January 1 – December 31, 2011

Evidence of Coverage

Your Medicare Health Benefits and Services as a Member of

UCare for Seniors Value (HMO-POS)

This booklet gives you the details about your Medicare health coverage from January 1 – December 31, 2011. It explains how to get the health care you need. This is an important legal document. Please keep it in a safe place.

UCare Customer Services:
For help or information, please call Customer Services or go to our web site at www.ucare.org
612-676-3600
1-877-523-1515 (Calls to these numbers are free.)
8 a.m. to 8 p.m. daily.
TTY users call: 612-676-6810 or 1-800-688-2534

This plan is offered by UCare Minnesota and UCare Wisconsin, Inc., referred to throughout the *Evidence of Coverage* as "UCare," "we," "us," or "our." *UCare for Seniors* Value is referred to as "plan" or "our plan."

UCare Minnesota and UCare Wisconsin, Inc. are health plans with Medicare contracts.

This information is available in a different format, including large print and audio tapes. Please call Customer Services at the number listed above if you need plan information in another format or language.

Benefits, premium, and/or copayments/coinsurance may change on January 1, 2012.

H2459_092210_5 CMS File & Use (09272010)
H4270_092210_1 CMS File & Use (09272010)

UCare

Table of Contents

This list of chapters and page numbers is just your starting point. For more help in finding information you need, go to the first page of a chapter. **You will find a detailed list of topics at the beginning of each chapter.**

Chapter 1. Getting started as a member of the plan

SECTION 1 Introduction

Section 1.1 What is the *Evidence of Coverage* booklet about?

This *Evidence of Coverage* booklet tells you how to get your Medicare medical care through our plan, a Medicare Advantage Plan. This booklet explains your rights and responsibilities, what is covered, and what you pay as a member of the plan.

- You are covered by Medicare, and you have chosen to get your Medicare health care coverage through our plan.
- There are different types of Medicare Advantage Plans. *UCare for Seniors* Value is a Medicare Advantage HMO Point-of-Service Plan (HMO stands for Health Maintenance Organization).

This plan is offered by UCare Minnesota and UCare Wisconsin, Inc., referred to throughout the *Evidence of Coverage* as "UCare," "we," "us," or "our." *UCare for Seniors* Value is referred to as "plan" or "our plan."

The word "coverage" and "covered services" refers to the medical care and services available to you as a member of the plan.

Section 1.2 What does this Chapter tell you?

Look through Chapter 1 of this *Evidence of Coverage* to learn:

- What makes you eligible to be a plan member?
- What is your plan service area?
- What materials will you get from us?
- What is your plan premium and how can you pay it?
- How do you keep the information in your membership record up to date?

Section 1.3 What if you are new to the plan?

If you are a new member, then it's important for you to learn how the plan operates – what the rules are, and what services are available to you. We encourage you to set aside some time to look through this *Evidence of Coverage* booklet.

If you are confused or concerned or just have a question, please contact Customer Services (contact information is on the cover of this booklet).

Section 1.4 Legal information about the *Evidence of Coverage*

It's part of our contract with you

This *Evidence of Coverage* is part of our contract with you about how the plan covers your care. Other parts of this contract include your enrollment form and any notices you receive from us about changes to your coverage or conditions that affect your coverage. These notices are sometimes called "riders" or "amendments."

The contract is in effect for the months in which you are enrolled in the plan between January 1, 2011 and December 31, 2011.

Medicare must approve our plan each year

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

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

Section 2.1 Your eligibility requirements

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

- You live in our geographic service area (section 2.3 below describes our service area)
- -- *and* -- you are entitled to Medicare Part A
- -- *and* -- you are enrolled in Medicare Part B
- -- *and* -- you do not have End Stage Renal Disease (ESRD), with limited exceptions, such as if you develop ESRD when you are already a member of a plan that we offer, or you were a member of a different plan that was terminated.

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

When you originally signed up for Medicare, you received information about how to get Medicare Part A and Medicare Part B. Remember:

- Medicare Part A generally covers services furnished by institutional providers such as hospitals, skilled nursing facilities, or home health agencies.
- Medicare Part B is for most other medical services, such as physician's services and other outpatient services.

Section 2.3 Here is the service area for the plan

Although Medicare is a federal program, the plan is available only to individuals who live in our plan service area. To stay a member of our plan, you must keep living in this service area. The service area is described below.

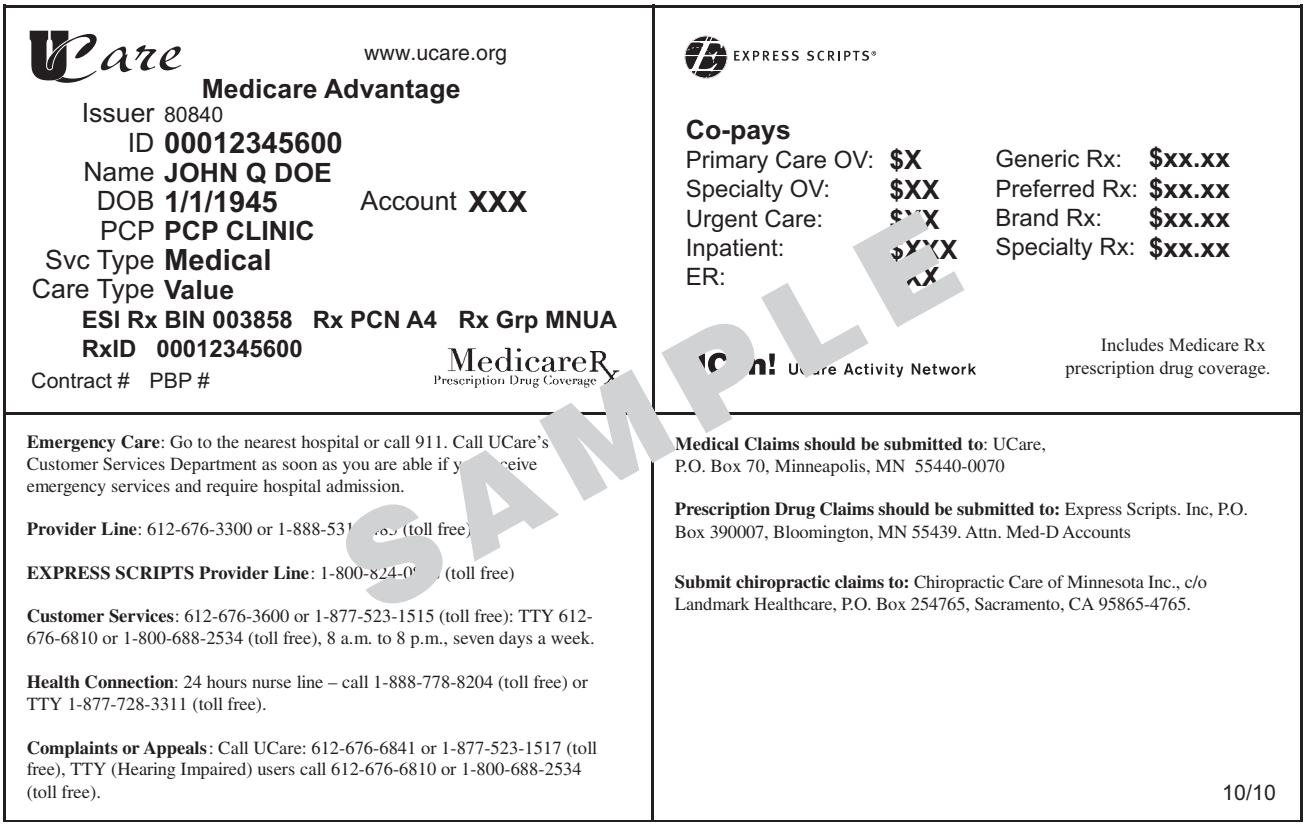
Our service area includes the State of Minnesota and the following counties in the State of Wisconsin: Ashland, Barron, Bayfield, Buffalo, Burnett, Chippewa, Crawford, Douglas, Dunn, Eau Claire, Grant, Iowa, Jackson, Juneau, La Crosse, Monroe, Pepin, Pierce, Polk, Richland, St. Croix, Sauk, Sawyer, Trempealeau, Vernon, and Washburn.

If you plan to move out of the service area, please contact Customer Services.

SECTION 3 What other materials will you get from us?

Section 3.1 Your plan membership card – Use it to get all covered medical care

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



As long as you are a member of our plan **you must <u>not</u> use your red, white, and blue Medicare card** to get covered medical services (with the exception of routine clinical research studies and hospice services). Keep your red, white, and blue Medicare card in a safe place in case you need it later.

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

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

Section 3.2 The *Provider Directory*: your guide to all providers in the plan network

Every year that you are a member of our plan, we will send you either a new *Provider Directory* or an update to your *Provider Directory.* This directory lists the plan network providers.

What are "network providers"?

Network providers are the doctors and other health care professionals, medical groups, hospitals, and other health care facilities that have an agreement with us to accept our payment and any plan cost-sharing as payment in full. We have arranged for these providers to deliver covered services to members in our plan.

Why do you need to know which providers are part of the plan network?

It is important to know which providers are part of the plan network because, with certain exceptions, while you are a member of our plan, you must use network providers to get your medical care and services covered at the in-network cost-sharing level. The only exceptions are emergencies, urgently needed care when the network is not available (generally, when you are out of the area), out-of-area dialysis services, cases in which we authorize use of out-of-network providers, and when using the Point-of-Service (POS) benefit. See Chapter 3 (*Using the plan coverage for your medical services*) for more specific information about emergency, out-of-network, and out-of-area coverage.

You can obtain certain covered services from out-of-network providers through the POS benefit at the out-of-network cost-sharing level. See the medical benefits chart in Chapter 4 for more information about the POS benefit.

If you don't have your copy of the *Provider Directory*, you can request a copy from Customer Services. You may ask Customer Services for more information about plan network providers, including their qualifications. Your *Provider Directory* also contains a listing of network pharmacies that can fill your Medicare Part B drugs (the *Pharmacy Directory* is attached to your *Provider Directory*).

SECTION 4 Your monthly premium for the plan

Section 4.1 How much is your plan premium?

As a member of our plan, you pay a monthly plan premium. The table below shows the monthly plan premium amount for each region we serve. In addition, you must continue to pay your Medicare Part B premium.

Plan name	Monthly plan premium
UCare for Seniors Value – Minnesota	$41

Plan name	Monthly plan premium
UCare for Seniors Value – Wisconsin	$58
Wisconsin Counties: Ashland, Barron, Bayfield, Buffalo, Burnett, Chippewa, Crawford, Douglas, Dunn, Eau Claire, Grant, Iowa, Jackson, Juneau, La Crosse, Monroe, Pepin, Pierce, Polk, Richland, St. Croix, Sauk, Sawyer, Trempealeau, Vernon, and Washburn.	

Many members are required to pay other Medicare premiums

As explained in Section 2 above, in order to be eligible for our plan, you must maintain your eligibility for Medicare Parts A and B. For that reason, some plan members will be paying a premium for Medicare Part A and most plan members will be paying a premium for Medicare Part B, in addition to paying the monthly plan premium. You must continue paying your Medicare Part B premium to remain a member of the plan.

- Your copy of *Medicare & You 2011* tells about these premiums in the section called "2011 Medicare Costs." This explains how the Part B premium differs for people with different incomes.
- Everyone with Medicare receives a copy of *Medicare & You* each year in the fall. Those new to Medicare receive it within a month after first signing up. You can also download a copy of *Medicare & You 2011* from the Medicare web site (http://www.medicare.gov). Or, you can order a printed copy by phone at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, seven days a week. TTY users call 1-877-486-2048.

Section 4.2 There are several ways you can pay your plan premium

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

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

Option 1: You can pay by check

You may decide to pay your monthly plan premium directly to us with a check made payable to UCare. We will send you a monthly plan premium bill via U.S. mail; you submit payment by check made payable to UCare. The mailing address for payments for Minnesota residents is P.O. Box 9122, Minneapolis, MN 55480-9122. For Wisconsin residents the address is P.O. Box 77041, Minneapolis, MN 55480-7741. Premium payments are due on the 1st of each month.

Option 2: You can pay by Electronic Funds Transfer

Instead of paying by check, you can have your monthly plan premium automatically withdrawn by Electronic Funds Transfer (EFT) from your checking or savings account. Automatic withdraw of your premium is on the 8th of each month (or the first business day following the 8th if it falls on a weekend or a banking holiday). This option is listed on the enrollment form and can be selected when filling out the form or you can call Customer Services to request an EFT application be mailed to your home.

Option 3: You can have the plan premium taken out of your monthly Social Security check

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

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

Your plan premium is due in our office by the 1st of the month. If we have not received your premium by the 14th of the month, we will send you a notice telling you that your plan membership will end if we do not receive your premium within 90 days.

If you are having trouble paying your premium on time, please contact Customer Services to see if we can direct you to programs that will help with your plan premium. If we end your membership due to non-payment of premiums, you will have coverage under Original Medicare. At the time we end your membership, you may still owe us for premiums you have not paid. In the future, if you want to enroll again in our plan (or another plan that we offer), you will need to pay these late premiums before you can enroll.

Section 4.3 Can we change your monthly plan premium during the year?

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

SECTION 5 Please keep your plan membership record up to date

Section 5.1 How to help make sure that we have accurate information about you

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

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

Call Customer Services to let us know about these changes:

- Changes to your name, your address, or your phone number.
- Changes in any other health insurance coverage you have (such as from your employer, your spouse's employer, workers' compensation, or Medicaid).
- If you have any liability claims, such as claims from an automobile accident.
- If you have been admitted to a nursing home.
- If you are participating in a clinical research study.

Read over the information we send you about any other insurance coverage you have

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

Once each year, we will send you a letter that lists any other medical or drug insurance coverage that we know about. Please read over this information carefully. If it is correct, you don't need to do anything. If the information is incorrect, or if you have other coverage that is not listed, please call Customer Services (phone numbers are on the cover of this booklet).

Chapter 2. Important phone numbers and resources

SECTION 1 Our contacts

(how to contact us, including how to reach Customer Services at the plan)

How to contact our Customer Services

For assistance with claims, billing or member card questions, please call or write to Customer Services. We will be happy to help you.

Customer Services	
CALL	612-676-3600 1-877-523-1515. Calls to this number are free. 8 a.m. to 8 p.m. daily.
TTY	612-676-6810 or 1-800-688-2534 These numbers require special telephone equipment and are only for people who have difficulties with hearing or speaking. Calls to these numbers are free. 8 a.m. to 8 p.m. daily.
FAX	612-884-2101 or 1-866-457-7145
WRITE	UCare **Attn: Medicare Analyst** P.O. Box 52 Minneapolis, MN 55440-0052
WEB SITE	www.ucare.org

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

You may call us if you have questions about our coverage decision process.

Coverage Decisions for Medical Care		
CALL	**For coverage decisions** Customer Services 612-676-3600 1-877-523-1515. Calls to this number are free. 8 a.m. to 8 p.m. daily.	**For fast appeals** Member Complaints, Appeals, and Grievances 612-676-6841 1-877-523-1517. Calls to this number are free. 8 a.m. to 4:30 p.m. Monday – Friday.

TTY	612-676-6810 or 1-800-688-2534 These numbers require special telephone equipment and are only for people who have difficulties with hearing or speaking. Calls to these numbers are free.	
FAX	612-884-2021 or 1-866-283-8015	
WRITE	**For coverage decisions** UCare **Attn: Standard Review** P.O. Box 52 Minneapolis, MN 55440-0052	**For fast appeals** UCare **Attn: Fast Appeal** P.O. Box 52 Minneapolis, MN 55440-0052

For more information on asking for coverage decisions about your medical care, see Chapter 7 (*What to do if you have a problem or complaint (coverage decisions, appeals, complaints*)).

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

Appeals for Medical Care	
CALL	Member Complaints, Appeals, and Grievances 612-676-6841 1-877-523-1517. Calls to this number are free. 8 a.m. to 4:30 p.m., Monday – Friday.
TTY	612-676-6810 or 1-800-688-2534 These numbers require special telephone equipment and are only for people who have difficulties with hearing or speaking. Calls to this number are free.
FAX	612-884-2021 or 1-866-283-8015 **Attn: Member Complaints, Appeals, and Grievances**
WRITE	UCare **Attn: Member Complaints, Appeals, and Grievances** P.O. Box 52 Minneapolis, MN 55440-0052 Or, **e-mail** us at cag@ucare.org

For more information on making an appeal about your medical care, see Chapter 7 (*What to do if you have a problem or complaint (coverage decisions, appeals, complaints*)).

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

Complaints about Medical Care	
CALL	Customer Services 612-676-3600 1-877-523-1515. Calls to this number are free. 8 a.m. to 8 p.m. daily.
TTY	612-676-6810 or 1-800-688-2534 These numbers require special telephone equipment and are only for people who have difficulties with hearing or speaking. Calls to these numbers are free.
FAX	612-884-2021 or 1-866-283-8015 **Attn: Member Complaints, Appeals, and Grievances**
WRITE	UCare **Attn: Member Complaints, Appeals, and Grievances** P.O. Box 52 Minneapolis, MN 55440-0052 Or, **e-mail** us at cag@ucare.org

For more information on making a complaint about your medical care, see Chapter 7 (*What to do if you have a problem or complaint (coverage decisions, appeals, complaints*)).

Where to send a request that asks us to pay for our share of the cost for medical care you have received

For more information on situations in which you may need to ask us for reimbursement or to pay a bill you have received from a provider, see Chapter 5 (*Asking us to pay our share of a bill you have received for medical services*)).

Please note: If you send us a payment request and we deny any part of your request, you can appeal our decision. See Chapter 7 *(What to do if you have a problem or complaint (coverage decisions, appeals, complaints)* for more information.

Payment Requests	
CALL	Customer Services 612-676-3600 1-877-523-1515. Calls to this number are free. 8 a.m. to 8 p.m. daily.

TTY	612-676-6810 or 1-800-688-2534 These numbers require special telephone equipment and are only for people who have difficulties with hearing or speaking. Calls to these numbers are free.
FAX	612-884-2021 or 1-866-283-8015
WRITE	UCare **Attn: DMR Department** P.O. Box 52 Minneapolis, MN 55440-0052

SECTION 2 Medicare

(how to get help and information directly from the federal Medicare program)

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

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

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

WEB SITE	http://www.medicare.gov This is the official government web site for Medicare. It gives you up-to-date information about Medicare and current Medicare issues. It also has information about hospitals, nursing homes, physicians, home health agencies, and dialysis facilities. It includes booklets you can print directly from your computer. It has tools to help you compare Medicare Advantage Plans and Medicare drug plans in your area. You can also find Medicare contacts in your state by selecting "Help and Support" and then clicking on "Useful Phone Numbers and Websites." If you don't have a computer, your local library or senior center may be able to help you visit this web site using its computer. Or, you can call Medicare at the number above and tell them what information you are looking for. They will find the information on the web site, print it out, and send it to you.

SECTION 3 State Health Insurance Assistance Program

(free help, information, and answers to your questions about Medicare)

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

The SHIP is independent (not connected with any insurance company or health plan). It is a state program that gets money from the federal government to give free local health insurance counseling to people with Medicare.

