what to do:** Call Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048. If you need help or more information: • Call the State Health Insurance Assistance Program (SHIP) at 1-800-333-2433 (TTY MN Relay 711 users call 711 or use your preferred relay service). In Minnesota, the SHIP is called the Senior LinkAge Line®. These calls are free. **OR** Enroll in a new Medicare plan. You'll automatically be disenrolled from our Medicare plan when your new plan's coverage begins. If you choose to leave our plan, your Medical Assistance will be provided fee-for-service. You can re-enroll in the non-integrated SNBC plan you were enrolled in before UCare Connect + Medicare by filling out a new enrollment form.

C2. Your Medical Assistance services

If you choose to leave our plan, your Medical Assistance will be provided fee-for-service. You can re-enroll in the non-integrated SNBC plan you were enrolled in before UCare Connect + Medicare enrollment by filling out a new enrollment form.

D. Your medical items, services and drugs until your membership in our plan ends

If you leave our plan, it may take time before your membership ends and your new Medicare and Medical Assistance coverage begins. During this time, you keep getting your drugs and health care through our plan until your new plan begins.

- Use our network providers to receive medical care.
- Use our network pharmacies including through our mail-order pharmacy services to get your prescriptions filled.
- If you're hospitalized on the day that your membership in our plan ends, UCare Connect + Medicare will cover your hospital stay until you're discharged. This will happen even if your new health coverage begins before you're discharged.

E. Other situations when your membership in our plan ends

These are cases when we must end your membership in our plan:

- If there's a break in your Medicare Part A and Medicare Part B coverage.
- If you no longer qualify for Medical Assistance. Our plan is for people who qualify for both Medicare and Medical Assistance.
- If you no longer meet the age requirements.
- If you move out of our service area.
- If you're away from our service area for more than six months
  - If you move or take a long trip, call Customer Service to find out if where you're moving or traveling to is in our plan's service area.
- If you go to jail or prison for a criminal offense.
- If you lie about or withhold information about other insurance you have for drugs.
- If you're not a United States citizen or aren't lawfully present in the United States.
  - You must be a United States citizen or lawfully present in the United States to be a member of our plan.

- The Centers for Medicare & Medicaid Services (CMS) notify us if you're not eligible to remain a member on this basis.
- We must disenroll you if you don't meet this requirement.

If you lose eligibility but can be expected to regain it within three months then you are still eligible for our plan. For a three-month period of deemed continued eligibility, we will continue to provide all covered Medicare and Medical Assistance benefits. During this period, you should not experience a change in the amount you pay or the services you receive.

We can make you leave our plan for the following reasons only if we get permission from Medicare and Medical Assistance first:

- If you intentionally give us incorrect information when you're enrolling in our plan and that information affects your eligibility for our plan.
- If you continuously behave in a way that's disruptive and makes it difficult for us to provide medical care for you and other members of our plan.
- If you let someone else use your Member ID Card to get medical care. (Medicare may ask the Inspector General to investigate your case if we end your membership for this reason.)

F. Rules against asking you to leave our plan for any health-related reason

We can't ask you to leave our plan for any reason related to your health. If you think we're asking you to leave our plan for a health-related reason, **call Medicare** at 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

G. Your right to make a complaint if we end your membership in our plan

If we end your membership in our plan, we must tell you our reasons in writing for ending your membership. We must also explain how you can file a grievance or make a complaint about our decision to end your membership. You can also refer to **Chapter 9** of this *Member Handbook* for information about how to make a complaint.

H. How to get more information about ending your plan membership

If you have questions or would like more information on ending your membership, you can call Customer Service at the number at the bottom of this page.

Chapter 11: Legal Notices

Introduction

This chapter includes legal notices that apply to your membership in our plan. Key terms and their definitions appear in alphabetical order in the last chapter of this *Member Handbook*.

Table of Contents

A. Notice about laws

Many laws apply to this *Member Handbook*. These laws may affect your rights and responsibilities even if the laws aren't included or explained in this *Member Handbook*. The main laws that apply are federal laws about the Medicare and Medical Assistance programs. Other federal and state laws may apply too.

