HealthPartners®

January 1 – December 31, 2011

Certificate of Coverage:

Your Medicare and Medical Assistance Health Benefits and Services and Prescription Drug Coverage as a Member of HealthPartners Classic Minnesota Senior Health Options (MSHO) Plan (HMO SNP)

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

HealthPartners Member Services:
For help or information, please call Member Services or go to our plan website at www.healthpartners.com.

Telephone: 952-967-7029 or
1-888-820-4285 (Calls to these numbers are free.)

TTY users call: 952-883-6060 or
1-800-443-0156 (Calls to these numbers are free.)

This plan is offered by HealthPartners, Inc., referred throughout the *Certificate of Coverage* as "we," "us," or "our." HealthPartners Classic Minnesota Senior Health Options Plan is referred to as "plan" or "our plan."

HealthPartners is a health plan with a Medicare contract.

Our plan will accept all eligible people who choose or are assigned to the Plan. We will not discriminate in regard to your physical or mental condition; health status; need for health services; marital status; age; sex; sexual orientation; national origin; race; color; religion or political beliefs.

CON-200.6 MSHO
H2422 MSHO1114 CMS Approved: 10/3/10

HealthPartners®

Attention. If you want free help translating this information, call HealthPartners® at 952-967-7029 or 1-888-820-4285.

ملاحظة: إذا أردت مساعدة مجانية في ترجمة هذه المعلومات، فاتصل على الرقم HealthPartners® 952-967-7029 أو 1-888-820-4285.

កំណត់សំគាល់ បើអ្នកចង់បានជំនួយបកប្រែព័ត៌មាននេះដោយមិនគិតថ្លៃ សូមទូរស័ព្ទទៅ HealthPartners® 952-967-7029 ឬ 1-888-820-4285 ។

Pažnja. Ako vam je potrebna besplatna pomoć za prevod ove informacije, nazovite HealthPartners® 952-967-7029 ili 1-888-820-4285.

Ceeb toom. Yog koj xav tau kev pab txhais cov xov no rau koj dawb, hu HealthPartners® 952-967-7029 lossis 1-888-820-4285.

ໂປດຊາບ. ຖ້າຫາກທ່ານຕ້ອງການການຊ່ວຍເຫຼືອໃນການແປຂໍ້ຄວາມດັ່ງກ່າວນີ້ຟຣີ, ຈົ່ງໂທຣ໌ຫາ HealthPartners® 952-967-7029 ຫຼື 1-888-820-4285.

Hubaddhu. Yoo akka odeeffannoon kun sii hiikamu gargaarsa tolaa feeta ta'e, lakkoofsi bilbiltu HealthPartners® 952-967-7160 ykn 1-888-820-4285.

Внимание: если вам нужна бесплатная помощь в переводе этой информации, позвоните HealthPartners® 952-967-7029 или 1-888-820-4285.

Ogow. Haddii aad dooneyso in lagaa kaalmeeyo tarjamadda macluumaadkani oo lacag la'aan ah, wac HealthPartners® 952-967-7159 ama 1-888-820-4285.

Atención. Si desea recibir asistencia gratuita para traducir esta información, llame a HealthPartners® al 952-967-7050 o al 1-888-820-4285.

Chú Ý. Nếu quý vị cần dịch thông-tin nầy miễn phí, xin gọi HealthPartners® 952-967-7029 hoặc 1-888-820-4285.

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This information is available in other forms to people with disabilities by calling 952-967-7029 (voice) or 1-888-820-4285 (toll free voice), 952-883-6060 (TTY), 1-800-443-0156 (toll free TTY), 711, or through the Minnesota Relay direct access numbers at 1-800-627-3529 (TTY, Voice, ASCII, Hearing Carry Over), or 1-877-627-3848 (Speech-to-Speech).

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

CON-200.6 MSHO

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 HealthPartners Classic Minnesota Senior Health Options Plan

SECTION 1 Introduction

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

This *Certificate of Coverage* booklet tells you how to get your Medicare and Medical Assistance services and prescription drugs 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 Medical Assistance, and you have chosen to get your Medicare and Medical Assistance services and your prescription drug coverage through our plan.
- There are different types of Medicare Advantage Plans. Our plan is a Medicare Advantage HMO Plan (HMO stands for Health Maintenance Organization).
- Our plan is a part of a program called Minnesota Senior Health Options. The Minnesota Department of Human Services designed this program to provide special care for seniors. This program combines your Medicare and Medical Assistance services. It combines your doctor, hospital, home care, nursing home care and other care into one coordinated care system.

This plan is offered by HealthPartners, Inc., referred throughout the Certificate of Coverage as "we," "us," or "our." HealthPartners Classic Minnesota Senior Health Options Plan is referred to as "plan" or "our plan."

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

Section 1.2 What does this Chapter tell you?

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

- What makes you eligible to be a plan member?
- What is your plan's 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 our 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 *Certificate of Coverage* booklet.

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

Section 1.4 Legal information about the *Certificate of Coverage*

It's part of our contract with you

This *Certificate 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, the *List of Covered Drugs (Formulary)*, and any notices you receive from us about changes to your coverage or conditions that affect your coverage. These notices are sometimes called "riders" or "amendments."

The contract is in effect for months in which you are enrolled in our 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 HealthPartners Classic Minnesota Senior Health Options 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.

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

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

Section 2.1 Your eligibility requirements

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

- You 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.
- -- *and* -- you meet the special eligibility requirements described below.

Special eligibility requirements for our plan

Our plan is designed to meet the needs of people who receive certain Medical Assistance benefits. To be eligible for our plan you must be age 65 and older and eligible for both Medicare and Medical Assistance.

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 plan service area for the plan

Although Medicare is a Federal program, our 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 these counties in Minnesota: Anoka, Benton, Carver, Chisago, Dakota, Hennepin, Ramsey, Scott, Sherburne, Stearns, Washington and Wright.

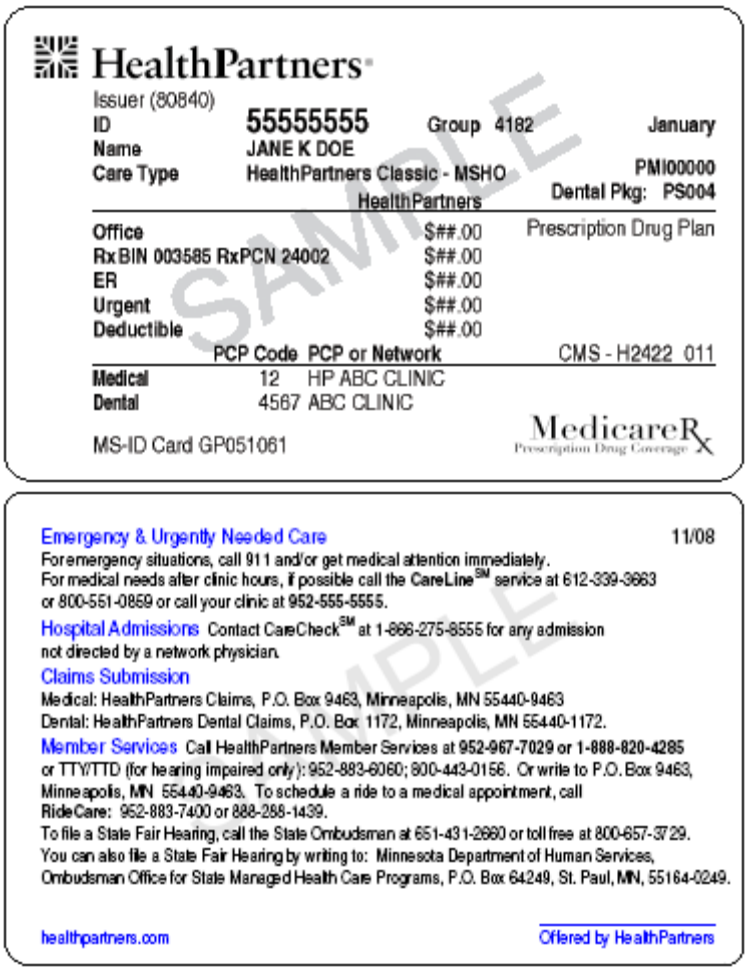
If you plan to move out of the service area, please contact Member Services.

SECTION 3 What other materials will you get from us?

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

While you are a member of our plan, you must use your membership card for our plan along with your Minnesota Health Care Programs card whenever you get any services covered by this plan and for prescription drugs you get at network pharmacies.

Here's a sample membership card to show you what yours will look like:



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 membership card for our plan 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 Member 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's 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 our 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 for Part D drugs 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 our network?

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

You may be eligible for Home and Community-Based Services. The HealthPartners network of Home and Community-Based providers includes HealthPartners contracted providers and county contracted providers. Your Care Coordinator has a list of these providers and will help you to determine if you are eligible for these services. You can call Member Services for more information.

If you don't have your copy of the *Provider Directory*, you can request a copy from Member Services. You may ask Member Services for more information about our network providers, including their qualifications. You can also see the *Provider Directory* at www.healthpartners.com, or download it from this website. Both Member Services and the website can give you the most up-to-date information about changes in our network providers.

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

What are "network pharmacies"?

Our *Provider Directory* gives you a complete list of our network pharmacies – that means all of the pharmacies that have agreed to fill covered prescriptions for our plan members.

Why do you need to know about network pharmacies?

You can use the *Provider Directory* to find the network pharmacy you want to use. This is important because, with few exceptions, you must get your prescriptions filled at one of our network pharmacies if you want our plan to cover (help you pay for) them.

We will send you a complete *Provider Directory* **at least once every three years**. Every year that you don't get a new *Provider Directory*, we'll send you an update that shows changes to the directory.

If you don't have the *Provider Directory*, you can get a copy from Member Services (phone numbers are on the front cover). At any time, you can call Member Services to get up-to-date information about changes in the pharmacy network. You can also find this information on our website at www.healthpartners.com.

Section 3.4 The plan's *List of Covered Drugs (Formulary)*

The plan has a *List of Covered Drugs (Formulary)*. We call it the "Drug List" for short. It tells which Part D prescription drugs are covered by *our plan*. It also tells you how to find out which Medical Assistance drugs are covered. The Part D drugs on this list are selected by the plan with the help of a team of doctors and pharmacists. The list must meet requirements set by Medicare. Medicare has approved the *plan's* Part D Drug List.

We will send you a copy of the Drug List. To get the most complete and current information about which drugs are covered, you can visit the plan's website www.healthpartners.com) or call Member Services (phone numbers are on the front cover of this booklet).

Section 3.5 Reports with a summary of payments made for your Part D prescription drugs

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

The *Explanation of Benefits* tells you the total amount you have spent on your Part D prescription drugs and the total amount we have paid for each of your Part D prescription drugs during the month. Chapter 6 (*What you pay for your Part D prescription drugs*) gives more information about the *Explanation of Benefits* and how it can help you keep track of your drug coverage.

An *Explanation of Benefits* summary is also available upon request. To get a copy, please contact Member Services.

SECTION 4 Your monthly premium for our plan

Section 4.1 How much is your plan premium?

You do not pay a separate monthly plan premium for *our plan*. **As long as you are eligible for Medical Assistance, you qualify for and are getting Extra Help paying your prescription drug plan costs and premiums. You must pay your Part B Premium unless it is paid for by the State.**

Many members are required to pay other Medicare premiums

Some plan members may be paying a premium for Medicare Part A and/or Medicare Part B. Many members do not pay premiums for Medicare Part A and/or Medicare Part B due to Medical Assistance eligibility. If you are paying for your Medicare Part B, you must continue paying your Medicare Part B premium for you to remain as 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 website (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, 7 days a week. TTY users call 1-877-486-2048.

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

Call Member Services to let us know about these changes:

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

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

- Name and address changes
- When you are admitted to a nursing home or other facility
- Adding or losing a household member
- New insurance – begin and end dates
- New job or income changes

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 Member Services (phone numbers are on the cover of this booklet).

Chapter 2. Important phone numbers and resources

SECTION 1 Our plan contacts (how to contact us, including how to reach Member Services at the plan)

How to contact our plan's Member Services

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

Member Services	
CALL	952-967-7029 or 1-888-820-4285. Calls to this number are free. Hours of Operation: 8:00 AM – 8:00 PM
TTY	952-883-6060 or 1-800-443-0156 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free. Hours of Operation: 8:00 AM – 8:00 PM
FAX	952-883-7333 or 952-883-7666
WRITE	HealthPartners Health Plan Member Services MS: 21103R P.O. Box 9463 Minneapolis, MN 55440-9463
WEBSITE	www.healthpartners.com

In addition, you may use the following contact information for certain services.

Chemical Dependency Services
Call: 952-967-7029 or 1-888-820-4285 (toll free)
Or
Write: HealthPartners
MS: 21103M
P.O. Box 1309
Minneapolis, MN 55440-1309

Chiropractic Services
Call: 952-967-7029 or 1-888-820-4285 (toll free)

Dental Services
Call: 952-967-7029 or 1-888-820-4285 (toll free)

Health Questions Phone Line
Available 24 hours CareLine: 612-339-3663 or 1-800-551-0859 (toll free) or
TTY 952-883-5474
Available 24 hours BabyLine: 612-333-BABY (2229) or 1-800-845-9297 (toll free)

Home and Community-Based Services
Call: 952-967-7029 or 1-888-820-4285

Interpreter Services

Hearing: Call 952-967-7029 or 1-888-820-4285 (toll free) or TTY 952-883-6060 or 1-800-443-0156 (toll free TTY)
Spoken Language: Call 952-967-7029 or 1-888-820-4285 (toll free)

Medical Equipment and Related Supplies Coverage Criteria
Call: 952-967-7029 or 1-888-820-4285 (toll free)

Mental Health Services
Call: 952-967-7029 or 1-888-820-4285 (toll free)
Or
Write: HealthPartners
MS: 21103 M
P.O. Box 1309
Minneapolis, MN 55440-1309

Prescriptions
Call: 952-967-7029 or 1-888-820-4285 (toll free)

Transportation
Call RideCare: 952-883-7400 or 1-888-288-1439 (toll free)

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	952-967-7029 or 1-888-820-4285. Calls to this number are free. Hours of Operation: 8:00 AM – 8:00 PM
TTY	952-883-6060 or 1-800-443-0156. This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free.
FAX	952-883-7333 or 952-883-7666.
WRITE	HealthPartners Health Plan Member Services MS: 21103R P.O. Box 9463 Minneapolis, MN 55440-9463

For more information on asking for coverage decisions about your medical care, see Chapter 9 (*What to do if you have a problem or complaint (coverage decisions, appeals, and complaints*).

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

Appeals for Medical Care	
CALL	952-967-7029 or 1-888-820-4285. Calls to this number are free. Hours of Operation: 8:00 AM – 8:00 PM
TTY	952-883-6060 or 1-800-443-0156. This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free.
FAX	952-853-8742.
WRITE	HealthPartners Health Plan Member Services MS: 21103R P.O. Box 9463 Minneapolis, MN 55440-9463

For more information on making an appeal about your medical care, see Chapter 9 (*What to do if you have a problem or complaint (coverage decisions, appeals, and complaints*).

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

Complaints about Medical Care	
CALL	952-967-7029 or 1-888-820-4285. Calls to this number are free. Hours of Operation: 8:00 AM – 8:00 PM

TTY	952-883-6060 or 1-800-443-0156. This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free.
FAX	952-853-8742.
WRITE	HealthPartners Health Plan Member Services MS: 21103R P.O. Box 9463 Minneapolis, MN 55440-9463

For more information on making a complaint about your medical care, see Chapter 9 (*What to do if you have a problem or complaint (coverage decisions, appeals, and complaints*).

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

Coverage Decisions for Part D Prescription Drugs	
CALL	1-800-492-7259. Calls to this number are free. Hours of Operation: 8:00 AM – 8:00 PM
TTY	952-883-6060 or 1-800-443-0156. This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free.
FAX	1-888-883-5434. On weekends, do not use the fax number; use the telephone number instead.

WRITE	HealthPartners Member Services Pharmacy Administration MS: 21111B P.O. Box 9463 Minneapolis, MN 55440-9463 Or deliver a written request to: HealthPartners Member Services Pharmacy Administration 8170 33rd Avenue South Bloomington, MN 55425

For more information on asking for coverage decisions about your Part D prescription drugs, see Chapter 9 (*What to do if you have a problem or complaint (coverage decisions, appeals, and complaints*).

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

Appeals for Part D Prescription Drugs	
CALL	952-883-7676 or 1-866-233-8734. Calls to this number are free. Hours of Operation: 8:00 AM – 8:00 PM
TTY	952-883-6060 or 1-800-443-0156. This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free.
FAX	For expedited appeals: 952-853-8742.

WRITE	HealthPartners Member Services MS: 21103R P.O. Box 9463 Minneapolis, MN 55440-9463 Or deliver a written request to: HealthPartners Member Services 8170 33rd Avenue South Bloomington, MN 55425

For more information on making an appeal about your Part D prescription drugs, see Chapter 9 (*What to do if you have a problem or complaint (coverage decisions, appeals, and complaints*).

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

Complaints about Part D prescription drugs	
CALL	952-883-7676 or 1-866-233-8734. Calls to this number are free. Hours of Operation: 8:00 AM – 8:00 PM
TTY	952-883-6060 or 1-800-443-0156. This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free.
FAX	For expedited grievances: 952-853-8742

WRITE	HealthPartners Member Services MS: 21103R P.O. Box 9463 Minneapolis, MN 55440-9463 Or deliver a written request to: HealthPartners Member Services 8170 33rd Avenue South Bloomington, MN 55425

For more information on making a complaint about your Part D prescription drugs, see Chapter 9 (*What to do if you have a problem or complaint (coverage decisions, appeals, and complaints*).

Where to send a request that asks us to pay for our share of the cost for a Part D drug you have received

We cannot pay you back for most medical bills that you pay. State and federal laws prevent us from paying you directly. The exception is if you pay for Part D prescription drugs. If you paid for a service that you think we should have covered, contact Member Services at the number listed on the front cover.

For more information on situations in which you may need to ask us for reimbursement or to pay a bill you have for a Part D covered drug, see Chapter 7 (*Asking the plan to pay its share of a bill you have received Part D drugs*).

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

Payment Requests for Part D Drugs	
CALL	952-967-7029 or 1-888-820-4285. Calls to these numbers are free.
TTY	952-883-6060 or 1-800-443-0156 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free.
WRITE	HealthPartners Health Plan Member Services MS: 21103R P.O. Box 9463 Minneapolis, MN 55440-9463

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 this number are free. 24 hours a day, 7 days a week.
TTY	1-877-486-2048 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free.
WEBSITE	http://www.medicare.gov This is the official government website for Medicare. It gives you up-to-date information about Medicare and current Medicare issues. It also has information about hospitals, nursing homes, physicians, home health agencies, and dialysis facilities. It includes 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 website 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 website, 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 the Senior LinkAge Line®.

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

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

Senior LinkAge Line®	
CALL	1-800-333-2433
TTY	Call the Minnesota Relay Service at 711 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.
WRITE	Minnesota Board on Aging PO Box 64976 St. Paul, MN 55164-0976
WEBSITE	www.mnaging.org and www.minnesotahelp.info

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.

Stratis Health 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. Stratis Health is an independent organization. It is not connected with our plan.

You should contact Stratis Health 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	
CALL	**Stratis Health Non-Hospital Immediate Appeal Line** This number has information about how to appeal a decision to end Medicare coverage for services received from a home health agency, nursing home, comprehensive outpatient rehabilitation facility, or hospice. This number is answered 8:30-4:30, 7 days a week. Toll-free: 1-877-624-1414 **Stratis Health Hospital Discharge Appeal Line** This number has information about how to appeal a decision to end Medicare coverage for hospital services. This number is answered 8:30-4:30, 7 days a week. Toll-free: 1-866-894-1327
WRITE	Stratis Health 2901 Metro Drive, Suite 400 Bloomington, MN 55425-1525
WEBSITE	www.stratishealth.org

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 7:00 am to 7:00 pm, 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 7:00 am to 7:00 pm, Monday through Friday.
WEBSITE	http://www.ssa.gov

SECTION 6 Medicaid or Medical Assistance (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. In Minnesota, the Medicaid program is called Medical Assistance. To find out more about Medical Assistance and its programs, contact the Minnesota Department of Human Services.

Our Plan is a part of a program called Minnesota Senior Health Options. The Minnesota Department of Human Services designed this program to provide special care for seniors. This program combines your Medicare and Medical Assistance services. It combines your doctor, hospital, home care, nursing home care and other care into one coordinated care system.

Minnesota Department of Human Services	
CALL	651) 431-2670 (Twin Cities metro area) or (800) 657-3739 (outside Twin Cities metro area)
TTY	(800) 627-3529 or 711 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.
WEBSITE	www.dhs.state.mn.us/healthcare

The Ombudsman for State Managed Health Care Programs, at the Minnesota Department of Human Services, helps people enrolled in a health plan in resolving service and billing problems. They can help you file a grievance or appeal with our Plan. The Ombudsman can also help you request a State Fair Hearing.

Minnesota Ombudsman for State Managed Health Care Programs	
CALL	(651) 431-2660 (Twin Cities metro area) or (800) 657-3729 (outside Twin Cities metro area)
TTY/TDD	711 or (800) 627-3529 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.
WRITE	Minnesota Department of Human Services Ombudsman for State Managed Health Care Programs PO Box 64249, St. Paul MN 55164-0249
WEBSITE	www.dhs.state.mn.us/managedcareombudsman

The Office of Ombudsman for Long Term Care assists people with concerns about nursing homes, boarding care homes, adult care homes (i.e. housing with services, assisted living, customized living, or foster care), home care services, and Medicare beneficiaries with hospital access or discharge concerns.