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

Senior LinkAge Line **(Minnesota)**	
CALL	1-800-333-2433
TTY	Minnesota Relay Service at 1-800-627-3529 or 711 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.
WRITE	Minnesota Board on Aging P.O. Box 64976 St. Paul, MN 55164-0976
WEB SITE	www.mnaging.org **or** www.minnesotahelp.info

The State Health Insurance Assistance Program of Wisconsin	
CALL	1-800-242-1060
TTY	Wisconsin Relay Service at 1-800-947-3529 or 711 These numbers require special telephone equipment and are only for people who have difficulties with hearing or speaking.
WRITE	1 W. Wilson Street, Room 450, P.O. Box 7850, Madison, WI 53707
WEB SITE	www.dhs.wisconsin.gov/aging/ship.htm

SECTION 4 Quality Improvement Organization

(paid by Medicare to check on the quality of care for people with Medicare)

There is a Quality Improvement Organization in each state. In Minnesota, the Quality Improvement Organization is called Stratis Health. In Wisconsin, the Quality Improvement Organization is called MetaStar.

The Quality Improvement Organization has a group of doctors and other health care professionals who are paid by the federal government. This organization is paid by Medicare to check on and help improve the quality of care for people with Medicare. The Quality Improvement Organization is an independent organization. It is not connected with us.

You should contact the Quality Improvement Organization in any of these situations:

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

Stratis Health (Minnesota)	
CALL	952-854-3306 or 1-877-787-2847
TTY	Minnesota Relay Service at 1-800-627-3529 or 711 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.
WRITE	2901 Metro Drive, Suite 400, Bloomington, MN 55425-1525
WEB SITE	www.stratishealth.org

MetaStar (Wisconsin)	
CALL	608-274-1940 or 1-800-362-2320
TTY	Wisconsin Relay Service at 1-800-947-3529 or 711 These numbers require special telephone equipment and are only for people who have difficulties with hearing or speaking.
WRITE	2909 Landmark Place, Madison, WI 53713
WEB SITE	www.metastar.com

SECTION 5 Social Security

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

Social Security Administration	
CALL	1-800-772-1213. Calls to this number are free. Available 7 a.m. to 7 p.m., Monday through Friday. You can use our automated telephone services to get recorded information and conduct some business 24 hours a day.
TTY	1-800-325-0778 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free. Available 7 a.m. to 7 p.m., Monday through Friday.
WEB SITE	http://www.ssa.gov

SECTION 6 Medicaid

(a joint federal and state program that helps with medical costs for some people with limited income and resources)

Medicaid is a joint federal and state government program that helps with medical costs for certain people with limited incomes and resources. Some people with Medicare are also eligible for Medicaid. Medicaid has programs that can help pay for your Medicare premiums and other costs, if you qualify. To find out more about Medicaid and its programs, contact Minnesota Department of Human Services or Wisconsin Department of Health Services.

Minnesota Department of Human Services	
CALL	651-431-2670 (Twin Cities metro) or 1-800-657-3739
TTY	1-800-627-3529 or 711 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.
WRITE	540 Cedar Street, P.O. Box 64249, St. Paul, MN 55164
WEB SITE	www.dhs.state.mn.us/healthcare

Wisconsin Department of Health Services	
CALL	608-266-1865
TTY	608-267-7371 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.
WRITE	1 W. Wilson Street, Madison, WI 53703
WEB SITE	www.dhfs.state.wi.us

SECTION 7 How to contact the Railroad Retirement Board

The Railroad Retirement Board is an independent federal agency that administers comprehensive benefit programs for the nation's railroad workers and their families. If you have questions regarding your benefits from the Railroad Retirement Board, contact the agency.

Railroad Retirement Board	
CALL	1-877-772-5772. Calls to this number are free. Available 9 a.m. to 3:30 p.m., Monday through Friday If you have a touch-tone telephone, recorded information and automated services are available 24 hours a day, including weekends and holidays.

TTY	1-312-751-4701 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are *not* free.
WEB SITE	http://www.rrb.gov

SECTION 8 Do you have "group insurance" or other health insurance from an employer?

If you (or your spouse) get benefits from your (or your spouse's) employer or retiree group, call the employer/union benefits administrator or Customer Services if you have any questions. You can ask about your (or your spouse's) employer or retiree health benefits, premiums, or the enrollment period.

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

Chapter 3. Using the plan coverage for your medical services

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

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

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

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

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

- **"Providers"** are doctors and other health care professionals that the state licenses to provide medical services and care. The term "providers" also includes hospitals and other health care facilities.
- **"Network providers"** are the doctors and other health care professionals, medical groups, hospitals, and other health care facilities that have an agreement with us to accept our payment and your cost-sharing amount as payment in full. We have arranged for these providers to deliver covered services to members in our plan. The providers in the plan network generally bill us directly for care they give you. When you see a network provider, you usually pay only your share of the cost for their services.
- **"Covered services"** include all the medical care, health care services, supplies, and equipment that are covered by our plan. Your covered services for medical care are listed in the medical benefits chart in Chapter 4.

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

The plan will generally cover your medical care as long as:

- **The care you receive is included in the medical benefits chart** (this chart is in Chapter 4 of this booklet).
- **The care you receive is considered medically necessary**. It needs to be accepted treatment for your medical condition.
- **You have a Primary Care Provider (a PCP) who is providing and overseeing your care.** As a member of our plan, you must choose a Primary Care Clinic (for more information about this, see Section 2.1 in this chapter).
- **You generally must receive your care from a network provider for it to be covered at the in-network cost-sharing level** (for more information about this, see Section 2 in this chapter). Care you receive from an out-of-network provider (a provider who is not part of the plan network) will not be covered unless:
  - The plan covers emergency care or urgently needed care that you get from an out-of-network provider. For more information about this, and to see what emergency or urgently needed care means, see Section 3 in this chapter.
  - If you need medical care that Medicare requires our plan to cover and the providers in the plan network cannot provide this care, you can get this care from an out-of-network provider. You must obtain authorization from us prior to seeking care. In this situation, you will pay the same as you would pay if you got the care from a network provider (in-network cost-sharing level).
  - You can obtain certain covered services under the Point-of-Service (POS) benefit at the out-of-network cost-sharing level. You do not need a referral from your PCP before getting services under the POS benefit. See Chapter 4 for more information about the POS benefit.

SECTION 2 Use providers in the plan network to get your medical care

Section 2.1 You must choose a Primary Care Clinic to provide and oversee your medical care

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

When you become a member of the plan, you must choose a Primary Care Clinic. You can see any Primary Care Provider (PCP) at your clinic. Your PCP is a provider who meets state requirements and is trained to give you basic medical care. The following are the types of providers that can act as a PCP: family medicine doctors, general practitioners, internists, and doctors in obstetrics/gynecology. Physician assistants and nurse practitioners cannot act as PCPs. You can obtain your routine or basic care from your PCP. Your PCP will also coordinate the rest of the covered services you get as a plan member. This includes but not limited to:

- X-rays.
- Laboratory tests.
- Therapies.
- Hospital admissions.
- Follow-up care.
- Care from doctors who are specialists (you can see any specialist in the network on your own without a referral).

"Coordinating" your services includes checking or consulting with other network providers about your care and how it is going. In some cases, your PCP will need to get prior authorization from us (see Chapter 4 for details). Because your PCP will provide and coordinate your medical care, you should have all of your past medical records sent to your PCP's office. Chapter 6 tells you how we will protect the privacy of your medical records and personal health information.

How do you choose your PCP?

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

Changing your PCP

You may change your PCP for any reason, at any time. Also, it's possible that your PCP might leave the plan network of providers and you would have to find a new PCP.

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

Section 2.2 How to get care from specialists and other network providers

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

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

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

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

Sometimes a specialist, clinic, hospital or other network provider you are using might leave the plan network. If this happens you will have to switch to another provider who is in the network or you can see an out-of-network provider if the service is covered by the Point-of-Service (POS) benefit. See Chapter 4 for more information about the POS benefit. See our *Provider Directory* for a listing of other network providers available in your area. We will only send you notice of provider network changes if your Primary Care Clinic leaves the network or if other clinics and hospitals that you regularly see are leaving the network. The notice will list network providers available in your area. If an urgent situation arises before you make a change to a new network provider, contact Customer Services and we can assist you in finding and selecting another provider.

Section 2.3 How to get care from out-of-network providers

Coverage is available for certain covered services provided by out-of-network providers and facilities under the Point-of-Service benefit at the out-of-network cost-sharing level. You do not need a referral from your PCP before getting services under the Point-of-Service benefit.

The following covered services are not covered under the Point-of-Service benefit:

- Chiropractic services.
- Eyewear.
- Transplant services.
- Comprehensive in-home health assessment.

See Chapter 4 for more details.

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

Section 3.1 Getting care if you have a medical emergency

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

When you have a "medical emergency," you believe that your health is in serious danger. A medical emergency can include severe pain, a bad injury, a sudden illness, or a medical condition that is quickly getting much worse.

If you have a medical emergency:

Get help as quickly as possible. Call 911 for help or go to the nearest emergency room, hospital, or urgent care center. Call for an ambulance if you need it. You do *not* need to get approval or a referral first from your PCP.

What is covered if you have a medical emergency?

You may get covered emergency medical care whenever you need it, anywhere in the United States or its territories. Our plan covers ambulance services in situations where getting to the emergency room in any other way could endanger your health. The plan also covers emergency medical care anywhere in the world. For more information, see the medical benefits chart in Chapter 4 of this booklet.

The doctors who are giving you emergency care will decide when your condition is stable and the medical emergency is over. After the emergency is over you are entitled to follow-up care to be sure your condition continues to be stable. Your follow-up care will be covered by our plan. If your emergency care is provided by out-of-network providers, we are available to assist in arranging for network providers to take over your care as soon as your medical condition and the circumstances allow. However, if you choose to remain with out-of-network providers, you will have to pay the Point-of-Service (POS) coinsurance, if eligible for the POS benefit.

What if it wasn't a medical emergency?

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

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

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

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

What is "urgently needed care"?

"Urgently needed care" is a non-emergency situation when you need medical care right away because of an illness, injury, or condition that you did not expect or anticipate, but your health is not in serious danger.

What if you are in the plan service area when you have an urgent need for care?

Whenever possible, you must use plan network providers when you are in the plan service area and you have an urgent need for care. (For more information about the plan service area, see Chapter 1, Section 2.3 of this booklet.)

In most situations, if you are in the plan service area, we will cover urgently needed care *only* if you get this care from a network provider and follow the other rules described earlier in this chapter. If the circumstances are unusual or extraordinary, and network providers are temporarily unavailable or inaccessible, our plan will cover urgently needed care that you get from an out-of-network provider.

What if you are <u>outside</u> the plan service area when you have an urgent need for care?

Suppose that you are temporarily outside our plan service area, but still in the United States. If you have an urgent need for care, you probably will not be able to find or get to one of the providers in the plan network. In this situation (when you are outside the service area and cannot get care from a network provider), our plan will cover urgently needed care that you get from any provider.

Our plan covers urgently needed care you receive anywhere in the world. For more information, see the medical benefits chart in Chapter 4 of this booklet.

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

Section 4.1 You can ask us to pay our share of the cost of your covered services

In limited instances, you may be asked to pay the full cost of the service. Other times, you may find that you have paid more than you expected under the coverage rules of the plan. In either case, you will want us to pay our share of the costs by reimbursing you for payments you have already made.

There may also be times when you get a bill from a provider for the full cost of medical care you have received. In many cases, you should send this bill to us so that we can pay our share of the costs for your covered medical services.

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

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

The plan covers all medical services that are medically necessary, are covered under Medicare, and are obtained consistent with plan rules. You are responsible for paying the full cost of services that aren't covered by our plan, either because they are not plan covered services, or plan rules were not followed.

If you have any questions about whether we will pay for any medical service or care that you are considering, you have the right to ask us whether we will cover it before you get it. If we say we will not cover your services, you have the right to appeal our decision not to cover your care.

Chapter 7 (*What to do if you have a problem or complaint*) has more information about what to do if you want a coverage decision from us or want to appeal a decision we have already made. You may also call Customer Services at the number on the front cover of this booklet to get more information about how to do this.

For covered services that have a benefit limitation, you pay the full cost of any services you get after you have used up your benefit for that type of covered service.

- You will have to pay the full cost of any Skilled Nursing Facility (SNF) days you use after we pay for 100 days per benefit period. Because SNF days used after the 100-day benefit period are not a Medicare-covered service and not covered under the plan, any amount you pay out-of-pocket for these days will *not* count toward your out-of-pocket maximum.
- Any amount you pay above the $75 allowance for eyeglass frames following cataract surgery *will* count toward your out-of-pocket maximum.

You can call Customer Services when you want to know how much of your benefit limit you have already used.

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

Section 5.1 What is a "clinical research study"?

A clinical research study is a way that doctors and scientists test new types of medical care, like how well a new cancer drug works. They test new medical care procedures or drugs by asking for volunteers to help with the study. This kind of study is one of the final stages of a research process that helps doctors and scientists see if a new approach works and if it is safe.

Not all clinical research studies are open to members of our plan. Medicare first needs to approve the research study. If you participate in a study that Medicare has not approved, *you will be responsible for paying all costs for your participation in the study*.

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

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

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

Although you do not need to get our permission to be in a clinical research study, **you do need to tell us before you start participating in a clinical research study.** Here is why you need to tell us:

1. We can let you know whether the clinical research study is Medicare-approved.
2. We can tell you what services you will get from clinical research study providers instead of from our plan.
3. We can keep track of the health care services that you receive as part of the study.

If you plan on participating in a clinical research study, contact Customer Services (see Chapter 2, Section 1 of this *Evidence of Coverage*).

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

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

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

Original Medicare pays most of the cost of the covered services you receive as part of the study. After Medicare has paid its share of the cost for these services, our plan will also pay for part of the costs. We will pay the difference between the cost-sharing in Original Medicare and your cost-sharing as a member of our plan. This means your costs for the services you receive as part of the study will not be higher than they would be if you received these services outside of a clinical research study.

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

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

Do you want to know more?

To find out what your coinsurance would be if you joined a Medicare-approved clinical research study, please call Customer Services (phone numbers are on the cover of this booklet).

You can get more information about joining a clinical research study by reading the publication "Medicare and Clinical Research Studies" on the Medicare web site (http://www.medicare.gov). You can also call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, seven days a week. TTY users should call 1-877-486-2048.

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

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

A religious non-medical health care institution is a facility that provides care for a condition that would ordinarily be treated in a hospital or skilled nursing facility care. If getting care in a hospital or a skilled nursing facility is against a member's religious beliefs, you must elect to have your coverage for care in a religious non-medical health care institution. You may choose to pursue medical care at any time for any reason. This benefit is provided only for Part A inpatient services (non-medical health care services). Medicare will only pay for non-medical health care services provided by religious non-medical health care institutions.

Section 6.2 What care from a religious non-medical health care institution is covered by our plan?

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

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

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

- The facility providing the care must be certified by Medicare.
- Our plan coverage of services you receive is limited to *non-religious* aspects of care.
- If you get services from this institution that are provided to you in your home, our plan will cover these services only if your condition would ordinarily meet the conditions for coverage of services given by home health agencies that are not religious non-medical health care institutions.

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

Medicare Inpatient Hospital coverage limits apply (see the medical benefits chart in Chapter 4).

Chapter 4. Medical Benefits Chart (what is covered and what you pay)

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

This chapter focuses on your covered services and what you pay for your medical benefits. It includes a medical benefits chart that gives a list of your covered services and tells how much you will pay for each covered service as a member of the plan. Later in this chapter, you can find information about medical services that are not covered. It also tells about limitations on certain services.

Section 1.1 What types of out-of-pocket costs do you pay for your covered services?

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

- A **"copayment"** means that you pay a fixed amount each time you receive a medical service. You pay a copayment at the time you get the medical service.
- **"Coinsurance"** means that you pay a percent of the total cost of a medical service. You pay a coinsurance at the time you get the medical service.

Some people qualify for State Medicaid programs to help them pay their out-of-pocket costs for Medicare. If you are enrolled in one of these programs, you may still have to pay a copayment for the service, depending on the rules in your state.

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

Because you are enrolled in a Medicare Advantage plan, there is a limit to how much you have to pay out-of-pocket each year for medical services that are covered under Medicare Part A and Part B (see the medical benefits chart in Section 2, below).

As a member of the plan, the most you will have to pay out-of-pocket for covered Part A and Part B services in 2011 is $3,400 (The amount you pay for your plan premium does not count toward your out-of-pocket maximum.) If you reach the maximum out-of-pocket payment amount of $3,400, you will not have to pay any out-of-pocket costs for the remainder of the year for covered Part A and Part B services. (You will have to continue to pay your plan premium and the Medicare Part B premium.)

The Point-of-Service benefit is **excluded** from counting toward the out-of-pocket maximum.

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

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

The medical benefits chart on the following pages lists the services the plan covers and what you pay out-of-pocket for each service. The services listed in the medical benefits chart are covered only when the following coverage requirements are met:

- Your Medicare covered services must be provided according to the coverage guidelines established by Medicare.
- Except in the case of preventive services and screening tests, your services (including medical care, services, supplies, and equipment) *must* be medically necessary. Medically necessary means that the services are used for the diagnosis, direct care, and treatment of your medical condition, and are not provided mainly for your convenience or that of your doctor.

- Some of the services listed in the medical benefits chart are covered *only* if your doctor or other network provider gets approval in advance (sometimes called "prior authorization") from us. This also applies to out-of-network providers under the Point-of-Service benefit. Covered services that need approval in advance are marked in the medical benefits chart by an asterisk (*). In addition, the following services not listed in the medical benefits chart require prior authorization: Inpatient rehabilitation services, spine surgery, radiofrequency ablation for facet mediated neck and back pain, electrical bone growth stimulators, and spinal cord stimulator implants for chronic pain.
- Our plan covers all Medicare-covered preventive services at no cost to you.

Services that are covered for you	**What you must pay** when you get these services
Inpatient Care	
Inpatient hospital care Covered services include: • Semi-private room (or a private room if medically necessary). • Meals including special diets. • Regular nursing services. • Costs of special care units (such as intensive or coronary care units). • Drugs and medications. • Lab tests. • X-rays and other radiology services. • Necessary surgical and medical supplies. • Use of appliances, such as wheelchairs. • Operating and recovery room costs. • Physical, occupational, and speech language therapy. • Under certain conditions, the following types of transplants are covered: corneal, kidney, kidney-pancreatic, heart, liver, lung, heart/lung, bone marrow, stem cell, and intestinal/multivisceral. If you need a transplant, we will arrange to have your case reviewed by a Medicare-approved transplant center that will decide whether you are a candidate for a transplant. • Blood – including storage and administration, and all other components of blood. Coverage begins with the first pint used. • Physician services.	$300 copayment each Medicare-covered hospital stay until discharged. If you get inpatient care at an out-of-network hospital after your emergency condition is stabilized, your cost is the cost-sharing you would pay at a network hospital.

Services that are covered for you	**What you must pay** when you get these services
Inpatient mental health care	
• 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 limit does not apply to Mental Health services provided in a psychiatric unit of a general hospital.	$300 copayment per stay.
Skilled Nursing Facility (SNF) care*	
(For a definition of "Skilled Nursing Facility," see Chapter 10 of this booklet. Skilled nursing facilities are sometimes called "SNFs.")	
No prior hospital stay is required. 100 days for each benefit period. Covered services include: • Semiprivate room (or a private room if medically necessary). • Meals, including special diets. • Regular nursing services. • Physical therapy, occupational therapy, and speech therapy. • Drugs administered to you as part of your plan of care. (This includes substances that are naturally present in the body, such as blood clotting factors.) • Blood – including storage and administration, and all other components of blood. Coverage begins with the first pint used. • Medical and surgical supplies ordinarily provided by SNFs. • Laboratory tests ordinarily provided by SNFs. • X-rays and other radiology services ordinarily provided by SNFs. • Use of appliances such as wheelchairs ordinarily provided by SNFs. • Physician services.	No copayment for days 1-20; $125 copayment per day for days 21-100.
Generally, you will get your SNF care from network facilities and pay the in-network cost sharing. Or you can go to an out-of-network facility and pay the Point-of-Service coinsurance. However, under certain conditions listed below, you may be able to pay in-network cost-sharing for a facility that isn't a network provider, if the facility accepts our amounts for payment. • A nursing home or continuing care retirement community where you were living right before you went to the hospital (as long as it provides skilled nursing facility care). • A SNF where your spouse is living at the time you leave the hospital.	

