Banner
University Health Plans
Banner – University Care Advantage

2020
EVIDENCE OF COVERAGE
SANTA CRUZ | YUMA



HMO SPECIAL NEEDS PLAN

H4931_EOC008CY20_C

January 1 – December 31, 2020

Evidence of Coverage:

Your Medicare Health Benefits and Services and Prescription Drug Coverage as a Member of Banner – University Care Advantage (HMO SNP)

This booklet gives you the details about your Medicare health care and prescription drug coverage from January 1 – December 31, 2020. It explains how to get coverage for the health care services and prescription drugs you need. **This is an important legal document. Please keep it in a safe place.**

This plan, **Banner – University Care Advantage**, is offered by **Banner – University Care Advantage.** (When this *Evidence of Coverage* says "we," "us," or "our," it means **Banner – University Care Advantage**. When it says "plan" or "our plan," it means **Banner – University Care Advantage**.)

This document is available for free in Spanish.

Please contact our Customer Care Center number at (877) 874-3930 for additional information. (TTY users should call 711.) Hours are 8 a.m. to 8 p.m., 7 days a week.

This document may be available in other formats such as Braille, large print or other alternate formats. For additional information, call our Customer Care Center number at (877) 874-3930 (TTY: 711).

Benefits, premium, deductible, and/or copayments/coinsurance may change on January 1, 2021.

The formulary, pharmacy network, and/or provider network may change at any time. You will receive notice when necessary.

Banner – University Care Advantage (HMO SNP) complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.
ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al (877) 874-3930 (TTY: 711).

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OMB Approval 0938-1051 (Expires: December 31, 2021)

2020 Evidence of Coverage

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CHAPTER 1

Getting started as a member

Chapter 1. Getting started as a member

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SECTION 1 Introduction

Section 1.1 You are enrolled in Banner – University Care Advantage, which is a specialized Medicare Advantage Plan (Special Needs Plan)

You are covered by both Medicare and AHCCCS (Medicaid):

- **Medicare** is 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 (kidney failure).
- **AHCCCS (Medicaid)** is a joint Federal and state government program that helps with medical costs for certain people with limited incomes and resources. Medicaid coverage varies depending on the state and the type of Medicaid you have. In Arizona, the Medicaid program is called the Arizona Health Care Cost Containment System (AHCCCS). Some people with AHCCCS (Medicaid) get help paying for their Medicare premiums and other costs. Other people also get coverage for additional services and drugs that are not covered by Medicare.

You have chosen to get your Medicare health care and your prescription drug coverage through our plan, Banner – University Care Advantage.

There are different types of Medicare health plans. Banner – University Care Advantage is a specialized Medicare Advantage Plan (a Medicare "Special Needs Plan"), which means its benefits are designed for people with special health care needs. Banner – University Care Advantage is designed specifically for people who have Medicare and who are also entitled to assistance from AHCCCS (Medicaid).

Because you get assistance from AHCCCS (Medicaid) with your Medicare Part A and B cost-sharing (deductibles, copayments, and coinsurance) you may pay nothing for your Medicare health care services. AHCCCS (Medicaid) may also provide other benefits to you by covering health care services that are not usually covered under Medicare. You will also receive "Extra Help" from Medicare to pay for the costs of your Medicare prescription drugs. Banner – University Care Advantage will help manage all of these benefits for you, so that you get the health care services and payment assistance that you are entitled to.

Banner – University Care Advantage is run by a non-profit organization. Like all Medicare Advantage Plans, this Medicare Special Needs Plan is approved by Medicare. The plan also has a contract with the Arizona Medicaid program to coordinate your AHCCCS (Medicaid) benefits. We are pleased to be providing your Medicare health care coverage, including your prescription drug coverage.

Coverage under this Plan qualifies as Qualifying Health Coverage (QHC) and satisfies the Patient Protection and Affordable Care Act's (ACA) individual shared responsibility requirement. Please visit the Internal Revenue Service (IRS) website at: https://www.irs.gov/Affordable-Care-Act/Individuals-and-Families for more information.

Section 1.2 What is the *Evidence of Coverage* booklet about?

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

It's important for you to learn what the plan's rules are and what services are available to you. We encourage you to set aside some time to look through this *Evidence of Coverage* booklet.

If you are confused or concerned or just have a question, please contact our plan's Customer Care Center (phone numbers are printed on the back cover of this booklet).