Office of Ombudsman for Long Term Care	
CALL	(651) 431-2555 (Twin Cities metro area) or (800) 657-3591 (outside Twin Cities metro area)
TTY/TDD	(800) 627-3529 or 711 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.
WRITE	Office of Ombudsman for Long-Term Care P.O. Box 64971 St. Paul, MN 55164-0971
WEBSITE	www.mnaging.org/advocate/ooltc.htm

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

Medicare's "Extra Help" Program

As long as you are eligible for Medical Assistance, you qualify for and are getting Extra Help paying your prescription drug plan costs described below. You do not need to do anything further to get this Extra Help.

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

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

If you have questions about Extra Help, call:

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

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

- If you need assistance in obtaining evidence of your proper co-payment level, contact Member Services at the number listed on the front cover.
- When we receive the evidence showing your copayment level, we will update our system so that you can pay the correct copayment when you get your next prescription at the pharmacy. If you overpay your copayment, we will reimburse you. Either we will forward a check to you in the amount of your overpayment or we will offset future copayments. If the pharmacy hasn't collected a copayment from you and is carrying your copayment as a debt owed by you, we may make the payment directly to the pharmacy. If a state paid on your behalf, we may make payment directly to the state. Please contact Member Services if you have questions.

SECTION 8 How to contact the Railroad Retirement Board

The Railroad Retirement Board is an independent Federal agency that administers comprehensive benefit programs for the nation's railroad workers and their families. If you 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 9:00 am to 3:30 pm, 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.
WEBSITE	http://www.rrb.gov

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

If you (or your spouse) get benefits from your (or your spouse's) employer or retiree group, call the employer/union benefits administrator or Member 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 our plan.

Chapter 3. Using the plan's coverage for your covered services

SECTION 1 Things to know about getting your covered services as a member of our plan

This chapter tells things you need to know about using the plan to get your covered services. 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 is covered by our plan use the benefits chart in the next chapter, Chapter 4 (*Benefits chart, what is covered*).

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 for Part D drugs amount as payment in full. We have arranged for these providers to deliver covered services to members in our plan. The providers in our network generally bill us directly for care they give you.
- **"Covered services"** include all the medical care, health care services, supplies, and equipment that are covered by our plan. Your covered services are listed in the benefits chart in Chapter 4.

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

The Plan will generally cover your care as long as:

- **The care you receive is included in the plan's Benefits Chart** (this chart is in Chapter 4 of this booklet).
- **Except in the case of preventive services, screening services and home and community based services, the care you receive 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.
- **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 PCP (for more information about this, see Section 2.1 in this chapter).

- In most situations, your PCP must give you approval in advance before you can use other providers in the plan's network, such as specialists, hospitals, skilled nursing facilities, or home health care agencies. This is called giving you a "referral." For more information about this, see Section 2.2 of this chapter.
- Referrals from your PCP are not required for emergency care or urgently needed care. There are also some other kinds of care you can get without having approval in advance from your PCP (for more information about this, see Section 2.3 of this chapter).

- **You generally must receive your care from a network provider** (for more information about this, see Section 2 in this chapter). In most cases, care you receive from an out-of-network provider (a provider who is not part of our plan's network) will not be covered. *Here are two exceptions:*
  - 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 our network cannot provide this care, you can get this care from an out-of-network provider. Plans may specify if authorization should be obtained from the plan prior to seeking care. In this situation, we would cover the cost of the care just as we would for a network provider.

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

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

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

When you become a member of our Plan, you must choose a plan provider to be your PCP. Your PCP is a physician, nurse practitioner or physician's assistant who meets state requirements and is trained to give you basic medical care. As we explain below, you will get your routine or basic care from your PCP. Your PCP will also coordinate the rest of the covered services you get as a member of our Plan. Your PCP will provide most of your care and will help you arrange or coordinate the rest of the covered services you get as a member of our Plan. This includes:

- your x-rays
- laboratory tests
- therapies
- care from doctors who are specialists
- hospital admissions, and
- follow-up care.

"Coordinating" your services includes checking or consulting with other plan providers about your care and how it is going. If you need certain types of covered services or supplies, you must get approval in advance from your PCP (such as giving you a referral to see a specialist). In some cases, your PCP will need to get prior authorization (approval) from us. Since your PCP will provide and coordinate your medical care, you should have all of your past medical records sent to your PCP's office. Chapter 8 tells you how we will protect the privacy of your medical records and personal health information.

How do you choose your PCP?

When you enroll in our Plan, you need to select a clinic. You need to receive care from a PCP who is located at your clinic. You can choose a PCP by using the *Provider Directory* or getting help from Member Services. You do need to communicate to HealthPartners which PCP you choose on your application form. If there is a particular plan specialist or hospital that you want to use, check first to be sure your PCP uses that specialist or hospital. You can change your PCP, as explained *under the heading "How you switch to another PCP?" later in this section*. The name and office telephone number of your PCP is printed on your membership card.

Changing your PCP

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

How you switch to another PCP?

You may change your PCP for any reason, at any time. To change your PCP, call Member Services.

When you call, be sure to tell Member Services if you are seeing specialists or getting other covered services that needed your PCP's approval (such as home health services and durable medical equipment). Member Services will help make sure that you can continue with the specialty care and other services you have been getting when you change your PCP. They will also check to be sure the PCP you want to switch to is accepting new patients. Member Services will tell you when the change to your new PCP will take effect.

They will also send you a new membership card that shows the name and phone number of your new PCP.

Sometimes a network provider you are using might leave the plan. If this happens, you will have to switch to another provider who is part of our plan. Member Services can assist you in finding and selecting another provider.

If a provider you choose is no longer part of the plan, you must choose another network provider. You may be able to continue to use services from a provider no longer a part of the plan network for up to 120 days for the following reasons:

- an acute condition
- a life-threatening mental or physical illness
- a pregnancy that is beyond the first three months (trimester);
- a physical or mental disability defined as an inability to engage in one or more major life activities. This applies to a disability that has lasted or is expected to last at least one year, or is likely to result in death;
- a disabling or chronic condition that is in an acute phase.

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

For more information, call Member Services.

Section 2.2 What kinds of care can you get without getting approval in advance from your PCP?

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

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

- Routine women's health care, which include breast exams, mammograms (x-rays of the breast), Pap tests, and pelvic exams. This care is covered without a referral from a network provider.
- Flu shots and pneumonia vaccinations as long as you get them from a network provider.
- Emergency services from network providers or from out-of-network providers.
- Urgently needed care from in-network providers or from out-of-network providers when network providers are temporarily unavailable or, e.g., when you are temporarily outside of the plan's service area.
- Kidney dialysis services that you get at a Medicare-certified dialysis facility when you are temporarily outside the plan's service area. ***Note:*** *If possible, please let us know before you leave the service area where you are going to be so we can help arrange for you to have maintenance dialysis while outside the service area.*

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

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

- Oncologists, 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.

For some types of referrals, your PCP may need to get approval in advance from our Plan (this is called getting a "service authorization").

It is very important to get a referral (approval in advance) from your PCP before you see a plan specialist or certain other providers (there are a few exceptions, including routine women's health care that we explain later in this section). **If you don't have a referral (approval in advance) before you get services from a specialist, you may have to pay for these services yourself.**

If the specialist wants you to come back for more care, check first to be sure that the referral (approval in advance) you got from your PCP for the first visit covers more visits to the specialist.

If there are specific specialists you want to use find out whether your PCP sends patients to these specialists.

A written referral may be for one visit or it may be a standing referral for more than one visit if you need ongoing services. We must give you a standing referral to a qualified specialist for any of these conditions:

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

If you do not get a written referral when needed, the bill may not be paid. . For more information, call Member Services

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

Sometimes a specialist, clinic, hospital or other network provider you are using might leave the plan. If this happens, you will have to switch to another provider who is part of our plan. Member Services can assist you in finding and selecting another provider.

If a provider you choose is no longer part of the plan, you must choose another network provider. You may be able to continue to use services from a provider no longer a part of the plan network for up to 120 days for the following reasons:

- an acute condition
- a life-threatening mental or physical illness
- a pregnancy that is beyond the first three months (trimester);
- a physical or mental disability defined as an inability to engage in one or more major life activities. This applies to a disability that has lasted or is expected to last at least one year, or is likely to result in death;
- a disabling or chronic condition that is in an acute phase.

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

For more information, call Member Services.

SECTION 3 How to get covered services when you have an emergency or an 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.
- **As soon as possible, make sure that our plan has been told about your emergency.** We need to follow up on your emergency care. You or someone else should call to tell us

about your emergency care, usually within 48 hours, at the phone number on the back of the membership card.

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 and Canada. Our plan covers ambulance services in situations where getting to the emergency room in any other way could endanger your health. For more information, see the Benefits chart in Chapter 4 of this booklet.

If you have an emergency, we will talk with the doctors who are giving you emergency care to help manage and follow up on your care. The doctors who are giving you emergency care will decide when your condition is stable and the medical emergency is over.

After the emergency is over you are entitled to follow-up care (this may also be called post-stabilization care) to be sure your condition continues to be stable. Your follow-up care will be covered by our plan. If your emergency care is provided by out-of-network providers, we will try to arrange for network providers to take over your care as soon as your medical condition and the circumstances allow.

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's service area when you have an urgent need for care?

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

In most situations, if you are in the plan's 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's service area when you have an urgent need for care?

Suppose that you are temporarily outside our plan's service area, but still in the United States or Canada. If you have an urgent need for care, you probably will not be able to find or get to one of the providers in our plan's 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 does not cover urgently needed care or any other care if you receive the care outside of the United States or Canada.

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

Section 4.1 You can ask the plan to pay our share of the cost of Part D Drugs only

We cannot pay you back for most medical bills that you pay. State and federal laws prevent us from paying you directly. The exception is if you pay for Part D prescription drugs. If you paid for a service that you think we should have covered, contact Member Services at the number listed on the front cover.

If you have paid more than your share for Part D prescription drugs, go to Chapter 7 (*Asking the plan to pay its share of a bill you have received for Part D drugs*) for information about what to do.

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

Our plan uses Medicare and Medical Assistance coverage rules to decide what services are medically necessary except for home and community based services which do not need to meet medically necessary criteria 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 they were obtained out-of-network where not authorized 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 9 (*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 Member 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 can call Member 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 our plan or your PCP. The providers that deliver your care as part of the clinical research study do *not* need to be part of our plan's network of providers.

Although you do not need to get our plan's permission to be in a clinical research study, **you do need to tell us before you start participating in a clinical research study.** 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 Member Services (see Chapter 2, Section 1 of this *Certificate 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?

You can get more information about joining a clinical research study by reading the publication "Medicare and Clinical Research Studies" on the Medicare website (http://www.medicare.gov). You can also call 1-800-MEDICARE (1-800-633-4227) 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

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

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

A religious non-medical health care institution is a facility that provides care for a condition that would ordinarily be treated in a hospital or skilled nursing facility. If getting care in a hospital or a skilled nursing facility is against a member's religious beliefs, our plan will instead provide 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's coverage of services you receive is limited to *non-religious* aspects of care.

- If you get services from this institution that are provided to you in 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 our plan before you are admitted to the facility or your stay will not be covered.

Medicare Inpatient Hospital coverage limits apply for this benefit, see Chapter 4 *Benefits chart (what is covered).*

Chapter 4. Benefits chart (what is covered)

SECTION 1 Understanding your covered services

This chapter focuses on your covered services. It includes a Benefits Chart that gives a list of your covered services as a member of our plan. Later in this chapter, you can find information about 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?

Because you are eligible for Medical Assistance, you qualify for and are receiving help to pay your out-of-pocket costs for Medicare. You do not have any additional co-payments for Medical Assistance.

SECTION 2 Use this *Benefits Chart* to find out what is covered for you

Section 2.1 Your benefits as a member of the plan

The Benefits Chart on the following pages lists the services our plan covers The services listed in the Benefits Chart are covered only when the following coverage requirements are met:

- Your Medicare and Medical Assistance covered services must be provided according to the coverage guidelines established by Medicare and Medical Assistance.
- Except in the case of preventive services and screening tests and home and community based services, your services (including medical care) *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.
- Enrollment in our plan does not guarantee that certain items are covered. Some prescription or medical equipment may not be covered. This is true even if they were covered before.
- You receive your care from a network provider. In most cases, care you receive from an out-of-network provider will not be covered. Chapter 3 provides more information about requirements for using network providers and the situations when we will cover services from an out-of-network provider.
- You have a primary care provider (PCP) who is providing and overseeing your care. In most situations, your PCP must give you approval in advance before you can see other providers in the plan's network. This is called giving you a "referral." Chapter 3 provides more information about getting a referral and the situations when you do not need a referral.

- Some of the services listed in the Benefits Chart are covered *only* if your doctor or other network provider gets approval in advance (sometimes called "prior authorization") from us. Covered services that need approval in advance are marked in the Benefits Chart by an asterisk *and* by a footnote.

- Our plan covers all Medicare-covered preventive services at no cost to you.

Restricted Recipient Program

The Restricted Recipient Program is a program for members who have received medical care and have not followed the rules or have misused services. If you are placed in this program, we may replace your regular member card with a Restricted Recipient Program card. You must get health services from one primary care provider, one drug store, one hospital or other provider located in your local trade area. You must do this for 24 or 36 months of eligibility for Minnesota Health Care Programs (MHCP). You may also be assigned to a home health agency. You will not be allowed to use the personal care assistance choice option or consumer directed services. Placement in the program will stay with you if you change health plans. Placement in the program will also stay with you if you change to fee for service. You will not lose eligibility for MHCP because of placement in the program. At the end of the 24 or 36 months, your health care services will be reviewed. If you still do not follow the rules, you will be placed in the program for an additional 36 months of eligibility. You have the right to appeal placement in the Restricted Recipient Program. See Chapter 9. The Restricted Recipient Program does not apply to Medicare covered services.

Benefits Chart

Services that are covered for you

Care Coordination

- Assisting you in arranging for, getting, and coordinating assessments, tests and health and continuing care services
- Developing and updating your care plan
- Communicating with a variety of agencies and persons
- Other services as outlined in your care plan

Chemical Dependency Services

See Chapter 2 for Chemical Dependency Services contact information.

Covered Services

- Assessment/diagnosis
- Outpatient treatment
- Inpatient hospital
- Primary residential inpatient stay*
- Outpatient methadone treatment*
- Detoxification, only if required for medical treatment
- Room and board with treatment determined necessary by chemical dependency assessment* (You may be able to get this service from our plan or the State. Call the number listed in Chapter 2 for more information.)

A qualified Plan network assessor will decide what type of chemical dependency care you need. You may get a second assessment if you do not agree with the first one. To get a second assessment you must send us a request. We must get your request within five working days of when you get the results of your first assessment or before you begin treatment (whichever is first). We will cover a second assessment by a different qualified assessor not in the Plan network. We will do this within five working days of when we get your request. To get **help choosing** a second assessment you may call the Personalized Assistance Line (PAL) 952-883-5811 or 1-888-638-8787 (toll free). If you agree with the second assessment, we will authorize services according to chemical dependency standards and the second assessment. You have the right to appeal.

*Requires a referral or service authorization. Ask your doctor who will direct your care.

Services that are covered for you

Chiropractic services

See Chapter 2 for Chiropractic services contact information.

Covered services

- Manual manipulation of the spine for subluxation only
- One annual examination *After 6 visits a referral or service authorization is required; ask your doctor who will direct your care.
- X-rays when needed to get a diagnosis of subluxation of the spine

Not Covered Services

- Other adjustments, vitamins, medical supplies, therapies and equipment
- Office visits that do not include manual manipulation of the spine

Dental services

See Chapter 2 for Dental services contact information.

Covered Services

- Diagnostic services
  - Comprehensive exam every five years
  - Periodic exam twice per calendar year
  - Problem focused exams (once per day per facility)
  - X-rays are limited to:
    - bitewing once per calendar year
    - single x-rays for diagnosis of problems
    - panoramic:
      - once every five years
      - as medically necessary for diagnosis and follow-up of oral and maxillofacial conditions and trauma
      - once every two years in limited situations
    - full mouth x-rays once every five years only when provided in an outpatient hospital or freestanding Ambulatory Surgery Center (ASC)
- Preventive services

*Requires a referral or service authorization. Ask your doctor who will direct your care.

Services that are covered for you

- Cleaning twice per calendar year
- Fluoride varnish once per calendar year
- Restorative services
  - Fillings
  - Sedative fillings for relief of pain
  - Crowns (excluding high cast noble crowns) are covered up to an annual maximum of $2,000
- Endodontics (Root canals) on anterior teeth, premolars and molars only
- Periodontics
  - Gross removal of plaque and tartar once every five years
  - Scaling and root planing once every two years only when provided in an outpatient hospital or freestanding Ambulatory Surgical Center (ASC)
- Prosthodontics
  - Removable prostheses (dentures and partials) once every six years per dental arch
- Oral surgery limited to extractions, biopsies and incision and drainage of abscesses
- Additional general services
  - Treatment for pain (once per day)
  - General anesthesia only when provided in an outpatient hospital or freestanding Ambulatory Surgical Center (ASC)

Not Covered Services

- Relines, repairs and rebases of removable prostheses (dentures and partials)
- Lost, stolen, or damaged and un-repairable prostheses

Diabetes self-monitoring, training, and supplies

For all people who have diabetes (insulin and non-insulin users).

Covered services

- Blood glucose monitor, blood glucose test strips, lancet devices and lancets, and glucose-control solutions for checking the accuracy of test strips and monitors
- Therapeutic shoes for people with diabetes who have severe diabetic foot disease, including fitting of shoes or inserts within certain limits
- Self-management training is covered under certain conditions
- For persons at risk of diabetes: Fasting plasma glucose tests.

*Requires a referral or service authorization. Ask your doctor who will direct your care.

Services that are covered for you

Diagnostic tests and therapeutic services and supplies

Covered services

- X-rays
- Radiation therapy
- Surgical supplies, such as dressings
- Supplies, such as splints and casts
- Laboratory tests
- Audiology
- Blood and blood products
- Other diagnostic tests ordered by your doctor

Dialysis (Kidney)

Covered services

- 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)

Doctor services, including office visits

Covered services

- Office visits, including medical and surgical care in a doctor's office
- Physical exam
- Preventive exam
- Treatment of illness and injury
- Medical or surgical services in a certified ambulatory surgical center or in a hospital outpatient setting

*Requires a referral or service authorization. Ask your doctor who will direct your care.

Services that are covered for you

- Consultation, diagnosis, and treatment by a specialist
- Hearing and balance exams
- Telehealth office visits including consultation, diagnosis and treatment by a specialist
- Second opinion prior to surgery
- Family Planning- open access service (For more information see Family Planning Services section.
- Gynecology (GYN) services – You have direct access to GYN providers for the following: annual preventive health exam, including follow-up exams that your doctor says are necessary; evaluation and treatment for gynecologic conditions or emergencies. To get the "direct access" services you must go to a provider in our Plan's network.
- Visits in the hospital or nursing home
- Outpatient hospital services

Emergency Medical Services and Post-Stabilization Care (Follow-up Care)

Coverage is limited to services provided in United States and Canada.

If you receive emergency care at an out-of-network hospital and need inpatient care after your emergency condition is stabilized, you must return to a network hospital in order for your care to continue to be covered.

Covered Services

- Emergency room services
- Post-stabilization care (follow-up care)
- Ambulance (air or ground)

Not Covered Services

- Emergency care or other health care services received from providers located outside the United States and Canada.

*Requires a referral or service authorization. Ask your doctor who will direct your care.

Eye Care Services

Covered services

- Eye Exams
- Eyeglasses, including identical replacement due to damage, loss or theft
- Repairs to frames and lenses for eyeglasses covered under our Plan
- Tints or polarized lenses, when medically necessary
- Tints and /or protective coating to first and/or second pair of eyeglasses
- Second pair of eyeglasses
- Contact lenses, when medically necessary under certain circumstances
- Glaucoma screening
- Outpatient doctor services for eye care.
- 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.

Not Covered Services

- Eyeglasses more than every 24 months unless medically necessary
- Bifocal lenses without line and progressive bifocals
- Protective coating for plastic lenses
- Contact lens supplies

*Requires a referral or service authorization. Ask your doctor who will direct your care.

Family Planning Services

Federal and State law allow you to choose any doctor, clinic, hospital, pharmacy, or family planning agency to get open access services. You can get open access services from any provider, even if they are not in the Plan network.

Covered Services

- Family planning exam and medical treatment – **open access service**
- Family planning lab and diagnostic tests – **open access service**
- Family planning methods (birth control pills, patch, ring, IUD, injections, implants) – **open access service**
- Family planning supplies with prescription (condom, sponge, foam, film, diaphragm, cap) - **open access service**
- Counseling and diagnosis of infertility, including related services - **open access service**
- Treatment for medical conditions of infertility – **Not an open access service**. You must see a provider in our Plan's network. **Note**: This service does not include artificial ways to become pregnant.
- Counseling and testing for sexually transmitted disease (STDs), AIDS and other HIV-related conditions - **open access service**
- Treatment for sexually transmitted diseases (STDs) - **open access service**
- Treatment for AIDS and other HIV-related conditions – **Not an open access service**. You must see a provider in the Plan network.
- Voluntary sterilization (You must be age 21 or older and you must sign a federal sterilization consent form. At least 30 days, but not more than 180 days, must pass between the date that you sign the form and the date of surgery - **open access service**
- Genetic counseling - **open access service**
- Genetic testing – **Not an open access service.** You must see a provider in the Plan network.

Not Covered Services

- Artificial ways to become pregnant (artificial insemination, including in-vitro fertilization and related services; fertility drugs and related services)
- Reversal of voluntary sterilization

*Requires a referral or service authorization. Ask your doctor who will direct your care.