Services that are covered for you	**What you must pay** when you get these services
Inpatient services covered when the hospital or SNF days aren't, or are no longer, covered As described above, the plan covers unlimited days for inpatient hospital care and up to 100 days per benefit period for skilled nursing facility (SNF) care. Once you have reached these coverage limits, the plan will no longer cover your stay in the SNF. However, we will cover certain types of services that you receive while you are still in the hospital or the SNF. Covered services include: • Physician services. • Tests (like X-ray or lab tests). • X-ray, radium, and isotope therapy including technician materials and services. • Surgical dressings, splints, casts and other devices used to reduce fractures and dislocations. • Prosthetics and orthotics devices (other than dental) that replace all or part of an internal body organ (including contiguous tissue), or all or part of the function of a permanently inoperative or malfunctioning internal body organ, including replacement or repairs of such devices. • Leg, arm, back, and neck braces; trusses, and artificial legs, arms, and eyes including adjustments, repairs, and replacements required because of breakage, wear, loss, or a change in the patient's physical condition. • Physical therapy, speech therapy, and occupational therapy.	See corresponding benefit description for applicable cost sharing.
Home health agency care* Covered services include: • 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 social services. • Medical equipment and supplies.	No copayment for most home health care services. There is cost sharing for physical and speech therapy, and durable medical equipment and related supplies. See corresponding benefit descriptions for cost sharing.

Services that are covered for you	**What you must pay** when you get these services
Hospice care	
You may receive care from any Medicare-certified hospice program. Original Medicare (rather than our Plan) will pay the hospice provider for the services you receive. Your hospice doctor can be a network provider or an out-of-network provider. You will still be a plan member and will continue to get the rest of your care that is unrelated to your terminal condition through our Plan. However, Original Medicare will pay for all of your Part A and Part B services. Your provider will bill Original Medicare for these services while your hospice election is in force. Covered services include: • Drugs for symptom control and pain relief, short-term respite care, and other services not otherwise covered by Original Medicare. • Home care. Our plan covers hospice consultation services (one time only) for a terminally ill person who hasn't elected the hospice benefit.	When you enroll in a Medicare-certified hospice program, your hospice services and your Original Medicare services are paid for by Original Medicare, not us.
Outpatient Services	
Physician services, including doctor's office visits	
Covered services include:	
• Office visits, including medical and surgical care in a physician's office.	No copayment.
• Medical or surgical services furnished in a certified ambulatory surgical center or in a hospital outpatient setting.	No copayment.
• Consultation, diagnosis, and treatment by a specialist.	$30 copayment per visit.
• Hearing and balance exams, if your doctor orders it to see if you need medical treatment.	No copayment.
• Routine hearing test once annually.	No copayment.
• Telehealth office visits including consultation, diagnosis and treatment by a specialist.	$30 copayment per visit.
• Second opinion by another network provider prior to surgery.	No copayment per visit with a PCP; $30 copayment per visit with a specialist.
• Outpatient hospital services.	No copayment.
• Non-routine dental care (covered services are limited to surgery of the jaw or related structures, setting fractures of the jaw or facial bones, extraction of teeth to prepare the jaw for radiation treatments of neoplastic cancer disease, or services that would be covered when provided by a physician).	See corresponding cost sharing for place of service.

Services that are covered for you	**What you must pay** when you get these services
Chiropractic services*	
We contract with Chiropractic Care of Minnesota, Inc. (CCMI) to provide chiropractic services. You need to see a CCMI provider to have coverage for this benefit. For help finding a chiropractor, call CCMI toll free at 1-888-638-7719, TTY at 1-800-627-3529. For help setting up an appointment, call UCare Customer Services at 612-676-3600 or 1-877-523-1515 (Calls to these numbers are free), 8 a.m. - 8 p.m. daily. TTY users call 612-676-6810 or 1-800-688-2534. Covered services include: • Manual manipulation of the spine to correct subluxation.	No copayment.
Podiatry services	
Covered services include: • Treatment of injuries and diseases of the feet (such as hammer toe or heel spurs). • Routine foot care for members with certain medical conditions affecting the lower limbs.	$30 copayment per visit.
Outpatient mental health care*	
We contract with Behavioral Healthcare Providers (BHP) and Mayo Management Services Inc. (MMSI) to provide mental health services: • Call BHP at 763-525-1746 or toll free 1-800-361-0491, Monday – Friday, 8 a.m. to 5 p.m. TTY at 1-800-627-3529. After hours calls are answered by Fairview University Mental Health Intake. • MMSI (if you chose a MMSI Primary Care Clinic) at toll free 1-800-645-6296. Covered services include: Mental health services provided by a doctor, clinical psychologist, clinical social worker, clinical nurse specialist, nurse practitioner, physician assistant, or other Medicare-qualified mental health care professional as allowed under applicable state laws.	$30 copayment per visit.
Partial hospitalization services*	
"Partial hospitalization" is a structured program of active psychiatric treatment that is more intense than the care received in your doctor's or therapist's office and is an alternative to inpatient hospitalization.	No copayment.

Services that are covered for you	**What you must pay** when you get these services
Outpatient substance abuse services*	
We contract with Behavioral Healthcare Providers (BHP) and Mayo Management Services Inc. (MMSI) to provide substance abuse services: • Call BHP at 763-525-1746 or toll free 1-800-361-0491, Monday – Friday, 8 a.m. to 5 p.m. TTY at 1-800-627-3529. After hours calls are answered by Fairview University Mental Health Intake. • MMSI (if you chose a MMSI Primary Care Clinic) at toll free 1-800-645-6296.	$25 copayment per visit.
Outpatient surgery, including services provided at hospital facilities and ambulatory surgical centers*	$200 copayment for each outpatient surgery; $25 copayment for all other outpatient hospital services.
Ambulance services • Covered ambulance services include fixed wing, rotary wing, and ground ambulance services, to the nearest appropriate facility that can provide care only if they are furnished to a member whose medical condition is such that other means of transportation are contraindicated (could endanger the person's health). The member's condition must require both the ambulance transportation itself and the level of service provided in order for the billed service to be considered medically necessary. • Non-emergency transportation by ambulance is appropriate if it is documented that the member's condition is such that other means of transportation are contraindicated (could endanger the person's health) and that transportation by ambulance is medically required.	$100 copayment per one-way trip.
Emergency care Worldwide coverage.	$50 copayment per visit; waived if admitted to the hospital within 24 hours for the same condition. If you receive emergency care at an out-of-network hospital and need inpatient care after your emergency condition is stabilized, your cost is the cost-sharing you would pay at a network hospital.
Urgently needed care Worldwide coverage.	$25 copayment per visit.

Services that are covered for you	**What you must pay** when you get these services
Outpatient rehabilitation services	
Covered services include:	
• Physical therapy, occupational therapy, speech language therapy.*	$30 copayment per visit.
• Cardiac rehabilitative therapy, intensive cardiac rehabilitation services, and pulmonary rehabilitation services.	$25 copayment per visit.
• Comprehensive Outpatient Rehabilitation Facility (CORF) services.	No copayment.
Durable medical equipment and related supplies*	
(For a definition of "durable medical equipment," see Chapter 10 of this booklet.) Covered items include, but are not limited to: wheelchairs, crutches, hospital bed, IV infusion pump, oxygen equipment, nebulizer, and walker.	20% coinsurance on the allowed amount.
Prosthetic devices and related supplies	
Devices (other than dental) that replace a body part or function. These include, but are not limited to: colostomy bags and supplies directly related to colostomy care, pacemakers, braces, prosthetic shoes, artificial limbs, and breast prostheses (including a surgical brassiere after a mastectomy). Includes certain supplies related to prosthetic devices, and repair and/or replacement of prosthetic devices. Also includes some coverage following cataract removal or cataract surgery – see "Vision Care" later in this section for more detail.	
• Prosthetic devices, and repair and/or replacement of prosthetic devices.	20% coinsurance on the allowed amount.
• Related supplies.	10% coinsurance on the allowed amount.
Diabetes self-monitoring, training, and supplies	
For all people who have diabetes (insulin and non-insulin users). Covered services include:	No copayment.
• Blood glucose monitor, blood glucose test strips, lancet devices and lancets, and glucose-control solutions for checking the accuracy of test strips and monitors. Coverage is limited to specific manufacturer brands.	
• For people with diabetes who have severe diabetic foot disease: One pair per calendar year of therapeutic custom-molded shoes (including inserts provided with such shoes) and two additional pairs of inserts, or one pair of depth shoes and three pairs of inserts (not including the non-customized removable inserts provided with such shoes). Coverage includes fitting.	
• Self-management training is covered under certain conditions.	
• For persons at risk of diabetes: Fasting plasma glucose tests according to Medicare coverage guidelines.	

Services that are covered for you	**What you must pay** when you get these services
Medical nutrition therapy	
For people with diabetes, renal (kidney) disease (but not on dialysis), and after a transplant when referred by your doctor.	No copayment.
Kidney disease education services	
Education to teach kidney care and help members make informed decisions about their care. For people with Stage IV chronic kidney disease when referred by their doctor. We cover up to six sessions of kidney disease education services per lifetime.	No copayment.
Outpatient diagnostic tests and therapeutic services and supplies	
Covered services include:	
• X-rays.	$25 copayment.
• Radiation therapy.	$25 copayment.
• Surgical supplies, such as dressings.	No copayment.
• Supplies, such as splints and casts.	No copayment.
• Laboratory tests.	$0 copayment for certain Medicare-covered preventive lab tests; $25 copayment for all other lab tests.
• Blood – including storage and administration, and all other components of blood. Coverage begins with the first pint used.	No copayment.
• Other outpatient diagnostic tests.	$0 copayment for certain Medicare-covered preventive diagnostic tests; $25 copayment for all other tests.

Services that are covered for you	**What you must pay** when you get these services
Vision care	
Covered services include:	
• Outpatient physician services for eye care.	$30 copayment per visit.
• One routine vision (eye) examination annually.	No copayment.
• For people who are at high risk of glaucoma, such as people with a family history of glaucoma, people with diabetes, and African-Americans who are age 50 and older: glaucoma screening once per year.	No copayment.
• One pair of eyeglasses or contact lenses after each cataract surgery that includes insertion of an intraocular lens. Corrective lenses/frames (and replacements) needed after a cataract removal without a lens implant. Must be obtained from a network provider.	After each cataract surgery: $75 benefit allowance for eyeglass frames, and no copayment for one pair of standard Medicare-covered eyeglass lenses or contact lenses. Progressive lenses, no-line bifocal or trifocal lenses, tinting (except for certain ultraviolet-screening coatings), scratch-resistant coatings, or oversized lenses are not covered unless required by Medicare coverage guidelines.
Preventive Care and Screening Tests	
Abdominal aortic aneurysm screening	
A one-time screening ultrasound for people at risk. The plan only covers this screening if you get a referral for it as a result of your "Welcome to Medicare" physical exam.	No copayment.
Bone mass measurement	
For qualified individuals (generally, this means people at risk of losing bone mass or at risk of osteoporosis), the following services are covered every 2 years or more frequently if medically necessary: procedures to identify bone mass, detect bone loss, or determine bone quality, including a physician's interpretation of the results.	No copayment.

Services that are covered for you	**What you must pay** when you get these services
Colorectal screening For people 50 and older, the following are covered: • Flexible sigmoidoscopy (or screening barium enema as an alternative) every 48 months. • Fecal occult blood test, every 12 months. For people at high risk of colorectal cancer, we cover: • Screening colonoscopy (or screening barium enema as an alternative) every 24 months. For people not at high risk of colorectal cancer, we cover: • Screening colonoscopy every 10 years, but not within 48 months of a screening sigmoidoscopy.	No copayment.
HIV screening For people who ask for an HIV screening test or who are at increased risk for HIV infection, we cover: • One screening exam every 12 months. For women who are pregnant, we cover: • Up to three screening exams during a pregnancy.	No copayment.
Immunizations Covered services include: • Pneumonia vaccine. • Flu shots, once a year in the fall or winter. • Hepatitis B vaccine if you are at high or intermediate risk of getting Hepatitis B. • Other vaccines if you are at risk. Out-of-network cost sharing does not apply to flu or pneumococcal vaccines when they are the only services received during the visit.	No copayment.
Mammography screening Covered services include: • One baseline exam between the ages of 35 and 39. • One screening every 12 months for women age 40 and older.	No copayment.

Services that are covered for you	**What you must pay** when you get these services
Pap test, pelvic exams, and clinical breast exams Covered services include: • For all women, pelvic exams, and clinical breast exams are covered once every 24 months. • For all women, one Pap test every 12 months.	No copayment.
Prostate cancer screening exams For men age 50 and older, covered services include the following - once every 12 months: • Digital rectal exam. • Prostate Specific Antigen (PSA) test.	No copayment.
Cardiovascular disease testing Blood tests for the detection of cardiovascular disease (or abnormalities associated with an elevated risk of cardiovascular disease).	No copayment.
Initial Preventative Physical Exam (Welcome to Medicare Physical Exam) A one-time physical exam for members within the first 12 months that they have Medicare Part B. Includes measurement of height, weight, body mass index, blood pressure, visual acuity screen and other routine measurements; an electrocardiogram; education, counseling and referral with respect to covered screening and preventive services. Doesn't include lab tests.	No copayment.
Personalized Prevention Plan Services (Annual Wellness Visit) Available to members in the first 12 months that they have Medicare Part B or 12 months after the member has the one-time Initial Preventative Physical Exam (Welcome to Medicare Physical Exam).	No copayment.
Other Services	
Dialysis (kidney) Covered services include: • Outpatient dialysis treatments (including dialysis treatments when temporarily out of the service area, as explained in Chapter 3). • Inpatient dialysis treatments (if you are admitted to a hospital for special care). • Self-dialysis training (includes training for you and anyone helping you with your home dialysis treatments). • Home dialysis equipment and supplies. • Certain home support services (such as, when necessary, visits by trained dialysis workers to check on your home dialysis, to help in emergencies, and check your dialysis equipment and water supply).	No copayment.

Services that are covered for you	**What you must pay** when you get these services
Medicare Part B prescription drugs These drugs are covered under Part B of Original Medicare. Members of our plan receive coverage for these drugs through our plan. Covered drugs include: • Drugs that usually aren't self-administered by the patient and are injected while you are getting physician services. • Drugs you take using durable medical equipment (such as nebulizers) that was authorized by us. • Clotting factors you give yourself by injection if you have hemophilia. • Immunosuppressive drugs, if you were enrolled in Medicare Part A at the time of the organ transplant. • Injectable osteoporosis drugs, if you are homebound, have a bone fracture that a doctor certifies was related to post-menopausal osteoporosis, and cannot self-administer the drug. • Antigens. • Certain oral anti-cancer drugs and anti-nausea drugs. • Certain drugs for home dialysis, including heparin, the antidote for heparin when medically necessary, topical anesthetics, and erythropoisis-stimulating agents (such as Epogen®, Procrit®, Epoetin Alfa, Aranesp®, or Darbepoetin Alfa). • Intravenous Immune Globulin for the home treatment of primary immune deficiency diseases.	$50 copayment, or the cost of the drug(s) if less, per office visit for Part B drugs infused or administered in a physician's office or outpatient setting. A $25 copayment per generic drug or a $50 copayment per brand-name drug at a retail pharmacy, or the cost of the drug if less.

Services that are covered for you	**What you must pay** when you get these services
Additional Benefits	
Health and wellness education programs **Resources to Stop Using Tobacco** Help to stop using tobacco through the Mayo Clinic Tobacco Quitline. Customized to your individual needs. Call the Mayo Clinic Tobacco Quitline at 1-888-642-5566. TTY 1-866-257-2971. **UCan! UCare Activity Network** • $15 reduction in monthly health club membership fees at a participating club. • UCan! Do-It-Yourself fitness kit for $10. • *EnhanceFitness*® classes led by certified instructors at no charge at participating community locations in Minnesota. Call Customer Services to order a kit, or for class or club locations. **Newsletter** *PrimeTime*, an award-winning newsletter containing helpful health care information and updates printed three times per year. **Nursing Hotline** Health Connection is a telephone service that is provided for members and is available for access to medical and health information 24 hours a day, including weekends and holidays. Call at 1-888-778-8204 or TTY if you are hearing impaired at 1-877-728-3311 (toll free). **Disease Management** Members have the opportunity to participate in a number of disease management programs if they meet certain eligibility requirements. These programs are designed to provide specialized management of particular chronic conditions. For more information on these programs, call the Disease Management Message Line at 612-676-6539 or 1-866-863-8303 (toll free). TTY call 612-676-6810 or 1-800-688-2534 (toll free).	No copayment.
In-home medical assessment Comprehensive health assessment by certain contracted medical professional vendors performed in home or in a Skilled Nursing Facility (SNF).	No copayment.

Section 2.2 Point-of-Service benefit

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

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

The following covered services are <u>not</u> covered under the Point-of-Service benefit:

- Chiropractic services.
- Eyewear.
- Transplant services.
- Comprehensive in-home health assessment.

Please note: Emergency care, urgently needed care, and renal (kidney) dialysis are required under the Medicare program to be covered in network and out of network. Therefore, when these services are provided by out-of-network providers, the Point-of-Service benefit coinsurance does not apply. For applicable copayments, see the corresponding benefit descriptions in the medical benefits chart in this Chapter 4.

Point-of-Service coinsurance
Coverage is 80% coinsurance on the allowed amount for covered services. You are responsible for 20% coinsurance on the allowed amount. There is a $20,000 annual member out-of-pocket cost maximum. There is also a $100,000 plan benefit maximum.

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

- For providers who have an agreement with CMS to accept assignment, the allowed amount is the Medicare fee schedule.
- For providers who do not accept assignment, they are not required to accept the Medicare fee schedule amount as payment in full. They may charge a higher amount which is called the Medicare limiting charge. For items and services paid under the Medicare fee schedule, the limiting charge is 115% of the fee schedule amount. For items and services CMS excludes from payment under the fee schedule, the limiting charge is 115% of 95% of the payment basis applicable to those who accept assignment.

Balance billing by the provider for amounts above the maximum charge is not allowed. Before getting services or items under this Point-of-Service benefit, you should ask the out-of-network provider whether or not he/she accepts assignment of Medicare benefits.

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

If you intend to use this benefit for inpatient hospitalization, we recommend you call Customer Services.

Whenever a claim is processed for the Point-of-Service benefit, members receive an Explanation of Benefits (EOB) outlining the payment made for the POS service(s). Appeal rights are also sent with the EOB. The Point-of-Service benefit is subject to the same appeals process as any other benefit.

SECTION 3 What types of *benefits* are not covered by the plan?

Section 3.1 Types of benefits we do *not* cover (exclusions)

This section tells you what kinds of benefits are "excluded." Excluded means that the plan doesn't cover these benefits.

The list below describes some services and items that aren't covered under any conditions and some that are excluded only under specific conditions.