Section 1.3 Legal information about the *Evidence of Coverage*

It's part of our contract with you

This *Evidence of Coverage* is part of our contract with you about how Banner – University Care Advantage 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 Banner – University Care Advantage between January 1, 2020, and December 31, 2020.

Each calendar year, Medicare allows us to make changes to the plans that we offer. This means we can change the costs and benefits of Banner – University Care Advantage after December 31, 2020. We can also choose to stop offering the plan, or to offer it in a different service area, after December 31, 2020.

Medicare must approve our plan each year

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

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

Section 2.1 Your eligibility requirements

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

- You have both Medicare Part A and Medicare Part B (Section 2.2 tells you about Medicare Part A and Medicare Part B)
- -- *and* -- You live in our geographic service area (Section 2.3 below describes our service area).
- -- *and* -- you are a United States citizen or are lawfully present in the United States
- -- *and* -- You do not have End-Stage Renal Disease (ESRD), with limited exceptions, such as if you develop ESRD when you are already a member of a plan that we offer, or you were a member of a different plan that was terminated.
- -- *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 AHCCCS (Medicaid) benefits. (AHCCCS (Medicaid) is a joint Federal and state government program that helps with medical costs for certain people with limited incomes and resources.) To be eligible for our plan you must be eligible for Medicare and Full AHCCCS (Medicaid) Benefits.

Please note: If you lose your eligibility but can reasonably be expected to regain eligibility within 6 months, then you are still eligible for membership in our plan (Chapter 4, Section 2.1 tells you about coverage and cost-sharing during a period of deemed continued eligibility).

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

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

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

Section 2.3 What is AHCCCS (Medicaid)?

AHCCCS (Medicaid) is a joint Federal and state government program that helps with medical and long-term care costs for certain people who have limited incomes and resources. Each state decides what counts as income and resources, who is eligible, what services are covered, and the cost for services. States also can decide how to run their program as long as they follow the Federal guidelines.

In addition, there are programs offered through AHCCCS (Medicaid) that help people with Medicare pay their Medicare costs, such as their Medicare premiums. These "Medicare Savings Programs" help people with limited income and resources save money each year:

- **Qualified Medicare Beneficiary (QMB):** Helps pay Medicare Part A and Part B premiums, and other cost-sharing (like deductibles, coinsurance, and copayments). (Some people with QMB are also eligible for full Medicaid benefits (QMB+).)
- **Specified Low-Income Medicare Beneficiary (SLMB):** Helps pay Part B premiums. (Some people with SLMB are also eligible for full Medicaid benefits (SLMB+).)

Section 2.4 Here is the plan service area for Banner – University Care Advantage

Although Medicare is a Federal program, Banner – University Care Advantage is available only to individuals who live in our plan service area. To remain a member of our plan, you must continue to reside in the plan service area. The service area is described below.

Our service area includes these counties in Arizona: Santa Cruz and Yuma.

If you plan to move out of the service area, please contact our Customer Care Center (phone numbers are printed on the back cover of this booklet). When you move, you will have a Special Enrollment Period that will allow you to switch to Original Medicare or enroll in a Medicare health or drug plan that is available in your new location.

It is also important that you call Social Security if you move or change your mailing address. You can find phone numbers and contact information for Social Security in Chapter 2, Section 5.

Section 2.5 U.S. Citizen or Lawful Presence

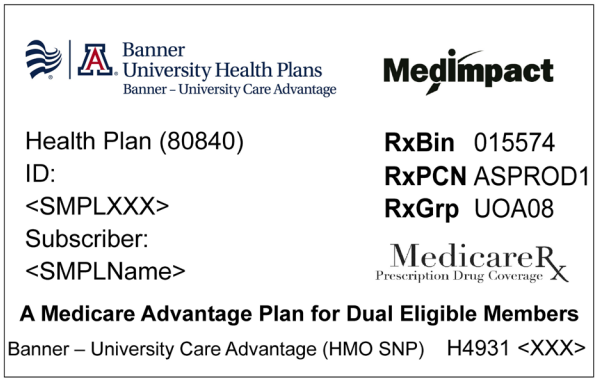
A member of a Medicare health plan must be a U.S. citizen or lawfully present in the United States. Medicare (the Centers for Medicare & Medicaid Services) will notify Banner – University Care Advantage if you are not eligible to remain a member on this basis. Banner – University Care Advantage must disenroll you if you do not meet this requirement.