Services that are covered for you

Health Services

Covered Services

- Services of a certified public health nurse or a registered nurse practicing in a public health nursing clinic under a governmental unit
- Advanced Practice Nurse services: Services provided by a nurse practitioner, nurse anesthetist, nurse midwife, or clinical nurse specialist
- Community health worker care coordination and patient education services
- Kidney disease education services – Education to teach kidney care and help members make informed decisions about their care.
- Tuberculosis care management and direct observation of drug intake
- Counseling and testing for sexually transmitted diseases (STDS), AIDS and other HIV-related conditions - **open access service**
- Treatment for AIDS and other HIV-related conditions - **Not an open access service**
- Treatment for sexually transmitted diseases (STDs) – **open access service.**
- Medical nutrition therapy

Hearing services

Covered Services

- Hearing tests
- Hearing aids and batteries
- Repair and replacement of hearing aids due to normal wear and tear, with limits

Home care services

Covered services

- Skilled nursing*
- Home health aide*
- Physical therapy, occupational therapy, and speech language therapy*
- Respiratory therapy
- Private duty nursing*
- Personal care assistant (PCA) services and supervision of PCA services*
- Medical social services*
- Medical equipment and supplies*

*Requires a referral or service authorization. Ask your doctor who will direct your care.

Services that are covered for you

Home and Community Based Services (Elderly Waiver)

See Chapter 2 for Home and Community Based Services contact information.

Covered Elderly Waiver (EW) Services:

- Adult Day Services (ADS): Health and social services given on a regular basis in a licensed setting.
- Adult Foster Care: A home that provides care in a family-like setting.
- Case Management: Management of your health and long-term care services among different health and social service workers.
- Chore Services: Services needed to keep your home clean and safe.
- Companion Services: Non-medical social support services for members who need supervision.
- Consumer Directed Community Support Services: Services that you manage yourself within a set budget.
- Customized Living/24 Hour Customized Living: A group of services given in an assisted living setting.
- Environmental Accessibility Adaptions: Physical changes to your home and vehicle needed to assure health and safety.
- Extended State Plan Home Health Care Services: This includes home health aide and nursing services that are over the Medical Assistance limit.
- Extended State Plan Private Duty Nursing – This includes private duty nursing services that are over the Medical Assistance limit.
- Extended State Plan Personal Care Assistance Services: Help with personal care and activities of daily living over the Medical Assistance limit.
- Family and Care Giver Training and Education: Training for unpaid caregivers.
- Home Delivered Meals: Meals delivered to your home.
- Homemaker Services: General household activities to keep up the home.
- Residential Care Services: A group of services offered in a licensed board and lodge setting.
- Respite Care: Short-term service when you cannot care for yourself, and your unpaid caregiver needs relief.
- Specialized Medical Supplies and Equipment: Supplies and equipment that are over the Medical Assistance limit or coverage.
- Transitional Supports Services: One time costs related to setting up a household (such as when a person leaves a nursing home).
- Transportation: A ride to activities and services in the community.

You must have a Long Term Care Consultation (LTCC) done and found to be nursing home certifiable to get these Elderly Waiver (EW) services. You can request to have this assessment in your home,

*Requires a referral or service authorization. Ask your doctor who will direct your care.

Services that are covered for you

apartment or facility where you live. Your MSHO care coordinator will meet with you and your family to talk about your care needs within 15 days if you call to ask for a visit.

Your MSHO care coordinator will give you information about community services, help you find services to stay in your home or community, and help you find services to move out of a nursing home or other facility.

You have the right to have friends or family present at the visit. You can designate a representative to help you make decisions. You can decide what your needs are and where you want to live. You can ask for services to best meet your needs. You can make the final decisions about your plan for services and help. You can choose who you want to provide the services and supports from those providers available from our Plan's network.

After the visit, your MSHO care coordinator will send you a letter that recommends services that best meet your needs. You will be sent a copy of the service plan you helped put together. Your care coordinator will help you file an appeal if you disagree with suggested services or were informed you may not qualify for these services.

People who live on the White Earth, Leech Lake or Fond du Lac Reservations can choose to get their EW services through the White Earth, Leech Lake or Fond du Lac tribal services or through our Plan. These EW options may be expanded to other reservations. Contact your tribe or our Plan if you have questions.

If you are currently on the Community Alternatives for Disabled Individuals (CADI), Community Alternative Care (CAC), Traumatic Brain Injury (TBI), or the Developmental Disability (DD) waiver, you will continue to get services covered by these programs in the same way you get them now. Your county case manager will continue to authorize these services and coordinate with your MSHO care coordinator.

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. Our plan will bill Original Medicare for these services while your hospice election is in force.

*Requires a referral or service authorization. Ask your doctor who will direct your care.

Services that are covered for you

Covered services

- 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.

Hospital care - Inpatient

Covered services

- Semi-private room (or a private room if medically necessary)
- Meals including special diets
- Regular nursing services
- Costs of special care units (e.g. 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, respiratory and speech language therapy
- Under certain conditions, the following types of transplants are covered: corneal, kidney, pancreas, pancreatic islet cell, kidney-pancreatic, heart, liver, lung, heart/lung, bone marrow, stem cell, intestine, intestine-liver 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. If you are sent outside of your community for a transplant, we will arrange or pay for appropriate lodging and transportation costs for you and a companion.
- Blood and blood products- including storage and administration
- Doctor services

*Requires a referral or service authorization. Ask your doctor who will direct your care.

Services that are covered for you

Hospital – Outpatient

Covered Services

- Urgent care for conditions that are not as serious as an emergency
- Outpatient surgery (including services provided at hospital facilities and ambulatory surgical centers)*
- Tests and x-rays
- Dialysis
- Emergency room services
- Post stabilization care (follow-up care)

Interpreter Services

See Chapter 2 for Interpreter Services for contact information.

Interpreter services are available to help you get services. Oral interpretation is available for any language.

Covered Services

- Spoken language interpreter services
- Hearing interpreter services

Medical equipment and related supplies

You need a prescription/doctor's order. You may call the Medical Equipment and Related Supplies Coverage Criteria phone number in Chapter 2 if you need more information on our Plan's durable medical equipment coverage criteria.
(For a definition of "durable medical equipment," see Chapter 12 of this booklet.)

Covered Services

- Prosthetics or orthotics (including a second pair of orthotic shoes or orthotic shoe insoles) *
- Durable medical equipment (e.g.: wheelchair, hospital bed, walker, crutches, wigs for people with alopecia areata) *

*Requires a referral or service authorization. Ask your doctor who will direct your care.

Services that are covered for you

- Repairs of medical equipment
- Batteries for medical equipment
- Some shoes when part of a leg brace or when custom molded
- Oxygen and oxygen equipment
- Supplies you may need to take care of a medical problem
- Incontinence products*
- IV infusion pump
- Nebulizer
- Nutritional/enteral products*
- Colostomy bags and supplies directly related to colostomy care
- Pacemakers
- Family planning supplies – open access service (See Family Planning services section)

*Requires a referral or service authorization. Ask your doctor who will direct your care.

Services that are covered for you

Mental Health Services

See Chapter 2 for Mental Health Services contact information.

Get mental health services from our Plan network of mental health providers.

If we or your network provider decides no structured mental health treatment is necessary, you may get a second opinion. For the second opinion, we must allow you to go to any qualified health professional who is not in the Plan network. We will pay for this. To get **help choosing** a second opinion, you may call the Personalized Assistance Line (PAL) 952-883-5811 or 1-888-638-8787 (toll free). We must consider the second opinion, but we have the right to disagree with the second opinion. You have the right to appeal our decision.

We will not determine medical necessity for court-ordered mental health services. Use a Plan network provider for your court-ordered mental health assessment.

Covered Services

- Adult Mental Health Crisis Services (Non-residential and residential): assessment, mobile intervention, treatment planning, and stabilization services.
- Adult Rehabilitative Mental Health Services (ARMHS): basic living/social skills, community intervention, medication education, and services to help you stay in the community.
- Assertive Community Treatment (ACT)
- Consultation between your primary care doctor and a psychiatrist about your care
- Crisis assessment and intervention in an emergency room or urgent care setting
- Day treatment and partial hospitalization
- Diagnostic assessment
- Dialectical behavior therapy for persons diagnosed with borderline personality disorder (This service is effective upon federal approval.)
- Explanation of findings
- Inpatient psychiatric hospital stay
- Intensive Residential Treatment Services (IRTS)*
- Medication management
- Mental Health Targeted Case Management for persons with serious and persistent mental illness (SPMI). You may be able to get this service from our plan or the State. Call the number listed in Chapter 2 for more information.*
- Mental health services provided via two-way interactive video, which would otherwise be covered as direct face-to-face services

*Requires a referral or service authorization. Ask your doctor who will direct your care.

Services that are covered for you

- Neuropsychological services
- Psychological testing
- Psychotherapy: individual, family, multifamily, and group

Not Covered Services

- Treatment at Rule 36 facilities that are not licensed as Intensive Residential Treatment Services (IRTS)
- Room and board associated with Intensive Residential Treatment Services (IRTS)

Nursing Home Services*

- Nursing Home Daily Rate – Our Plan is responsible for paying a total of 180 days of nursing home room and board. If you need continued nursing home care beyond the 180 days, the Minnesota Department of Human Services (DHS) will pay directly for your care. If DHS is currently paying for your care in the nursing home, DHS, not our Plan, will continue to pay for your care.
- You may meet special criteria that enable you to get skilled nursing facility (SNF) coverage under Medicare. Our Plan will pay up to 100 days of coverage per benefit period. No prior hospital stay is required.

Covered services

- Semiprivate room (or a private room if medically necessary)
- Meals, including special diets
- Regular nursing services
- Physical therapy, occupational therapy, speech therapy and respiratory 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.)
- Medical supplies and equipment
- Use of appliances such as wheelchairs ordinarily provided by SNFs

Generally, you will get your SNF care from plan facilities. However, under certain conditions listed below, you may be able to pay in-network cost-sharing for a facility that isn't a plan provider, if the facility accepts our plan's amounts for payment.

- A nursing home or continuing care retirement community where you were living right before you went to the hospital (as long as it provides skilled nursing facility care).

*Requires a referral or service authorization. Ask your doctor who will direct your care.

Services that are covered for you

- A SNF where your spouse is living at the time you leave the hospital.

Out-of-Area Services

Covered Services

- A service you need when you are temporarily out of the Plan service area*
- A service you need after you move from our service area while you are still a Plan member*
- Emergency services for an emergency that needs treatment right away
- Post-stabilization care (follow-up care)
- Medically necessary urgent care when you are outside of the Plan service area. (Call Member Services at the phone number on the front cover as soon as possible.)
- Covered services that are not available in the Plan service area*

Not Covered Services

- Emergency care or other health care services received from providers located outside the United States and Canada.

Out-of-Network Services

Covered Services

- Certain services you need that you cannot get through a Plan network provider*
- Emergency services for an emergency that needs treatment right away
- Post-stabilization care (follow-up care)
- A second opinion for mental health and chemical dependency
- Open access services

Podiatry services

Covered services

- 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

*Requires a referral or service authorization. Ask your doctor who will direct your care.

Services that are covered for you

Prescription drugs - See Chapters 5 and 6 for Information on Medicare Part D Prescription Drugs

Chapter 5 explains the Part D prescription drug benefit, including rules you must follow to have prescriptions covered. What you pay for your Part D prescription drugs through our plan is listed in Chapter 6.

Medicare Part B Covered 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 doctor services
- Drugs you take using durable medical equipment (such as nebulizers) that was authorized by the plan
- Clotting factors you give yourself by injection if you have hemophilia
- Immunosuppressive Drugs, if you were enrolled in Medicare Part A at the time of the organ transplant
- Injectable osteoporosis drugs, if you are homebound, have a bone fracture that a doctor certifies was related to post-menopausal osteoporosis, and cannot self-administer the drug
- Antigens
- 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

Medical Assistance Covered Drugs

- Our Plan will cover some Medical Assistance covered drugs that are not covered by Medicare Parts B and D. These include drugs such as benzodiazepines, barbiturates, some over-the-counter products, and some prescription cough and cold medicines.
- The drug must be on our covered drug list (formulary). We will cover a non-formulary drug if your doctor shows us that: 1) the drug that is normally covered has caused a harmful reaction to you; 2) there is a reason to believe the drug that is normally covered would cause a harmful reaction; or 3) the drug prescribed by your doctor is more effective for you than the drug that is normally covered. The drug must be in a class of drugs that is covered.

*Requires a referral or service authorization. Ask your doctor who will direct your care.

Services that are covered for you

- We will cover an antipsychotic drug, even if it is not on our drug list, if your provider certifies this is best for you. There is no co-pay for anti-psychotic drugs. In certain cases, we will cover other drugs used to treat a mental illness or emotional disturbance even if the drug is not on our approved drug list. We will do this for up to one year if your provider certifies the drug is best for you and you have been treated with the drug for 90 days before: 1) we removed the drug from our drug list; or 2) you enrolled in our Plan
- You may ask us to cover your drug even if it is not on our formulary.

- You may ask us to waive limits on your drug. For example, we may limit the amount of the drug that we will cover if your drug has a quantity limit. You may ask us to waive the limit and cover more.
- You can ask for an exception to the formulary for anti-psychotic prescription drugs prescribed to treat emotional disturbances or mental illness, and your right to receive certain non-formulary drugs for diagnosed mental illness or emotional disturbance when our formulary changes or you change health plans.
- If pharmacy staff tells you the drug is not covered and asks you to pay, ask them to call your doctor. We cannot pay you back if you pay for it. There may be another drug that will work that is covered by our Plan. If the pharmacy won't call your doctor, you can. You can also call our Plan Member Services at the phone number in Chapter 2 for help.

Not Covered Drugs

- Drugs used to enhance fertility
- Drugs used to treat impotence
- Drugs or products to promote weight loss
- Drugs used to treat hair loss for a cosmetic reason

Preventive Services

Abdominal aortic aneurysm screening

Bone mass measurement

Procedures to identify bone mass, detect bone loss, or determine bone quality, including a doctor's interpretation of the results.

Colorectal screening

*Requires a referral or service authorization. Ask your doctor who will direct your care.

Services that are covered for you

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
- Zoster vaccine
- Other vaccines if you are at risk

We also cover some vaccines under our outpatient prescription drug benefit.

HIV Screening

Mammography screening

Pap test, pelvic exams, and clinical breast exams

Prostate cancer screening exams

Cardiovascular disease testing

Blood tests for the detection of cardiovascular disease (or abnormalities associated with an elevated risk of cardiovascular disease).

Rehabilitation services

Covered services

- Physical therapy*
- Occupational therapy*
- Speech and language therapy
- Respiratory therapy
- Cardiac rehabilitative therapy
- Intensive cardiac rehabilitation services
- Pulmonary rehabilitation services
- Comprehensive Outpatient Rehabilitation (CORF) services

*Requires a referral or service authorization. Ask your doctor who will direct your care.

Services that are covered for you
Not Covered Services • Vocational Rehabilitation • Health clubs and spas
Surgery **Covered Services** • Office/clinic visits/surgery* • Outpatient surgery (including services provided at ambulatory surgical centers) * • Port wine stain removal • Reconstructive surgery (e.g., following mastectomy; following surgery for injury, sickness or other diseases; for birth defects.) • Anesthesia services • Circumcisions when medically necessary* • Bariatric Surgery * **Not Covered Services** • Cosmetic surgery • Sex reassignment surgery
Transplants* Organ and tissue transplants, including: kidney, cornea, bone marrow, stem cell, heart, heart-lung, liver, lung, pancreas, pancreas-kidney, pancreatic islet cell, intestine, intestine-liver, and other transplants. • The type of transplant must be: 1) listed in the Minnesota Department of Human Services Provider Manual; 2) a type covered by Medicare; or 3) be approved by the State's medical review agent. • Transplants must be done at transplant centers that meet the United Network for Organ Sharing (UNOS) standards or at Medicare approved transplant centers. • Stem cell or bone marrow transplants centers must meet the standards set by the Foundation for the Accreditation of Cellular Therapy (FACT).

*Requires a referral or service authorization. Ask your doctor who will direct your care.

Services that are covered for you

Transportation

If you need transportation to and from health services that we cover, call the Transportation phone number in Chapter 2. The Plan is not required to provide transportation to your Primary Care Clinic if it is over 30 miles from your home. If you need a ride and closer clinic in our network is not available, please call the transportation number in Chapter 2.

Covered Services

- Emergency ambulance (air or ground) - Covered services include ambulance services to-the nearest appropriate facility furnished to persons whose medical condition is such that other means of transportation could endanger the person's health.
- Non-emergency ambulance
- Special transportation (for people who, because of physical or mental impairment, cannot safely use a common carrier and do not need an ambulance)
- Common carrier transportation (e.g., bus or cab).

Urgent care

An urgent condition is not as serious as an emergency. This is care for a condition that needs prompt treatment to stop the condition from getting worse. Urgent care is available 24 hours a day. Call Member Services at the phone number in Chapter 2 as soon as possible when you get urgent care outside the Plan service area.

Covered Services

- Urgent care within our Plan's service area.
- Urgent care outside of our Plan's service area.

Not Covered Services

- Emergency care or other health care services received from providers located outside the United States and Canada.

*Requires a referral or service authorization. Ask your doctor who will direct your care.

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 benefits listed in this section (or elsewhere in this booklet), and neither will Original Medicare. In most cases, Medical Assistance will not pay either except for those services listed at the end of this section. Another exception for both Medicare and Medical Assistance services: If a benefit on the exclusion list is found upon appeal to be a 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 service, go to Chapter 9, Section 5.3 in this booklet.)

In addition to any exclusions or limitations described in the Benefits Chart, or anywhere else in this *Certificate of Coverage,* **the following items and services aren't covered under Original Medicare, Medical Assistance or by our plan:**

- Services considered not reasonable and necessary, according to the standards of Original Medicare, unless these services are listed by our plan as 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.
- Private room in a hospital, except when it is considered medically necessary.
- Personal items in your room at a hospital or a skilled nursing facility, such as a telephone or a television.
- Emergency care and other health services received from providers located outside the United States and Canada
- Autopsies
- 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 needed because of an accidental injury or to improve the function of 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.

- Self-administered prescription drugs for treatment of sexual dysfunction, including erectile dysfunction, impotence, and anorgasmy or hyporgasmy.
- Reversal of sterilization procedures and sex change operations
- Naturopath services (uses natural or alternative treatments).
- Services provided to veterans in Veterans Affairs (VA) facilities.
- Any services listed above that aren't covered will remain not covered even if received at an emergency facility.

These benefits are not covered by Health Plans, but may be covered by the State, County, or Tribe. To find out more about these benefits, call the Minnesota Health Care Programs Member Helpdesk at 651- 431-2670 or 1-800-657-3739 (toll-free).

- Case management for people with developmental disabilities
- Intermediate care facility for people who are mentally retarded (ICF/MR)
- Nursing home stays for which our Plan is not otherwise responsible. See "Nursing Home Services" in the Benefits Chart.
- Treatment at Rule 36 facilities which are not licensed as Intensive Residential Treatment Services (IRTS)
- Room and board associated with Intensive Residential Treatment Services (IRTS)
- Services provided by a state regional treatment center, a State-owned long term care facility or an institution for mental disease (IMD) unless approved by us or the service is ordered by a court under conditions specified in law.
- Services provided by federal institutions
- Job training and educational services
- Day training and habilitation
- In certain cases, mileage reimbursement for rides not otherwise covered by the Plan, to get to and from health appointments (for example, in your own car). Contact your county for more information

Chapter 5. Using the plan's coverage for your Part D prescription drugs

SECTION 1 Introduction

Section 1.1 This chapter describes your coverage for Part D drugs

This chapter explains rules for using your coverage for Part D drugs. The next chapter tells what you pay for Part D drugs (Chapter 6, *What you pay for your Part D prescription drugs*).

In addition to your coverage for Part D drugs, the Plan also covers some drugs under the plan's Medicare medical benefits:

- The plan covers drugs you are given during covered stays in the hospital or in a skilled nursing facility. Chapter 4 (*Benefits chart, what is covered*) tells about the benefits for drugs during a covered hospital or skilled nursing facility stay.

- Medicare Part B also provides benefits for some drugs. Part B drugs include certain chemotherapy drugs, certain drug injections you are given during an office visit, and drugs you are given at a dialysis facility. Chapter 4 (*Benefits chart, what is covered*) tells about the benefits for Part B drugs.

The two examples of drugs described above are covered by the plan's Medicare medical benefits. In addition, the plan also covers some Medical Assistance covered drugs that are not covered by Medicare Part D. Chapter 4 (Benefits Chart) tells about the benefits for Medical Assistance covered drugs.

This chapter explains rules for using your coverage for Part D drugs. The next chapter tells what you pay for Part D drugs (Chapter 6, *What you pay for your Part D prescription drugs*).

Section 1.2 Basic rules for the plan's Part D drug coverage

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

- You must have a network provider write your prescription. (For more information, see Section 2, *Your prescriptions should be written by a network provider.*)
- You must use a network pharmacy to fill your prescription. (See Section 3, *Fill your prescriptions at a network pharmacy.*)
- Your drug must be on the plan's *List of Covered Drugs (Formulary)* (we call it the "Drug List" for short). (See Section 4, *Your drugs need to be on the plan's drug list*.)
- Your drug must be considered "medically necessary," meaning reasonable and necessary for treatment of your injury or illness. It also needs to be an accepted treatment for your medical condition.

SECTION 2 Your prescriptions should be written by a network provider

Section 2.1 In most cases, your prescription must be from a network provider

You need to get your prescription (as well as your other care) from a provider in the plan's provider network. This person would often be your primary care provider (your PCP). It could also be another professional in our provider network if your PCP has referred you for care.

To find network providers, look in the *Provider Directory*.

The plan will cover prescriptions from providers who are not in the plan's network only in a few special circumstances. These include:

- Prescriptions you get in connection with emergency care.
- Prescriptions you get in connection with urgently needed care when network providers are not available.
- Dialysis you get when you are traveling outside of the plan's service area.