If you get benefits that are excluded, you must pay for them yourself. We won't pay for the medical benefits listed in this section (or elsewhere in this booklet), and neither will Original Medicare. The only exception: If a benefit on the exclusion list is found upon appeal to be a medical benefit that we should have paid for or covered because of your specific situation. (For information about appealing a decision we have made to not cover a medical service, go to Chapter 7, Section 5.3 in this booklet.)

In addition to any exclusions or limitations described in the medical benefits chart, or anywhere else in this *Evidence of Coverage*, **the following items and services aren't covered under Original Medicare or by our plan:**

- Services considered not reasonable and necessary, according to the standards of Original Medicare, unless these services are listed by us as a covered services.
- Experimental medical and surgical procedures, equipment and medications, unless covered by Original Medicare. However, certain services may be covered under a Medicare-approved clinical research study. See Chapter 3, Section 5 for more information on clinical research studies.
- Surgical treatment for morbid obesity, except when it is considered medically necessary and covered under Original Medicare.
- Private room in a hospital, except when it is considered medically necessary.
- Private duty nurses.
- Personal items in your room at a hospital or a skilled nursing facility, such as a telephone or a television.
- Full-time nursing care in your home.
- Custodial care, unless it is provided with covered skilled nursing care and/or skilled rehabilitation services. Custodial care, or non-skilled care, is care that helps you with activities of daily living, such as bathing or dressing.
- Homemaker services include basic household assistance, including light housekeeping or light meal preparation.
- Fees charged by your immediate relatives or members of your household.
- Meals delivered to your home.
- 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 procedures, unless because of an accidental injury or to improve a malformed part of the body. However, all stages of reconstruction are covered for a breast after a mastectomy, as well as for the unaffected breast to produce a symmetrical appearance.
- Routine dental care, such as cleanings, filings or dentures. However, non-routine dental care received at a hospital may be covered.

- Chiropractic care, other than manual manipulation of the spine consistent with Medicare coverage guidelines.
- Routine foot care, except for the limited coverage provided according to Medicare guidelines.
- Orthopedic shoes, unless the shoes are part of a leg brace and are included in the cost of the brace or the shoes are for a person with diabetic foot disease.
- Supportive devices for the feet, except for orthopedic or therapeutic shoes for people with diabetic foot disease.
- Hearing aids.
- Eyeglasses, radial keratotomy, LASIK surgery, vision therapy and other low vision aids. However, eyeglasses are covered for people after cataract surgery.
- Outpatient prescription drugs including drugs for treatment of sexual dysfunction, including erectile dysfunction, impotence, and anorgasmy or hyporgasmy.
- Reversal of sterilization procedures, sex change operations, and non-prescription contraceptive supplies.
- Acupuncture.
- Naturopath services (uses natural or alternative treatments).
- Services provided to veterans in Veterans Affairs (VA) facilities. However, when emergency services are received at VA hospital and the VA cost-sharing is more than the cost-sharing under our plan. We will reimburse veterans for the difference. Members are still responsible for our cost-sharing amounts.
- Any services listed above that aren't covered will remain not covered even if received at an emergency facility.

Chapter 5. Asking us to pay our share of a bill you have received for medical services

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

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

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

There may also be times when you get a bill from a provider for the full cost of medical care you have received. In many cases, you should send this bill to us instead of paying it. We will look at the bill and decide whether the services should be covered. If we decide they should be covered, we will pay the provider directly.

Here are examples of situations in which you may need to ask us to pay you back or to pay a bill you have received:

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

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

   - If you pay the entire amount yourself at the time you receive the care, you need to ask us to pay you back for our share of the cost. Send us the bill, along with documentation of any payments you have made.
   - At times you may get a bill from the provider asking for payment that you think you do not owe. Send us this bill, along with documentation of any payments you have already made.
     - If the provider is owed anything, we will pay the provider directly.
     - If you have already paid more than your share of the cost of the service, we will determine how much you owed and pay you back for our share of the cost.

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

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

   - Whenever you get a bill from a network provider that you think is more than you should pay, send us the bill. We will contact the provider directly and resolve the billing problem.
   - If you have already paid a bill to a network provider, but you feel that you paid too much, send us the bill along with documentation of any payment you have made and ask us to pay you back the difference between the amount you paid and the amount you owed under the plan.

All of the examples above are types of coverage decisions. This means that if we deny your request for payment, you can appeal our decision. Chapter 7 of this booklet (*What to do if you have a problem or complaint (coverage decisions, appeals, complaints)*) has information about how to make an appeal.

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

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

Send us your request for payment, along with your bill and documentation of any payment you have made. It's a good idea to make a copy of your bill and receipts for your records.

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

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

Please be sure to contact Customer Services if you have any questions. If you don't know what you owe, or you receive bills and you don't know what to do about those bills, we can help. You can also call if you want to give us more information about a request for payment you have already sent to us.

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

Section 3.1 We check to see whether we should cover the service and how much we owe

When we receive your request for payment, we will let you know if we need any additional information from you. Otherwise, we will consider your request and decide whether to pay it and how much we owe.

- If we decide that the medical care is covered and you followed all the rules for getting the care, we will pay for our share of the cost. If you have already paid for the service, we will mail your reimbursement of our share of the cost to you. If you have not paid for the service yet, we will mail the payment directly to the provider. (Chapter 3 explains the rules you need to follow for getting your medical services.)
- If we decide that the medical care is *not* covered, or you did *not* follow all the rules, we will not pay for our share of the cost. Instead, we will send you a letter that explains the reasons why we are not sending the payment you have requested and your rights to appeal that decision.

Section 3.2 If we tell you that we will not pay for the medical care, you can make an appeal

If you think we have made a mistake in turning you down your request for payment, you can make an appeal. If you make an appeal, it means you are asking us to change the decision we made when we turned down your request for payment.

For the details on how to make this appeal, go to Chapter 7 of this booklet (*What to do if you have a problem or complaint (coverage decisions, appeals, complaints)*). The appeals process is a legal process with detailed procedures and important deadlines. If making an appeal is new to you, you will find it helpful to start by reading Section 4 of Chapter 7. Section 4 is an introductory section that explains the process for coverage decisions and appeals and gives definitions of terms such as "appeal." Then after you have read Section 4, you can go to the Section 5.3 to learn how to make an appeal about getting paid back for a medical service.

Chapter 6. Your rights and responsibilities

SECTION 1 We must honor your rights as a member of the plan

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

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

We have people and translation services available to answer questions from non-English speaking members. We can also give you information in Braille, in large print, or other alternate formats if you need it. If you are eligible for Medicare because of disability, we are required to give you information about the plan benefits that is accessible and appropriate for you.

If you have any trouble getting information from us because of problems related to language or disability, please call Medicare at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, seven days a week, and tell them that you want to file a complaint. TTY users call 1-877-486-2048.

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

We must obey laws that protect you from discrimination or unfair treatment. **We do not discriminate** based on a person's race, disability, religion, sex, health, ethnicity, creed (beliefs), age, or national origin.

If you want more information or have concerns about discrimination or unfair treatment, please call the Department of Health and Human Services' **Office for Civil Rights** 1-800-368-1019 (TTY 1-800-537-7697) or your local Office for Civil Rights.

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

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

As a member of our plan, you have the right to choose a Primary Care Provider in the plan network to provide and arrange for your covered services (Chapter 3 explains more about this). Call Customer Services to learn which doctors are accepting new patients (phone numbers are on the cover of this booklet). You also have the right to go to a women's health specialist (such as a gynecologist) and all other specialists without a referral.

As a plan member, you have the right to get appointments and covered services from the plan network of providers *within a reasonable amount of time*. This includes the right to get timely services from specialists when you need that care.

If you think that you are not getting your medical care within a reasonable amount of time, Chapter 7 of this booklet tells what you can do.

Section 1.4 We must protect the privacy of your personal health information

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

- Your "personal health information" includes the personal information you gave us when you enrolled in this plan as well as your medical records and other medical and health information.

- The laws that protect your privacy give you rights related to getting information and controlling how your health information is used. We give you a written notice, called a "Notice of Privacy Practice" that tells about these rights and explains how we protect the privacy of your health information.

How do we protect the privacy of your health information?

- We make sure that unauthorized people don't see or change your records.
- In most situations, if we give your health information to anyone who isn't providing your care or paying for your care, *we are required to get written permission from you first.* Written permission can be given by you or by someone you have given legal power to make decisions for you.
- There are certain exceptions that do not require us to get your written permission first. These exceptions are allowed or required by law.
  - For example, we are required to release health information to government agencies that are checking on quality of care.
  - Because you are a member of our plan through Medicare, we are required to give Medicare your health information. If Medicare releases your information for research or other uses, this will be done according to federal statutes and regulations.

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

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

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

If you have questions or concerns about the privacy of your personal health information, please call Customer Services (phone numbers are on the cover of this booklet).

Section 1.5 We must give you information about us, the plan network of providers, and your covered services

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

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

- **Information about us.** This includes, for example, information about our financial condition. It also includes information about the number of appeals made by members and our performance ratings, including how our plan has been rated by plan members and how it compares to other Medicare Advantage health plans.
- **Information about the plan network providers.**
  - For example, you have the right to get information from us about the qualifications of the providers in the plan network and how we pay the providers in the plan network.
  - For a list of the providers in the plan network, see the *Provider Directory*.
  - For more detailed information about our providers, you can call Customer Services (phone numbers are on the cover of this booklet) or visit our web site at www.ucare.org.

- **Information about your coverage and rules you must follow in using your coverage.**
  - In Chapters 3 and 4 of this booklet, we explain what medical services are covered for you, any restrictions to your coverage, and what rules you must follow to get your covered medical services.
  - If you have questions about the rules or restrictions, please call Customer Services (phone numbers are on the cover of this booklet).
- **Information about why something is not covered and what you can do about it.**
  - If a medical service is not covered for you, or if your coverage is restricted in some way, you can ask us for a written explanation. You have the right to this explanation even if you received the medical service from an out-of-network provider.
  - If you are not happy or if you disagree with a decision we make about what medical care is covered for you, you have the right to ask us to change the decision. For details on what to do if something is not covered for you in the way you think it should be covered, see Chapter 7 of this booklet. It gives you the details about how to ask us for a decision about your coverage and how to make an appeal if you want us to change our decision. (Chapter 7 also tells about how to make a complaint about quality of care, waiting times, and other concerns.)
  - If you want to ask us to pay our share of a bill you have received for medical care, see Chapter 5 of this booklet.

Section 1.6 We must support your right to make decisions about your care

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

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

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

- **To know about all of your choices.** This means that you have the right to be told about all of the treatment options that are recommended for your condition, no matter what they cost or whether they are covered by our plan.
- **To know about the risks.** You have the right to be told about any risks involved in your care. You must be told in advance if any proposed medical care or treatment is part of a research experiment. You always have the choice to refuse any experimental treatments.
- **The right to say "no."** You have the right to refuse any recommended treatment. This includes the right to leave a hospital or other medical facility, even if your doctor advises you not to leave. Of course, if you refuse treatment, you accept full responsibility for what happens to your body as a result.
- **To receive an explanation if you are denied coverage for care.** You have the right to receive an explanation from us if a provider has denied care that you believe you should receive. To receive this explanation, you will need to ask us for a coverage decision. Chapter 7 of this booklet tells how to ask us for a coverage decision.

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

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

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

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

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

- **Get the form.** If you want to have an advance directive, you can get a form from your lawyer, from a social worker, or from some office supply stores. You can sometimes get advance directive forms from organizations that give people information about Medicare.
- **Fill it out and sign it.** Regardless of where you get this form, keep in mind that it is a legal document. You should consider having a lawyer help you prepare it.
- **Give copies to appropriate people.** You should give a copy of the form to your doctor and to the person you name on the form as the one to make decisions for you if you can't. You may want to give copies to close friends or family members as well. Be sure to keep a copy at home.

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

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

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

What if your instructions are not followed?

If you have signed an advance directive, and you believe that a doctor or hospital hasn't followed the instructions in it, you may file a complaint with:

- In Minnesota, Office of Health Facility Complaints at the Minnesota Department of Health, 85 East Seventh Place, P.O. Box 64900, St. Paul, MN 55164-0900. Call 651-201-4201 or toll-free 1-800-369-7994.
- In Wisconsin, Wisconsin Department of Health Services, Division of Quality Assurance, P.O. Box 2969, Madison, WI 53701-2969. Call 608-266-8481.

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

If you have any problems or concerns about your covered services or care, Chapter 7 of this booklet tells what you can do. It gives the details about how to deal with all types of problems and complaints.

As explained in Chapter 7, what you need to do to follow up on a problem or concern depends on the situation. You might need to ask us to make a coverage decision for you, make an appeal to us to change a coverage decision, or make a complaint. Whatever you do – ask for a coverage decision, make an appeal, or make a complaint – **we are required to treat you fairly.**

You have the right to get a summary of information about the appeals and complaints that other members have filed against us in the past. To get this information, please call Customer Services (phone numbers are on the cover of this booklet).

Section 1.8 What can you do if you think you are being treated unfairly or your rights are not being respected?

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

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

Is it about something else?

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

- You can **call Customer Services** (phone numbers are on the cover of this booklet).
- You can **call the State Health Insurance Assistance Program**. For details about this organization and how to contact it, go to Chapter 2, Section 3.

Section 1.9 How to get more information about your rights

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

- You can **call Customer Services** (phone numbers are on the cover of this booklet).
- You can **call the State Health Insurance Assistance Program**. For details about this organization and how to contact it, go to Chapter 2, Section 3.
- You can contact **Medicare**.
  - You can visit the Medicare web site (http://www.medicare.gov) to read or download the publication "Your Medicare Rights & Protections."
  - Or, you can call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, seven days a week. TTY users should call 1-877-486-2048.

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

Section 2.1 What are your responsibilities?

Things you need to do as a member of the plan are listed below. If you have any questions, please call Customer Services (phone numbers are on the cover of this booklet). We're here to help.

- ***Get familiar with your covered services and the rules you must follow to get these covered services.*** *Use this* Evidence of Coverage *booklet to learn what is covered for you and the rules you need to follow to get your covered services.*
  - Chapters 3 and 4 give the details about your medical services, including what is covered, what is not covered, rules to follow, and what you pay.
- ***If you have any other health insurance coverage in addition to our plan, or separate prescription drug coverage, you are required to tell us.*** *Please call Customer Services to let us know.*
  - We are required to follow rules set by Medicare to make sure that you are using all of your coverage in combination when you get your covered services from our plan. This is called "**coordination of benefits**" because it involves coordinating the health benefits you get from our plan with any other benefits available to you. We'll help you with it.
- ***Tell your doctor and other health care providers that you are enrolled in our plan.*** *Show your plan membership card whenever you get your medical care.*
- ***Help your doctors and other providers help you by giving them information, asking questions, and following through on your care.***
  - To help your doctors and other health providers give you the best care, learn as much as you are able to about your health problems and give them the information they need about you and your health. Follow the treatment plans and instructions that you and your doctors agree upon.
  - If you have any questions, be sure to ask. Your doctors and other health care providers are supposed to explain things in a way you can understand. If you ask a question and you don't understand the answer you are given, ask again.
- ***Be considerate.*** *We expect all our members to respect the rights of other patients. We also expect you to act in a way that helps the smooth running of your doctor's office, hospitals, and other offices.*
- ***Pay what you owe.*** *As a plan member, you are responsible for these payments:*
  - You must pay your plan premiums to continue being a member of our plan.
  - In order to be eligible for our plan, you must maintain your eligibility for Medicare Part A and Part B. For that reason, some plan members must pay a premium for Medicare Part A and most plan members must pay a premium for Medicare Part B to remain a member of the plan.
  - For some of your medical services covered by the plan, you must pay your share of the cost when you get the service. This will be a copayment (a fixed amount) or coinsurance (a percentage of the total cost). Chapter 4 tells what you must pay for your medical services.
  - If you get any medical services that are not covered by our plan or by other insurance you may have, you must pay the full cost.
- ***Tell us if you move.*** *If you are going to move, it's important to tell us right away. Call Customer Services (phone numbers are on the cover of this booklet).*
  - **If you move *outside* of our plan service area, you cannot remain a member of our plan.** (Chapter 1 tells about our service area.) We can help you figure out whether you are moving outside our service area. If you are leaving our service area, we can let you know if we have a plan in your new area.

- **If you move *within* our service area, we still need to know** so we can keep your membership record up to date and know how to contact you.

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

- Phone numbers and calling hours for Customer Services are on the cover of this booklet.
- For more information on how to reach us, including our mailing address, please see Chapter 2.

Chapter 7. What to do if you have a problem or complaint (coverage decisions, appeals, complaints)

BACKGROUND

COVERAGE DECISIONS AND APPEALS

MAKING COMPLAINTS

BACKGROUND

SECTION 1 Introduction

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

This chapter explains two types of processes for handling problems and concerns:

- For some types of problems, you need to use the **process for coverage decisions and making appeals**.
- For other types of problems you need to use the **process for making complaints**.

Both of these processes have been approved by Medicare. To ensure fairness and prompt handling of your problems, each process has a set of rules, procedures, and deadlines that must be followed by us and by you.

Which one do you use? That depends on the type of problem you are having. The guide in Section 3 will help you identify the right process to use.

Section 1.2 What about the legal terms?

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

To keep things simple, this chapter explains the legal rules and procedures using more common words in place of certain legal terms. For example, this chapter generally says "making a complaint" rather than "filing a grievance," "coverage decision" rather than "organization determination" and "Independent Review Organization" instead of "Independent Review Entity." It also uses abbreviations as little as possible.

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

SECTION 2 You can get help from government organizations that are not connected with us

Section 2.1 Where to get more information and personalized assistance

Sometimes it can be confusing to start or follow through the process for dealing with a problem. This can be especially true if you do not feel well or have limited energy. Other times, you may not have the knowledge you need to take the next step. Perhaps both are true for you.

Get help from an independent government organization

We are always available to help you. But in some situations you may also want help or guidance from someone who is not connected with us. You can always contact your **State Health Insurance Assistance Program (SHIP)**. This government program has trained counselors in every state. The program is not connected with us or with any insurance company or health plan. The counselors at this program can help you understand which process you should use to handle a problem you are having. They can also answer your questions, give you more information, and offer guidance on what to do.