B. Federal Notice about nondiscrimination

We don't discriminate or treat you differently because of your race, ethnicity, national origin, color, religion, sex, age, mental or physical disability, health status, claims experience, medical history, genetic information, evidence of insurability, or geographic location within the service area. All organizations that provide Medicare Advantage plans, like our plan, must obey federal laws against discrimination, including Title VI of the Civil Rights Act of 1964, the Rehabilitation Act of 1973, the Age Discrimination Act of 1975, the Americans with Disabilities Act, Section 1557 of the Affordable Care Act, all other laws that apply to organizations that get federal funding, and any other laws and rules that apply for any other reason.

If you want more information or have concerns about discrimination or unfair treatment:

- Call the Department of Health and Human Services, Office for Civil Rights at 1-800-368-1019. TTY users can call 1-800-537-7697. You can also visit www.hhs.gov/ocr for more information.

C. State Notice about nondiscrimination

According to state human rights laws we don't discriminate or treat you differently because of your race, color, national origin, creed, religion, sexual orientation, public assistance status, age, physical or mental disability, sex (including sex stereotypes and gender identity), marital status, political beliefs, medical condition, health status, receipt of health care services, claims experience, medical history or genetic information.

If you want more information or have concerns about discrimination or unfair treatment:

- Call your local Office for Civil Rights Midwest Region, at 233 N. Michigan Ave., Suite 240, Chicago, IL 60601. You can also call the toll-free numbers above, fax 1-202-619-3818, or email ocrmail@hhs.gov.

- If you have a disability and need help accessing health care services or a provider, call Customer Service. If you have a complaint, such as a problem with wheelchair access, Customer Service can help.

D. Notice about Medicare as a second payer and Medical Assistance as a payer of last resort

Sometimes someone else must pay first for the services we provide you. For example, if you're in a car accident or if you're injured at work, insurance or Workers Compensation must pay first.

We have the right and responsibility to collect for covered Medicare services for which Medicare isn't the first payer.

We comply with federal and state laws and regulations relating to the legal liability of third parties for health care services to members. We take all reasonable measures to ensure that Medical Assistance is the payer of last resort.

Chapter 12: Definitions of important words

Introduction

This chapter includes key terms used throughout this *Member Handbook* with their definitions. The terms are listed in alphabetical order. If you can't find a term you're looking for or if you need more information than a definition includes, contact Customer Service.

Actions: These include:

- Denial or limited authorization of type or level of service
- Reduction, suspension, or stopping of a service that was approved before
- Denial of all or part of a payment or service
- Not providing services in a reasonable amount of time
- Not acting within required time frames for grievances or appeals
- Denial of member's request to get services out of network for members living in a rural area with only one health plan

Activities of daily living (ADL): The things people do on a normal day, such as eating, using the toilet, getting dressed, bathing, or brushing teeth.

Administrative law judge (ALJ): A judge that reviews a level 3 appeal.

AIDS drug assistance program (ADAP): A program that helps eligible individuals living with HIV/AIDS have access to life-saving HIV medications.

Ambulatory surgical center: A facility that provides outpatient surgery to patients who don't need hospital care and who aren't expected to need more than 24 hours of care.

Appeal: A way for you to challenge our action if you think we made a mistake. You can ask us to change a coverage decision by filing an appeal. **Chapter 9** of this *Member Handbook* explains appeals, including how to make an appeal.

Behavioral Health: An all-inclusive term referring to mental health and substance use disorders.

Biological Product: A drug that's made from natural and living sources like animal cells, plant cells, bacteria, or yeast. Biological products are more complex than other drugs and can't be copied exactly, so alternative forms are called biosimilars (Also refer to "Original Biological Product" and "Biosimilar").

Biosimilar: A biological product that's very similar, but not identical, to the original biological product. Biosimilars are as safe and effective as the original biological product. Some biosimilars may be substituted for the original biological product at the pharmacy without needing a new prescription (Refer to "Interchangeable Biosimilar").

Benefit Period: The way that both our plan and Original Medicare measures your use of hospital and skilled nursing facility (SNF) services. A benefit period begins the day you go into a hospital or skilled nursing facility. The benefit period ends when you haven't received any inpatient hospital care (or skilled care in a SNF) for 60 days in a row. If you go into a hospital or a skilled nursing facility after one benefit period has ended, a new benefit period begins. There is no limit to the number of benefit periods.