Other than these circumstances, you must have approval in advance ("prior authorization") from the plan to get coverage of a prescription from an out-of-network provider.

If you pay "out-of-pocket" for a prescription written by an out-of-network provider and you think we should cover this expense, please contact Member Services or send the bill to us for payment. Chapter 7, Section 2.1 tells how to ask us to pay our share of the cost.

If the drug is a Medical Assistance covered drug, we cannot pay you back for a Medical Assistance covered drug that you pay out-of-pocket. State and federal laws prevent us from paying you directly. If you paid for a prescription drug that you think we should have covered, contact Member Services at the number listed in on the cover.

SECTION 3 Fill your prescription at a network pharmacy or through the plan's mail-order service

Section 3.1 To have your prescription covered, use a network pharmacy

In most cases, your prescriptions are covered *only* if they are filled at the plan's network pharmacies. (See Section 3.5 for information about when we would cover prescriptions filled at out-of-network pharmacies.)

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

Section 3.2 Finding network pharmacies

How do you find a network pharmacy in your area?

To find a network pharmacy, you can look in your *Provider Directory*, visit our website (www.healthpartners.com), or call Member Services (phone numbers are on the cover). Choose whatever is easiest for you.

You may go to any of our network pharmacies. If you switch from one network pharmacy to another, and you need a refill of a drug you have been taking, you can ask either to have a new prescription written by a doctor or to have your prescription transferred to your new network pharmacy.

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

If the pharmacy you have been using leaves the plan's network, you will have to find a new pharmacy that is in the network. To find another network pharmacy in your area, you can get help from Member Services (phone numbers are on the cover) or use the *Provider Directory*.

What if you need a specialized pharmacy?

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

- Pharmacies that supply drugs for home infusion therapy.
- Pharmacies that supply drugs for residents of a long-term-care facility. Usually, a long-term care facility (such as a nursing home) has its own pharmacy. Residents may get prescription drugs through the facility's pharmacy as long as it is part of our network. If your long-term care pharmacy is not in our network, please contact Member Services.
- Pharmacies that serve the Indian Health Service / Tribal / Urban Indian Health Program (not available in Puerto Rico). Except in emergencies, only Native Americans or Alaska Natives have access to these pharmacies in our network.
- Pharmacies that dispense certain drugs that are restricted by the FDA to certain locations, require extraordinary handling, provider coordination, or education on its use. (Note: This scenario should happen rarely.)

To locate a specialized pharmacy, look in your *Provider Directory* or call Member Services.

Section 3.3 Using the plan's mail-order services

For certain kinds of drugs, you can use the plan's network mail-order services. Generally, the drugs available through mail order are drugs that you take on a regular basis, for a chronic or long-term medical condition. The drugs available through our plan's mail order service are marked as "**mail-order" drugs** in our Drug List.

Our plan's mail-order service requires you to order up to at least a 90 day supply.

To get information about filling your prescriptions by mail you can call Member Services.

If you use a mail-order pharmacy not in the plan's network, your prescription will not be covered.

Usually a mail-order pharmacy order will get to you in no more than 5 to 8 business days. If your mail order drug is delayed, you may request that the drug be sent to a retail pharmacy near you. At that time a full month supply of the drug will be filled. You will be charged the co-payment that applies.

Section 3.4 How can you get a long-term supply of drugs?

When you get a long-term supply of drugs, your cost sharing may be lower. The plan offers two ways to get a long-term supply of "mail-order" drugs on our plan's Drug List. (Mail-order drugs are drugs that you take on a regular basis, for a chronic or long-term medical condition.)

1. **Some retail pharmacies** in our network allow you to get a long-term supply of mail-order drugs. Some of these retail pharmacies may agree to accept the mail-order cost-sharing amount for a long-term supply of mail-order drugs. Other retail pharmacies may not agree to accept the mail-order cost-sharing amounts for a long-term supply of mail-order drugs. In this case you will be responsible for the difference in price. Your *Provider Directory* tells you which pharmacies in our network can give you a long-term supply of mail-order drugs. You can also call Member Services for more information.
2. For certain kinds of drugs, you can use the plan's network **mail-order services.** These drugs are marked as mail-order drugs on our plan's Drug List. Our plan's mail-order service requires you to order up to a 90-day supply. See Section 3.3 for more information about using our mail-order services.

Section 3.5 When can you use a pharmacy that is not in the plan's network?

Your prescription may be covered in certain situations

We have network pharmacies outside of our service area where you can get your prescriptions filled as a member of our plan. Generally, we cover drugs filled at an out-of-network pharmacy

only when you are not able to use a network pharmacy. Here are the circumstances when we would cover prescriptions filled at an out-of-network pharmacy:

- **If you need a prescription because of a medical emergency**

  We will cover up to a 30-day supply for prescriptions that are filled at an out-of-network pharmacy if the prescriptions are related to care for a medical emergency or urgently needed care.

- **If you need a prescription when you travel or are away from the Plan's service area**

  If you take a prescription drug on a regular basis and you are going on a trip, be sure to check your supply of the drug before you leave. When possible, take along all the medication you will need. You may be able to order your prescription drugs ahead of time through our network mail order pharmacy service or through a retail network pharmacy that offers an extended supply.

  If you are traveling within the US, but outside of the Plan's service area, and you become ill, lose or run out of your prescription drugs, we will cover prescriptions that are filled at an out-of-network pharmacy if you follow all other coverage rules identified within this document and a network pharmacy is not available.

  Prior to filling your prescription at an out-of-network pharmacy, call our Member Services to find out if there is a network pharmacy in the area where you are traveling. If there are no network pharmacies in that area, our Member Services may be able to make arrangements for you to get your prescriptions from an out-of-network pharmacy.

  We cannot pay for any prescriptions that are filled by pharmacies outside the United States, even for a medical emergency.

- **Other times you can get your prescription covered if you go to an out-of-network pharmacy**

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

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

  - If you are trying to fill a covered prescription drug that is not regularly stocked at a network retail or mail order pharmacy (these drugs include orphan drugs or other specialty pharmaceuticals).

In these situations, **please check first with Member Services** to see if there is a network pharmacy nearby.

How do you ask for reimbursement from the plan?

If you must use an out-of-network pharmacy, you will generally have to pay the full cost (rather than paying your normal share of the cost) when you fill your prescription. You can ask us to reimburse you for our share of the cost. (Chapter 7, Section 2.1 explains how to ask the plan to pay you back.) **If the drug is a Medical Assistance covered drug, we cannot pay you back for a Medical Assistance covered drug that you pay out-of-pocket. State and federal laws prevent us from paying you directly. If you paid for a prescription drug that you think we should have covered, contact Member Services at the number listed in on the cover.**

SECTION 4 Your drugs need to be on the plan's "Drug List"

Section 4.1 The "Drug List" tells which Part D drugs are covered

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

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

We will generally cover a drug on the plan's Drug List as long as you follow the other coverage rules explained in this chapter and the drug is medically necessary, meaning reasonable and necessary for treatment of your injury or illness. It also needs to be an accepted treatment for your medical condition.

The Drug List includes both brand-name and generic drugs

A generic drug is a prescription drug that has the same active ingredients as the brand-name drug. It works just as well as the brand-name drug, but it costs less. There are generic drug substitutes available for many brand-name drugs.

What is *not* on the Drug list?

The plan does not cover all prescription drugs.

- In some cases, the law does not allow any Medicare plan to cover certain types of drugs (for more information about this, see Section 8.1 in this chapter).
- In other cases, we have decided not to include a particular drug on the Drug List.

Section 4.2 There are two "cost-sharing tiers" for drugs on the Drug List

Every drug on the plan's Drug List is in one of two cost-sharing tiers. In general, the higher the cost-sharing tier, the higher your cost for the drug:

- Cost Sharing Tier 1 is the lowest tier. It includes generic drugs. They generally cost less than brand drugs in the same drug category.
- Cost Sharing Tier 2 is the higher tier. It includes brand drugs. They generally cost more than generic drugs in the same drug category.

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

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

Section 4.3 How can you find out if a specific drug is on the Drug List?

You have three ways to find out:

1. Check the most recent Drug List we sent you in the mail.
2. Visit the plan's website (www.healthpartners.com). The Drug List on the website is always the most current.
3. Call Member Services to find out if a particular drug is on the plan's Drug List or to ask for a copy of the list. Phone numbers for Member Services are on the front cover.

SECTION 5 There are restrictions on coverage for some drugs

Section 5.1 Why do some drugs have restrictions?

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

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

Section 5.2 What kinds of restrictions?

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

Restricting brand name drugs when a generic version is available

A "generic" drug works the same as a brand-name drug, but usually costs less. **When a generic version of a brand-name drug is available, our network pharmacies will provide you the generic version.** We usually will not cover the brand name drug when a generic version is available. However, if your doctor has told us the medical reason that the generic drug will not work for you or has written "No substitutions" on your prescription for a brand name drug, then we will cover the brand-name drug. (Your share of the cost may be greater for the brand-name drug than for the generic drug.)

Getting plan approval in advance

For certain drugs, you or your doctor need to get approval from the plan before we will agree to cover the drug for you. This is called "**prior authorization.**" Sometimes plan approval is required so we can be sure that your drug is covered by Medicare rules. Sometimes the requirement for getting approval in advance helps guide appropriate use of certain drugs. If you do not get this approval, your drug might not be covered by the plan.

Trying a different drug first

This requirement encourages you to try safer or more effective drugs before the plan covers another drug. For example, if Drug A and Drug B treat the same medical condition, the plan may require you to try Drug A first. If Drug A does not work for you, the plan will then cover Drug B. This requirement to try a different drug first is called "**Step Therapy.**"

Quantity limits

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

Section 5.3 Do any of these restrictions apply to your drugs?

The plan's Drug List includes information about the restrictions described above. To find out if any of these restrictions apply to a drug you take or want to take, check the Drug List. For the most up-to-date information, call Member Services (phone numbers are on the front cover) or check our website (www.healthpartners.com).

SECTION 6 What if one of your drugs is not covered in the way you'd like it to be covered?

Section 6.1 There are things you can do if your drug is not covered in the way you'd like it to be covered

Suppose there is a prescription drug you are currently taking, or one that you and your doctor think you should be taking. We hope that your drug coverage will work well for you, but it's possible that you might have a problem. For example:

- **What if the drug you want to take is not covered by the plan?** For example, the drug might not be covered at all. Or maybe a generic version of the drug is covered but the brand-name version you want to take is not covered.
- **What if the drug is covered, but there are extra rules or restrictions on coverage for that drug?** As explained in Section 5, some of the drugs covered by the plan have extra rules to restrict their use. For example, you might be required to try a different drug first, to see if it will work, before the drug you want to take will be covered for you. Or there might be limits on what amount of the drug (number of pills, etc.) is covered during a particular time period.
- **What if the drug is covered, but it is in a cost-sharing tier that makes your cost sharing more expensive than you think it should be?** The plan puts each covered drug into one of two different cost-sharing tiers. How much you pay for your prescription depends in part on which cost-sharing tier your drug is in.

There are things you can do if your drug is not covered in the way that you'd like it to be covered. Your options depend on what type of problem you have:

- If your drug is not on the Drug List or if your drug is restricted, go to Section 6.2 to learn what you can do.
- If your drug is in a cost-sharing tier that makes your cost more expensive than you think it should be, go to Section 6.3 to learn what you can do.

Section 6.2 What can you do if your drug is not on the Drug List or if the drug is restricted in some way?

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

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

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

You may be able to get a temporary supply

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

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

1. The change to your drug coverage must be one of the following types of changes:

- The drug you have been taking is **no longer on the plan's Drug List**.
- -- or -- the drug you have been taking is **now restricted in some way** (Section 5 in this chapter tells about restrictions).

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

- **For those members who were in the plan last year and aren't in a long-term care facility:**

  We will cover a temporary supply of your drug **one time only during the first 90 days of the calendar year**. This temporary supply will be for a maximum of *a* 30-day supply, or less if your prescription is written for fewer days. The prescription must be filled at a network pharmacy.

- **For those members who are new to the plan and aren't in a long-term care facility:**

  We will cover a temporary supply of your drug **one time only during the first 90 days of your membership** in the plan. This temporary supply will be for a maximum of *a* 30-day supply, or less if your prescription is written for fewer days.

- **For those who are a new member, and resident in a long-term care facility:**

  We will cover a temporary supply of your drug **during the first 90 days of your membership** in the plan. The first supply will be for a maximum of *a* 31-day supply, or less if your prescription is written for fewer days. If needed, we will cover additional refills during your first 90 days in the plan.

- **For those who have been a member of the plan for more than 90 days, and are a resident of a long-term care facility and need a supply right away:**

  We will cover one 31-day supply, or less if your prescription is written for fewer days. This is in addition to the above long-term care transition supply.

- **Transition Policy**
  Current members may also be affected by changes in our formulary from one year to the next. Members should talk to their doctors to decide if they should switch to a different drug that we cover or request a formulary exception to get coverage for the drug. Please contact Member Services if your drug is not on our formulary, is subject to certain restrictions, such as prior or step therapy or will no longer be on our formulary next year, and you need help switching to a different drug that we cover or requesting a formulary exception.

  If you are a current member affected by a formulary change from one year to the next, we will provide you with the opportunity to request a formulary exception in advance for the following year.

  When a member goes to a network pharmacy and we provide a temporary supply of a drug that isn't on our formulary or that has coverage restrictions or limits we will cover a 30-day supply (unless the prescription is written for fewer days). After we cover the temporary 30-day supply, we generally will not pay for these drugs as part of our transition policy again. We will provide you with a written notice after we cover your temporary supply. This notice will explain the steps you can take to request an exception and how to work with your doctor to decide if you should switch to a different drug that we cover.

  If current members in our plan have changes in their level of care, such as entering a long-term care facility or leaving a hospital, we will grant early refills when needed.

  Please note that this policy applies only to those drugs that are "Part D drugs" and bought at a network pharmacy. The policy can't be used to buy a non-Part D drug or a drug out of network, unless you qualify for out of network access. See Chapter 4 for information about non-Part D drugs and any policies that may apply to non-Part D drugs.

To ask for a temporary supply, call Member Services (phone numbers are on the front cover).

During the time when you are getting a temporary supply of a drug, you should talk with your doctor to decide what to do when your temporary supply runs out. Perhaps there is a different drug covered by the plan that might work just as well for you. Or you and your doctor can ask the plan to make an exception for you and cover the drug in the way you would like it to be covered. The sections below tell you more about these options.

You can change to another drug

Start by talking with your doctor. Perhaps there is a different drug covered by the plan that might work just as well for you. You can call Member Services to ask for a list of covered drugs that treat the same medical condition. This list can help your doctor to find a covered drug that might work for you.

You can file an exception

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

If you are a current member and a drug you are taking will be removed from the formulary or restricted in some way for next year, we will allow you to request a formulary exception in advance for next year. We will tell you about any change in the coverage for your drug for the following year. You can then ask us to make an exception and cover the drug in the way you would like it to be covered for the following year. We will give you an answer to your request for an exception before the change takes effect.

If you and your doctor or other prescriber want to ask for an exception, Chapter 9, Section 6.2 tells what to do. It explains the procedures and deadlines that have been set by Medicare to make sure your request is handled promptly and fairly.

Section 6.3 What can you do if your drug is in a cost-sharing tier you think is too high?

If your drug is in a cost-sharing tier you think is too high, here are things you can do:

You can change to another drug

Start by talking with your doctor or other prescriber. Perhaps there is a different drug in a lower cost-sharing tier that might work just as well for you. You can call Member Services to ask for a list of covered drugs that treat the same medical condition. This list can help your doctor to find a covered drug that might work for you.

You can file an exception

You and your doctor or other prescriber can ask the plan to make an exception in the cost-sharing tier for the drug so that you pay less for the drug. If your doctor or other prescriber says that you have medical reasons that justify asking us for an exception, your doctor or other prescriber can help you request an exception to the rule.

If you and your doctor or other prescriber want to ask for an exception, Chapter 9, Section 6.2 tells what to do. It explains the procedures and deadlines that have been set by Medicare to make sure your request is handled promptly and fairly.

SECTION 7 What if your coverage changes for one of your drugs?

Section 7.1 The Drug List can change during the year

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

- **Add or remove drugs from the Drug List**. New drugs become available, including new generic drugs. Perhaps the government has given approval to a new use for an existing drug. Sometimes, a drug gets recalled and we decide not to cover it. Or we might remove a drug from the list because it has been found to be ineffective.
- **Add or remove a restriction on coverage for a drug** (for more information about restrictions to coverage, see Section 5 in this chapter).
- **Replace a brand-name drug with a generic drug.**

In almost all cases, we must get approval from Medicare for changes we make to the plan's Drug List.

Section 7.2 What happens if coverage changes for a drug you are taking?

How will you find out if your drug's coverage has been changed?

If there is a change to coverage *for a drug you are taking*, the plan will send you a notice to tell you. Normally, **we will let you know at least 60 days ahead of time**.

Once in a while, a drug is **suddenly recalled** because it's been found to be unsafe or for other reasons. If this happens, the plan will immediately remove the drug from the Drug List. We will let you know of this change right away. Your doctor will also know about this change, and can work with you to find another drug for your condition.

Do changes to your drug coverage affect you right away?

If any of the following types of changes affect a drug you are taking, the change will not affect you until January 1 of the next year if you stay in the plan:

- If we move your drug into a higher cost-sharing tier.
- If we put a new restriction on your use of the drug.
- If we remove your drug from the Drug List, but not because of a sudden recall or because a new generic drug has replaced it.

If any of these changes happens for a drug you are taking, then the change won't affect your use or what you pay as your share of the cost until January 1 of the next year. Until that date, you probably won't see any increase in your payments or any added restriction to your use of the drug. However, on January 1 of the next year, the changes will affect you.

In some cases, you will be affected by the coverage change before January 1:

- If a **brand-name drug you are taking is replaced by a new generic drug**, the plan must give you at least 60 days' notice or give you a 60-day refill of your brand-name drug at a network pharmacy.
    - During this 60-day period, you should be working with your doctor to switch to the generic or to a different drug that we cover.
    - Or you and your doctor or other prescriber can ask the plan to make an exception and continue to cover the brand-name drug for you. For information on how to ask for an exception, see Chapter 9 (*What to do if you have a problem or complaint*).
- Again, if a drug is **suddenly recalled** because it's been found to be unsafe or for other reasons, the plan will immediately remove the drug from the Drug List. We will let you know of this change right away.
    - Your doctor will also know about this change, and can work with you to find another drug for your condition.

SECTION 8 What types of drugs are *not* covered by the plan?

Section 8.1 Types of drugs we do not cover

This section tells you what kinds of prescription drugs are "excluded." This means that Medicare or Medical assistance does not pay for these drugs.

If you get drugs that are excluded by both Medicare and Medical Assistance, you must pay for them yourself. We won't pay for the drugs that are listed in this section. The only exception: If the requested drug is found upon appeal to be a drug that is not excluded and 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 drug, go to Chapter 9, Section 6.5 in this booklet.)

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

- Our plan's Part D drug coverage cannot cover a drug that would be covered under Medicare Part A or Part B.
- Our plan cannot cover a drug purchased outside the United States and its territories.

- Our plan usually cannot cover off-label use. "Off-label use" is any use of the drug other than those indicated on a drug's label as approved by the Food and Drug Administration.
    - Generally, coverage for "off-label use" is allowed only when the use is supported by certain reference books. These reference books are the American Hospital Formulary Service Drug Information, the DRUGDEX Information System, and the USPDI or its successor. If the use is not supported by any of these reference books, then our plan cannot cover its "off-label use."

Also, by law, these categories of drugs are not covered by Medicare drug plans or Medical Assistance.

- Drugs when used to promote fertility
- Drugs when used for cosmetic purposes or to promote hair growth
- Drugs when used for the treatment of sexual or erectile dysfunction, such as Viagra, Cialis, Levitra, and Caverject
- Drugs or products to promote weight loss
- Outpatient drugs for which the manufacturer seeks to require that associated tests or monitoring services be purchased exclusively from the manufacturer as a condition of sale

SECTION 9 Show your plan membership card when you fill a prescription

Section 9.1 Show your membership card

To fill your prescription, show your plan membership card at the network pharmacy you choose. When you show your plan membership card, the network pharmacy will automatically bill the plan for *our* share of your covered prescription drug cost. You will need to pay the pharmacy *your* share of the cost when you pick up your prescription.

Section 9.2 What if you don't have your membership card with you?

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

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

If the drug is a Medical Assistance covered drug, we cannot pay you back for a Medical Assistance covered drug that you pay out-of-pocket. State and federal laws prevent us from paying you directly. If you paid for a prescription drug that you think we should have covered, contact Member Services at the number listed on the cover.

SECTION 10 Part D drug coverage in special situations

Section 10.1 What if you're in a hospital or a skilled nursing facility for a stay that is covered by the plan?

If you are admitted to a hospital or to a skilled nursing facility for a stay covered by the plan, we will generally cover the cost of your prescription drugs during your stay. Once you leave the hospital or skilled nursing facility, the plan will cover your drugs as long as the drugs meet all of our rules for coverage. See the previous parts of this section that tell about the rules for getting drug coverage. Chapter 6 (*What you pay for your Part D prescription drugs*) gives more information about drug coverage and what you pay.

Please Note: When you enter, live in, or leave a skilled nursing facility, you are entitled to a special enrollment period. During this time period, you can switch plans or change your coverage at any time. (Chapter 10, *Ending your membership in the plan*, tells how you can leave our plan and join a different Medicare plan.)

Section 10.2 What if you're a resident in a long-term care facility?

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

Check your *Provider Directory* to find out if your long-term care facility's pharmacy is part of our network. If it isn't, or if you need more information, please contact Member Services.

What if you're a resident in a long-term care facility and become a new member of the plan?