SECTION 3 What other materials will you get from us?

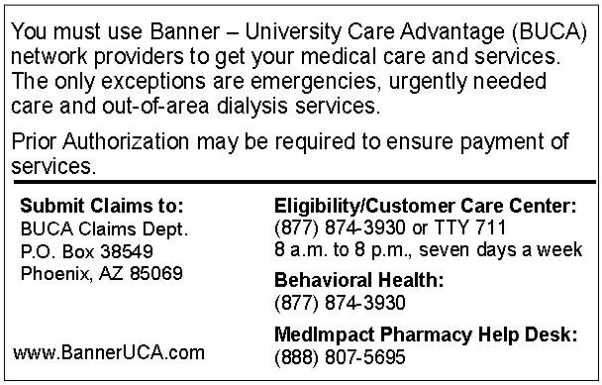
Section 3.1 Your plan membership card – Use it to get all covered care and prescription drugs

While you are a member of our plan, you must use your membership card for our plan whenever you get any services covered by this plan and for prescription drugs you get at network pharmacies. You should also show the provider your AHCCCS (Medicaid) card. Here's a sample membership card to show you what yours will look like:

SAMPLE (FRONT SIDE)



SAMPLE (BACK SIDE)



As long as you are a member of our plan, in most cases, **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). You may be asked to show your Medicare card if you need hospital 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 Banner – University Care Advantage membership card while you are a plan member, you may have to pay the full cost yourself.

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

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

The *Provider Directory* lists our network providers and durable medical equipment suppliers. Those that do not accept AHCCCS (Medicaid) will have an indicator that is explained in the footnote.

What are "network providers"?

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

The most recent list of providers is available on our website at www.BannerUCA.com.

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

It is important to know which providers are part of our network because, with limited exceptions, while you are a member of our plan you must use network providers to get your medical care and services. The only exceptions are emergencies, urgently needed services when the network is not available (generally, when you are out of the area), out-of-area dialysis services, and cases in which Banner – University Care Advantage 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.

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

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

What are "network pharmacies"?

Network pharmacies are all of the pharmacies that have agreed to fill covered prescriptions for our plan members.

Why do you need to know about network pharmacies?

You can use the *Pharmacy Directory* to find the network pharmacy you want to use. There are changes to our network of pharmacies for next year. An updated Pharmacy Directory is located on our website at www.BannerUCA.com. You may also call our Customer Care Center for updated provider information or to ask us to mail you a Pharmacy Directory. **Please review the 2020 Pharmacy Directory to see which pharmacies are in our network**.

If you don't have the *Pharmacy Directory*, you can get a copy from our Customer Care Center (phone numbers are printed on the back cover of this booklet). At any time, you can call our Customer Care Center to get up-to-date information about changes in the pharmacy network. You can also find this information on our website at www.BannerUCA.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 under the Part D benefit included in Banner – University Care Advantage. In addition to the drugs covered by Part D, some prescription drugs are covered for you under your AHCCCS (Medicaid) benefits. The Drug List tells you how to find out which drugs are covered under AHCCCS (Medicaid).

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 Banner – University Care Advantage Drug List.

The Drug List also tells you if there are any rules that restrict coverage for your drugs.

We will provide 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.BannerUCA.com) or call our Customer Care Center (phone numbers are printed on the back cover of this booklet).

Section 3.5 The *Part D Explanation of Benefits* (the "Part D EOB"): 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 summary report to help you understand and keep track of payments for your Part D prescription drugs. This summary report is called the *Part D Explanation of Benefits* (or the "Part D EOB").

The *Part D Explanation of Benefits* tells you the total amount you, or others on your behalf, 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.

A *Part D Explanation of Benefits* summary is also available upon request. To get a copy, please contact our Customer Care Center (phone numbers are printed on the back cover of this booklet).

SECTION 4 Your monthly premium for Banner – University Care Advantage

Section 4.1 How much is your plan premium?

You do not pay a separate monthly plan premium for Banner – University Care Advantage. You must continue to pay your Medicare Part B premium (unless your Part B premium is paid for you by AHCCCS (Medicaid) or another third party).