Brand name drug: A drug that's made and sold by the company that originally made the drug. Brand name drugs have the same ingredients as the generic versions of the drugs. Generic drugs are usually made and sold by other drug companies and are generally not available until the patent on the brand name drug has ended.

Care coordinator: One main person who works with you, with the health plan, and with your care providers to make sure you get the care you need.

Care team: Refer to "Interdisciplinary Care Team."

Catastrophic coverage stage: The stage in the Medicare Part D drug benefit where our plan pays all costs of your drugs until the end of the year. You begin this stage when you (or other qualified parties on your behalf) have spent $2,100 for Part D covered drugs during the year. You pay nothing.

Centers for Medicare & Medicaid Services (CMS): The federal agency in charge of Medicare. **Chapter 2** Section E of this *Member Handbook* explains how to contact CMS.

Clinical Trial: A qualified medical study test that is: subject to a defined peer review; sponsored by a clinical research program that meets federal and state rules and approved standards; and whose true results are reported.

Complaint: A written or spoken statement saying that you have a problem or concern about your covered services or care. This includes any concerns about the quality of service, quality of your care, our network providers, or our network pharmacies. The formal name for "making a complaint" is "filing a grievance".

Comprehensive outpatient rehabilitation facility (CORF): A facility that mainly provides rehabilitation services after an illness, accident, or major operation. It provides a variety of services, including physical therapy, social or psychological services, respiratory therapy, occupational therapy, speech therapy, and home environment evaluation services.

Copay: A fixed amount you pay as your share of the cost each time you get certain drugs. For example, you might pay $2 or $5 for a drug.

Cost sharing: Amounts you have to pay when you get certain drugs. Cost sharing includes copays.

Cost-sharing tier: A group of drugs with the same copay. Every drug on the *List of Covered Drugs* (also known as the *Drug List*) is in a cost-sharing tier.

Coverage decision: A decision about what benefits we cover. This includes decisions about covered drugs and services or the amount we pay for your health services. **Chapter 9** of this *Member Handbook* explains how to ask us for a coverage decision.

Covered drugs: The term we use to mean all of the prescription and over-the-counter (OTC) drugs covered by our plan.

Covered services: The general term we use to mean all the health care, long-term services and supports, supplies, prescription and over-the-counter drugs, equipment, and other services our plan covers.

Cultural competence training: Training that provides additional instruction for our health care providers that helps them better understand your background, values, and beliefs to adapt services to meet your social, cultural, and language needs.

Customer Service: A department in our plan responsible for answering your questions about membership, benefits, grievances, and appeals. Refer to **Chapter 2** of this *Member Handbook* for more information about Customer Service.

Daily cost-sharing rate: A rate that may apply when your doctor prescribes less than a full month's supply of certain drugs for you and you're required to pay a copay. A daily cost-sharing rate is the copay divided by the number of days in a month's supply.

Here's an example: Let's say the copay for your drug for a full month's supply (a 30-day supply) is $1.35. This means that the amount you pay for your drug is less than $0.05 per day. If you get a 7 day supply of the drug, your payment is less than $0.05 per day multiplied by 7 days, for a total payment less than $0.35.

Direct access services: You can use any provider in our plan's network to get these services. You don't need a referral or prior authorization before getting services.

Disenrollment: The process of ending your membership in our plan. Disenrollment may be voluntary (your own choice) or involuntary (not your own choice).

Drug management program (DMP): A program that helps make sure members safely use prescription opioids and other frequently abused medications.

Drug tiers: Groups of drugs on our *Drug List*. Generic, brand name, or over-the-counter (OTC) drugs are examples of drug tiers. Every drug on the *Drug List* is in a tier.

Dual eligible individual: A person who qualifies for Medicare and Medical Assistance coverage.

Dual eligible special needs plan (D-SNP): Health plan that serves individuals who are eligible for both Medicare and Medical Assistance. Our plan is a D-SNP.