If you need a drug that is not on our Drug List or is restricted in some way, the plan will cover a **temporary supply** of your drug during the first *90 days* of your membership. The first supply will be for a maximum of *a 31-day supply*, or less if your prescription is written for fewer days. If needed, we will cover additional refills during your first *90 days* in the plan.

If you have been a member of the plan for more than *90 days* and need a drug that is not on our Drug List or if the plan has any restriction on the drug's coverage, we will cover one *31-day* supply, or less if your prescription is written for fewer days.

During the time when you are getting a temporary supply of a drug, you should talk with your doctor or other prescriber to decide what to do when your temporary supply runs out. Perhaps there is a different drug covered by the plan that might work just as well for you. Or you and your doctor can ask the plan to make an exception for you and cover the drug in the way you would like it to be covered. If you and your doctor want to ask for an exception, Chapter 9, Section 6.2 tells what to do.

Section 10.3 What if you're also getting drug coverage from an employer or retiree group plan?

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

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

Special note about 'creditable coverage':

Each year your employer or retiree group should send you a notice by November 15 that tells if your prescription drug coverage for the next calendar year is "creditable" and the choices you have for drug coverage.

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

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

SECTION 11 Programs on drug safety and managing medications

Section 11.1 Programs to help members use drugs safely

We conduct drug use reviews for our members to help make sure that they are getting safe and appropriate care. These reviews are especially important for members who have more than one provider who prescribes their drugs.

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

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

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

Section 11.2 Programs to help members manage their medications

We have programs that can help our members with special situations. For example, some members have several complex medical conditions or they may need to take many drugs at the same time, or they could have very high drug costs.

These programs are voluntary and free to members. A team of pharmacists and doctors developed the programs for us. The programs can help make sure that our members are using the drugs that work best to treat their medical conditions and help us identify possible medication errors.

If we have a program that fits your needs, we will automatically enroll you in the program and send you information. If you decide not to participate, please notify us and we will withdraw your participation in the program.

Chapter 6. What you pay for your Part D prescription drugs

SECTION 1 Introduction

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

This chapter focuses on what you pay for your Part D prescription drugs. To keep things simple, we use "drug" in this chapter to mean a Part D prescription drug. As explained in Chapter 5, some drugs are covered under Original Medicare, Medical Assistance or are excluded by law.

To understand the payment information we give you in this chapter, you need to know the basics of what drugs are covered, where to fill your prescriptions, and what rules to follow when you get your covered drugs. Here are materials that explain these basics:

- **The plan's *List of Covered Drugs (Formulary).*** To keep things simple, we call this the "Drug List."
  - This Drug List tells which drugs are covered for you.
  - It also tells which of the two "cost-sharing tiers" the drug is in and whether there are any restrictions on your coverage for the durg.
  - If you need a copy of the Drug List, call Member Services (phone numbers are on the cover of this booklet). You can also find the Drug List on our website at www.healthpartners.com. The Drug List on the website is always the most current.
- **Chapter 5 of this booklet.** Chapter 5 gives the details about your Part D prescription drug coverage, including rules you need to follow when you get your covered Part D drugs. Chapter 5 also tells which types of prescription drugs are not covered by our plan.
- **The plan's *Provider Directory.*** In most situations you must use a network pharmacy to get your covered drugs (see Chapter 5 for the details). The *Provider Directory* has a list of pharmacies in the plan's network and it tells how you can use the plan's mail-order service to get certain types of drugs. It also explains how you can get a long-term supply of a drug (such as filling a prescription for a three month's supply).

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

Section 2.1 What are the two drug payment stages?

As shown in the table below, there are two "drug payment stages" for your Part D prescription drug coverage. How much you pay for a Part D drug depends on which of these stages you are in at the time you get a prescription filled or refilled.

Stage 1 *Initial Coverage Stage*	**Stage 2** *Catastrophic Coverage Stage*
The plan pays its share of the cost of your drugs and **you pay your share of the cost.** You stay in this stage until your out-of-pocket costs for the year total $4,550. (Details are in Section 4 **of this chapter.)**	Once you have paid enough for your drugs to move on to this last payment stage, **the plan will pay all of the costs** of your drugs for the rest of the year. (Details are in Section 5 of this chapter.)

As shown in this summary of the two payment stages, whether you move on to the next payment stage depends on how much **you and/or the plan spends** for your drugs while you are in each stage.

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

Section 3.1 We send you a monthly report called the "Explanation of Benefits"

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

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

Our plan will prepare a written report called the *Explanation of Benefits* (it is sometimes called the "EOB") when you have had one or more prescriptions filled. It includes:

- **Information for that month**. This report gives the payment details about the prescriptions you have filled during the previous month. It shows the total drug costs, what the plan paid, and what you and others on your behalf paid.
- **Totals for the year since January 1.** This is called "year-to-date" information. It shows you the total drug costs and total payments for your drugs since the year began.

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

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

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

Make sure we have the information we need. There are times you may pay for prescription drugs when we will not automatically get the information we need. To help us keep track of your out-of-pocket costs, you may give us copies of receipts for drugs that you have purchased. (If you are billed for a covered drug, you can ask our plan to pay our share of the cost. For instructions on how to do this, go to Chapter 7, Section 2 of this booklet.) **We cannot pay you back for a Medical Assistance covered drug that you pay out-of-pocket. State and federal laws prevent us from paying you directly. If you paid for a prescription drug that you think we should have covered, contact Member Services at the number listed on the cover. Medical Assistance covered drugs will not be included or tracked to move you to the next coverage stage.**

Here are some types of situations when you may want to give us copies of your drug receipts to be sure we have a complete record of what you have spent for your drugs:

  - When you purchase a covered Part D drug at a network pharmacy at a special price or using a discount card that is not part of our plan's benefit.
  - When you made a copayment for drugs that are provided under a drug manufacturer patient assistance program.
  - Any time you have purchased Part D covered drugs at out-of-network pharmacies or other times you have paid the full price for a covered drug under special circumstances.
- **Send us information about the payments others have made for you.** Payments made by certain other individuals and organizations also count toward your out-of-pocket costs and help qualify you for catastrophic coverage. For example, payments made by a State

Pharmaceutical Assistance Program, an AIDS drug assistance program, the Indian Health Service, and most charities count toward your out-of-pocket costs. You should keep a record of these payments and send them to us so we can track your costs.

- **Check the written report we send you.** When you receive an *Explanation of Benefits* in the mail, please look it over to be sure the information is complete and correct. If you think something is missing from the report, or you have any questions, please call us at Member Services (phone numbers are on the cover of this booklet). Be sure to keep these reports. They are an important record of your Part D drug expenses.

SECTION 4 During the Initial Coverage Stage, the plan pays its share of your drug costs and you pay your share

Section 4.1 What you pay for a drug depends on the drug and where you fill your prescription

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

The plan has two cost-sharing tiers

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

- Cost Sharing Tier 1 is the lowest tier. It includes generic tier drugs. They generally cost less than brand tier drugs in the same drug category.
- Cost Sharing Tier 2 is the higher tier. It includes brand tier drugs. They generally cost more than generic tier drugs in the same drug category.

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

Your pharmacy choices

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

- A retail pharmacy that is in our plan's network
- A pharmacy that is not in the plan's network
- The plan's mail-order pharmacy

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

Section 4.2 A table that shows your costs for a one month 30-day supply of a drug

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

- **"Copayment"** means that you pay a fixed amount each time you fill a prescription.
- As shown in the table below, the amount of the copayment depends on which cost-sharing tier your drug is in.

Drug Tier	Medicare Co-payment for Medicare covered drugs	Medicare Co-payment for Institutionalized	Medicaid Co-payment for Medical Assistance covered drugs
Generic	$1.10 or $2.50 depending upon your income	None	None
Brand	$3.30 or $6.30 depending upon your income	None	None
Specialty Drugs	$3.30 or $6.30 depending upon your income	None	None

Section 4.3 A table that shows your costs for a long-term 90 day supply of a drug

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

Your share of the cost when you get a long-term 90 day supply of a covered Part D prescription drug from:

Drug Tier	Medicare Co-payment for Medicare covered drugs	Medicare Co-payment for Institutionalized	Medicaid Co-payment for Medical Assistance covered drugs
Generic	$1.10 or $2.50 depending upon your income	None	None
Brand	$3.30 or $6.30 depending upon your income	None	None
Specialty Drugs	$3.30 or $6.30 depending upon your income	None	None

Section 4.4 You stay in the Initial Coverage Stage until your out-of-pocket drug costs for the year reach $4,550

You stay in the Initial Coverage Stage until the total out-of-pocket for the prescription drugs you have filled and refilled reaches the **$4,550 limit for the Initial Coverage Stage**.

Your total drug cost is based on adding together what you have paid and what the plan has paid:

- **What <u>you</u> have paid** for all the covered drugs you have gotten since you started with your first drug purchase of the year. This includes:
  - The total you paid as your share of the cost for your drugs during the Initial Coverage Stage.
- **What the <u>plan</u> has paid** as its share of the cost for your drugs during the Initial Coverage Stage.

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

The *Explanation of Benefits* that we send to you will help you keep track of how much you have spent for your drugs during the year. Many people do not reach the $4,550 limit in a year.

We will let you know if you reach this $4,550 amount. If you do reach this amount, you will leave the Initial Coverage Stage and move on to the Catastrophic Coverage Stage.

SECTION 5 During the Catastrophic Coverage Stage, the plan pays all of the costs for your drugs

Section 5.1 Once you are in the Catastrophic Coverage Stage, you will stay in this stage for the rest of the year

You qualify for the Catastrophic Coverage Stage when your out-of-pocket costs plus the amount paid by us has reached the $4,550 limit for the calendar year. Once you are in the Catastrophic Coverage Stage, you will stay in this payment stage until the end of the calendar year.

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

SECTION 6 What you pay for vaccinations covered by Part D depends on how and where you get them

Section 6.1 Our plan has separate coverage for the vaccine medication itself and for the cost of giving you the vaccination shot

Our plan provides coverage of a number of Part D vaccines. This section applies only to vaccines covered by Part D. We also provide vaccines that are considered medical benefits. You can find out about coverage of these vaccines by going to Chapter 4, *Benefits Chart, (what is covered).*

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

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

What do you pay for a Part D vaccination?

What you pay for a vaccination depends on three things:

1. **The type of Part D vaccine** (what you are being vaccinated for).
   - Zostavax, a vaccine that can help prevent shingles in adults 60 years of age or older
2. **Where you get the vaccine medication.**
3. **Who gives you the vaccination shot.**

What you pay at the time you get the Part D vaccination can vary depending on the circumstances. For example:

- Sometimes when you get your Part D vaccination shot, you will have to pay the entire cost for both the vaccine medication and for getting the vaccination shot. You can ask our plan to pay you back for our share of the cost.
- Other times, when you get the Part D vaccine medication or the vaccination shot, you will pay only your share of the cost.
- **Remember, we cannot pay you back for most medical bills that you pay. State and federal laws prevent us from paying you directly. The exception is if you pay for Part D prescription drugs including Part D vaccines. If you paid for a service that you think we should have covered, contact Member Services at the number listed on the front cover.**

To show how this works, here are three common ways you might get a Part D vaccination shot.

Situation 1: You buy the vaccine at the pharmacy and you get your vaccination shot at the network pharmacy. (Whether you have this choice depends on where you live. Some states do not allow pharmacies to administer a vaccination.)

- You will have to pay the pharmacy the amount of your copayment for the vaccine itself.
- Our plan will pay for the cost of giving you the vaccination shot.

9Situation 2: You buy the Part D vaccine at your pharmacy, and then take it to your doctor's office where they give you the vaccination shot.

- You will have to pay the pharmacy the amount of your copayment for the vaccine itself.
- When your doctor gives you the vaccination shot, you will pay the entire cost for this service.
- You can then ask our plan to pay our share of the cost by using the procedures that are described in Chapter 7 of this booklet *(Asking the plan to pay its share of a bill you have received for covered services or drugs)*.
- You will be reimbursed the amount charged by the doctor for administering the vaccine.

Situation 3: You get the Part D vaccination at your doctor's office.

- When you get the vaccination, you may have to pay for the entire cost of the vaccine and its administration
- You can then ask our plan to pay our share of the cost by using the procedures that are described in Chapter 7 of this booklet *(Asking the plan to pay its share of a bill you have received for covered services or drugs)*
- You will be reimbursed the amount you paid less your normal copayment for the vaccine (including administration)

Section 6.2 You may want to call us at Member Services before you get a vaccination

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

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

Chapter 7. Asking the plan to pay its share of a bill you have received for covered services or drugs

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

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

We cannot pay you back for most medical bills that you pay. State and federal laws prevent us from paying you directly. The exception is if you pay for Part D prescription drugs. If you paid for a service that you think we should have covered, contact Member Services at the number listed on the front cover.

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

There may also be times when you get a bill from a provider for the full cost of Part D drugs 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 Part D drugs should be covered. If we decide they should be covered, we will pay the provider directly.

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

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

Network providers should always bill the plan directly. They should only ask you for your share of the cost for Part D drugs. 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. **We cannot pay you back for most medical bills including drugs covered by Medical Assistance that you pay. State and federal laws prevent us from paying you directly. The exception is if you pay for Part D prescription drugs.**
- If you have already paid a bill to a network provider for Part D drugs, 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.

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

If you go to an out-of-network pharmacy and try to use your membership card to fill a prescription for a Part D drug, the pharmacy may not be able to submit the claim directly to us. When that happens, you will have to pay the full cost of your prescription. **Remember, we cannot pay you back for most medical bills including drugs covered by Medical Assistance that you pay. State and federal laws prevent us from paying you directly. The exception is if you pay for Part D prescription drugs.**

- Save your receipt and send a copy to us when you ask us to pay you back for our share of the cost of the Part D drug.

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

If you do not have your plan membership card with you, you can ask the pharmacy to call the plan or to look up your plan enrollment information. However, if the pharmacy cannot get the enrollment information they need right away, you may need to pay the full cost of the Part D prescription yourself.

- Save your receipt and send a copy to us when you ask us to pay you back for our share of the cost. **Remember, we cannot pay you back for most medical bills including drugs covered by Medical Assistance that you pay. State and federal laws prevent us from paying you directly. The exception is if you pay for Part D prescription drugs.**

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

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

- For example, the Part D drug may not be on the plan's *List of Covered Drugs (Formulary)*; or it could have a requirement or restriction that you didn't know about or don't think should apply to you. If you decide to get the drug immediately, you may need to pay the full cost for it.
- Save your receipt and send a copy to us when you ask us to pay you back. In some situations, we may need to get more information from your doctor in order to pay you back for our share of the cost. **Remember, we cannot pay you back for most medical bills including drugs covered by Medical Assistance that you pay. State and federal laws prevent us from paying you directly. The exception is if you pay for Part D prescription drugs.**
- **Drugs purchased at a better cash price**. In rare circumstances when you have bought a covered Part D drug at a network pharmacy under a special price or discount card that is outside the Plan's benefit, you may submit a paper claim to have your out-of-pocket expense count towards qualifying you for catastrophic coverage.

- **Copayments for drugs provided under a drug manufacturer patient assistance program**. If you get help from, and pay copayments under, a drug manufacturer patient assistance program outside our Plan's benefit, you may submit a paper claim to have your out-of-pocket expense count towards qualifying you for catastrophic coverage.

All of the examples above are types of coverage decisions. This means that if we deny your request for payment for a Part D drug, you can appeal our decision. Chapter 9 of this booklet (*What to do if you have a problem or complaint (coverage decisions, appeals, complaints)*) has information about how to make an appeal.

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

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

Send us your request for payment for a Part D drug, 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:

HealthPartners
Member Services
Pharmacy Administration
MS: 21111B
P.O. Box 9463
Minneapolis, MN 55440-9463

Or deliver a written request to:

HealthPartners
Member Services
Pharmacy Administration
8170 33rd Avenue South
Bloomington, MN 55425

Please be sure to contact Member 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. **We cannot pay you back for most medical bills that you pay. State and federal laws prevent us from paying you directly. The exception is if you pay for Part D prescription drugs. If you paid for a service that you think we should have covered, contact Member Services at the number listed on the front cover.**

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 or drug and how much we owe

When we receive your request for payment for a Part D drug, 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 Part D drug is covered and you followed all the rules for getting the drug, we will pay for our share of the cost. If you have already paid for the Part D drug, we will mail your reimbursement of our share of the cost to you. If you have not paid for the Part D drug yet, we will mail the payment directly to the provider. (Chapter 5 explains the rules you need to follow for getting your Part D prescription drugs.)
- If we decide that the Part D drug 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 or drug, you can make an appeal

If you think we have made a mistake in turning down your request for payment of the Part D drug, 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 9 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 9. 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 in Chapter 9 that tells what to do for your situation:

- If you want to make an appeal about getting paid back for a Part D drug, go to Section 6.6 of Chapter 9.

SECTION 4 Other situations in which you should save your receipts and send them to the plan

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

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

The following is a situation when you should send us receipts to let us know about payments you have made for your drugs:

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

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

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

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

Chapter 8. Your rights and responsibilities

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

Section 1.1 We must provide information in a way that works for you (in languages other than English or other alternate formats)

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

Our plan has people and translation services available to answer questions from non-English speaking members. We can also give you information in 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's benefits that is accessible and appropriate for you.

If you have any trouble getting information from our plan because of problems related to language or disability, please call Medicare at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 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

Our plan must obey laws that protect you from discrimination or unfair treatment. **We do not discriminate** based on a person's race, disability, religion, sex, sexual orientation, 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 Member Services (phone numbers are on the cover of this booklet). If you have a complaint, such as a problem with wheelchair access, Member Services can help.

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

As a member of our plan, you have the right to choose a primary care provider (PCP) in the plan's network to provide and arrange for your covered services (Chapter 3 explains more about this). Call Member Services to learn which doctors are accepting new patients (phone numbers are on the cover of this booklet). You have the right to choose where you get family planning services. You have the right to get a second opinion for medical, mental health and chemical dependency services. You also have the right to go to a women's health specialist (such as a gynecologist) without a referral.

As a plan member, you have the right to get appointments and covered services from the plan's network of providers *within a reasonable amount of time*. This includes the right to get timely services from specialists when you need that care. You also have the right to get your prescriptions filled or refilled at any of our network pharmacies without long delays. You have the right to get services you need 24 hours a day, seven days a week. This includes emergencies.

If you think that you are not getting your care or Part D drugs within a reasonable amount of time, Chapter 9 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 including information about your Part D prescription drugs. If Medicare releases your information for research or other uses, this will be done according to Federal statutes and regulations.
    - We, and the health providers who take care of you, have the right to see information about your health care. When you enrolled in the Minnesota Health Care Program, you gave your consent for us to do this. We will keep this information private according to law.

You can 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 Member Services (phone numbers are on the cover of this booklet).

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

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

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

- **Information about our plan**. This includes, for example, information about the plan's financial condition. It also includes information about the number of appeals made by members and the plan's performance ratings, including how it has been rated by plan members and how it compares to other Medicare Advantage health plans. You have the right to get the results of an external quality review study from the State, if you ask for them.

- **Information about our network providers including our network pharmacies.**
    - For example, you have the right to get information from us about the qualifications of the providers and pharmacies in our network and how we pay the providers in our network. You have the right to get the following from us, if you ask for it:
        - Whether we use a physician incentive plan that affects the use of referral services;
        - The type(s) of incentive arrangements used;
        - Whether stop-loss protection is provided; and
        - Results of a member survey if one is required because of our physician incentive plan.

- For a list of the providers in the plan's network, see the *Provider Directory*.
- For a list of the pharmacies in the plan's network, see the *Provider Directory.*
- For more detailed information about our providers or pharmacies, you can call Member Services (phone numbers are on the cover of this booklet) or visit our website at www.healthpartners.com.

- **Information about your coverage and rules you must follow in using your coverage.**
  - In Chapters 3 and 4 of this booklet, we explain what services are covered for you, any restrictions to your coverage, and what rules you must follow to get your covered services.
  - To get the details on your Part D prescription drug coverage, see Chapters 5 and 6 of this booklet plus the plan's *List of Covered Drugs (Formulary).* These chapters, together with the *List of Covered Drugs*, tell you what drugs are covered and explain the rules you must follow and the restrictions to your coverage for certain drugs.
  - If you have questions about the rules or restrictions, please call Member 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 service or Part D drug is not covered for you, or if your coverage is restricted in some way, you can ask us for a written explanation. You have the right to this explanation even if you received the service or drug from an out-of-network provider or pharmacy.
  - If you are not happy or if you disagree with a decision we make about what care or Part D drug 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 9 of this booklet. It gives you the details about how to ask the plan for a decision about your coverage and how to make an appeal if you want us to change our decision. (Chapter 9 also tells about how to make a complaint about quality of care, waiting times, and other concerns.)
  - If you want to ask our plan to pay our share of a bill you have received for a Part D prescription drug, see Chapter 7 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. It also includes being told about programs our plan offers to help members manage their medications and use drugs safely.
- **To know about the risks.** You have the right to be told about any risks involved in your care. You must be told in advance if any proposed medical care or treatment is part of a research experiment. You always have the choice to refuse any experimental treatments.
- **The right to say "no."** You have the right to refuse any recommended treatment. This includes the right to leave a hospital or other medical facility, even if your doctor advises you not to leave. You also have the right to stop taking your medication. Of course, if you refuse treatment or stop taking medication, you accept full responsibility for what happens to your body as a result.
- **To 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 9 of this booklet tells how to ask the plan for a coverage decision.
- **To get help to identify services needed to help you stay in the least restrictive environment.**
- **To be free of restraints or seclusion used as a means of coercion, discipline, convenience or retaliation.**

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

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

- Fill out a written form to give **someone the legal authority to make medical decisions for you** if you ever become unable to make decisions for yourself.

- **Give your doctors written instructions** about how you want them to handle your medical care if you become unable to make decisions for yourself.