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

You can also get help and information from Medicare

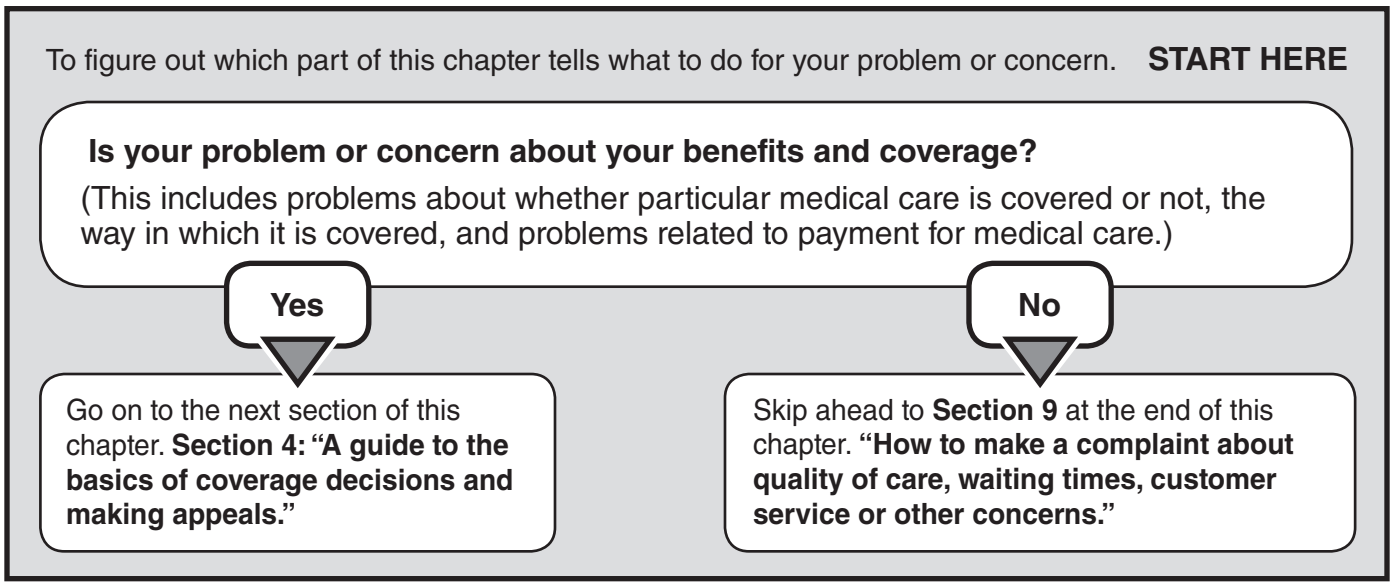
For more information and help in handling a problem, you can also contact Medicare. Here are two ways to get information directly from Medicare:

- You can call 1-800-MEDICARE (1-800-633-4227) 24 hours a day, seven days a week. TTY users should call 1-877-486-2048.
- You can visit the Medicare web site (http://www.medicare.gov).

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

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

If you have a problem or concern and you want to do something about it, you don't need to read this whole chapter. You just need to find and read the parts of this chapter that apply to your situation. The guide that follows will help.



COVERAGE DECISIONS AND APPEALS

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

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

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

Asking for coverage decisions

A coverage decision is a decision we make about your benefits and coverage or about the amount we will pay for your medical services. We and/or your doctor make a coverage decision for you whenever you go to a doctor for medical care. You can also contact us and ask for a coverage decision. For example, if you want to know if we will cover a medical service before you receive it, you can ask us to make a coverage decision for you.

We are making a coverage decision for you whenever we decide what is covered for you and how much we pay. In some cases we might decide a service is not covered or is no longer covered by Medicare for you. If you disagree with this coverage decision, you can make an appeal.

Making an appeal

If we make a coverage decision and you are not 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 have made.

When you make an appeal, we review the coverage decision we have made to check to see if we were following all of the rules properly. When we have completed the review we give you our decision.

If we say no to all or part of your Level 1 Appeal, your case will automatically go on to a Level 2 Appeal. The Level 2 Appeal is conducted by an independent organization that is not connected to us. If you are not satisfied with the decision at the Level 2 Appeal, you may be able to continue through several more levels of appeal.

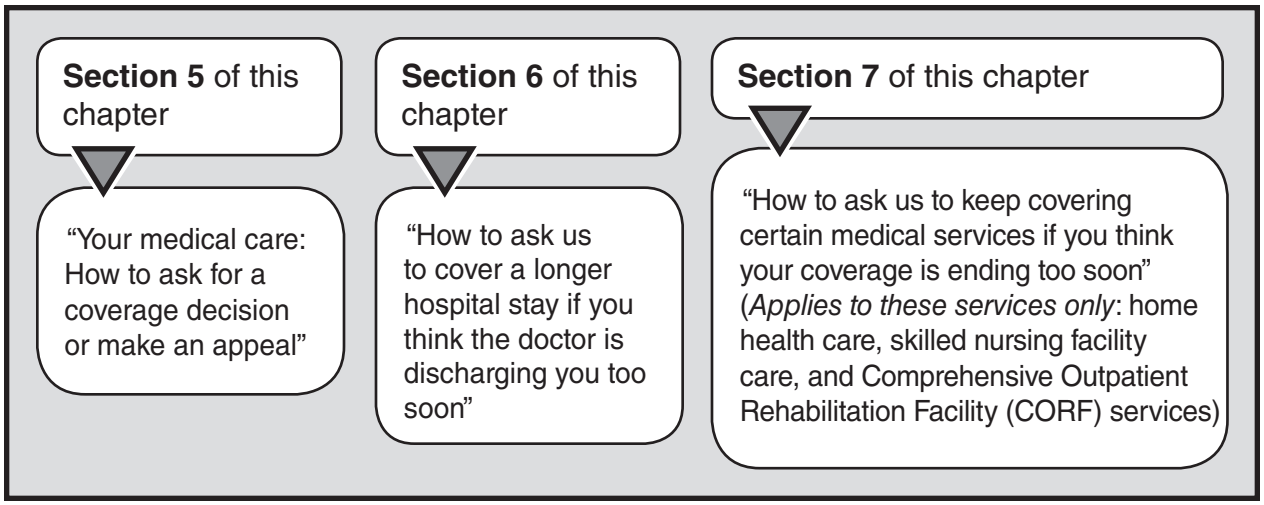
Section 4.2 How to get help when you are asking for a coverage decision or making an appeal

Would you like some help? Here are resources you may wish to use if you decide to ask for any kind of coverage decision or appeal a decision:

- You **can call Customer Services** (phone numbers are on the cover).
- To **get free help from an independent organization** that is not connected with us, contact your State Health Insurance Assistance Program (see Section 2 of this chapter).
- **Your doctor or other provider can make a request for you.** Your doctor or other provider can request a coverage decision or a Level 1 Appeal on your behalf. To request any appeal after Level 1, your doctor or other provider must be appointed as your representative.
- **You can ask someone to act on your behalf.** If you want to, you can name another person to act for you as your "representative" to ask for a coverage decision or make an appeal.
  - There may be someone who is already legally authorized to act as your representative under State law.
  - If you want a friend, relative, your doctor or other provider, or other person to be your representative, call Customer Services and ask for the form to give that person permission to act on your behalf. The form must be signed by you and by the person who you would like to act on your behalf. You must give us a copy of the signed form.
- **You also have the right to hire a lawyer to act for you.** You may contact your own lawyer, or get the name of a lawyer from your local bar association or other referral service. There are also groups that will give you free legal services if you qualify. However, **you are not required to hire a lawyer** to ask for any kind of coverage decision or appeal a decision.

Section 4.3 Which section of this chapter gives the details for <u>your</u> situation?

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



If you're still not sure which section you should be using, please call Customer Services (phone numbers are on the front cover). You can also get help or information from government organizations such as your State Health Insurance Assistance Program (Chapter 2, Section 3, of this booklet has the phone numbers for this program).

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

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

Section 5.1 This section tells what to do if you have problems getting coverage for medical care or if you want us to pay you back for our share of the cost of your care

This section is about your benefits for medical care and services. These are the benefits described in Chapter 4 of this booklet: *Medical Benefits Chart (what is covered and what you pay*). To keep things simple, we generally refer to "medical care coverage" or "medical care" in the rest of this section, instead of repeating "medical care or treatment or services" every time.

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

1. You are not getting certain medical care you want, and you believe that this care is covered by our plan.

2. We will not approve the medical care your doctor or other medical provider wants to give you, and you believe that this care is covered by the plan.

3. You have received medical care or services that you believe should be covered by the plan, but we have said we will not pay for this care.

4. You have received and paid for medical care or services that you believe should be covered by the plan, and you want to ask us to reimburse you for this care.

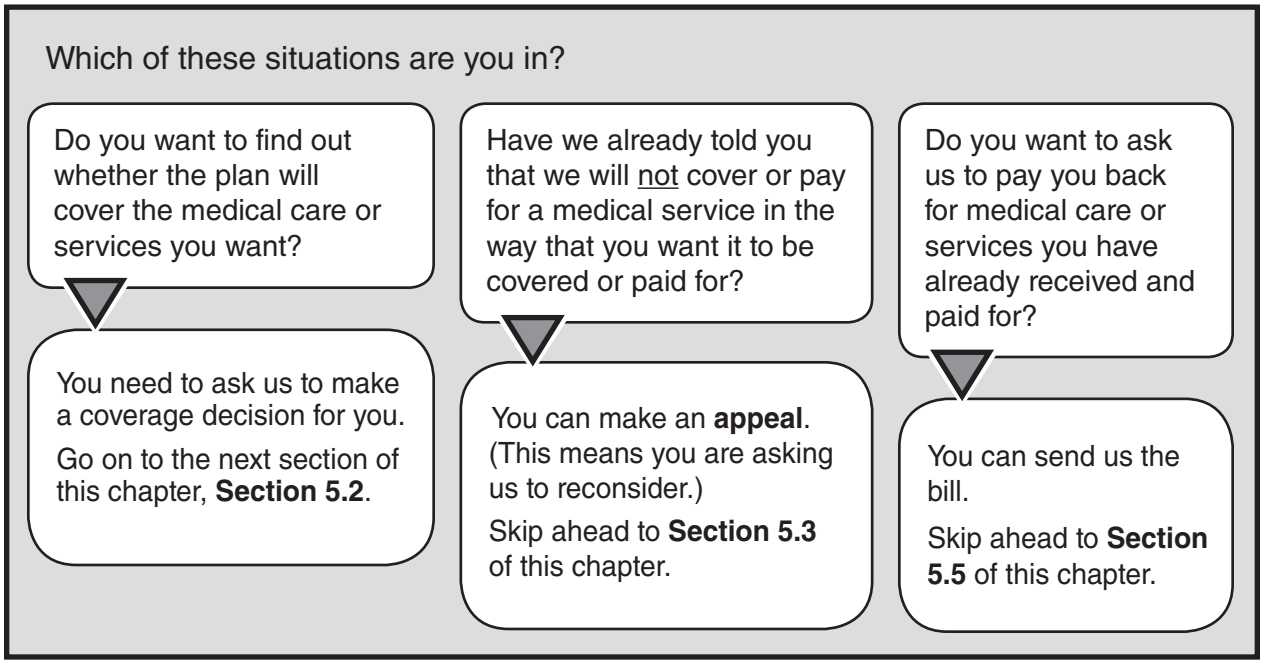
5. You are being told that coverage for certain medical care you have been getting will be reduced or stopped, and you believe that reducing or stopping this care could harm your health.

   • NOTE: **If the coverage that will be stopped is for hospital care, home health care, skilled nursing facility care, or Comprehensive Outpatient Rehabilitation Facility (CORF) services,** you need to read

a separate section of this chapter because special rules apply to these types of care. Here's what to read in those situations:

- Chapter 7, Section 6: *How to ask for a longer hospital stay if you think you are being asked to leave the hospital too soon.*
- Chapter 7, Section 7: *How to ask us to keep covering certain medical services if you think your coverage is ending too soon.* This section is about three services only: home health care, skilled nursing facility care, and Comprehensive Outpatient Rehabilitation Facility (CORF) services.

• For *all other* situations that involve being told that medical care you have been getting will be stopped, use this section (Section 5) as your guide for what to do.



Section 5.2 Step-by-step: How to ask for a coverage decision (how to ask us to authorize or provide the medical care coverage you want)

Legal Terms	When a coverage decision involves your medical care, it is called an **"organization determination."**

Step 1: You ask us to make a coverage decision on the medical care you are requesting. If your health requires a quick response, you should ask us to make a **"fast decision."**

Legal Terms	A "fast decision" is called an **"expedited decision."**

How to request coverage for the medical care you want

- Start by calling, writing, or faxing us to make your request for us to provide coverage for the medical care you want. You, or your doctor, or your representative can do this.
- For the details on how to contact us, go to Chapter 2, Section 1 and look for the section called, *How to contact us when you are asking for a coverage decision about your medical care*.

Generally we use the standard deadlines for giving you our decision

When we give you our decision, we will use the "standard" deadlines unless we have agreed to use the "fast" deadlines. **A standard decision means we will give you an answer within 14 days** after we receive your request.

- **However, we can take up to 14 more days** if you ask for more time, or if we need information (such as medical records) that may benefit you. If we decide to take extra days to make the decision, we will tell you in writing.
- If you believe we should *not* take extra days, you can file a "fast complaint" about our decision to take extra days. When you file a fast complaint, we will give you an answer to your complaint within 24 hours. (The process for making a complaint is different from the process for coverage decisions and appeals. For more information about the process for making complaints, including fast complaints, see Section 9 of this chapter.)

If your health requires it, ask us to give you a "fast decision"

- **A fast decision means we will answer within 72 hours.**
  - **However, we can take up to 14 more days** if we find that some information is missing that may benefit you, or if you need time to get information to us for the review. If we decide to take extra days, we will tell you in writing.
  - If you believe we should *not* take extra days, you can file a "fast complaint" about our decision to take extra days. (For more information about the process for making complaints, including fast complaints, see Section 9 of this chapter.) We will call you as soon as we make the decision.
- **To get a fast decision, you must meet two requirements:**
  - You can get a fast decision only if you are asking for coverage for medical care *you have not yet received*. (You cannot get a fast decision if your request is about payment for medical care you have already received.)
  - You can get a fast decision *only* if using the standard deadlines could *cause serious harm to your health or hurt your ability to function.*
- **If your doctor tells us that your health requires a "fast decision," we will automatically agree to give you a fast decision.**
- If you ask for a fast decision on your own, without your doctor's support, we will decide whether your health requires that we give you a fast decision.
  - If we decide that your medical condition does not meet the requirements for a fast decision, we will send you a letter that says so (and we will use the standard deadlines instead).
  - This letter will tell you that if your doctor asks for the fast decision, we will automatically give a fast decision.
  - The letter will also tell how you can file a "fast complaint" about our decision to give you a standard decision instead of the fast decision you requested. (For more information about the process for making complaints, including fast complaints, see Section 9 of this chapter.)

<u>Step 2:</u> We consider your request for medical care coverage and we give you our answer.

*Deadlines for a **"fast"** coverage decision*

- Generally, for a fast decision, we will give you our answer **within 72 hours**.
  - As explained above, we can take up to 14 more days under certain circumstances. If we decide to take extra days to make the decision, we will tell you in writing. If we take extra days, it is called "an extended time period."

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

- **If our answer is yes to part or all of what you requested,** we must authorize or provide the medical care coverage we have agreed to provide within 72 hours after we received your request. If we extended the time needed to make our decision, we will provide the coverage by the end of that extended period.
- **If our answer is no to part or all of what you requested,** we will send you a written statement that explains why we said no.

*Deadlines for a **"standard"** coverage decision*

- Generally, for a standard decision, we will give you our answer **within 14 days of receiving your request.**
  - We can take up to 14 more days ("an extended time period") under certain circumstances. If we decide to take extra days to make the decision, we will tell you in writing.
  - If we do not give you our answer within 14 days (or if there is an extended time period, by the end of that period), you have the right to appeal. Section 5.3 below tells how to make an appeal.
- **If our answer is yes to part or all of what you requested,** we must authorize or provide the coverage we have agreed to provide within 14 days after we received your request. If we extended the time needed to make our decision, we will provide the coverage by the end of that extended period.
- **If our answer is no to part or all of what you requested**, we will send you a written statement that explains why we said no.

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

- If we say no, you have the right to ask us to reconsider – and perhaps change – this decision by making an appeal. Making an appeal means making another try to get the medical care coverage you want.
- If you decide to make appeal, it means you are going on to Level 1 of the appeals process (see Section 5.3 below).

Section 5.3 Step-by-step: How to make a Level 1 Appeal (how to ask for a review of a medical care coverage decision made by us)

Legal Terms	When you start the appeal process by making an appeal, it is called the "first level of appeal" or a "Level 1 Appeal." An appeal to us about a medical care coverage decision is called a plan **"reconsideration."**

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

What to do

- **To start an appeal you, your representative, or in some cases your doctor must contact us.** For details on how to reach us for any purpose related to your appeal, go to Chapter 2, Section 1 look for section called, *How to contact us when you are making an appeal about your medical care.*
- **If you are asking for a standard appeal, make your standard appeal in writing by submitting a signed request.**
- **If you are asking for a fast appeal, make your appeal in writing or call us** at the phone number shown in Chapter 2, Section 1 (*How to contact us when you are making an appeal about your medical care*).
- **You must make your appeal request within 60 calendar days** from the date on the written notice we sent

to tell you our answer to your request for a coverage decision. If you miss this deadline and have a good reason for missing it, we may give you more time to make your appeal.

- **You can ask for a copy of the information regarding your medical decision and add more information to support your appeal.**
  - You have the right to ask us for a copy of the information regarding your appeal. We are allowed to charge a fee for copying and sending this information to you.
  - If you wish, you and your doctor may give us additional information to support your appeal.

If your health requires it, ask for a "fast appeal" (you can make an oral request)

Legal Terms	A "fast appeal" is also called an **"expedited appeal."**

- If you are appealing a decision we made about coverage for care you have not yet received, you and/or your doctor will need to decide if you need a "fast appeal."
- The requirements and procedures for getting a "fast appeal" are the same as those for getting a "fast decision." To ask for a fast appeal, follow the instructions for asking for a fast decision. (These instructions are given earlier in this section.)
- If your doctor tells us that your health requires a "fast appeal," we will give you a fast appeal.

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

- When we are reviewing your appeal, we take another careful look at all of the information about your request for coverage of medical care. We check to see if we were following all the rules when we said no to your request.
- We will gather more information if we need it. We may contact you or your doctor to get more information.

*Deadlines for a **"fast" appeal***

- When we are using the fast deadlines, we must give you our answer **within 72 hours after we receive your appeal**. We will give you our answer sooner if your health requires us to do so.
  - However, if you ask for more time, or if we need to gather more information that may benefit you, we **can take up to 14 more calendar days.** If we decide to take extra days to make the decision, we will tell you in writing.
  - If we do not give you an answer within 72 hours (or by the end of the extended time period if we took extra days), we are required to automatically send your request on to Level 2 of the appeals process, where it will be reviewed by an independent organization. Later in this section, we tell you about this organization and explain what happens at Level 2 of the appeals process.
- **If our answer is yes to part or all of what you requested,** we must authorize or provide the coverage we have agreed to provide within 72 hours after we receive your appeal.
- **If our answer is no to part or all of what you requested,** we will send you a written denial notice informing you that we have automatically sent your appeal to the Independent Review Organization for a Level 2 Appeal.

*Deadlines for a **"standard" appeal***

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

- However, if you ask for more time, or if we need to gather more information that may benefit you, **we can take up to 14 more calendar days.**
- If we do not give you an answer by the deadline above (or by the end of the extended time period if we took extra days), we are required to send your request on to Level 2 of the appeals process, where it will be reviewed by an independent outside organization. Later in this section, we tell about this review organization and explain what happens at Level 2 of the appeals process.

- **If our answer is yes to part or all of what you requested,** we must authorize or provide the coverage we have agreed to provide within 30 days after we receive your appeal.
- **If our answer is no to part or all of what you requested**, we will send you a written denial notice informing you that we have automatically sent your appeal to the Independent Review Organization for a Level 2 Appeal.

Step 3: If we say no to part or all of your appeal, your case will *automatically* be sent on to the next level of the appeals process.

- To make sure we were following all the rules when we said no to your appeal, **we are required to send your appeal to the "Independent Review Organization."** When we do this, it means that your appeal is going on to the next level of the appeals process, which is Level 2.

Section 5.4 Step-by-step: How to make a Level 2 Appeal

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

Legal Terms	The formal name for the "Independent Review Organization" is the **"Independent Review Entity."** It is sometimes called the **"IRE."**

Step 1: The Independent Review Organization reviews your appeal.