Durable medical equipment (DME): Certain items your doctor orders for use in your own home. Examples of these items are 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 and supplies, nebulizers, and walkers.

Emergency: A medical emergency when you, or any other person with an average knowledge of health and medicine, believe that you have medical symptoms that need immediate medical attention to prevent death, loss of or serious impairment to a bodily function (and if you're a pregnant woman, loss of an unborn child). The medical symptoms may be an illness, injury, severe pain, or a medical condition that's quickly getting worse.

Emergency care: Covered services given by a provider trained to give emergency services and needed to treat a medical or behavioral health emergency.

Emergency medical transportation: Ambulance services, including ground and air transportation for an emergency medical condition.

Exception: Permission to get coverage for a drug not normally covered or to use the drug without certain rules and limitations.

Excluded services: Services that aren't covered by this health plan.

External Quality Review Study: A study about how quality, timeliness and access of care are provided by UCare Connect + Medicare. This study is external and independent.

Extra Help: Medicare program that helps people with limited incomes and resources reduce Medicare Part D drug costs, such as premiums, deductibles, and copays. Extra Help is also called the “Low-income subsidy,” or “LIS".

E-visit: Secure, encrypted web access via remote technology, providing online exchange of non-urgent medical information between a health care provider and an established patient.

E-visits follow established medical protocols and the prescribing and/or treatment recommendations follow state laws and are within the provider's scope of practice.

Family planning: Information, services and supplies to help a person decide about having children. These decisions include choosing to have a child, when to have a child or not to have a child.

Generic drug: A drug approved by the FDA to use in place of a brand name drug. A generic drug has the same ingredients as a brand name drug. It's usually cheaper and works just as well as the brand name drug.

Grievance: A complaint you make about us or one of our network providers or pharmacies. This includes a complaint about the quality of your care or the quality of service provided by your health plan.

Health plan: An organization made up of doctors, hospitals, pharmacies, providers of long-term services, and other providers. It also has care coordinators to help you manage all your providers and services. All of them work together to provide the care you need.

Health risk assessment (HRA): A review of your medical history and current condition. It's used to learn about your health and how it might change in the future.

Home and Community-Based Services (HCBS): Additional services that are provided to help you remain in your home.

Home health aide: A person who provides services that don't need the skills of a licensed nurse or therapist, such as help with personal care (like bathing, using the toilet, dressing, or carrying out the prescribed exercises). Home health aides don't have a nursing license or provide therapy.

Home health care: Health care services for an illness or injury given in your home or in the community where normal life activities take the member.

Housing stabilization services: Services to help people with disabilities, including mental illness and substance use disorder, and seniors find and keep housing. The purpose of these services is to support a person's transition into housing, increase long-term stability in housing in the community, and avoid future periods of homelessness or institutionalization.

Hospice: A program of care and support to help people who have a terminal prognosis live comfortably. A terminal prognosis means that a person has been medically certified as terminally ill, meaning having a life expectancy of 6 months or less.

- An enrollee who has a terminal prognosis has the right to elect hospice.

- A specially trained team of professionals and caregivers provide care for the whole person, including physical, emotional, social, and spiritual needs.
- We're required to give you a list of hospice providers in your geographic area.

Hospital inpatient care/Hospitalization: Care in a hospital that requires admission as an inpatient and usually requires an overnight stay. An overnight stay for observation could be outpatient care.

Hospital outpatient care: Care in a hospital that usually doesn't require an overnight stay. An overnight stay for observation could be outpatient care.

Improper/inappropriate billing: A situation when a provider (such as a doctor or hospital) bills you more than our cost-sharing amount for services. Call Customer Service if you get any bills you don't understand.

As a plan member, you only pay our plan's cost-sharing amounts when you get services we cover. We don't allow providers to bill you more than this amount.

Independent review organization (IRO): An independent organization hired by Medicare that reviews a level 2 appeal. It isn't connected with us and isn't a government agency. This organization decides whether the decision we made is correct or if it should be changed. Medicare oversees its work. The formal name is the **Independent Review Entity.**

Individualized Support Plan: A plan for what services you'll get and how you'll get them. Your plan may include medical services, behavioral health services, and long-term services and supports.