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

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

- **Get the form.** 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. Chapter 2 tells how to find resources from the Senior Linkage Line at www.MinnesotaHelp.info. You can also contact Member Services to ask for the forms (phone numbers are on the covered of this booklet).
- **Fill it out and sign it.** Regardless of where you get this form, keep in mind that it is a legal document. You should consider having a lawyer help you prepare it.
- **Give copies to appropriate people.** You should give a copy of the form to your doctor and to the person you name on the form as the one to make decisions for you if you can't. You may want to give copies to close friends or family members as well. Be sure to keep a copy at home.

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

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

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

What if your instructions are not followed?

If you have signed an advance directive, and you believe that a doctor or hospital hasn't followed the instructions in it, you may file a complaint with the Office of Health Facility Complaints at the Minnesota Department of Health at 651-201-4201 or toll-free at 1-800-369-7994.

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

If you have any problems or concerns about your covered services or care, Chapter 9 of this booklet tells what you can do. It gives the details about how to deal with all types of problems and complaints.

As explained in Chapter 9, what you need to do to follow up on a problem or concern depends on the situation. You might need to ask our plan to make a coverage decision for you, make an appeal to us to change a coverage decision, or make a complaint. Whatever you do – ask for a coverage decision, make an appeal, or make a complaint – **we are required to treat you fairly.**

You have the right to get a summary of information about the appeals and complaints that other members have filed against our plan in the past. To get this information, please call Member 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 Member 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 Member 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 also get help from the Minnesota Ombudsman for State Managed Health Care Programs. Contact information is in Chapter 2 of this booklet.
- You can contact **Medicare**.
    - You can visit the Medicare website (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, 7 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 Member 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* Certificate 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 covered services, including what is covered, what is not covered, rules to follow.
    - Chapters 5 and 6 give the details about your coverage for Part D prescription drugs.
- ***If you have any other health insurance coverage or prescription drug coverage in addition to our plan, you are required to tell us.*** *Please call Member Services to let us know.*
    - We are required to follow rules set by Medicare and Medical Assistance to make sure that you are using all of your coverage in combination when you get your covered services from our plan. This is called "**coordination of benefits**" because it involves coordinating the health and drug benefits you get from our plan with any other health and drug benefits available to you. We'll help you with it.

- ***Tell your doctor and other health care providers that you are enrolled in our plan.*** *Show your plan membership card and Minnesota Health Care Programs card whenever you get your care or Part D prescription drugs.*

- ***Help your doctors and other providers help you by giving them information, asking questions, and following through on your care.***
    - To help your doctors and other health providers give you the best care, learn as much as you are able to about your health problems and give them the information they need about you and your health. Follow the treatment plans and instructions that you and your doctors agree upon.
    - Establish a relationship with a Plan network primary care doctor before you become ill. This helps you and your primary care doctor understand your total health condition.
    - 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.
    - Practice preventive health care. Have tests, exams and shots recommended for you based on your age and gender.
- ***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:*
    - In order to be eligible for our plan, you must maintain your eligibility for Medicare Part A and Part B. Some plan members may be paying a premium for Medicare Part A and /or Medicare Part B. Many members do not pay premiums for Medicare Part A and/or Medicare Part B due to Medical Assistance eligibility. If you are paying for your Medicare Part B, you must continue paying your Medicare Part B premium for you to remain as a member of the plan.
    - For some of your Part D drugs covered by the plan, you must pay your share of the cost when you get the drug. This will be a copayment (a fixed amount). Chapter 6 tells what you must pay for your Part D prescription drugs.
    - If you get any medical services or drugs 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 Member 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 member 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 Member 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 9. What to do if you have a problem or complaint (coverage decisions, appeals, and 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 also called grievances.**.

Both of these processes have been approved by Medicare and Medical Assistance. 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 simpler words in place of certain legal terms. For example, this chapter generally says “making a complaint” rather than “filing a grievance,” “coverage decision” rather than “organization determination” or “coverage determination,” 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 our plan or with any insurance company or health plan. The counselors at this program can help you understand which process you should use to handle a problem you are having. They can also answer your questions, give you more information, and offer guidance on what to do.

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

You can also get help and information from Medicare

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

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

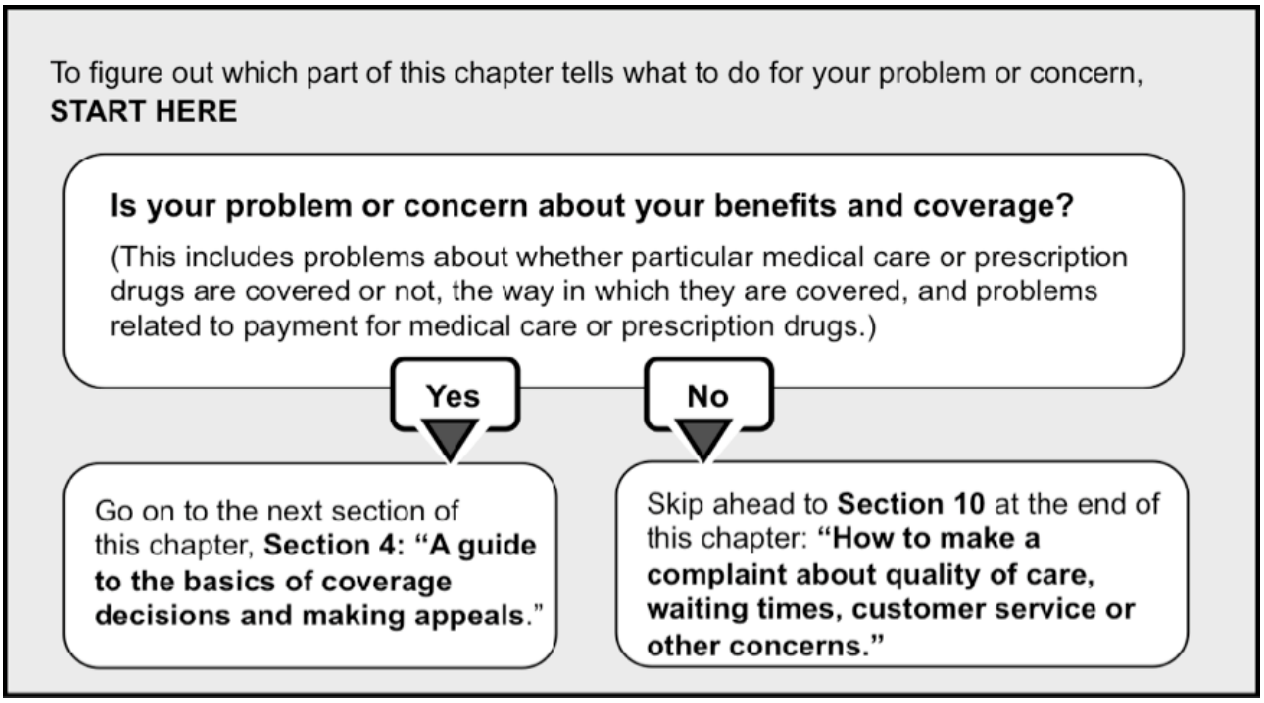
You can also get help and information from the Minnesota Ombudsman for State Managed Health Care Programs

The Minnesota Ombudsman for State Managed Health Care Programs, at the Minnesota Department of Human Services can help you file a complaint or appeal with our Plan. The Ombudsman can also help you request a State Fair Hearing. You will find the phone number for the Ombudsman in Chapter 2, Section 6 of this booklet.

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 services and prescription drugs, 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 services or drugs. We and/or your doctor make a coverage decision for you whenever you go to a doctor for medical care. You can also contact the plan and ask for a coverage decision. For example, if you want to know if we will cover a 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 or drug is not covered or is no longer covered by Medicare or Medical Assistance 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 this Level 1 Appeal for Medicare covered services, you can go on to a Level 2 Appeal. The Level 2 Appeal is conducted by an independent organization that is not connected to our plan. 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.

As a plan member, some of your plan services may also be covered by Medical Assistance. Therefore, if you believe that we improperly denied you a service or payment for a service, you

may also have the right to appeal this decision to Medical Assistance. We will let you know in writing if you have the right to appeal our decision to Medical Assistance.

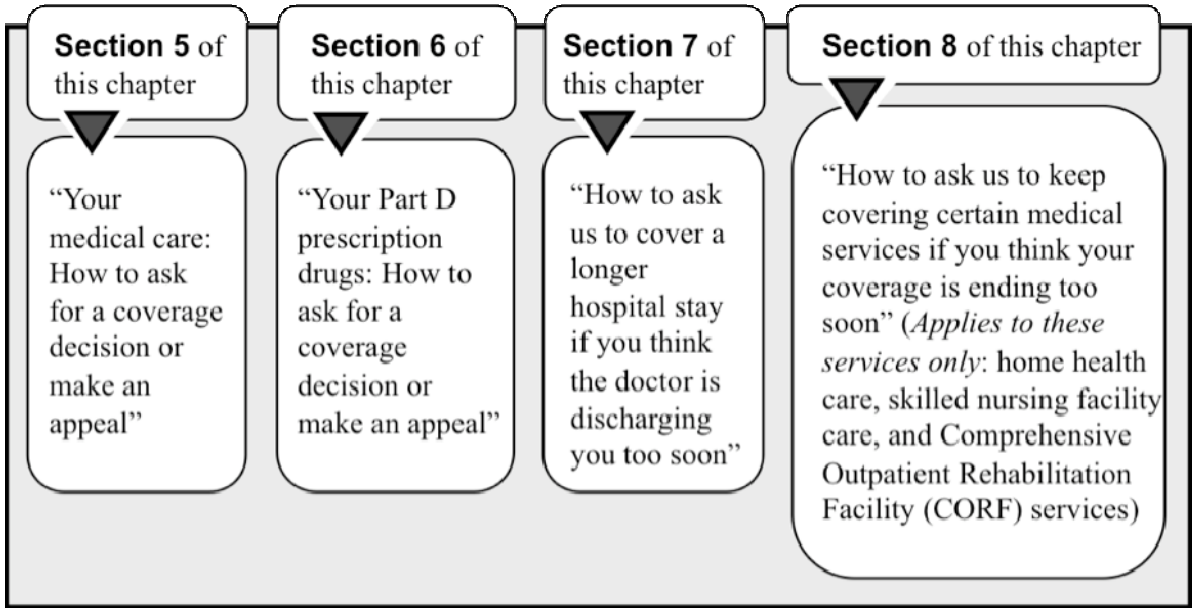
Section 4.2 How to get help when you are asking for a coverage decision or making an appeal

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 us at Member Services** (phone numbers are on the cover).
- To **get free help from an independent organization** that is not connected with our plan, contact the Minnesota Ombudsman for State Managed Health Care Programs or 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 prescriber must be appointed as your "representative".
- **You can ask someone to act on your behalf.** If you want to, you can name another person to act for you as your "representative" to ask for a coverage decision or make an appeal.
    - There may be someone who is already legally authorized to act as your representative under State law.
    - If you want a friend, relative, your doctor or other provider, or other person to be your representative, call Member 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 our plan 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 four different types of situations that involve coverage decisions and appeals. Since each situation has different rules and deadlines, we give the details for each one in a separate section:



If you're still not sure which section you should be using, please call Member Services (phone numbers are on the front cover). You can also get help or information from government organizations such as your Minnesota Ombudsman for State Managed Health Care Programs or State Health Insurance Assistance Program (Chapter 2, Section 3 and Section 6, 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 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 other services.. These are the benefits described in Chapter 4 of this booklet: *Benefits chart (what is covered*). 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.

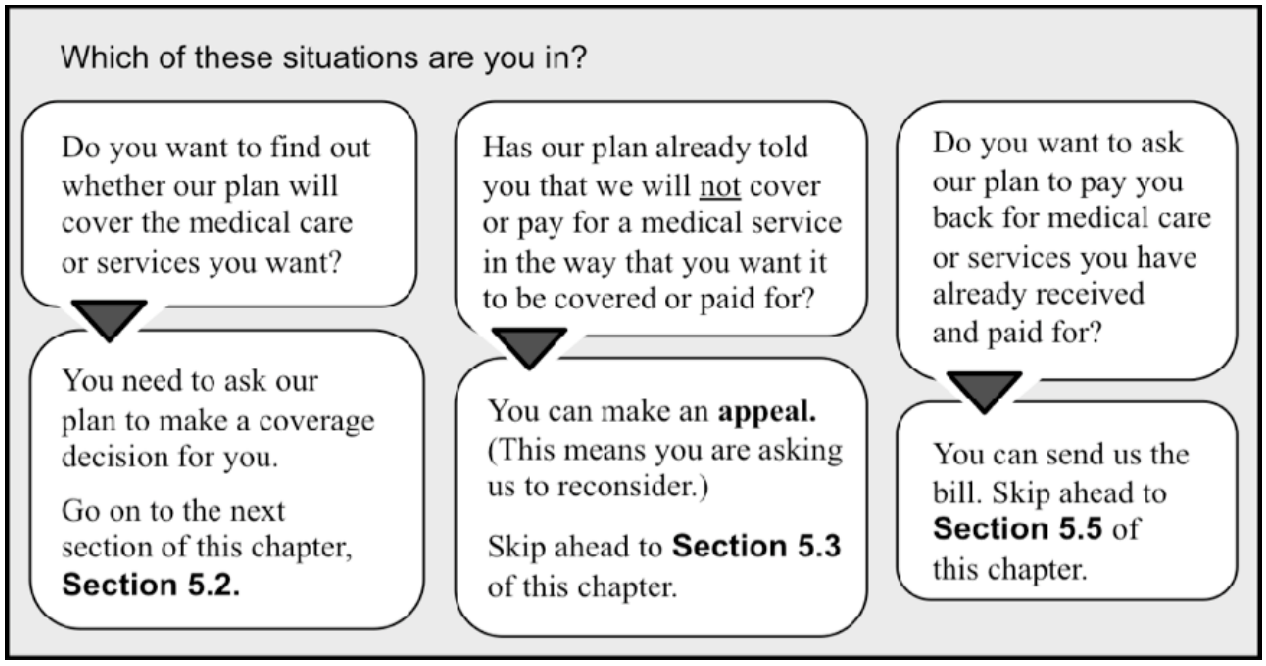
This section tells what you can do if you are in any of the five following situations:

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

2. Our plan will not approve the medical care your doctor or other medical provider wants to give you, and you believe that this care is covered by the plan.
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 Part D drugs that you believe should be covered by the plan, and you want to ask our plan to reimburse you for this care.

   NOTE: If the service or drug is Medical Assistance covered, we cannot pay you back for a Medical Assistance covered drugs or services that you pay for out-of-pocket. State and federal laws prevent us from paying you directly. If you paid for a prescription drug or service that you think we should have covered, contact Member Services at the number listed on the cover.

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 9, Section 7: *How to ask for a longer hospital stay if you think you are being asked to leave the hospital too soon.*
     - Chapter 9, Section 8: *How to ask our plan 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 our plan 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."**

<u>Step 1:</u> You ask our plan to make a coverage decision on the medical care you are requesting. If your health requires a quick response, you should ask us to make a **"fast 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 our plan 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 our plan 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 10 business 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 72 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 10 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 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 10 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, our plan 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 10 of this chapter.)

<u>Step 2:</u> Our plan considers 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 10 business 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 10 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 our plan says 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 our plan)

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 the plan about a medical care coverage decision is called a plan **"reconsideration."**

Step 1: You contact our plan 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 our plan.** 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 our plan 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.** You may also ask for an appeal by calling us at the phone number shown in Chapter 2, Section 1 (*How to contact our plan when you are making an appeal about your medical care*).
- **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 our plan when you are making an appeal about your medical care*).
- **You must make your appeal request within 90 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 our plan 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: Our plan considers your appeal and we give you our answer.

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

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

- When we are using the fast deadlines, we must give you our answer **within 72 hours after we receive your appeal**. We will give you our answer sooner if your health requires us to do so.
  - However, if you ask for more time, or if we need to gather more information that may benefit you, we **can take up to 14 more calendar days.** If we decide to take extra days to make the decision, we will tell you in writing.
  - For Medicare covered services, 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.

- **For Medicare covered services, 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 for decisions regarding Medicare covered services.

*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.**
    - For Medicare covered services, 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 for decisions regarding Medicare covered services.

<u>Step 3:</u> If our plan says no to part or all of your appeal for Medicare covered services, 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, **our plan is required to send your Medicare 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 our plan says no to your Level 1 Appeal, your case will *automatically* be sent on to the next level of the appeals process for decisions regarding Medicare covered services. During the Level 2 Appeal, the **Independent Review Organization** reviews the decision our plan 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."**

<u>Step 1:</u> 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 our plan and it is not a government agency. This organization is a company chosen by Medicare to handle the job of being the Independent Review Organization. Medicare oversees its work.
- 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 for decisions regarding Medicare covered services.

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

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

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

- If you had a standard appeal to our plan at Level 1, you 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 for decisions regarding Medicare covered services.
- 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 our plan that your request (or part of your request) for coverage for medical care should not be approved. (This is called "upholding the decision." 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) for decisions regarding Medicare covered services.
- If your Level 2 Appeal is turned down and you meet the requirements to continue with the appeals process for decisions regarding Medicare covered services, 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 9 in this chapter tells more about Levels 3, 4, and 5 of the appeals process for decisions regarding Medicare covered services.

Additional Appeal Rights under Medical Assistance

As a plan member, some of your plan services may also be covered by Medical Assistance. Therefore, if you believe that we improperly denied you a service or payment for a service, you may also have the right to appeal this decision to Medical Assistance. We will let you know in writing if you have the right to appeal our decision to Medical Assistance.

If you disagree with a decision or have a complaint regarding a Medical Assistance covered service, you can do any of the following:

- You can call our plan to file an appeal

- You can write to our plan to file an appeal
- You can write to the Minnesota Department of Human Services to request a State Fair Hearing. You may request a State Fair Hearing at any time during the plan's appeal process. You do not have to file an appeal with the plan before you request a State fair hearing. If you request a State fair hearing instead of filing an appeal with the plan, the timelines for appealing to the plan still are applicable as described in the Appeal Level 1.

Continuation of Services

If we are stopping or reducing medical care, services or a non-Part D drug, you can keep getting the medical care, service or non-Part D drug if you file a plan appeal or request a State Fair Hearing within 10 days (30 days for PCA services) after we send you the notice or before the service is stopped or reduced, whichever is later. The participating treating provider must agree the medical care, service or non-Part D drug should continue. The medical care, service or non-Part D drug can continue until the appeal or State Fair Hearing is resolved. If you lose the appeal or State Fair Hearing, you may be billed for the medical care, service or non-Part D drug.

State Fair Hearing Process

You may request a State Fair Hearing at any time during the plan's appeal process for services covered by Medical Assistance. You do not have to file an appeal with the plan before you request a State Fair Hearing. If you request a State Fair Hearing instead of filing an appeal with the plan, the timelines for appealing to the health plan still are applicable as described in the Appeal Level 1.

A State Fair Hearing is a hearing at the State to review a decision made by us. You must request a hearing in writing. You may ask for a hearing if you disagree with:

- the delivery of health services;
- enrollment in the plan;
- denial in full or part of a claim or service;
- our failure to act within required timelines for service authorizations and appeals; or
- any other action.

You must ask for a State Fair Hearing **within 30 days** of the date of the Notice of Action or the decision in a plan appeal. You can have up to 90 days to request a State Fair Hearing if you have a good reason for being late.

Write to: Minnesota Department of Human Services
Appeals Office
P.O. Box 64941
St. Paul, MN 55164-0941

Or fax to: 651- 431-7523

1. A Human Services Judge from the State Appeals Office will hold a hearing. You can choose to attend the hearing in person or by telephone.
2. Tell the State why you disagree with the decision made by us.
3. You can ask a friend, relative, advocate, provider, or lawyer to help you.
4. The process can take between 30-90 days. If your hearing is about an urgently needed service, tell the Judge (see contact information above) or the Minnesota State Ombudsman for Managed Care Programs when you call or write to them. See Section 2 for contact information.
5. If your hearing is about a medical necessity denial, you may ask for an expert medical opinion. This will be from an outside reviewer. There is no cost to you.

If you disagree with the ruling of the State Fair Hearing process, you may appeal to the District Court in your county.

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

We cannot pay you back for most medical bills that you pay. State and federal laws prevent us from paying you directly. The exception is if you pay for Part D prescription drugs see Section 6 below. If you paid for a service that you think we should have covered, contact Member Services at the number listed on the front cover.

SECTION 6 Your Part D prescription drugs: How to ask for a coverage decision or make an appeal

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

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

Your benefits as a member of our plan include coverage for many outpatient prescription drugs. Medicare calls these outpatient prescription drugs "Part D drugs." You can get these drugs as long as they are included in our plan's *List of Covered Drugs (Formulary)* and they are medically necessary for you, as determined by your primary care doctor or other provider.

- **This section is about your Part D drugs only.** To keep things simple, we generally say "drug" in the rest of this section, instead of repeating "covered outpatient prescription drug" or "Part D drug" every time.
- For details about what we mean by Part D drugs, the *List of Covered Drugs*, rules and restrictions on coverage, and cost information, see Chapter 5 (*Using our plan's coverage*

for your Part D prescription drugs) and Chapter 6 (*What you pay for your Part D prescription drugs*).