- **The Independent Review Organization is an outside, independent organization that is hired by Medicare**. This organization is not connected with us and it is not a government agency. This organization is a company chosen by Medicare to handle the job of being the Independent Review Organization. Medicare oversees its work.
- We will send the information about your appeal to this organization. This information is called your "case file." **You have the right to ask us for a copy of your case file.** We are allowed to charge you a fee for copying and sending this information to you.
- You have a right to give the Independent Review Organization additional information to support your appeal.
- Reviewers at the Independent Review Organization will take a careful look at all of the information related to your appeal.

*If you had a "fast" appeal at Level 1, you will also have a **"fast" appeal** at Level 2*

- If you had a fast appeal to us at Level 1, you will automatically receive a fast appeal at Level 2. The review organization must give you an answer to your Level 2 Appeal **within 72 hours** of when it receives your appeal.
- However, if the Independent Review Organization needs to gather more information that may benefit you, **it can take up to 14 more calendar days**.

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

- If you had a standard appeal to us at Level 1, you will automatically receive a standard appeal at Level 2. The review organization must give you an answer to your Level 2 Appeal **within 30 calendar days** of when it receives your appeal.
- However, if the Independent Review Organization needs to gather more information that may benefit you, **it can take up to 14 more calendar days**.

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

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

- **If the review organization says yes to part or all of what you requested,** we must authorize the medical care coverage within 72 hours or provide the service within 14 calendar days after we receive the decision from the review organization.
- **If this organization says no to part or all of your appeal**, it means they agree with us that your request (or part of your request) for coverage for medical care should not be approved. (This is called "upholding the decision." It is also called "turning down your appeal.")
  - The notice you get from the Independent Review Organization will tell you in writing if your case meets the requirements for continuing with the appeals process. For example, to continue and make another appeal at Level 3, the dollar value of the medical care coverage you are requesting must meet a certain minimum. If the dollar value of the coverage you are requesting is too low, you cannot make another appeal, which means that the decision at Level 2 is final.

Step 3: If your case meets the requirements, you choose whether you want to take your appeal further.

- There are three additional levels in the appeals process after Level 2 (for a total of five levels of appeal).
- If your Level 2 Appeal is turned down and you meet the requirements to continue with the appeals process, you must decide whether you want to go on to Level 3 and make a third appeal. The details on how to do this are in the written notice you got after your Level 2 Appeal.
- The Level 3 Appeal is handled by an administrative law judge. Section 8 in this chapter tells more about Levels 3, 4, and 5 of the appeals process.

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

If you want to ask us for payment for medical care, start by reading Chapter 5 of this booklet: *Asking us to pay our share of a bill you have received for medical services*. Chapter 5 describes the situations in which you may need to ask for reimbursement or to pay a bill you have received from a provider. It also tells how to send us the paperwork that asks us for payment.

Asking for reimbursement is asking for a coverage decision from us

If you send us the paperwork that asks for reimbursement, you are asking us to make a coverage decision (for more information about coverage decisions, see Section 4.1 of this chapter). To make this coverage decision, we will check to see if the medical care you paid for is a covered service (see Chapter 4: *Medical Benefits Chart (what is covered and what you pay)*). We will also check to see if you followed all the rules for using your coverage for medical care (these rules are given in Chapter 3 of this booklet: *Using the plan coverage for your medical services*).

We will say yes or no to your request

- If the medical care you paid for is covered and you followed all the rules, we will send you the payment for our share of the cost of your medical care within 60 calendar days after we receive your request. Or, if you haven't paid for the services, we will 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 medical care is *not* covered, or you did *not* follow all the rules, we will not send payment. Instead, we will send you a letter that says we will not pay for the services and the reasons why. (When we turn down your request for payment, it's the same as saying *no* to your request for a coverage decision.)

What if you ask for payment and we say that we will not pay?

If you do not agree with our decision to turn you down, **you can make an appeal**. If you make an appeal, it means you are asking us to change the coverage decision we made when we turned down your request for payment.

To make this appeal, follow the process for appeals that we describe in part 5.3 of this section. Go to this part for step-by-step instructions. When you are following these instructions, please note:

- If you make an appeal for reimbursement, we must give you our answer within 60 calendar days after we receive your appeal. (If you are asking us to pay you back for medical care you have already received and paid for yourself, you are not allowed to ask for a fast appeal.)
- If the Independent Review Organization reverses our decision to deny payment, we must send the payment you have requested 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 you requested to you or to the provider within 60 calendar days.

SECTION 6 How to ask us to cover a longer hospital stay if you think the doctor is discharging you too soon

When you are admitted to a hospital, you have the right to get all of your covered hospital services that are necessary to diagnose and treat your illness or injury. For more information about our coverage for your hospital care, including any limitations on this coverage, see Chapter 4 of this booklet: *Medical Benefits Chart (what is covered and what you pay).*

During your hospital stay, your doctor and the hospital staff will be working with you to prepare for the day when you will leave the hospital. They will also help arrange for care you may need after you leave.

- The day you leave the hospital is called your "**discharge date**." The plan coverage of your hospital stay ends on this date.
- When your discharge date has been decided, your doctor or the hospital staff will let you know.
- If you think you are being asked to leave the hospital too soon, you can ask for a longer hospital stay and your request will be considered. This section tells you how to ask.

Section 6.1 During your hospital stay, you will get a written notice from Medicare that tells about your rights

During your hospital stay, you will be given a written notice called *An Important Message from Medicare about Your Rights.* Everyone with Medicare gets a copy of this notice whenever they are admitted to a hospital. Someone at the hospital is supposed to give it to you within two days after you are admitted.

1. Read this notice carefully and ask questions if you don't understand it. It tells you about your rights as a hospital patient, including:

- Your right to receive Medicare-covered services during and after your hospital stay, as ordered by your doctor. This includes the right to know what these services are, who will pay for them, and where you can get them.
- Your right to be involved in any decisions about your hospital stay, and know who will pay for it.
- Where to report any concerns you have about quality of your hospital care.
- What to do if you think you are being discharged from the hospital too soon.

Legal Terms	The written notice from Medicare tells you how you can **"make an appeal."** Making an appeal is a formal, legal way to ask for a delay in your discharge date so that your hospital care will be covered for a longer time. (Section 7.3 below tells how to make this appeal.)

2. You must sign the written notice to show that you received it and understand your rights.

- You or someone who is acting on your behalf must sign the notice. (Section 4 of this chapter tells how you can give written permission to someone else to act as your representative.)
- Signing the notice shows *only* that you have received the information about your rights. The notice does not give your discharge date (your doctor or hospital staff will tell you your discharge date). Signing the notice **does *not* mean** you are agreeing on a discharge date.

3. Keep your copy of the signed notice so you will have the information about making an appeal (or reporting a concern about quality of care) handy if you need it.

- If you sign the notice more than two days before the day you leave the hospital, you will get another copy before you are scheduled to be discharged.
- To look at a copy of this notice in advance, you can call Customer Services or 1-800 MEDICARE (1-800-633-4227), 24 hours a day, seven days a week. TTY users should call 1-877-486-2048. You can also see it online at http://www.cms.hhs.gov.

Section 6.2 Step-by-step: How to make a Level 1 Appeal to change your hospital discharge date

If you want to ask for your hospital services to be covered by our plan for a longer time, you will need to use the appeals process to make this request. Before you start, understand what you need to do and what the deadlines are.

- **Follow the process.** Each step in the first two levels of the appeals process is explained below.
- **Meet the deadlines.** The deadlines are important. Be sure that you understand and follow the deadlines that apply to things you must do.
- **Ask for help if you need it**. If you have questions or need help at any time, please call Customer Services (phone numbers are on the front cover of this booklet). Or call your State Health Insurance Assistance Program, a government organization that provides personalized assistance (see Section 2 of this chapter).

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

Legal Terms	When you start the appeal process by making an appeal, it is called the "first level of appeal" or a "Level 1 Appeal."

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

Legal Terms	A "fast review" is also called an **"immediate review"** or an **"expedited review."**

What is the Quality Improvement Organization?

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

How can you contact this organization?

- The written notice you received (*An Important Message from Medicare*) tells you how to reach this organization. (Or find the name, address, and phone number of the Quality Improvement Organization for your state in Chapter 2, Section 4, of this booklet.)

Act quickly:

- To make your appeal, you must contact the Quality Improvement Organization *before* you leave the hospital and **no later than your planned discharge date.** (Your "planned discharge date" is the date that has been set for you to leave the hospital.)
  - If you meet this deadline, you are allowed to stay in the hospital *after* your discharge date *without paying for it* while you wait to get the decision on your appeal from the Quality Improvement Organization.
  - If you do *not* meet this deadline, and you decide to stay in the hospital after your planned discharge date, *you may have to pay all of the costs* for hospital care you receive after your planned discharge date.
- If you miss the deadline for contacting the Quality Improvement Organization about your appeal, you can make your appeal directly to our plan instead. For details about this other way to make your appeal, see Section 6.4.

Step 2: The Quality Improvement Organization conducts an independent review of your case.

What happens during this review?

- Health professionals at the Quality Improvement Organization (we will call them "the reviewers" for short) will ask you (or your representative) why you believe coverage for the services should continue. You don't have to prepare anything in writing, but you may do so if you wish.
- The reviewers will also look at your medical information, talk with your doctor, and review information that the hospital and our plan has given to them.
- By noon of the day after the reviewers informed us of your appeal, you will also get a written notice that gives your planned discharge date and explains the reasons why your doctor, the hospital, and we think it is right (medically appropriate) for you to be discharged on that date.

Legal Terms	This written explanation is called the "**Detailed Notice of Discharge."** You can get a sample of this notice by calling Customer Services or 1-800-MEDICARE (1-800-633-4227, 24 hours a day, seven days a week. TTY users should call 1-877-486-2048). Or you can get see a sample notice online at http://www.cms.hhs.gov/BNI/

Step 3: Within one full day after it has all the needed information, the Quality Improvement Organization will give you its answer to your appeal.

What happens if the answer is yes?

- If the review organization says *yes* to your appeal, **our plan must keep providing your covered hospital services for as long as these services are medically necessary.**
- You will have to keep paying your share of the costs (such as deductibles or copayments, if these apply). In addition, there may be limitations on your covered hospital services. (See Chapter 4 of this booklet).

What happens if the answer is no?

- If the review organization says *no* to your appeal, they are saying that your planned discharge date is medically appropriate. (Saying *no* to your appeal is also called *turning down* your appeal.) If this happens, **the plan coverage for your hospital services will end** at noon on the day *after* the Quality Improvement Organization gives you its answer to your appeal.
- If the review organization says *no* to your appeal and you decide to stay in the hospital, then **you may have to pay the full cost** of hospital care you receive after noon on the day after the Quality Improvement Organization gives you its answer to your appeal.

Step 4: If the answer to your Level 1 Appeal is no, you decide if you want to make another appeal.

- If the Quality Improvement Organization has turned down your appeal, *and* you stay in the hospital after your planned discharge date, then you can make another appeal. Making another appeal means you are going on to "Level 2" of the appeals process.

Section 6.3 Step-by-step: How to make a Level 2 Appeal to change your hospital discharge date

If the Quality Improvement Organization has turned down your appeal, *and* you stay in the hospital after your planned discharge date, then you can make a Level 2 Appeal. During a Level 2 Appeal, you ask the Quality Improvement Organization to take another look at the decision they made on your first appeal.

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

Step 1: You contact the Quality Improvement Organization again and ask for another review.

- You must ask for this review **within 60 calendar days** after the day when the Quality Improvement Organization said *no* to your Level 1 Appeal. You can ask for this review only if you stayed in the hospital after the date that your coverage for the care ended.

Step 2: The Quality Improvement Organization does a second review of your situation.

- Reviewers at the Quality Improvement Organization will take another careful look at all of the information related to your appeal.

Step 3: Within 14 calendar days, the Quality Improvement Organization reviewers will decide on your appeal and tell you their decision.

If the review organization says yes:

- **We must reimburse you** for our share of the costs of hospital care you have received since noon on the day after the date your first appeal was turned down by the Quality Improvement Organization. **We must continue providing coverage** for your hospital care for as long as it is medically necessary.
- You must continue to pay your share of the costs and coverage limitations may apply.

If the review organization says no:

- It means they agree with the decision they made to your Level 1 Appeal and will not change it. This is called "upholding the decision." It is also called "turning down your appeal."
- The notice you get will tell you in writing what you can do if you wish to continue with the review process. It will give you the details about how to go on to the next level of appeal, which is handled by a judge.

Step 4: If the answer is no, you will need to decide whether you want to take your appeal further by going on to Level 3.

- There are three additional levels in the appeals process after Level 2 (for a total of five levels of appeal). If the review organization turns down your Level 2 Appeal, you can choose whether to accept that decision or whether to go on to Level 3 and make another appeal. At Level 3, your appeal is reviewed by a judge.
- Section 8 in this chapter tells more about Levels 3, 4, and 5 of the appeals process.

Section 6.4 What if you miss the deadline for making your Level 1 Appeal?

You can appeal to us instead

As explained above in Section 6.2, you must act quickly to contact the Quality Improvement Organization to start your first appeal of your hospital discharge. ("Quickly" means before you leave the hospital and no later than your planned discharge date). If you miss the deadline for contacting this organization, there is another way to make your appeal.

If you use this other way of making your appeal, *the first two levels of appeal are different.*

Step-by-Step: How to make a Level 1 *Alternate* Appeal

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

Legal Terms	A "fast" review (or "fast appeal") is also called an **"expedited" review** (or **"expedited appeal"**).

Step 1: Contact us and ask for a "fast review."

- For details on how to contact us, go to Chapter 2, Section 1 and look for the section called, *How to contact us when you are making an appeal about your medical care*.
- **Be sure to ask for a "fast review**." This means you are asking us to give you an answer using the "fast" deadlines rather than the "standard" deadlines.

Step 2: We do a "fast" review of your planned discharge date, checking to see if it was medically appropriate.

- During this review, we take a look at all of the information about your hospital stay. We check to see if your planned discharge date was medically appropriate. We will check to see if the decision about when you should leave the hospital was fair and followed all the rules.
- In this situation, we will use the "fast" deadlines rather than the standard deadlines for giving you the answer to this review.

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

- **If we say yes to your fast appeal,** it means we have agreed with you that you still need to be in the hospital after the discharge date, and will keep providing your covered services for as long as it is medically necessary. It also means that we have agreed to reimburse you for our share of the costs of care you have received since the date when we said your coverage would end. (You must pay your share of the costs and there may be coverage limitations that apply.)
- **If we say no to your fast appeal,** we are saying that your planned discharge date was medically appropriate. Our coverage for your hospital services ends as of the day we said coverage would end.
- If you stayed in the hospital *after* your planned discharge date, then **you may have to pay the full cost** of hospital care you received after the planned discharge date. You will be responsible for the cost of care starting from noon on the day after our plan says no to your appeal.

Step 4: If we say *no* to your fast appeal, your case will *automatically* be sent on to the next level of the appeals process.

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

Step-by-Step: How to make a Level 2 *Alternate* Appeal

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

Legal Terms	The formal name for the "Independent Review Organization" is the **"Independent Review Entity."** It is sometimes called the **"IRE."**

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

- We are required to send the information for your Level 2 Appeal to the Independent Review Organization within 24 hours of when we tell you that we are saying no to your first appeal. (If you think we are not meeting this deadline or other deadlines, you can make a complaint. The complaint process is different from the appeal process. Section 9 of this chapter tells how to make a complaint.)

Step 2: The Independent Review Organization does a "fast review" of your appeal. The reviewers give you an answer within 72 hours.

- **The Independent Review Organization is an outside, independent organization that is hired by Medicare**. This organization is not connected with us and it is not a government agency. This organization is a company chosen by Medicare to handle the job of being the Independent Review Organization. Medicare oversees its work.

- Reviewers at the Independent Review Organization will take a careful look at all of the information related to your appeal of your hospital discharge.
- **If this organization says *yes* to your appeal,** then we must reimburse you (pay you back) for our share of the costs of hospital care you have received since the date of your planned discharge. We must also continue the plan coverage of your hospital services for as long as it is medically necessary. You must continue to pay your share of the costs. If there are coverage limitations, these could limit how much we would reimburse or how long we would continue to cover your services.
- **If this organization says *no* to your appeal,** it means they agree with us that your planned hospital discharge date was medically appropriate. (This is called "upholding the decision." It is also called "turning down your appeal.")
  - The notice you get from the Independent Review Organization will tell you in writing what you can do if you wish to continue with the review process. It will give you the details about how to go on to a Level 3 Appeal, which is handled by a judge.

Step 3: If the Independent Review Organization turns down your appeal, you choose whether you want to take your appeal further.

- There are three additional levels in the appeals process after Level 2 (for a total of five levels of appeal). If reviewers say no to your Level 2 Appeal, you decide whether to accept their decision or go on to Level 3 and make a third appeal.
- Section 8 in this chapter tells more about Levels 3, 4, and 5 of the appeals process.

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

Section 7.1 *This section is about three services only:* Home health care, skilled nursing facility care, and Comprehensive Outpatient Rehabilitation Facility (CORF) services

This section is about the following types of care *only*:

- **Home health care services** you are getting.
- **Skilled nursing care** you are getting as a patient in a skilled nursing facility. (To learn about requirements for being considered a "skilled nursing facility," see Chapter 10, *Definitions of important words*.)
- **Rehabilitation care** you are getting as an outpatient at a Medicare-approved Comprehensive Outpatient Rehabilitation Facility (CORF). Usually, this means you are getting treatment for an illness or accident, or you are recovering from a major operation. (For more information about this type of facility, see Chapter 10, *Definitions of important words*.)

When you are getting any of these types of care, you have the right to keep getting your covered services for that type of care for as long as the care is needed to diagnose and treat your illness or injury. For more information on your covered services, including your share of the cost and any limitations to coverage that may apply, see Chapter 4 of this booklet: *Medical Benefits Chart (what is covered and what you pay).*

When we decide it is time to stop covering any of the three types of care for you, we are required to tell you in advance. When your coverage for that care ends, *we will stop paying our share of the cost for your care.*

If you think we are ending the coverage of your care too soon, **you can appeal our decision**. This section tells you how to ask.

Section 7.2 We will tell you in advance when your coverage will be ending

1. **You receive a notice in writing.** At least two days before we are going to stop covering your care, the agency or facility that is providing your care will give you a notice.
   - The written notice tells you the date when our plan will stop covering the care for you.

Legal Terms	In this written notice, we are telling you about a **"coverage decision"** we have made about when to stop covering your care. (For more information about coverage decisions, see Section 4 in this chapter.)

   - The written notice also tells what you can do if you want to ask us to change this decision about when to end your care, and keep covering it for a longer period of time.

Legal Terms	In telling what you can do, the written notice is telling how you can **"make an appeal."** Making an appeal is a formal, legal way to ask us to change the coverage decision we have made about when to stop your care. (Section 7.3 below tells how you can make an appeal.)

Legal Terms	The written notice is called the "**Notice of Medicare Non-Coverage."** To get a sample copy, call Customer Services or 1-800-MEDICARE (1-800-633-4227, 24 hours a day, seven days a week. TTY users should call 1-877-486-2048.). Or see a copy online at http://www.cms.hhs.gov/BNI/

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

Section 7.3 Step-by-step: How to make a Level 1 Appeal to have the plan cover your care for a longer time

If you want to ask us to cover your care for a longer period of time, you will need to use the appeals process to make this request. Before you start, understand what you need to do and what the deadlines are.