Initial coverage stage: The stage before your total Medicare Part D drug expenses reach $2,100. This includes amounts you paid, what our plan paid on your behalf, and the low-income subsidy. You begin in this stage when you fill your first prescription of the year. During this stage, we pay part of the costs of your drugs, and you pay your share.

Inpatient: A term used when you're formally admitted to the hospital for skilled medical services. If you're not formally admitted, you may still be considered an outpatient instead of an inpatient even if you stay overnight.

Integrated D-SNP: A dual-eligible special needs plan that covers Medicare and most or all Medicaid services under a single health plan for certain groups of individuals eligible for both Medicare and Medicaid. These individuals are known as full-benefit dually eligible individuals.

Interchangeable Biosimilar: A biosimilar that may be substituted at the pharmacy without needing a new prescription because it meets additional requirements about the potential for automatic substitution. Automatic substitution at the pharmacy is subject to state law.

Interdisciplinary Care Team (ICT or Care team): A care team may include doctors, nurses, counselors, or other health professionals who are there to help you get the care you need. Your care team also helps you make a support plan.

***List of Covered Drugs* (*Drug List*):** A list of prescription and over-the-counter (OTC) drugs we cover. We choose the drugs on this list with the help of doctors and pharmacists. The *Drug List* tells you if there are any rules you need to follow to get your drugs. The *Drug List* is sometimes called a "formulary".

Long-term services and supports (LTSS): Long-term services and supports help improve a long-term medical condition. Most of these services help you stay in your home so you don't have to go to a nursing facility or hospital. LTSS include Community-Based Services and Nursing Facilities (NF).

Low-income subsidy (LIS): Refer to "Extra Help"

Medically Accepted Indication: A use of a drug that is either approved by the Food and Drug Administration or supported by certain reference books.

Medicaid (or Medical Assistance): A program run by the federal government and the state that helps people with limited incomes and resources pay for long-term services and supports and medical costs.

Medical Assistance: This is the name of Minnesota's Medicaid program. Medical Assistance is run by the state and is paid for by the state and the federal government. It helps people with limited incomes and resources pay for long-term services and supports and medical costs.

- It covers extra services and some drugs not covered by Medicare.
- Medicaid programs vary from state to state, but most health care costs are covered if you qualify for both Medicare and Medicaid.

Medically necessary: This describes services, supplies, or drugs you need to prevent, diagnose, or treat a medical condition or to maintain your current health status. This includes care that keeps you from going into a hospital or nursing facility. It also means the services, supplies, or drugs meet accepted standards of medical practice. Medically necessary care is appropriate for your condition. This includes care related to physical conditions and mental health. It includes the kind and level of services. It includes the number of treatments. It also includes where you get the services and how long they continue. Medically necessary services must:

- be the services that other providers would usually order.
- help you get better or stay as well as you are.
- help stop your condition from getting worse.
- help prevent and find health problems.

Medicare: The federal health insurance program for people 65 years of age or older, some people under age 65 with certain disabilities, and people with end-stage renal disease (generally those with permanent kidney failure who need dialysis or a kidney transplant). People with Medicare can get their Medicare health coverage through Original Medicare or a managed support plan (refer to "Health plan")

Medicare Advantage: A Medicare program, also known as "Medicare Part C" or "MA" that offers MA plans through private companies. Medicare pays these companies to cover your Medicare benefits.

Medicare Appeals Council (Council): A council that reviews a level 4 appeal. The Council is part of the Federal government.

Medicare-covered services: Services covered by Medicare Part A and Medicare Part B. All Medicare health plans, including our plan, must cover all the services covered by Medicare Part A and Medicare Part B.

Medicare diabetes prevention program (MDPP): A structured health behavior change program that provides training in long-term dietary change, increased physical activity, and strategies for overcoming challenges to sustaining weight loss and a healthy lifestyle.

Medicare Part A: The Medicare program that covers most medically necessary hospital, skilled nursing facility, home health, and hospice care.

Medicare Part B: The Medicare program that covers services (such as lab tests, surgeries, and doctor visits) and supplies (such as wheelchairs and walkers) that are medically necessary to treat a disease or condition. Medicare Part B also covers many preventive and screening services.