In some situations, your plan premium could be more

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

- Some members are required to pay a Part D **late enrollment penalty** because they did not join a Medicare drug plan when they first became eligible or because they had a continuous period of 63 days or more when they didn't have "creditable" prescription drug coverage. ("Creditable" means the drug coverage is expected to pay, on average, at least as much as Medicare's standard prescription drug coverage.) For these members, the Part D late enrollment penalty is added to the plan's monthly premium. Their premium amount will be the monthly plan premium plus the amount of their Part D late enrollment penalty.
    - If you receive "Extra Help" from Medicare to pay for your prescription drugs, you will not pay a late enrollment penalty.
    - If you ever lose your low income subsidy ("Extra Help"), you would be subject to the monthly Part D late enrollment penalty if you have ever gone without creditable prescription drug coverage for 63 days or more.
    - If you are required to pay the Part D late enrollment penalty, the cost of the late enrollment penalty depends on how long you went without Part D or creditable prescription drug coverage.

Some members are required to pay other Medicare premiums

Some members are required to pay other Medicare premiums. As explained in Section 2 above, in order to be eligible for our plan, you must maintain your eligibility for AHCCCS (Medicaid) as well as have both Medicare Part A and Medicare Part B. For most Banner – University Care Advantage members, AHCCCS (Medicaid) pays for your Part A premium (if you don't qualify for it automatically) and for your Part B premium. If AHCCCS (Medicaid) is not paying your Medicare premiums for you, you must continue to pay your Medicare premiums to remain a member of the plan.

Your copy of *Medicare & You 2020* gives information about these premiums in the section called "2020 Medicare Costs." 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 2020* from the Medicare website (https://www.medicare.gov). Or, you can order a printed copy by phone at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users call 1-877-486-2048.

Section 4.2 If you pay a Part D late enrollment penalty, there are several ways you can pay your penalty

If you are required to pay a Part D late enrollment penalty, there are two ways you can pay the penalty. Our Customer Care Center can help you with your penalty payment option. Phone numbers are located on the back cover of this booklet.

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

Option 1: You can pay by check

You can pay your late enrollment penalty by check. We can help you set up your payments on a monthly schedule. The check should be made out to Banner – University Care Advantage and mailed to:

Banner – University Care Advantage
Attn: Customer Care
2701 E. Elvira Road
Tucson, AZ 85756

If you have any questions on what a late enrollment penalty is, or have trouble paying the penalty by check, please call our Customer Care Center at (877) 874-3930, or TTY users should dial 711, 8 a.m. to 8 p.m., 7 days a week. One of our representatives will help you with this. Your check must be received by the 10th of the month.

Option 2: You can have the Part D late enrollment penalty taken out of your monthly Social Security check

You can have the Part D late enrollment penalty taken out of your monthly Social Security check. Contact our Customer Care Center for more information on how to pay your monthly penalty this way. We will be happy to help you set this up. (Phone numbers for our Customer Care Center are printed on the back cover of this booklet.)

What to do if you are having trouble paying your Part D late enrollment penalty

If you are having trouble paying your Part D late enrollment penalty on time, please contact our Customer Care Center to see if we can direct you to programs that will help with your penalty. (Phone numbers for our Customer Care Center are printed on the back cover of this booklet.)

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

No. We are not allowed to begin charging a monthly plan premium during the year. If the monthly plan premium changes for next year, we will tell you in September and the change will take effect on January 1.

However, in some cases, you may need to start paying or may be able to stop paying a late enrollment penalty. (The late enrollment penalty may apply if you had a continuous period of 63 days or more when you didn't have "creditable" prescription drug coverage.) This could happen if you become eligible for the "Extra Help" program or if you lose your eligibility for the "Extra Help" program during the year:

- If you currently pay the Part D late enrollment penalty and become eligible for "Extra Help" during the year, you would be able to stop paying your penalty.
- If you ever lose your low income subsidy ("Extra Help"), you would be subject to the monthly Part D late enrollment penalty if you have ever gone without creditable prescription drug coverage for 63 days or more.

You can find out more about the "Extra Help" program in Chapter 2, Section 7.

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/Medical Group.

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

Let us know about these changes:

- Changes to your name, your address, or your phone number
- Changes in any other health insurance coverage you have (such as from your employer, your spouse's employer, workers' compensation, or AHCCCS (Medicaid))
- If you have any liability claims, such as claims from an automobile accident
- If you have been admitted to a nursing home
- If you receive care in an out-of-area or out-of-network hospital or emergency room

- If your designated responsible party (such as a caregiver) changes
- If you are participating in a clinical research study

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

It is also important to contact Social Security if you move or change your mailing address. You can find phone numbers and contact information for Social Security in Chapter 2, Section 5.