- **Follow the process.** Each step in the first two levels of the appeals process is explained below.
- **Meet the deadlines.** The deadlines are important. Be sure that you understand and follow the deadlines that apply to things you must do. There are also deadlines our plan must follow. (If you think we are not meeting our deadlines, you can file a complaint. Section 9 of this chapter tells you how to file a complaint.)
- **Ask for help if you need it**. If you have questions or need help at any time, please call Customer Services (phone numbers are on the front cover of this booklet). Or call your State Health Insurance Assistance Program, a government organization that provides personalized assistance (see Section 2 of this chapter).

During a Level 1 Appeal, the Quality Improvement Organization reviews your appeal and decides whether to change the decision made by us.

Legal Terms	When you start the appeal process by making an appeal, it is called the "first level of appeal" or "Level 1 Appeal."

<u>Step 1:</u> Make your Level 1 Appeal: contact the Quality Improvement Organization in your state and ask for a review. You must act quickly.

What is the Quality Improvement Organization?

- This organization is a group of doctors and other health care experts who are paid by the federal government. These experts are not part of us. They check on the quality of care received by people with Medicare and review our decisions about when it's time to stop covering certain kinds of medical care.

How can you contact this organization?

- The written notice you received tells you how to reach this organization. (Or find the name, address, and phone number of the Quality Improvement Organization for your state in Chapter 2, Section 4, of this booklet.)

What should you ask for?

- Ask this organization to do an independent review of whether it is medically appropriate for us to end coverage for your medical services.

Your deadline for contacting this organization.

- You must contact the Quality Improvement Organization to start your appeal *no later than noon of the day after you receive the written notice telling you when we will stop covering your care*.
- If you miss the deadline for contacting the Quality Improvement Organization about your appeal, you can make your appeal directly to us instead. For details about this other way to make your appeal, see Section 7.5.

<u>Step 2:</u> The Quality Improvement Organization conducts an independent review of your case.

What happens during this review?

- Health professionals at the Quality Improvement Organization (we will call them "the reviewers" for short) will ask you (or your representative) why you believe coverage for the services should continue. You don't have to prepare anything in writing, but you may do so if you wish.
- The review organization will also look at your medical information, talk with your doctor, and review information that our plan has given to them.
- By the end of the day the reviewers informed us of your appeal, you will also get a written notice from us that give our reasons for wanting to end the plan coverage for your services.

Legal Terms	This notice explanation is called the "**Detailed Explanation of Non-Coverage."**

<u>Step 3:</u> Within one full day after they have all the information they need, the reviewers will tell you their decision.

What happens if the reviewers say yes to your appeal?

- If the reviewers say *yes* to your appeal, then **we must keep providing your covered services for as long as it is medically necessary.**
- You will have to keep paying your share of the costs (such as deductibles or copayments, if these apply). In addition, there may be limitations on your covered services (see Chapter 4 of this booklet).

What happens if the reviewers say no to your appeal?

- If the reviewers say *no* to your appeal, then **your coverage will end on the date we have told you.** We will stop paying our share of the costs of this care.
- If you decide to keep getting the home health care, or skilled nursing facility care, or Comprehensive Outpatient Rehabilitation Facility (CORF) services *after* this date when your coverage ends, then **you will have to pay the full cost** of this care yourself.

Step 4: If the answer to your Level 1 Appeal is no, you decide if you want to make another appeal.

- This first appeal you make is "Level 1" of the appeals process. If reviewers say *no* to your Level 1 Appeal – and you choose to continue getting care after your coverage for the care has ended – then you can make another appeal.
- Making another appeal means you are going on to "Level 2" of the appeals process.

Section 7.4 Step-by-step: How to make a Level 2 Appeal to have the plan cover your care for a longer time

If the Quality Improvement Organization has turned down your appeal and you choose to continue getting care after your coverage for the care has ended, then you can make a Level 2 Appeal. During a Level 2 Appeal, you ask the Quality Improvement Organization to take another look at the decision they made on your first appeal.

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

Step 1: You contact the Quality Improvement Organization again and ask for another review.

- You must ask for this review **within 60 days** after the day when the Quality Improvement Organization said *no* to your Level 1 Appeal. You can ask for this review only if you continued getting care after the date that your coverage for the care ended.

Step 2: The Quality Improvement Organization does a second review of your situation.

- Reviewers at the Quality Improvement Organization will take another careful look at all of the information related to your appeal.

Step 3: Within 14 days, the Quality Improvement Organization reviewers will decide on your appeal and tell you their decision.

What happens if the review organization says yes to your appeal?

- **We must reimburse you** for our share of the costs of care you have received since the date when we said your coverage would end. **The plan must continue providing coverage** for the care for as long as it is medically necessary.
- You must continue to pay your share of the costs and there may be coverage limitations that apply.

What happens if the review organization says no?

- It means they agree with the decision they made to your Level 1 Appeal and will not change it. (This is called "upholding the decision." It is also called "turning down your appeal.")
- The notice you get will tell you in writing what you can do if you wish to continue with the review process. It will give you the details about how to go on to the next level of appeal, which is handled by a judge.

Step 4: If the answer is no, you will need to decide whether you want to take your appeal further.

- There are three additional levels of appeal after Level 2, for a total of five levels of appeal. If reviewers turn down your Level 2 Appeal, you can choose whether to accept that decision or to go on to Level 3 and make another appeal. At Level 3, your appeal is reviewed by a judge.
- Section 8 in this chapter tells more about Levels 3, 4, and 5 of the appeals process.

Section 7.5 What if you miss the deadline for making your Level 1 Appeal?

You can appeal to our plan instead

As explained above in Section 7.3, you must act quickly to contact the Quality Improvement Organization to start your first appeal (within a day or two, at the most). If you miss the deadline for contacting this organization, there is another way to make your appeal. If you use this other way of making your appeal, *the first two levels of appeal are different.*

Step-by-Step: How to make a Level 1 *Alternate* Appeal

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

Here are the steps for a Level 1 Alternate Appeal:

Legal Terms	A "fast" review (or "fast appeal") is also called an **"expedited" review** (or **"expedited appeal"**).

Step 1: Contact us and ask for a "fast review."

- For details on how to contact us, go to Chapter 2, Section 1 and look for the section called, *How to contact us when you are making an appeal about your medical care*.
- **Be sure to ask for a "fast review**." This means you are asking us to give you an answer using the "fast" deadlines rather than the "standard" deadlines.

Step 2: We do a "fast" review of the decision we made about when to end coverage for your services.

- During this review, we take another look at all of the information about your case. We check to see if we were following all the rules when we set the date for ending the plan coverage for services you were receiving.
- We will use the "fast" deadlines rather than the standard deadlines for giving you the answer to this review. (Usually, if you make an appeal to us and ask for a "fast review," we are allowed to decide whether to agree to your request and give you a "fast review." But in this situation, the rules require us to give you a fast response if you ask for it.)

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

- **If we say yes to your fast appeal,** it means we have agreed with you that you need services longer, and will keep providing your covered services for as long as it is medically necessary. It also means that we have agreed to reimburse you for our share of the costs of care you have received since the date when we said your coverage would end. (You must pay your share of the costs and there may be coverage limitations that apply.)
- **If we say no to your fast appeal,** then your coverage will end on the date we have told you and we will not pay after this date. We will stop paying our share of the costs of this care.
- If you continued to get home health care, or skilled nursing facility care, or Comprehensive Outpatient Rehabilitation Facility (CORF) services *after* the date when we said your coverage would end, then **you will have to pay the full cost** of this care yourself.

Step 4: If we say *no* to your fast appeal, your case will *automatically* go on to the next level of the appeals process.

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

Step-by-Step: How to make a Level 2 *Alternate* Appeal

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

Legal Terms	The formal name for the "Independent Review Organization" is the **"Independent Review Entity."** It is sometimes called the **"IRE."**

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

- We are required to send the information for your Level 2 Appeal to the Independent Review Organization within 24 hours of when we tell you that we are saying no to your first appeal. (If you think we are not meeting this deadline or other deadlines, you can make a complaint. The complaint process is different from the appeal process. Section 9 of this chapter tells how to make a complaint.)

Step 2: The Independent Review Organization does a "fast review" of your appeal. The reviewers give you an answer within 72 hours.

- **The Independent Review Organization is an outside, independent organization that is hired by Medicare**. This organization is not connected with us and it is not a government agency. This organization is a company chosen by Medicare to handle the job of being the Independent Review Organization. Medicare oversees its work.
- Reviewers at the Independent Review Organization will take a careful look at all of the information related to your appeal.
- **If this organization says *yes* to your appeal,** then we must reimburse you (pay you back) for our share of the costs of care you have received since the date when we said your coverage would end. We must also continue to cover the care for as long as it is medically necessary. You must continue to pay your share of the costs. If there are coverage limitations, these could limit how much we would reimburse or how long we would continue to cover your services.

- **If this organization says *no* to your appeal,** it means they agree with the decision we made to your first appeal and will not change it. (This is called "upholding the decision." It is also called "turning down your appeal.")
  - The notice you get from the Independent Review Organization will tell you in writing what you can do if you wish to continue with the review process. It will give you the details about how to go on to a Level 3 Appeal.

Step 3: If the Independent Review Organization turns down your appeal, you choose whether you want to take your appeal further.

- There are three additional levels of appeal after Level 2, for a total of five levels of appeal. If reviewers say no to your Level 2 Appeal, you can choose whether to accept that decision or whether to go on to Level 3 and make another appeal. At Level 3, your appeal is reviewed by a judge.
- Section 8 in this chapter tells more about Levels 3, 4, and 5 of the appeals process.

SECTION 8 Taking your appeal to Level 3 and beyond

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

This section may be appropriate for you if you have made a Level 1 Appeal and a Level 2 Appeal, and both of your appeals have been turned down.

If the dollar value of the item or medical service you have appealed meets certain minimum levels, you may be able to go on to additional levels of appeal. If the dollar value is less than the minimum level, you cannot appeal any further. If the dollar value is high enough, the written response you receive to your Level 2 Appeal will explain who to contact and what to do to ask for a Level 3 Appeal.

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

Level 3 Appeal	**A judge who works for the federal government** will review your appeal and give you an answer. This judge is called an "Administrative Law Judge."

- **If the Administrative Law Judge says yes to your appeal, the appeals process *may* or *may not* be over** - We will decide whether to appeal this decision to Level 4. Unlike a decision at Level 2 (Independent Review Organization), we have the right to appeal a Level 3 decision that is favorable to you.
  - If we decide *not* to appeal the decision, we must authorize or provide you with the service within 60 days after receiving the judge's decision.
  - If we decide to appeal the decision, we will send you a copy of the Level 4 Appeal request with any accompanying documents. We may wait for the Level 4 Appeal decision before authorizing or providing the service in dispute.
- **If the Administrative Law Judge says no to your appeal, the appeals process *may* or *may not* be over**.
  - If you decide to accept this decision that turns down your appeal, the appeals process is over.
  - If you do not want to accept the decision, you can continue to the next level of the review process. If the administrative law judge says no to your appeal, the notice you get will tell you what to do next if you choose to continue with your appeal.

Level 4 Appeal	The **Medicare Appeals Council** will review your appeal and give you an answer. The Medicare Appeals Council works for the federal government.

- **If the answer is yes, or if the Medicare Appeals Council denies our request to review a favorable Level 3 Appeal decision, the appeals process *may* or *may not* be over** - We will decide whether to appeal this decision to Level 5. Unlike a decision at Level 2 (Independent Review Organization), we have the right to appeal a Level 4 decision that is favorable to you.
  - If we decide *not* to appeal the decision, we must authorize or provide you with the service within 60 days after receiving the Medicare Appeals Council's decision.
  - If we decide to appeal the decision, we will let you know in writing.
- **If the answer is no or if the Medicare Appeals Council denies the review request, the appeals process *may* or *may not* be over**.
  - If you decide to accept this decision that turns down your appeal, the appeals process is over.
  - If you do not want to accept the decision, you might be able to continue to the next level of the review process. If the Medicare Appeals Council says no to your appeal, the notice you get will tell you whether the rules allow you to go on to a Level 5 Appeal. If the rules allow you to go on, the written notice will also tell you who to contact and what to do next if you choose to continue with your appeal.

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

- This is the last step of the administrative appeals process.

MAKING COMPLAINTS

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

If your problem is about decisions related to benefits, coverage, or payment, then this section is *not for you*. Instead, you need to use the process for coverage decisions and appeals. Go to Section 4 of this chapter.

Section 9.1 What kinds of problems are handled by the complaint process?

This section explains how to use the process for making complaints. The complaint process is used for certain types of problems *only.* This includes problems related to quality of care, waiting times, and the customer service you receive. Here are examples of the kinds of problems handled by the complaint process.

If you have any of these kinds of problems, you can "make a complaint"

Quality of your medical care

- Are you unhappy with the quality of the care you have received (including care in the hospital)?

Respecting your privacy

- Do you believe that someone did not respect your right to privacy or shared information about you that you feel should be confidential?

Disrespect, poor customer service, or other negative behaviors

- Has someone been rude or disrespectful to you?
- Are you unhappy with how our Customer Services has dealt with you?
- Do you feel you are being encouraged to leave our plan?

Waiting times

- Are you having trouble getting an appointment, or waiting too long to get it?
- Have you been kept waiting too long by doctors or other health professionals? Or by Customer Services or other staff at our plan?
- Examples include waiting too long on the phone, in the waiting room, or in the exam room.

Cleanliness

- Are you unhappy with the cleanliness or condition of a clinic, hospital, or doctor's office?

Information you get from us

- Do you believe we have not given you a notice that we are required to give?
- Do you think written information we have given you is hard to understand?

The next page has more examples of possible reasons for making a complaint

These types of complaints are all related to the *timeliness* of our actions related to coverage decisions and appeals

The process of asking for a coverage decision and making appeals is explained in sections 4-8 of this chapter. If you are asking for a decision or making an appeal, you use that process, not the complaint process.

However, if you have already asked for a coverage decision or made an appeal, and you think that we are not responding quickly enough, you can also make a complaint about our slowness. Here are examples:

- If you have asked us to give you a "fast response" for a coverage decision or appeal, and we have said we will not, you can make a complaint.
- If you believe we are not meeting the deadlines for giving you a coverage decision or an answer to an appeal you have made, you can make a complaint.
- When a coverage decision we made is reviewed and we are told that we must cover or reimburse you for certain medical services, there are deadlines that apply. If you think we are not meeting these deadlines, you can make a complaint.
- When we do not give you a decision on time, we are required to forward your case to the Independent Review Organization. If we do not do that within the required deadline, you can make a complaint.

Section 9.2 The formal name for "making a complaint" is "filing a grievance"

Legal Terms	• What this section calls a **"complaint"** is also called a **"grievance."** • Another term for **"making a complaint"** is **"filing a grievance."** • Another way to say "**using the process for complaints"** is "**using the process for filing a grievance."**

Section 9.3 Step-by-step: Making a complaint

<u>Step 1:</u> Contact us promptly – either by phone or in writing.

- **Usually, calling Customer Services is the first step.** If there is anything else you need to do, Customer Services will let you know. Call 612-676-3600 or 1-877-523-1515, 8 a.m. to 8 p.m. daily. TTY users call 612-676-6810 or 1-800-688-2534.
- **If you do not wish to call (or you called and were not satisfied), you can put your complaint in writing and send it to us.** If you do this, it means that we will use our *formal procedure* for answering grievances. Here's how it works:

  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 problem or tell you our decision. If you request a written response to your oral complaint, we will respond in writing to you.
- We may extend the timeframe for resolving your oral complaint by an additional 14 calendar days if you request the extension or if we justify a need for additional information and the delay is in your best interest. If we extend the deadline, we must immediately notify you in writing of the reason(s) for the delay.
- If we cannot resolve your oral complaint over the phone, or if you do not agree or are dissatisfied with our response, we have a formal procedure where you can file a written grievance.

Written complaint

- You can write us about your complaint. Mail your written grievance letter to:

  UCare
  Member Complaints, Appeals, and Grievances
  P.O. Box 52
  Minneapolis, MN 55440-0052
  Or **e-mail** us at cag@ucare.org

  If you prefer to deliver your written grievance to us, our street address is:
  500 Stinson Blvd. NE
  Minneapolis, MN 55413
  You can also fax your written grievance to us at 612-884-2021 or 1-866-283-8015 toll free.

- We can help you put your complaint in writing. If you need help, call Customer Services.
- We will notify you within three (3) business days that we have received your written complaint.
- Within 30 days we will send you a letter about our findings or decision.

- **Whether you call or write, you should contact Customer Services right away.** The complaint must be made within 60 calendar days after you had the problem you want to complain about.
- **If you are making a complaint because we denied your request for a "fast response" to a coverage decision or appeal, we will automatically give you a "fast" complaint.** If you have a "fast" complaint, it means we will give you **an answer within 24 hours.**

Legal Terms	What this section calls a **"fast complaint"** is also called a **"fast grievance."**

Step 2: We look into your complaint and give you our answer.

- **If possible, we will answer you right away.** If you call us with a complaint, we may be able to give you an answer on the same phone call. If your health condition requires us to answer quickly, we will do that.
- **Most complaints are answered in 30 calendar days.** If we need more information and the delay is in your best interest or if you ask for more time, we can take up to 14 more days (44 days total) to answer your complaint.
- **If we do not agree** with some or all of your complaint or don't take responsibility for the problem you are complaining about, we will let you know. Our response will include our reasons for this answer. We must respond whether we agree with the complaint or not.

Section 9.4 You can also make complaints about quality of care to the Quality Improvement Organization

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

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

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

Chapter 8. Ending your membership in the plan

SECTION 1 Introduction

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

Ending your membership in the plan may be **voluntary** (your own choice) or **involuntary** (not your own choice):

- You might leave our plan because you have decided that you *want* to leave.
  - There are only certain times during the year, or certain situations, when you may voluntarily end your membership in the plan. Section 2 tells you *when* you can end your membership in the plan.
  - The process for voluntarily ending your membership varies depending on what type of new coverage you are choosing. Section 3 tells you *how* to end your membership in each situation.
- There are also limited situations where you do not choose to leave, but we are required to end your membership. Section 5 tells you about situations when we must end your membership.

If you are leaving our plan, you must continue to get your medical care through our plan until your membership ends.

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

You may end your membership in our plan only during certain times of the year, known as enrollment periods. All members have the opportunity to leave the plan during the Annual Enrollment Period and during the Medicare Advantage Annual Disenrollment Period. In certain situations, you may also be eligible to leave the plan at other times of the year.

Section 2.1 You can end your membership during the Annual Enrollment Period

You can end your membership during the **Annual Enrollment Period** (also known as the "Annual Coordinated Election Period"). This is the time when you should review your health and drug coverage and make a decision about your coverage for the upcoming year.

- **When is the Annual Enrollment Period?** This happens from November 15 to December 31 in 2010.
- **What type of plan can you switch to during the Annual Enrollment Period?** During this time, you can review your health coverage and your prescription drug coverage. You can choose to keep your current coverage or make changes to your coverage for the upcoming year. If you decide to change to a new plan, you can choose any of the following types of plans:
  - Another Medicare Advantage Plan. (You can choose a plan that covers prescription drugs or one that does not cover prescription drugs.)
  - Original Medicare *with* a separate Medicare prescription drug plan.
  - *– or –* Original Medicare *without* a separate Medicare prescription drug plan.
- **When will your membership end?** Your membership will end when your new plan coverage begins on January 1.

Section 2.2 You can end your membership during the Medicare Advantage Annual Disenrollment Period, but your choices are more limited

You have the opportunity to make *one* change to your health coverage during the **Medicare Advantage Annual Disenrollment Period**.