Medicare Part C: The Medicare program, also known as "Medicare Advantage" or "MA" that lets private health insurance companies provide Medicare benefits through an MA Plan.

Medicare Part D: The Medicare drug benefit program. We call this program "Part D" for short. Medicare Part D covers outpatient drugs, vaccines, and some supplies not covered by Medicare Part A or Medicare Part B or Medicaid. Our plan includes Medicare Part D.

Medicare Part D drugs: Drugs covered under Medicare Part D. Congress specifically excludes certain categories of drugs from coverage under Medicare Part D. Medicaid may cover some of these drugs.

Medication Therapy Management (MTM): Medicare Part D program for complex health needs provided to people who meet certain requirements or are in a Drug Management

Program. MTM services usually include a discussion with a pharmacist or health care provider to review medications. Refer to **Chapter 5** of this *Member Handbook* for more information.

Member (member of our plan, or plan member): A person with Medicare and Medicaid who qualifies to get covered services, who has enrolled in our plan, and whose enrollment has been confirmed by the Centers for Medicare & Medicaid Services (CMS) and the state.

***Member Handbook* and Disclosure Information:** This document, along with your enrollment form and any other attachments, or riders, which explain your coverage, what we must do, your rights, and what you must do as a member of our plan.

Minnesota Senior Care Plus (MSC+): A program in which the State contracts with health plans to cover and manage health care and Elderly Waiver services for Medical Assistance enrollees age 65 and over.

Minnesota Senior Health Options (MSHO): A program in which the State and CMS contract with health plans, including our plan, to provide services only for seniors eligible for both Medicare and Medical Assistance, including those covered by MSC+.

Network pharmacy: A pharmacy (drug store) that agreed to fill prescriptions for our plan members. We call them “network pharmacies” because they agreed to work with our plan. In most cases, we cover your prescriptions only when filled at one of our network pharmacies.

Network provider: "Provider" is the general term we use for doctors, nurses, and other people who give you services and care. The term also includes hospitals, home health agencies, clinics, and other places that give you health care services, medical equipment, and long-term services and supports.

- They're licensed or certified by Medicare and by the state to provide health care services.
- We call them "network providers" when they agree to work with our health plan, accept our payment, and don't charge members an extra amount.
- While you're a member of our plan, you must use network providers to get covered services. Network providers are also called "plan providers".

Notice of Action: A form or letter we send to you telling you about a decision on a claim, a service or any other action taken by our plan. This is also called a Denial, Termination, or Reduction (DTR).

Nursing home certifiable: A decision that you need a nursing home level of care. A screener uses a process called a Long Term Care Consultation to decide.

Nursing home or facility: A place that provides care for people who can't get their care at home but don't need to be in the hospital.

Ombudsperson: An office in your state that works as an advocate on your behalf. They can answer questions if you have a problem or complaint and can help you understand what to do. The ombudsperson's services are free. You can find more information in **Chapters 2 and 9** of this *Member Handbook.*

Open access services: Federal and state law allow you to choose any qualified health care provider, clinic, hospital, pharmacy, or family planning agency — even if not in our plan's network — to get these services.

Organization determination: Our plan makes an organization determination when we, or one of our providers, decide about whether services are covered or how much you pay for covered services. Organization determinations are called "coverage decisions". **Chapter 9** of this *Member Handbook* explains coverage decisions.

Original Biological Product: A biological product that has been approved by the FDA and serves as the comparison for manufacturers making a biosimilar version. It's also called a reference product.

Original Medicare (traditional Medicare or fee-for-service Medicare): The government offers Original Medicare. Under Original Medicare, services are covered by paying doctors, hospitals, and other health care providers amounts that Congress determines.

- You can use any doctor, hospital, or other health care provider that accepts Medicare. Original Medicare has two parts: Medicare Part A (hospital insurance) and Medicare Part B (medical insurance).
- Original Medicare is available everywhere in the United States.
- If you don't want to be in our plan, you can choose Original Medicare.

Out-of-network pharmacy: A pharmacy that hasn't agreed to work with our plan to coordinate or provide covered drugs to members of our plan. Our plan doesn't cover most drugs you get from out-of-network pharmacies unless certain conditions apply.