Part D coverage decisions and appeals

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

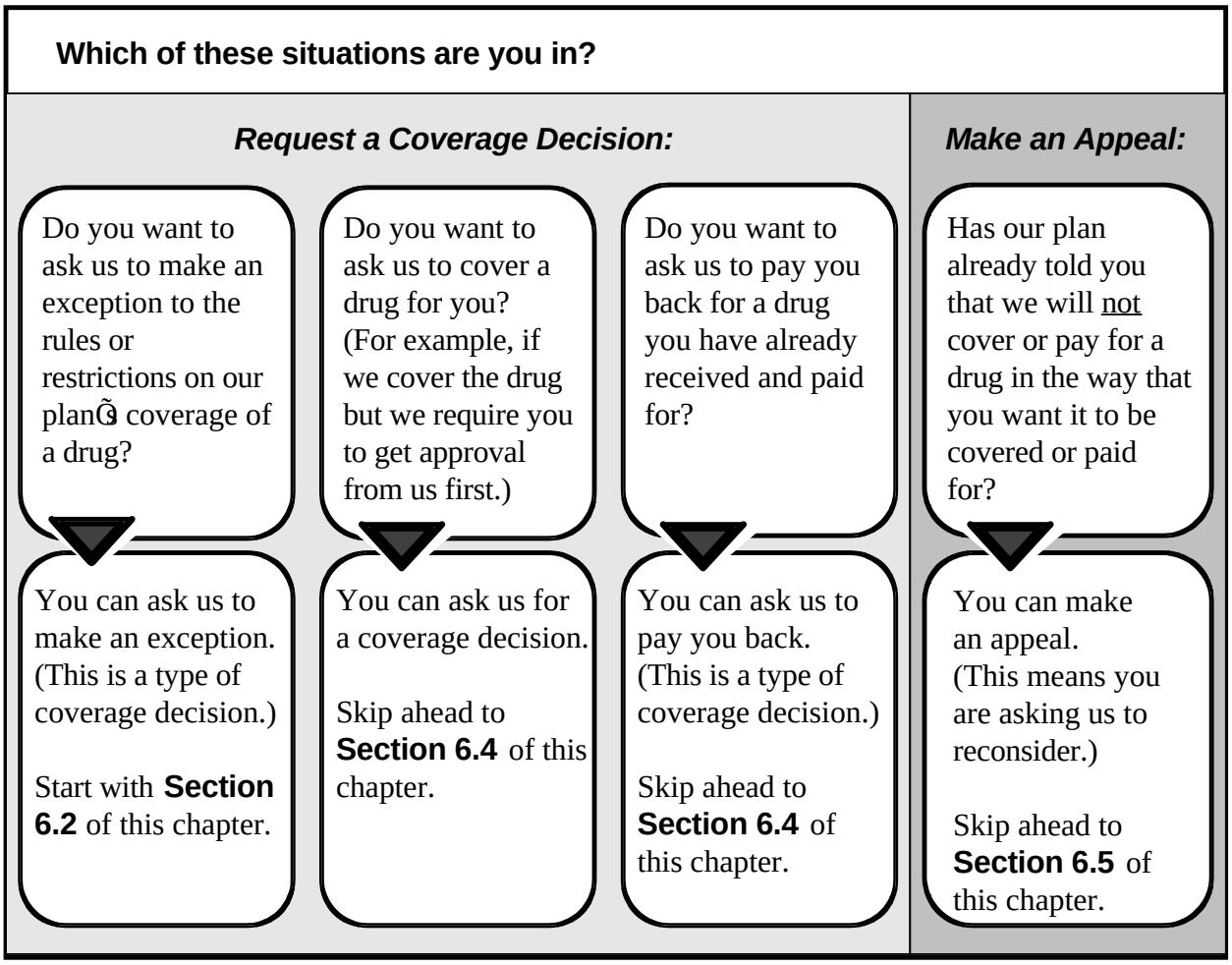
Legal Terms	A coverage decision is often called an **"initial determination"** or "initial decision." When the coverage decision is about your Part D drugs, the initial determination is called a **"coverage determination."**

Here are examples of coverage decisions you ask us to make about your Part D drugs:

- You ask us to make an exception, including:
  - Asking us to cover a Part D drug that is not on the plan's *List of Covered Drugs*
  - Asking us to waive a restriction on the plan's coverage for a drug (such as limits on the amount of the drug you can get)
  - Asking to pay a lower cost-sharing amount for a covered non-preferred drug
- You ask us whether a drug is covered for you and whether you satisfy any applicable coverage rules. (For example, when your drug is on the plan's *List of Covered Drugs* but we require you to get approval from us before we will cover it for you.)
- You ask us to pay for a prescription drug you already bought. This is a request for a coverage decision about payment.

If you disagree with a coverage decision we have made, you can appeal our decision.

This section tells you both how to ask for coverage decisions and how to request an appeal. Use this guide to help you determine which part has information for your situation:



Section 6.2 What is an exception?

If a drug is not covered in the way you would like it to be covered, you can ask the plan to make an "exception." An exception is a type of coverage decision. Similar to other types of coverage decisions, if we turn down your request for an exception, you can appeal our decision.

When you ask for an exception, your doctor or other prescriber will need to explain the medical reasons why you need the exception approved. We will then consider your request. Here are three examples of exceptions that you or your doctor or other prescriber can ask us to make:

1. **Covering a Part D drug for you that is not on our plan's *List of Covered Drugs (Formulary)*.** (We call it the "Drug List" for short.)

Legal Terms	Asking for coverage of a drug that is not on the Drug List is sometimes called asking for a **"formulary exception."**

- If we agree to make an exception and cover a drug that is not on the Drug List, you will need to pay the cost-sharing amount that applies to drugs in tier 2 for brand name drugs or tier 1 for generic drugs. You cannot ask for an exception to the copayment or co-insurance amount we require you to pay for the drug.
- You cannot ask for coverage of any "excluded drugs" or other non-Part D drugs which Medicare does not cover. (For more information about excluded drugs, see Chapter 5.)

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

Legal Terms	Asking for removal of a restriction on coverage for a drug is sometimes called asking for a **"formulary exception."**

- The extra rules and restrictions on coverage for certain drugs include:
  - *Being required to use the generic version* of a drug instead of the brand-name drug.
  - *Getting plan approval in advance* before we will agree to cover the drug for you. (This is sometimes called "prior authorization.")
  - *Being required to try a different drug first* before we will agree to cover the drug you are asking for. (This is sometimes called "step therapy.")]
  - *Quantity limits*. For some drugs, there are restrictions on the amount of the drug you can have.
- If our plan agrees to make an exception and waive a restriction for you, you can ask for an exception to the copayment or co-insurance amount we require you to pay for the drug.

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

Section 6.3 Important things to know about asking for exceptions

Your doctor must tell us the medical reasons

Your doctor or other prescriber must give us a written statement that explains the medical reasons for requesting an exception. For a faster decision, include this medical information from your doctor or other prescriber when you ask for the exception.

Typically, our Drug List includes more than one drug for treating a particular condition. These different possibilities are called "alternative" drugs. If an alternative drug would be just as effective as the drug you are requesting and would not cause more side effects or other health problems, we will generally *not* approve your request for an exception.

Our plan can say yes or no to your request

- If we approve your request for an exception, our approval usually is valid until the end of the plan year. This is true as long as your doctor continues to prescribe the drug for you and that drug continues to be safe and effective for treating your condition.
- If we say no to your request for an exception, you can ask for a review of our decision by making an appeal. Section 6.5 tells how to make an appeal if we say no.

The next section tells you how to ask for a coverage decision, including an exception.

Section 6.4 Step-by-step: How to ask for a coverage decision, including an exception

Step 1: You ask our plan to make a coverage decision about the drug(s) or payment you need. If your health requires a quick response, you must ask us to make a **"fast decision." You cannot ask for a fast decision if you are asking us to pay you back for a drug you already bought.**

What to do

- **Request the type of coverage decision you want.** Start by calling, writing, or faxing our plan to make your request. You, your representative, or your doctor (or other prescriber) can do this. For the details, go to Chapter 2, Section 1 and look for the section called, *How to contact our plan when you are asking for a coverage decision about your Part D prescription drugs*. Or if you are asking us to pay you back for a drug, go to the section called, *Where to send a request that asks us to pay for our share of the cost for medical care or a drug you have received.*
- **You or your doctor or someone else who is acting on your behalf** can ask for a coverage decision. Section 4 of this chapter tells how you can give written permission to someone else to act as your representative. You can also have a lawyer act on your behalf.
- **If you want to ask our plan to pay you back for a drug,** start by reading Chapter 7 of this booklet: *Asking the plan to pay its share of a bill you have received for medical services or drugs.* Chapter 7 describes the situations in which you may need to ask for reimbursement. It also tells how to send us the paperwork that asks us to pay you back for our share of the cost of a drug you have paid for.
- **If you are requesting an exception, provide the "doctor's statement."** Your doctor or other prescriber must give us the medical reasons for the drug exception you are requesting. (We call this the "doctor's statement.") Your doctor or other

prescriber can fax or mail the statement to our plan. Or your doctor or other prescriber can tell us on the phone and follow up by faxing or mailing the signed statement. See Sections 6.2 and 6.3 for more information about exception requests.

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

Legal Terms	A "fast decision" is called an **"expedited 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 72 hours after we receive your doctor's statement. A fast decision means we will answer within 24 hours.
- **To get a fast decision, you must meet two requirements:**
  - You can get a fast decision only if you are asking for a *drug you have not yet received*. (You cannot get a fast decision if you are asking us to pay you back for a drug you already bought.)
  - 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 or other prescriber 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 or other prescriber's support), our plan 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 or other prescriber asks for the fast decision, we will automatically give a fast decision.
  - The letter will also tell how you can file a complaint about our decision to give you a standard decision instead of the fast decision you requested. It tells how to file a "fast" complaint, which means you would get our 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, see Section 10 of this chapter.)

<u>Step 2:</u> Our plan considers your request and we give you our answer.

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

- If we are using the fast deadlines, we must give you our answer **within 24 hours**.

- Generally, this means within 24 hours after we receive your request. If you are requesting an exception, we will give you our answer within 24 hours after we receive your doctor's statement supporting your request. We will give you our answer sooner if your health requires us to.
- If we do not meet this deadline, we are required to send your request on to Level 2 of the appeals process, where it will be reviewed by an independent outside organization. Later in this section, we tell about this review organization and explain what happens at Appeal Level 2.

- **If our answer is yes to part or all of what you requested,** we must provide the coverage we have agreed to provide within 24 hours after we receive your request or doctor's statement supporting your request.
- **If our answer is no to part or all of what you requested,** we will send you a written statement that explains why we said no.

*Deadlines for a **"standard"** coverage decision about a Part D drug you have not yet received*

- If we are using the standard deadlines, we must give you our answer **within 72 hours.**
  - Generally, this means within 72 hours after we receive your request. If you are requesting an exception, we will give you our answer within 72 hours after we receive your doctor's statement supporting your request. We will give you our answer sooner if your health requires us to.
  - If we do not meet this deadline, we are required to send your request on to Level 2 of the appeals process, where it will be reviewed by an independent organization. Later in this section, we tell about this review organization and explain what happens at Appeal Level 2.
- **If our answer is yes to part or all of what you requested –**
  - If we approve your request for coverage, we must **provide the coverage** we have agreed to provide **within 72 hours** after we receive your request or doctor's statement supporting your request.
- **If our answer is no to part or all of what you requested**, we will send you a written statement that explains why we said no.

Deadlines for a "standard" coverage decision about payment for a drug you have already bought

- We must give you our answer **within 14 calendar days** after we receive your request.
  - If we do not meet this deadline, we are required to send your request on to Level 2 of the appeals process, where it will be reviewed by an independent organization. Later in this section, we tell about this review organization and explain what happens at Appeal Level 2.

- If our answer is yes to part or all of what you requested, we are also required to make payment to you within 14 calendar days after we receive your request

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

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

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

Section 6.5 Step-by-step: How to make a Level 1 Appeal (how to ask for a review of a coverage decision made by our plan)

Legal Terms	When you start the appeals process by making an appeal, it is called the "first level of appeal" or a "Level 1 Appeal." An appeal to the plan about a Part D drug coverage decision is called a plan **"redetermination."**

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

What to do

- **To start your appeal, you (or your representative or your doctor or other prescriber) must contact our plan.**
    - For details on how to reach us by phone, fax, or mail, for any purpose related to your appeal, go to Chapter 2, Section 1, and look for the section called, *How to contact our plan when you are making an appeal about your Part D prescription drugs.*
- **If you are asking for a standard appeal, make your appeal by submitting a written request.** You may also ask for an appeal by calling us at the phone number shown in Chapter 2, Section 1 (*How to contact our plan when you are making an appeal about your Part D prescription drugs*).
- **If you are asking for a fast appeal, you may make your appeal in writing or you may call us at the phone number shown in Chapter 2, Section 1** *(How to contact our plan when you are making an appeal about your part D prescription drugs).*
- **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 in your appeal and add more information.**
  - 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 or other prescriber may give us additional information to support your appeal.

If your health requires it, ask for a "fast appeal"

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

- If you are appealing a decision our plan made about a drug you have not yet received, you and your doctor or other prescriber will need to decide if you need a "fast appeal."
- The requirements for getting a "fast appeal" are the same as those for getting a "fast decision" in Section 6.4 of this chapter.

Step 2: Our plan considers your appeal and we give you our answer.

- When our plan is reviewing your appeal, we take another careful look at all of the information about your coverage request. We check to see if we were following all the rules when we said no to your request. We may contact you or your doctor or other prescriber to get more information.

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

- If 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 it.
  - If we do not give you an answer within 72 hours, we are required to send your request on to Level 2 of the appeals process, where it will be reviewed by an Independent Review Organization. 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 provide the coverage we have agreed to provide within 72 hours after we receive your appeal.
- **If our answer is no to part or all of what you requested,** we will send you a written statement that explains why we said no and how to appeal our decision.

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

- If we are using the standard deadlines, we must give you our answer **within 7 calendar days** after we receive your appeal. We will give you our decision sooner if you have not received the drug yet and your health condition requires us to do so.
    - If we do not give you a decision within 7 calendar days, we are required to send your request on to Level 2 of the appeals process, where it will be reviewed by an Independent Review Organization. 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 –**
    - If we approve a request for coverage, we must **provide the coverage** we have agreed to provide as quickly as your health requires, but **no later than 7 calendar days** after we receive your appeal.
    - If we approve a request to pay you back for a drug you already bought, we are required to **send payment to you within 30 calendar days** after we receive your appeal request.
- **If our answer is no to part or all of what you requested**, we will send you a written statement that explains why we said no and how to appeal our decision.

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

- If our plan says no to your appeal, you then choose whether to accept this decision or continue by making another appeal.
- If you decide to make another appeal, it means your appeal is going on to Level 2 of the appeals process (see below).

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

If our plan says no to your appeal, you then choose whether to accept this decision or continue by making another appeal. If you decide to go on to a Level 2 Appeal, the **Independent Review Organization** reviews the decision our plan 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: To make a Level 2 Appeal, you must contact the Independent Review Organization and ask for a review of your case.

- If our plan says no to your Level 1 Appeal, the written notice we send you will include **instructions on how to make a Level 2 Appeal** with the Independent Review Organization. These instructions will tell who can make this Level 2 Appeal, what deadlines you must follow, and how to reach the review organization.
- When you make an appeal to the Independent Review Organization, we will send the information we have 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.

Step 2: The Independent Review Organization does a review of your appeal and gives you an answer.

- **The Independent Review Organization is an outside, independent organization that is hired by Medicare**. This organization is not connected with our plan and it is not a government agency. This organization is a company chosen by Medicare to review our decisions about your Part D benefits with our plan.
- Reviewers at the Independent Review Organization will take a careful look at all of the information related to your appeal. The organization will tell you its decision in writing and explain the reasons for it.

*Deadlines for **"fast" appeal** at Level 2*

- If your health requires it, ask the Independent Review Organization for a "fast appeal."
- If the review organization agrees to give you a "fast appeal," the review organization must give you an answer to your Level 2 Appeal **within 72 hours** after it receives your appeal request.
- **If the Independent Review Organization says yes to part or all of what you requested,** we must provide the drug coverage that was approved by the review organization **within 24 hours** after we receive the decision from the review organization.

*Deadlines for **"standard" appeal** at Level 2*

- If you have a standard appeal at Level 2, the review organization must give you an answer to your Level 2 Appeal **within 7 calendar days** after it receives your appeal.

- **If the Independent Review Organization says yes to part or all of what you requested –**
  - If the Independent Review Organization approves a request for coverage, we must **provide the drug coverage** that was approved by the review organization **within 72 hours** after we receive the decision from the review organization.
  - If the Independent Review Organization approves a request to pay you back for a drug you already bought, we are required to s**end payment to you within 30 calendar days** after we receive the decision from the review organization.

What if the review organization says no to your appeal?

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

To continue and make another appeal at Level 3, the dollar value of the drug coverage you are requesting must meet a minimum amount. If the dollar value of the coverage you are requesting is too low, you cannot make another appeal and the decision at Level 2 is final. The notice you get from the Independent Review Organization will tell you if the dollar value of the coverage you are requesting is high enough to continue with the appeals process.

Step 3: If the dollar value of the coverage you are requesting meets the requirement, you choose whether you want to take your appeal further.

- There are three additional levels in the appeals process after Level 2 (for a total of five levels of appeal).
- If your Level 2 Appeal is turned down and you meet the requirements to continue with the appeals process, you must decide whether you want to go on to Level 3 and make a third appeal. If you decide to make a third appeal, the details on how to do this are in the written notice you got after your second appeal.
- The Level 3 Appeal is handled by an administrative law judge. Section 9 in this chapter tells more about Levels 3, 4, and 5 of the appeals process.

SECTION 7 How to ask us to cover a longer 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: *Benefits chart (what is covered).*

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**." Our plan's 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 7.1 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 7.2 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 2 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 Member Services or 1-800 MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week TTY users should call 1-877-486-2048). You can also see it online at http://www.cms.hhs.gov.

Section 7.2 Step-by-step: How to make a Level 1 Appeal to change your hospital discharge date

If you want to ask for your 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 Member 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."

<u>Step 1:</u> 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 our plan. This organization is paid by Medicare to check on and help improve the quality of care for people with Medicare. This includes reviewing hospital discharge dates for people with Medicare.

How can you contact this organization?

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

Act quickly:

- To make your appeal, you must contact the Quality Improvement Organization *before* you leave the hospital and **no later than your planned discharge date.** (Your "planned discharge date" is the date that has been set for you to leave the hospital.)
    - If you meet this deadline, you are allowed to stay in the hospital *after* your discharge date *without paying for it* while you wait to get the decision on your appeal from the Quality Improvement Organization.
    - If you do *not* meet this deadline, and you decide to stay in the hospital after your planned discharge date, *you may have to pay all of the costs* for hospital care you receive after your planned discharge date.
- If you miss the deadline for contacting the Quality Improvement Organization about your appeal, you can make your appeal directly to our plan instead. For details about this other way to make your appeal, see Section 7.4.

Ask for a "fast review":

- You must ask the Quality Improvement Organization for a **"fast review"** of your discharge. Asking for a "fast review" means you are asking for the organization to use the "fast" deadlines for an appeal instead of using the standard deadlines.

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

<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 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 our plan 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 our plan 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 Member Services or 1-800-MEDICARE (1-800-633-4227, 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.) Or you can get see a sample notice online at http://www.cms.hhs.gov/BNI/

<u>Step 3:</u> 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, **our plan's 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 7.3 Step-by-step: How to make a Level 2 Appeal to change your hospital discharge date

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

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:

- **Our plan 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. **Our plan 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 9 in this chapter tells more about Levels 3, 4, and 5 of the appeals process.

Section 7.4 What if you miss the deadline for making your Level 1 Appeal?

You can appeal to our plan instead

As explained above in Section 7.2, 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 our plan, 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 our plan and ask for a "fast review."

- For details on how to contact our plan, go to Chapter 2, Section 1 and look for the section called, *How to contact our plan 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: Our plan does a "fast" review of your planned discharge date, checking to see if it was medically appropriate.

- During this review, our plan takes 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: Our plan gives you our decision within 72 hours after you ask for a "fast review" ("fast appeal").

- **If our plan says 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 our plan says 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.

Step 4: If our plan says *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, **our plan is 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 our plan says 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 our plan 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 10 of this chapter tells how to make a complaint.)

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

- **The Independent Review Organization is an outside, independent organization that is hired by Medicare**. This organization is not connected with our plan and it is not a government agency. This organization is a company chosen by Medicare to handle the job of being the Independent Review Organization. Medicare oversees its work.
- 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 our plan 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's 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 our plan 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 9 in this chapter tells more about Levels 3, 4, and 5 of the appeals process.

SECTION 8 How to ask us to keep covering certain medical services if you think your coverage is ending too soon

Section 8.1 *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 12, *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 12, *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 our plan decides 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, *our plan will stop paying its 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 8.2 We will tell you in advance when your coverage will be ending

1. **You receive a notice in writing.** At least two days before our plan is going to stop covering your care, 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 our plan to change this decision about when to end your care, and keep covering it for a longer period of time.

Legal Terms	In telling 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 our plan to change the coverage decision we have made about when to stop your care. (Section 8.3 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 Member Services or 1-800-MEDICARE (1-800-633-4227, 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.). Or see a copy online at 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 the plan that it's time to stop getting the care.

Section 8.3 Step-by-step: How to make a Level 1 Appeal to have our plan cover your care for a longer time

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

- **Follow the process.** Each step in the first two levels of the appeals process is explained below.

- **Meet the deadlines.** The deadlines are important. Be sure that you understand and follow the deadlines that apply to things you must do. There are also deadlines our plan must follow. (If you think we are not meeting our deadlines, you can file a complaint. Section 10 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 Member 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 our plan.

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 our plan. They check on the quality of care received by people with Medicare and review plan 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 our plan 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 our plan instead. For details about this other way to make your appeal, see Section 8.4.

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 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 our plan of your appeal, you will also get a written notice from the plan that gives our reasons for wanting to end the plan's coverage for your services.

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

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

What happens if the reviewers say yes to your appeal?

- If the reviewers say *yes* to your appeal, then **our plan 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.** Our plan will stop paying its 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 8.4 Step-by-step: How to make a Level 2 Appeal to have our plan cover your care for a longer time

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

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?

- **Our plan must reimburse you** for our share of the costs of care you have received since the date when we said your coverage would end. **Our 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 9 in this chapter tells more about Levels 3, 4, and 5 of the appeals process.