- **When is the Medicare Advantage Annual Disenrollment Period?** This happens every year from January 1 to February 14.

- **What type of plan can you switch to during the Medicare Advantage Annual Disenrollment Period?** During this time, you can cancel your Medicare Advantage enrollment and switch to Original Medicare. If you choose to switch to Original Medicare, you may also choose a separate Medicare prescription drug plan at the same time.
- **When will your membership end?** Your membership will end on the first day of the month after we get your request to switch to Original Medicare. If you also choose to enroll in a Medicare prescription drug plan, your membership in the drug plan will begin at the same time.

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

In certain situations, members of the plan may be eligible to end their membership at other times of the year. This is known as a **Special Enrollment Period**.

- **Who is eligible for a Special Enrollment Period?** If any of the following situations apply to you, you are eligible to end your membership during a Special Enrollment Period. These are just examples, for the full list you can contact us, call Medicare, or visit the Medicare web site (http://www.medicare.gov):
  - Usually, when you have moved.
  - If you have Medicaid.
  - If you live in a facility, such as a nursing home.
- **When are Special Enrollment Periods?** The enrollment periods vary depending on your situation.
- **What can you do?** If you are eligible to end your membership because of a special situation, you can choose to change both your Medicare health coverage and prescription drug coverage. This means you can choose any of the following types of plans:
  - Another Medicare Advantage Plan. (You can choose a plan that covers prescription drugs or one that does not cover prescription drugs.)
  - Original Medicare *with* a separate Medicare prescription drug plan.
  - – ***or*** – Original Medicare *without* a separate Medicare prescription drug plan.
- **When will your membership end?** Your membership will usually end on the first day of the month after we receive your request to change your plan.

Section 2.4 Where can you get more information about when you can end your membership?

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

- You can **call Customer Services** (phone numbers are on the cover of this booklet).
- You can find the information in the *Medicare & You 2011* Handbook.
  - Everyone with Medicare receives a copy of *Medicare & You* each fall. Those new to Medicare receive it within a month after first signing up.
  - You can also download a copy from the Medicare web site (http://www.medicare.gov). Or, you can order a printed copy by calling Medicare at the number below.
- You can contact **Medicare** at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, seven days a week. TTY users should call 1-877-486-2048.

SECTION 3 How do you end your membership in our plan?

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

Usually, to end your membership in our plan, you simply enroll in another health plan during one of the enrollment periods (see Section 2 for information about the enrollment periods). One exception is when you want to switch from our plan to Original Medicare *without* a Medicare prescription drug plan. In this situation, you must contact Customer Services and ask to be disenrolled from our plan.

The table below explains how you should end your membership in our plan.

If you would like to switch from our plan to:	This is what you should do:
• Another Medicare Advantage Plan.	• Enroll in the new Medicare Advantage Plan. You will automatically be disenrolled from the plan when your new plan's coverage begins.
• Original Medicare *with* a separate Medicare prescription drug plan.	• Enroll in the new Medicare prescription drug plan. You will automatically be disenrolled from the plan when your new plan's coverage begins.
• Original Medicare *without* a separate Medicare prescription drug plan.	• **Contact Customer Services and ask to be disenrolled from the plan (phone numbers are on the cover of this booklet).** • You can also contact **Medicare** at 1-800-MEDICARE (1-800-633-4227), 24-hours a day, seven days a week, and ask to be disenrolled. TTY users should call 1-877-486-2048. • You will be disenrolled from the plan when your coverage in Original Medicare begins.

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

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

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

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

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

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

We must end your membership in the plan if any of the following happen:

- If you do not stay continuously enrolled in Medicare Part A and Part B.
- If you move out of our service area for more than six months.
  - If you move or take a long trip, you need to call Customer Services to find out if the place you are moving or traveling to is in our plan area.
- If you become incarcerated.
- If you intentionally give us incorrect information when you are enrolling in our plan and that information affects your eligibility for our plan.
- If you continuously behave in a way that is disruptive and makes it difficult for us to provide medical care for you and other members of our plan.
  - We cannot make you leave our plan for this reason unless we get permission from Medicare first.
- If you let someone else use your membership card to get medical care.
  - If we end your membership because of this reason, Medicare may have your case investigated by the Inspector General.
- If you do not pay the plan premiums for 90 days.
  - We must notify you in writing that you have 90 days to pay the plan premium before we end your membership.

Where can you get more information?

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

- You can call **Customer Services** for more information (phone numbers are on the cover of this booklet).

Section 5.2 We cannot ask you to leave our plan for any reason related to your health

What should you do if this happens?

If you feel that you are being asked to leave our plan because of a health-related reason, you should call Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048. You may call 24 hours a day, seven days a week.

Section 5.3 You have the right to make a complaint if we end your membership in our plan

If we end your membership in our plan, we must tell you our reasons in writing for ending your membership. We must also explain how you can make a complaint about our decision to end your membership. You can also look in Chapter 7, Section 9 for information about how to make a complaint.

Chapter 9. Legal notices

SECTION 1 Notice about governing law

Many laws apply to this *Evidence of Coverage* and some additional provisions may apply because they are required by law. This may affect your rights and responsibilities even if the laws are not included or explained in this document. The principal law that applies to this document is Title XVIII of the Social Security Act and the regulations created under the Social Security Act by the Centers for Medicare & Medicaid Services (CMS). In addition, other federal laws may apply and, under certain circumstances, the laws of the state you live in.

SECTION 2 Notice about nondiscrimination

We don't discriminate based on a person's race, disability, religion, sex, health, ethnicity, creed, age, or national origin. All organizations that provide Medicare Advantage Plans, like us, 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, all other laws that apply to organizations that get federal funding, and any other laws and rules that apply for any other reason.

SECTION 3 Notice about the member's term of coverage

Your coverage under this *Evidence of Coverage* (EOC) will begin on the CMS-confirmed effective date and will end on the date of disenrollment, or on December 31. Services must be received (expenses must be incurred) during the term of your coverage. In no event is there coverage under the plan before your effective date or after your disenrollment date with one exception. If on December 31 you are an inpatient in a hospital, a rehabilitation hospital, or a distinct part of a hospital used as an inpatient rehabilitation unit, your coverage for Medicare Part A inpatient expenses will continue until you are discharged from that place of confinement.

SECTION 4 Notice about amendments

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

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

SECTION 5 Notice about assignment of rights

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

SECTION 6 Notice about conformity with statutes

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

SECTION 7 Notice about clerical error

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

SECTION 8 Appointed representative

You can name (appoint) someone to serve as your personal representative. You can name a relative, friend, advocate, doctor, or someone else to act for you. Some other persons may already be authorized under state law to act for you. If you currently have a Power of Attorney, you will need to send a copy of the papers to us so that this information will be saved in your file. If you want someone to act for you, then you and the person you want to act for you must sign and date a statement that gives this person legal permission to act as your representative. This statement must be sent to us at the address shown in Chapter 2. You can call the Customer Services number in Chapter 2 to learn how to name your representative and to receive the Statement of Representative form. **Please note** that we cannot discuss member-specific information with someone other than the member or member's representative unless otherwise allowed by law.

SECTION 9 Provider opt out of Medicare

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

SECTION 10 Quality at UCare

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

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

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

SECTION 11 Providing notice

A. Your notices to us.

We welcome your telephone calls with any questions or concerns about any aspect of coverage, any inquiries about the contracted status of any provider, or coverage rules. Please call Customer Services.

B. Our notices to you.

We will send any correspondence, including any legal notices, to you at the most recent address you have provided. It is your responsibility to advise us as soon as possible of any address changes. We may from time to time delegate discretionary authority to other persons or entities providing services in regard to this *Evidence of Coverage* (EOC). Their notices to you will have the same legal force and effect as they would if they came from us.

SECTION 12 Third party liability

If you suffer an injury or illness for which a third party is liable due to a negligent or intentional act or omission causing such illness or injury, you must promptly notify us of the same. We will send you a statement of the reasonable charges for services provided in connection with the injury or illness. If you recover any sums from the responsible third party, we shall be reimbursed out of such recovery from a third party for the services provided, subject to the limitations in the following paragraphs:

1) **Our payments are less than the judgment or settlement amount.** If our payments are less than the judgment or settlement amount, the recovery is computed as follows:

   a) Determine the ratio of the procurement costs to the total judgment or settlement payment.

   b) Apply the ratio to our payment. The product is our share of procurement costs.

   c) Subtract our share of procurement costs from our payments. The remainder is our recovery amount.

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

3) **We incur procurement costs because of opposition to its recovery**. If we must bring suit against the party that received payment because that party opposes our recovery, the recovery amount is the lower of the following:

   a) Our payment.

   b) The total judgment or settlement amount, minus the party's total procurement cost.

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

Chapter 10. Definitions of important words

Allowed amount – For network providers, the amount paid by us for services and supplies following our developed fee schedule. For out-of-network providers, the amount paid by UCare for services and supplies is the lesser of the provider's billed amount or the Medicare-allowed amount. The **Medicare-allowed amount** is dependent upon the provider's Medicare participating status.

- For providers who have an agreement with CMS to accept assignment, the allowed amount is the Medicare fee schedule.
- For providers who do not accept assignment, they are not required to accept the Medicare fee schedule amount as payment in full. They may charge a higher amount which is called the Medicare limiting charge. For items and services paid under the Medicare fee schedule, the limiting charge is 115% of the fee schedule amount. For items and services CMS excludes from payment under the fee schedule, the limiting charge is 115% of 95% of the payment basis applicable to those who accept assignment.

Appeal – An appeal is something you do if you disagree with a decision to deny a request for health care services or payment for services you already received. You may also make an appeal if you disagree with a decision to stop services that you are receiving. For example, you may ask for an appeal if we don't pay for an item or service you think you should be able to receive. Chapter 7 explains appeals, including the process involved in making an appeal.

Balance billing – A request for payment from a provider for amounts above the Medicare maximum charge. Members are not responsible for balance billing amounts.

Benefit period – For both our plan and Original Medicare, a benefit period is used to determine coverage for inpatient stays in skilled nursing facilities. A benefit period begins on the first day you go to a Medicare-covered inpatient hospital or a Skilled Nursing Facility (SNF). The benefit period ends when you haven't been an inpatient at any hospital or SNF for 60 days in a row. If you go to the hospital (or SNF) after one benefit period has ended, a new benefit period begins. There is no limit to the number of benefit periods you can have.

The type of care that is covered depends on whether you are considered an inpatient for hospital and SNF stays. You must be admitted to the hospital as an inpatient, not just under observation. You are an inpatient in a SNF only if your care in the SNF meets certain standards for skilled level of care. Specifically, in order to be an inpatient in a SNF, you must need daily skilled-nursing or skilled-rehabilitation care, or both.

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

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

Comprehensive Outpatient Rehabilitation Facility (CORF) – A facility that mainly provides rehabilitation services after an illness or injury, and provides a variety of services including physician's services, physical therapy, social or psychological services, and outpatient rehabilitation.

Cost-sharing – Cost-sharing refers to amounts that a member has to pay when services are received. It includes any combination of the following three types of payments: (1) any deductible amount we may impose before services are covered; (2) any fixed "copayment" amount that we require when a specific service is received; or (3) any "coinsurance" amount, a percentage of the total amount paid for a service, that we require when a specific service is received.

Covered services – The general term we use to mean all of the health care services and supplies that are covered by our plan.

Creditable prescription drug coverage – Prescription drug coverage (for example, from an employer or union) that is expected to cover, on average, at least as much as Medicare's standard prescription drug coverage. People who have this kind of coverage when they become eligible for Medicare can generally keep that coverage without paying a penalty, if they decide to enroll in Medicare prescription drug coverage later.

Custodial care – Care for personal needs rather than medically necessary needs. Custodial care is care that can be provided by people who don't have professional skills or training. This care includes help with walking, dressing, bathing, eating, preparation of special diets, and taking medication. Medicare does not cover custodial care unless it is provided as other care you are getting in addition to daily skilled nursing care and/or skilled rehabilitation services.

Customer services – A department within our organization responsible for answering your questions about your membership, benefits, grievances, and appeals. See Chapter 2 for information about how to contact Customer Services.

Disenroll or **Disenrollment** – The process of ending your membership in our plan. Disenrollment may be voluntary (your own choice) or involuntary (not your own choice).

Durable Medical Equipment – Certain medical equipment that is ordered by your doctor for use in the home. Examples are walkers, wheelchairs, or hospital beds.

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

Evidence of Coverage (EOC) and Disclosure Information – This document, along with your enrollment form and any other attachments, riders, or other optional coverage selected, which explains your coverage, what we must do, your rights, and what you have to do as a member of our plan.

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

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

Hospital stay – Starts when you are admitted as an inpatient at a hospital and ends when you are discharged by the attending physician.

Maximum charge – The maximum amount a provider is allowed to charge for a service under the Medicare program.

Medicaid (or Medical Assistance) – A joint federal and state program that helps with medical costs for some people with low incomes and limited resources. Medicaid programs vary from state to state, but most health care costs are covered if you qualify for both Medicare and Medicaid. See Chapter 2, Section 6 for information about how to contact Medicaid in your state.

Medically necessary – Drugs, services, or supplies that are proper and needed for the diagnosis or treatment of your medical condition; are used for the diagnosis, direct care, and treatment of your medical condition; meet the standards of good medical practice in the local community; and are not mainly for your convenience or that of your doctor.

Medicare – The federal health insurance program for people 65 years of age or older, some people under age 65 with certain disabilities, and people with End-Stage Renal Disease (generally those with permanent kidney failure who need dialysis or a kidney transplant). People with Medicare can get their Medicare health coverage through Original Medicare, a Medicare Cost Plan, or a Medicare Advantage Plan.

Medicare Advantage (MA) Plan – Sometimes called Medicare Part C. A plan offered by a private company that contracts with Medicare to provide you with all your Medicare Part A (Hospital) and Part B (Medical) benefits. A Medicare Advantage Plan can be an HMO, PPO, a Private Fee-for-Service (PFFS) plan, or a Medicare Medical Savings Account (MSA) plan. In most cases, Medicare Advantage Plans also offer Medicare Part D (prescription drug coverage). These plans are called **Medicare Advantage Plans with Prescription Drug Coverage**. Everyone who has Medicare Part A and Part B is eligible to join any Medicare Health Plan that is offered in their area, except people with End-Stage Renal Disease (unless certain exceptions apply).

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

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

Medicare Prescription Drug Coverage (Medicare Part D) – Insurance to help pay for outpatient prescription drugs, vaccines, biologicals, and some supplies not covered by Medicare Part A or Part B.

"Medigap" (Medicare Supplement Insurance) Policy – Medicare supplement insurance sold by private insurance companies to fill "gaps" in Original Medicare. Medigap policies only work with Original Medicare. (A Medicare Advantage Plan is not a Medigap policy.)

Member (Member of our plan, or "plan member") – A person with Medicare who is eligible to get covered services, who has enrolled in our plan and whose enrollment has been confirmed by the Centers for Medicare & Medicaid Services (CMS).

Network Provider – "Provider" is the general term we use for doctors, other health care professionals, hospitals, and other health care facilities that are licensed or certified by Medicare and by the State to provide health care services. We call them "**network providers**" when they have an agreement with us to accept our payment and any plan cost-sharing as payment in full, and in some cases to coordinate as well as provide covered services to members of our plan. We pay network providers based on the agreements we have with the providers or if the providers agree to provide you with plan-covered services.

Organization determination – The Medicare Advantage organization has made an organization determination when it, or one of its providers, makes a decision about whether services are covered or how much you have to pay for covered services.

Original Medicare ("Traditional Medicare" or "Fee-for-service" Medicare) – Original Medicare is offered by the government, and not a private health plan like Medicare Advantage Plans and prescription drug plans. Under Original Medicare, Medicare services are covered by paying doctors, hospitals and other health care providers payment amounts established by Congress. You can see any doctor, hospital, or other health care provider that accepts Medicare. You must pay the deductible. Medicare pays its share of the Medicare-approved amount, and you pay your share. Original Medicare has two parts: Part A (Hospital Insurance) and Part B (Medical Insurance) and is available everywhere in the United States.

Out-of-network provider or Out-of-network facility – A provider or facility with which we have not arranged to coordinate or provide covered services to members of our plan. Out-of-network providers are providers that are not employed, owned, or operated by us or are not under contract to deliver covered services to you. Using out-of-network providers or facilities is explained in this booklet in Chapter 3.

Out-of-Pocket Costs – See the definition for "cost-sharing" above. A member's cost-sharing requirement to pay for a portion of services received is also referred to as the member's "out-of-pocket" cost requirement.

Out-of-Pocket Maximum – The maximum amount that you pay out-of-pocket during the calendar year, usually at the time services are received, for covered Part A (Hospital Insurance) and Part B (Medical Insurance) services. Plan premiums and Medicare Part A and Part B premiums do not count toward the out-of-pocket maximum.

Part C – see "Medicare Advantage (MA) Plan."

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

Point-of-Service benefit – Coverage for certain covered services provided by out-of-network physicians or providers, within the United States and territories, at a higher cost-sharing level (out-of-network level).

Preferred Provider Organization (PPO) Plan – A Preferred Provider Organization plan is a Medicare Advantage plan that has a network of contracted providers that have agreed to treat plan members for a specified payment amount. A PPO plan must cover all plan benefits whether they are received from network or out-of-network providers. Member cost-sharing will generally be higher when plan benefits are received from out-of-network providers. PPO plans have an annual limit on your out-of-pocket costs for services received from network (preferred) providers and a higher catastrophic limit on your total annual out-of-pocket costs for services from both network (preferred) and out-of-network (non-preferred) providers.

Primary Care Provider (PCP) – A health care professional you select to coordinate your health care. Your PCP is responsible for providing or authorizing covered services while you are a plan member. Chapter 3 tells more about PCPs.

Prior authorization – Approval in advance to get services. Some in-network medical services are covered only if your doctor or other network provider gets "prior authorization" from us. Covered services that need prior authorization are marked in the medical benefits chart in Chapter 4.

Quality Improvement Organization (QIO) – Groups of practicing doctors and other health care experts that are paid by the federal government to check and improve the care given to Medicare patients. They must review your complaints about the quality of care given by Medicare Providers. See Chapter 2, Section 4 for information about how to contact the QIO in your state and Chapter 7 for information about making complaints to the QIO.

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

Service area – "Service area" is the geographic area approved by the Centers for Medicare & Medicaid Services (CMS) within which an eligible individual may enroll in a certain plan, and in the case of network plans, where a network must be available to provide services.

Skilled Nursing Facility (SNF) Care – A level of care in a SNF ordered by a doctor that must be given or supervised by licensed health care professionals. It may be skilled nursing care, or skilled rehabilitation services, or both. Skilled nursing care includes services that require the skills of a licensed nurse to perform or supervise. Skilled rehabilitation services are physical therapy, speech therapy, and occupational therapy. Physical therapy includes exercise to improve the movement and strength of an area of the body, and training on how to use special equipment, such as how to use a walker or get in and out of a wheelchair. Speech therapy includes exercise to regain and strengthen speech and/or swallowing skills. Occupational therapy helps you learn how to perform usual daily activities, such as eating and dressing by yourself.

Special Needs Plan – A special type of Medicare Advantage plan that provides more focused health care for specific groups of people, such as those who have both Medicare and Medicaid, who reside in a nursing home, or who have certain chronic medical conditions.

Urgently needed care – Urgently needed care is a non-emergency situation when you need medical care right away because of an illness, injury, or condition that you did not expect or anticipate, but your health is not in serious danger.

Notes:

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