Out-of-network provider or **Out-of-network facility:** A provider or facility that isn't employed, owned, or operated by our plan and isn't under contract to provide covered services to members of our plan. **Chapter 3** of this *Member Handbook* explains out-of-network providers or facilities.

Out-of-pocket costs: The cost-sharing requirement for members to pay for part of the drugs they get is also called the "out-of-pocket" cost requirement. Refer to the definition for "cost-sharing" above

Over-the-counter (OTC) drugs: Over-the-counter drugs are drugs or medicines that a person can buy without a prescription from a health care professional.

Palliative care: Palliative care helps people with serious illnesses feel better. It prevents or treats symptoms and side effects of disease and treatment. Palliative care also treats emotional, social, practical, and spiritual problems that illnesses can bring up. Palliative care can be given at the same time as treatments meant to cure or treat the disease. Palliative care may be given when the illness is diagnosed, throughout treatment, during follow-up, and at the end of life.

Part A: Refer to "Medicare Part A."

Part B: Refer to "Medicare Part B."

Part C: Refer to "Medicare Part C."

Part D: Refer to "Medicare Part D."

Part D drugs: Refer to "Medicare Part D drugs."

Personal health information (also called Protected health information) (PHI): Information about you and your health, such as your name, address, social security number, physician visits, and medical history. Refer to our Notice of Privacy Practices for more information about how we protect, use, and disclose your PHI, as well as your rights with respect to your PHI.

Physician services: Health care services provided or coordinated by a medical physician licensed under state law (M.D. – Medical Doctor or D.O. – Doctor of Osteopathic Medicine).

Preventive services: Health care to prevent illness or detect illness at an early stage, when treatment is likely to work best (for example, preventive services include Pap tests, flu shots, and screening mammograms).

Primary care clinic (PCC): The facility where you get most of the health care services you need, such as annual checkups, and helps coordinate your care. You may need to choose a primary care clinic when you enroll in our plan.

Primary care provider (PCP): The doctor or other provider you use first for most health problems. They make sure you get the care you need to stay healthy.

- They 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 use your primary care provider before you use any other health care provider.
- Refer to **Chapter 3** of this *Member Handbook* for information about getting care from primary care providers.

Prior authorization (PA): An approval you must get from us before you can get a specific service or drug or use an out-of-network provider. Our plan may not cover the service or drug if you don't get approval first.

Our plan covers some network medical services only if your doctor or other network provider gets PA from us.

- Covered services that need our plan's PA are marked in **Chapter 4** of this *Member Handbook*.

Our plan covers some drugs only if you get PA from us.

- Covered drugs that need our plan's PA are marked in the *List of Covered Drugs*.

Prosthetics and Orthotics: Medical devices ordered by your doctor or other health care provider that include, but aren't limited to, arm, back, and neck braces; artificial limbs; artificial eyes; and devices needed to replace an internal body part or function, including ostomy supplies and enteral and parenteral nutrition therapy.

Provider: The general term we use for doctors, nurses, and other people who give you services and care. The term also includes hospitals, home health agencies, clinics, and other places that give you health care services, medical equipment, and long-term services and supports. They're licensed or certified by Medicare and by the state to provide health care services.

Quality of care complaint: In this handbook, "quality of care complaint" means an expressed dissatisfaction about health care services resulting in potential or actual harm to a member. Complaints may be about access; provider and staff competence; clinical appropriateness or care; communications; behavior; facility and environmental considerations; and other factors that can have a negative effect on the quality of health care services.

Quality improvement organization (QIO): A group of doctors and other health care experts who help improve the quality of care for people with Medicare. The federal government pays the QIO to check and improve the care given to patients. Refer to **Chapter 2** of this *Member Handbook* for information about the QIO.

Quantity limits: A limit on the amount of a drug you can have. We may limit the amount of the drug that we cover per prescription.

Real Time Benefit Tool: A portal or computer application in which enrollees can look up complete, accurate, timely, clinically appropriate, enrollee-specific covered drugs and benefit information. This includes cost sharing amounts, alternative drugs that may be used for the same health condition as a given drug, and coverage restrictions (prior authorization, step therapy, quantity limits) that apply to alternative drugs.