Section 8.5 What if you miss the deadline for making your Level 1 Appeal?

You can appeal to our plan instead

As explained above in Section 9.3, 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 our plan, 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 our plan and ask for a "fast review."

- For details on how to contact our plan, go to Chapter 2, Section 1 and look for the section called, *How to contact our plan 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: Our plan does a "fast" review of the decision we made about when to end coverage for your services.

- During this review, our plan takes another look at all of the information about your case. We check to see if we were following all the rules when we set the date for ending the plan's coverage for services you were receiving.

- We will use the "fast" deadlines rather than the standard deadlines for giving you the answer to this review. (Usually, if you make an appeal to our plan 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: Our plan gives you our decision within 72 hours after you ask for a "fast review" ("fast appeal").

- **If our plan says 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 our plan says no to your fast appeal,** then your coverage will end on the date we have told you and our plan will not pay after this date. Our plan will stop paying its 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 our plan says *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, **our plan is 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 our plan says 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 our plan 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 10 of this chapter tells how to make a complaint.)

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

- **The Independent Review Organization is an outside, independent organization that is hired by Medicare**. This organization is not connected with our plan and it is not a government agency. This organization is a company chosen by Medicare to handle the job of being the Independent Review Organization. Medicare oversees its work.
- 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 our plan 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 our plan 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 9 in this chapter tells more about Levels 3, 4, and 5 of the appeals process.

SECTION 9 Taking your appeal to Level 3 and beyond

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

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

If the dollar value of the Medicare covered 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.

Section 9.2 Levels of Appeal 3, 4, and 5 for Part D Drug 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 drug 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 answer is yes, the appeals process is over**. What you asked for in the appeal has been approved.
- **If the answer is no, the appeals process *may* or *may not* be over**.
  - If you decide to accept this decision that turns down your appeal, the appeals process is over.
  - If you do not want to accept the decision, you can continue to the next level of the review process. 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, the appeals process is over**. What you asked for in the appeal has been approved.
- **If the answer is no, the appeals process *may* or *may not* be over**.
  - If you decide to accept this decision that turns down your appeal, the appeals process is over.
  - If you do not want to accept the decision, you might be able to continue to the next level of the review process. It depends on your situation. Whenever the reviewer says no to your appeal, the notice you get will tell you whether the rules allow you to go on to another level of 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 stage of the appeals process.

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

MAKING COMPLAINTS

SECTION 10 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 10.1 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 Member 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, pharmacists, or other health professionals? Or by Member Services or other staff at our plan?
- Examples include waiting too long on the phone, in the waiting room, in the exam room, or when getting a prescription.

Cleanliness

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

Information you get from our plan

- 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

Possible complaints (continued)

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

The process of asking for a coverage decision and making appeals is explained in sections 4-9 of this chapter. If you are asking for a decision or making an appeal, you use that process, not the complaint process.

However, if you have already asked for a coverage decision or made an appeal, and you think that our plan is 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 our plan is 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 our plan is told that we must cover or reimburse you for certain medical services or drugs, there are deadlines that apply. If you think we are not meeting these deadlines, you can make a complaint.
- When our plan does not give you a decision on time, we are required to forward your case to the Independent Review Organization. If we do not do that within the required deadline, you can make a complaint.

Section 10.2 The formal name for "making a complaint" is "filing a grievance"

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 10.3 Step-by-step: Making a complaint

Step 1: Contact us promptly – either by phone or in writing.

- **Usually, calling Member Services is the first step.** If there is anything else you need to do, Member Services will let you know.

  CALL 952-967-7029 or 1-888-820-4285. Calls to this number are free.

  TTY 952-883-6060 or 1-800-443-0156. This number requires special telephone equipment. Calls to this number are free.

  Hours of Operation: 8:00 a.m. – 8:00 p.m., Monday – Friday

- **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:

  This is called the written complaint process. You can send us a letter about your complaint. Write to the address listed in Chapter 2. We will notify you within 10 days that the complaint has been received. The complaint must be submitted within 90 days if the complaint is regarding medical care, services or non-Part D drugs. The complaint must be submitted within 60 days if the complaint is regarding Part D drugs. We must address your complaint as quickly as your case requires based on your health status, but no later than 30 days after receiving your complaint. We may extend the time frame by up to 14 days if you ask for the extension, or if we justify a need for additional information and the delay is in your best interest. We will tell you within 30 days that we are taking extra time and the reasons why. If we deny your complaint in whole or in part, our written decision will explain why we denied it.

If you do not agree with our decision, you can review your concerns with the Managed Care Ombudsman. You may also file a complaint with the Minnesota Department of Health or present your concerns to the HealthPartners Member Appeals Committee in writing or in person.

- **Whether you call or write, you should contact Member Services right away.** The complaint must be made within 90 calendar days after you had the medical problem you want to complain about. The complaint must be made within 60 days if it is regarding a Part D drug.
- **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 72 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.

Step 3 If you are not satisfied with our decision, you may call or write to the Minnesota Department of Health

To file a complaint with the Minnesota Department of Health

Write to: Minnesota Department of Health
Health Policy and Systems Compliance Division
Managed Care Systems
P.O. Box 64882
St. Paul, MN 55164-0882

Or Call: 651-201-5100 (Twin Cities metro) or toll-free 1-800-657-3916

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

You can make your complaint about the quality of care you received to our plan 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 10. Ending your membership in the plan

SECTION 1 Introduction

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

Ending your membership in our 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.
  - You can end your membership in the plan at any time.
  - 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 covered services through our plan until your membership ends.

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

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

Section 2.1 You can end your membership during a Special Enrollment Period

Members of our plan are eligible to end their membership at any time 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.
  - If you have Medicaid.
  - If you are eligible for Extra Help with paying for your Medicare prescriptions.
  - If you live in a facility, such as a nursing home.

What can you do? Our plan currently provides both Medicare and Medical Assistance services. By disenrolling from our plan, your coverage for Medicare and Medical Assistance services will change. In some cases you have choices to make.

Coverage for Medical Assistance

If you choose to leave our plan, you will be automatically enrolled in our plan's Minnesota Senior Care Plus (MSC+) plan for your Medical Assistance services if our MSC+ plan is offered in your county. You can ask in writing to be enrolled in the MSC+ plan you were enrolled in before our plan's MSHO enrollment. If our plan does not have an MSC+ plan in your county, you will be enrolled in the MSC+ plan that is available in your county. Contact your county financial worker if you have questions.

If you currently have a medical spenddown and you choose to leave our plan, your Medical Assistance will be provided fee-for-service. You will not be enrolled in another health plan for Medical Assistance services.

Coverage for Medicare

If you are eligible to end your membership because of a special situation, you can choose to change both your Medicare health coverage and Part D 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.

  Note: If you disenroll from a Medicare prescription drug plan and go without creditable prescription drug coverage, you may need to pay a late enrollment penalty if you join a Medicare drug plan later. ("Creditable" coverage means the coverage is at least as good as Medicare's standard prescription drug coverage.)

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 2.2 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 Member 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 website (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, 7 days a week. TTY users should call 1-877-486-2048.

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

Section 3.1 You can end your membership by enrolling in another plan

Usually, to end your membership in our plan, you can enroll in another health plan at any time. 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 our plan's Member Services and ask to be disenrolled from our plan.

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

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

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

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

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

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

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

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

- If you do not stay continuously enrolled in Medicare Part A and Part B.
- If you lose eligibility for Medical Assistance - If you have Medicare and lose eligibility for Medical Assistance, our Plan will continue to provide plan benefits for up to three months. If after three months you have not regained Medical Assistance, coverage with our Plan will end. You will need to choose a new Part D plan in order to continue getting coverage for Medicare covered drugs. If you need help, you can call the Senior Linkage Line at 1-866-333-2466.
- If you do not pay your medical spenddown, if applicable.
- 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 Member Services to find out if the place you are moving or traveling to is in our plan's area.
- If you become incarcerated.
- If you lie about or withhold information about other insurance you have that provides prescription drug coverage.
- If you intentionally give us incorrect information when you are enrolling in our plan and that information affects your eligibility for our plan.
- 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.
- You do not meet the plan's special eligibility requirements as stated in Chapter 1, section 2.1

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 **Member 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, 7 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 9, Section 10 for information about how to make a complaint.

Chapter 11. Legal notices

SECTION 1 Notice about governing law

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

SECTION 2 Notice about 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 our plan, must obey Federal laws against discrimination, including Title VI of the Civil Rights Act of 1964, the Rehabilitation Act of 1973, the Age Discrimination Act of 1975, the Americans with Disabilities Act, 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 Subrogation or other claims

You may have other sources of payment for your medical care. They might be from another person, group, insurance company or other organization. Federal and State laws provide that Medical Assistance benefits pay only if no other source of payment exists. If you have a claim against another source for injuries, we will make a separate claim for medical care we covered for you. The laws require you to help us do this. The claim may be recovered from any source that may be responsible for payment of the medical care we covered for you. The amount of the claim will not be more than Federal and State laws allow.

Chapter 12. Definitions of important words

Action – Our Plan's denial or decrease of a requested service. This includes:

- the denial or decrease in the type or level of service;
- the decrease, suspension, or stopping of a service that was approved before;
- the denial of all or part of payment for a service;
- not providing services in a reasonable amount of time;
- not acting within required time frames for grievances and appeals;
- denial of a member's request to get services out of network for members living in a rural area with only one health plan.

Anesthesia – Drugs that make you fall asleep for an operation.

Appeal – An appeal is something you do if you disagree with a decision to deny a request for health care services or prescription drugs or payment for services or drugs 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 our plan doesn't pay for a drug, item, or service you think you should be able to receive. Chapter 9 explains appeals, including the process involved in making an appeal.

Autopsy – An exam that is done on the body of someone who dies. It is done to find out what caused a person's death.

Benefit Period – For both our plan and Original Medicare, a benefit period is used to determine coverage for inpatient stays in hospitals and skilled nursing facilities. A benefit period begins on the first day you go to a Medicare-covered inpatient hospital or a skilled nursing facility. The benefit period ends when you haven't been an inpatient at any hospital or SNF for 60 days in a row. If you go to the hospital (or SNF) after one benefit 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.

Brand Name Drug – A prescription drug that is manufactured and sold by the pharmaceutical company that originally researched and developed the drug. Brand name drugs have the same active-ingredient formula as the generic version of the drug. However, generic drugs are manufactured and sold by other drug manufacturers and are generally not available until after the patent on the brand name drug has expired.

Care Coordinator – A person who develops, coordinates, and provides supports and services stated in the care plan. This person works in partnership with the plan.

Catastrophic Coverage Stage – The stage in the Part D Drug Benefit where you no longer pay a copayment or coinsurance for your Part D drugs after you or other qualified parties on your behalf have spent $4,550 in covered drugs during the covered year.

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

Certificate of Coverage (COC) 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.

Chemical Dependency – Using alcohol or drugs in a way that harms you.

Clinical Trial – A qualified medical study test that is: subject to a defined peer review; sponsored by a clinical research program that meets federal and state rules and approved standards; and whose true results are reported.

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.

Co-payment or co-pay – An amount that you are responsible to pay to the provider. Some adults must pay a part of the provider's charges for some services. Co-payments are usually paid at the time service is provided.

Cost-Sharing – Cost-sharing refers to amounts that a member has to pay when Part D drugs are received. It includes any fixed "copayment" amount that a plan requires when a specific drug is received.

Cost-Sharing Tier – Every drug on the list of covered drugs is in one of two cost-sharing tiers. In general, the higher the cost-sharing tier, the higher your cost for the drug.

Coverage Determination – A decision about whether a medical service or drug prescribed for you is covered by the plan and the amount, if any, you are required to pay for the service or prescription. In general, if you bring your prescription to a pharmacy and the pharmacy tells you the prescription isn't covered under your plan, that isn't a coverage determination. You need to call or write to your plan to ask for a formal decision about the coverage.

Covered Drugs – The term we use to mean all of the prescription drugs covered by our plan.

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.

Direct Access Services – You can go to any provider in our Plan's network to get these services. You do not need a referral or service authorization before getting services.

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

Durable Medical Equipment – Equipment that can withstand repeated use. It is used for a medical purpose. The equipment must be medically necessary and ordered by a doctor. Examples of durable medical equipment include walkers, wheelchairs, hospital beds and equipment that supplies a person with oxygen.

Emergency – A condition that needs treatment right away. It is a condition that a reasonable person believes needs prompt care, and without prompt care, it could cause: serious physical or mental harm; continuing severe pain; serious damage to body functions, organs, or parts; or death.

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.

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

Experimental – A service that has not been proven to be safe and effective.

External Quality Review Study – A study about how quality, timeliness and access of care are provided by us. This study is external and independent.

Family Planning – Information, services, and supplies that help a person decide about having children. These decisions include choosing to have a child, when to have a child, or not to have a child.

Formulary – See "List of Covered Drugs."

Generic Drug – A prescription drug that is approved by the Food and Drug Administration (FDA) as having the same active ingredient(s) as the brand-name drug. Generally, generic drugs cost less than brand-name drugs.

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

Home and Community Based Services - Additional services that are provided to help you remain in your home..

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.

Home health care – Care that is provided in your home that is medically necessary and ordered by a doctor.

Inpatient Care – Health care that you get when you are admitted to a hospital.

Inpatient Hospital Stay - A stay in a hospital or treatment center that usually lasts 24 hours or more.

Initial Coverage Limit – The maximum limit of coverage under the Initial Coverage Stage.

Initial Coverage Stage – This is the stage before your total out-of-pocket have reached $4,550, including amounts you've paid and what our plan has paid on your behalf.

List of Covered Drugs (Formulary or "Drug List") – A list of covered drugs provided by the plan. The drugs on this list are selected by the plan with the help of doctors and pharmacists. The list includes both brand-name and generic drugs.

Long Term Care Consultation – A review done to find the type and level of services needed.

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

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 – Care that is appropriate for the condition. This includes care related to physical conditions and mental health. It includes the kind and level of service. It includes the number of treatments. It also includes where you get the service and how long it continues. Medically necessary care must:

-be the service that other providers would usually order.

-help you get better, or stay as well as you are.

-help stop the condition from getting worse.

-help prevent and find health problems.

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

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

Minnesota Senior Care Plus (MSC+) – A program in which the State contracts with health plans to cover and manage health care and Elderly Waiver services for Medical Assistance enrollees age 65 and older.

Minnesota Senior Health Options (MSHO) – A program offered by the Minnesota Department of Human Services and health plans, including our Plan, for seniors eligible for both Medicare and Medical Assistance

Network Pharmacy – A network pharmacy is a pharmacy where members of our plan can get their prescription drug benefits. We call them "network pharmacies" because they contract with our plan. In most cases, your prescriptions are covered only if they are filled at one of our network pharmacies.

Network Provider – "Provider" is the general term 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 our plan to accept our payment as payment in full, and in some cases to coordinate as well as provide covered services to members of our plan. Our plan pays network providers based on the agreements it has with the providers or if the providers agree to provide you with plan-covered services. Network providers may also be referred to as "plan providers."

Notice of Action – A form or letter we send you telling you about a decision on a claim, a service, or any other action taken by our Plan.

Nursing Home Certifiable –A decision that you need a nursing home level of care. A screener uses a screening process called a Long Term Care Consultation to decide.

Open Access Services – Federal and state law allow you to choose any doctor, clinic, hospital, pharmacy, or family planning agency - even if not in the our Plan's network - to get these 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-Area Service - Health care provided to an enrollee by a non-network provider outside of the Plan Service Area.

Out-of-Network Pharmacy – A pharmacy that doesn't have a contract with our plan to coordinate or provide covered drugs to members of our plan. As explained in this Certificate of Coverage, most drugs you get from out-of-network pharmacies are not covered by our plan unless certain conditions apply.

Out-of-Network Provider or Out-of-Network Facility – A provider or facility 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 our plan 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.

Outpatient Hospital Services - Services provided at a hospital or outpatient facility which are not at an inpatient level of care. These services may also be available at your clinic or other health facility.

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

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

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

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

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.

Physician Incentive Plan - Special payment arrangements between our Plan and the doctor that may affect the use of referrals. It may also affect other services that you might need.

Post-stabilization Care: Also called follow-up care. A hospital service needed to help a person's condition stay stable after having emergency care. It starts when the hospital asks for health plan approval. It continues until: the person is discharged; the health plan doctor begins care or; the hospital doctor and health plan agree to a different arrangement.

Prescriptions – Medicines and drugs ordered by a medical provider.

Preventive Services – Services that help you stay healthy, such as routine physicals, immunizations, and well-person care. These services help find and prevent health problems. Follow-up on conditions that have been diagnosed (like diabetes checkup) are *not* preventive.

Primary Care 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.

Primary Care Clinic – The clinic you chose for your routine health care. This clinic will provide or approve most of your care. The name of your clinic appears on the Plan member card.

Prior Authorization – Approval in advance to get services or certain drugs that may or may not be on our formulary. Some in-network medical services are covered only if your doctor or other network provider gets "prior authorization" from our plan. Covered services that need prior authorization are marked in the Benefits Chart in Chapter 4. Some drugs are covered only if your doctor or other network provider gets "prior authorization" from us. Covered drugs that need prior authorization are marked in the formulary.

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 for information about how to contact the QIO in your state and Chapter 9 for information about making complaints to the QIO.

Quantity Limits – A management tool that is designed to limit the use of selected drugs for quality, safety, or utilization reasons. Limits may be on the amount of the drug that we cover per prescription or for a defined period of time.

Rehabilitation Services – Services that help restore or maintain a person's health function. These services include physical therapy, cardiac rehabilitation, speech and language therapy, and occupational therapy.

Restricted Recipient Program – A program for members who have received medical care and have not followed the rules or have misused services. If you are in this program, you must get health services from one primary care provider, one drug store, one hospital or other provider. You will not be allowed to use the personal assistance choice option or consumer directed services. You must do this for 24 or 36 months of eligibility.

Second Opinion – If you do not agree with an opinion you get from a network provider, you have the right to get an opinion from another provider. Our Plan will pay for this. For medical conditions, the second opinion will be from another network provider. For mental health services, the second opinion will be from an out-of-plan provider. For chemical dependency services, the second opinion will be from a different qualified assessor who is not in our Plan.

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.

Service Authorization: Our Plan's approval that is needed for some services before you get them.

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.

Standing Referral - Written consent from you Primary Care Clinic to see a specialist for more than one time (for on-going care) or written consent from us to see a non-network specialist more than one time (for on-going care).

State Fair Hearing – A hearing at the State to review a decision made by our Plan. You must request a hearing in writing. You may ask for a hearing if you disagree with:

- the delivery of health services;
- enrollment in our Plan;
- denial in full or part of a claim or service;
- failure our Plan to act within required timelines for service authorizations, grievances and appeals; or
- any other action or grievance.

Step Therapy – A utilization tool that requires you to first try another drug to treat your medical condition before we will cover the drug your physician may have initially prescribed.

Subrogation – Our Plan's right to collect money in your name from another person, group, or insurance company. We have this right when you get medical care from our Plan that is covered by another source or third party payer.

Supplemental Security Income (SSI) – A monthly benefit paid by the Social Security Administration to people with limited income and resources who are disabled, blind, or age 65 and older. SSI benefits are not the same as Social Security benefits.

Urgent Care: Care for a condition that needs prompt treatment to stop the condition from getting worse. An urgent condition is not as serious as an emergency. Urgent Care is available 24 hours a day.

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.

HealthPartners has different ways of paying providers.

HealthPartners' goal is to provide affordable care for our members. We also encourage best care practices. We want to reward providers for meeting your needs.

Some providers are paid on a "discounted fee-for-service" basis. This means that the health plan pays the provider a set amount for each service.

Some providers are paid on a "discount" basis. This means that when a provider sends us a bill, we have agreed to pay a reduced rate on behalf of our members. We pay a predetermined percentage of the total bill for services.

Some providers are paid a "salary." A provider who gets a salary may get extra payments. They may get this extra money if they have high quality of care and patient satisfaction.

We pay some groups of providers on a "capitated" basis. This means that the provider group receives a set fee each month for each member enrolled in the provider group's clinic. It doesn't matter how many services the member actually receives. Provider groups are required to manage the budget for all of their patients.

Sometimes we have a "case rate" arrangement with providers. This means for a set of services we pay a set fee. This set fee is called the "case rate." We have two kinds of case rates. Sometimes we pay a case rate for a maximum number of services within a certain time period. We may also pay providers a "case rate" for all services needed for a selected time period.

Sometimes we have "withhold" arrangements with providers. This means that part of the provider's payment is set aside until the end of the year. At the end of the year, the following may happen:

• Withholds can be used to pay other providers who give services to members. These other providers might include specialists or hospitals. If all of the withhold money is not used by the end of the year, then the provider may get all or part of the remaining money.

• Withholds can be used to establish "cost targets" for care expenses. If total care costs are less than the withheld money; the remainder is returned to the clinic at the end of the year.

These settlement methods may also consider quality of care measures. This helps them to decide what is to be returned to the provider at the end of the year.

"Capitation" and "withhold" arrangements may be based on quality of care, as well as other factors. Providers may also purchase "stop loss" insurance, which reduces the chances that treating patients with costly illnesses will negatively affect the provider's finances. It also helps make sure that providers do not limit care because they are at financial risk for part of the cost of that care.

Some providers, usually hospitals, are paid a set fee to treat certain conditions. We may pay hospitals and other institutional providers a set fee, or "per diem." A per diem payment is based on the number of days the patient spent in the facility.

Our payment to providers may include a combination of some or all of the methods. For example, we may capitate a provider for certain types of care and pay that same provider on a fee-for-service basis for other types of care. In addition, although we may pay a clinic using one type of payment method, that clinic may pay its employees using another payment method.

Check with your individual provider or Member Services to find out how your provider is paid