Referral: A referral is your primary care provider's (PCP's) approval to use a provider other than your PCP. If you don't get approval first, we may not cover the services. You don't need a referral to use certain specialists, such as women's health specialists. You can find more information about referrals in **Chapters 3 and 4** of this *Member Handbook*.

Rehabilitation services: Treatment you get to help you recover from an illness, accident or major operation. Refer to **Chapter 4** of this *Member Handbook* to learn more about rehabilitation services.

Restricted Recipient Program: A program for members who got medical care and haven't followed the rules or have misused services. If you're in this program, you must get health services from one designated primary care provider, one clinic, one hospital used by the primary care provider, and one pharmacy. UCare may designate other health care providers. You must do this for at least 24 months of eligibility for Minnesota Health Care Programs. Members in this program who fail to follow program rules will be required to continue in the program for an additional 36 months. The restricted recipient program doesn't apply to Medicare-covered services.

Service area: A geographic area where a health plan accepts members if it limits membership based on where people live. For plans that limit which doctors and hospitals you may use, it's generally the area where you can get routine (non-emergency) services. Only people who live in our service area can enroll in our plan.

Skilled nursing facility (SNF): A nursing facility with the staff and equipment to give skilled nursing care and, in most cases, skilled rehabilitative services and other related health services.

Skilled nursing facility (SNF) care: Skilled nursing care and rehabilitation services provided on a continuous, daily basis, in a skilled nursing facility. Examples of skilled nursing facility care include physical therapy or intravenous (IV) injections that a registered nurse or a doctor can give.

Specialist: A doctor who provides health care for a specific disease or part of the body.

State Appeal: If your doctor or other provider asks for a Medical Assistance service that we won't approve, or we won't continue to pay for a Medical Assistance service you already have, you can ask for a hearing. If the hearing is decided in your favor, we must give you the service you asked for. You must ask for a hearing in writing. You may ask for a hearing if you disagree with any of the following:

- A denial, termination or reduction of service
- Enrollment in the Plan
- Denial in full or part of a claim or service
- Our failure to act within required timelines for prior authorization and appeals

- Any other action

State Medicaid agency: In Minnesota, this agency is the Minnesota Department of Human Services.

Step therapy: A coverage rule that requires you to try another drug before we cover the drug you ask for.

Supplemental Security Income (SSI): A monthly benefit Social Security pays to people with limited incomes and resources who are disabled, blind, or age 65 and over. SSI benefits aren't the same as Social Security benefits.

Support plan: Refer to "Individualized Support Plan."

Telehealth services: Interactive, real-time virtual visits that allow providers to evaluate, diagnose and treat you without an in-person office visit. They are often used for follow-up visits, to manage chronic conditions and medications, to consult with specialists, and other clinical services.

Urgently needed care: Care you get for an unforeseen illness, injury, or condition that isn't an emergency but needs care right away. You can get urgently needed care from out-of-network providers when you can't get to network providers because given your time, place, or circumstances, it's not possible, or it's unreasonable to obtain services from network providers (for example when you're outside our plan’s service area and you require medically needed immediate services for an unseen condition but it's not a medical emergency).

UCare Connect + Medicare Customer Service

Method	Customer Service
CALL	612-676-3310 or 1-855-260-9707 (this call is free) 8 am – 8 pm, seven days a week We have free interpreter services for people who don't speak English.
TTY	612-676-6810 or 1-800-688-2534 (this call is free) 8 am – 8 pm, seven days a week This number is for people who have difficulty with hearing or speaking. You must have special equipment to call it.
FAX	612-676-6501 1-866-457-7145
WRITE	**Attn: Customer Service** UCare PO Box 52 Minneapolis, MN 55440-0052
WEBSITE	**ucare.org**

? **If you have questions**, please call UCare Connect + Medicare at 612-676-3310 or 1-855-260-9707 (this call is free), TTY 612-676-6810 or 1-800-688-2534 (this call is free), 8 am – 8 pm, seven days a week. **For more information, visit ucare.org.**