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. (For more information about how our coverage works when you have other insurance, see Section 7 in this chapter.)

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 our Customer Care Center (phone numbers are printed on the back cover of this booklet).

SECTION 6 We protect the privacy of your personal health information

Section 6.1 We make sure that your health information is protected

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.

For more information about how we protect your personal health information, please go to Chapter 8, Section 1.4 of this booklet.

SECTION 7 How other insurance works with our plan

Section 7.1 Which plan pays first when you have other insurance?

When you have other insurance (like employer group health coverage), there are rules set by Medicare that decide whether our plan or your other insurance pays first. The insurance that pays first is called the "primary payer" and pays up to the limits of its coverage. The one that pays second, called the "secondary payer," only pays if there are costs left uncovered by the primary coverage. The secondary payer may not pay all of the uncovered costs.

These rules apply for employer or union group health plan coverage:

- If you have retiree coverage, Medicare pays first.
- If your group health plan coverage is based on your or a family member's current employment, who pays first depends on your age, the number of people employed by your employer, and whether you have Medicare based on age, disability, or End-Stage Renal Disease (ESRD):
    - If you're under 65 and disabled and you or your family member is still working, your group health plan pays first if the employer has 100 or more employees or at least one employer in a multiple employer plan that has more than 100 employees.
    - If you're over 65 and you or your spouse is still working, your group health plan pays first if the employer has 20 or more employees or at least one employer in a multiple employer plan that has more than 20 employees.
- If you have Medicare because of ESRD, your group health plan will pay first for the first 30 months after you become eligible for Medicare.

These types of coverage usually pay first for services related to each type:

- No-fault insurance (including automobile insurance)
- Liability (including automobile insurance)
- Black lung benefits
- Workers' compensation

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

If you have other insurance, tell your doctor, hospital, and pharmacy. If you have questions about who pays first, or you need to update your other insurance information, call our Customer Care Center (phone numbers are printed on the back cover of this booklet). You may need to give your plan member ID number to your other insurers (once you have confirmed their identity) so your bills are paid correctly and on time.

CHAPTER 2

Important phone numbers and resources

Chapter 2. Important phone numbers and resources

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SECTION 1 Banner – University Care Advantage contacts (how to contact us, including how to reach our Customer Care Center at the plan)

How to contact our plan's Customer Care Center

For assistance with claims, billing, or member card questions, please call or write to Banner – University Care Advantage Customer Care Center. We will be happy to help you.

Method	Customer Care Center – Contact Information
CALL	(877) 874-3930 Calls to this number are free. Hours of operation are 8 a.m. to 8 p.m., 7 days a week. Customer Care Center also has free language interpreter services available for non-English speakers.
TTY	711 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 are 8 a.m. to 8 p.m., 7 days a week.
FAX	(520) 874-3434
WRITE	Banner – University Care Advantage 2701 E. Elvira Road Tucson, AZ 85756
WEBSITE	www.BannerUCA.com

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

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

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

Method	Coverage Decisions for Medical Care or Part D Prescription Drugs – Contact Information
CALL	(877) 874-3930 Calls to this number are free. Hours of operation are 8 a.m. to 8 p.m., 7 days a week.
TTY	711 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 are 8 a.m. to 8 p.m., 7 days a week.
FAX	(866) 465-8340
WRITE	Banner – University Care Advantage 2701 E. Elvira Road Tucson, AZ 85756 Email: BUHPGrievances&Appeals@bannerhealth.com
WEBSITE	www.BannerUCA.com

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

An appeal is a formal way of asking us to review and change a coverage decision we have made. For more information on making an appeal about your medical care or Part D prescription drugs, see Chapter 9 (*What to do if you have a problem or complaint (coverage decisions, appeals, complaints*)).

Method	Appeals for Medical Care or Part D Prescription Drugs – Contact Information
CALL	(877) 874-3930 Calls to this number are free. Hours of operation are 8 a.m. to 8 p.m., 7 days a week.
TTY	711 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 are 8 a.m. to 8 p.m., 7 days a week.
FAX	(866) 465-8340
WRITE	Banner – University Care Advantage 2701 E. Elvira Road Tucson, AZ 85756 Email: BUHPGrievances&Appeals@bannerhealth.com
WEBSITE	www.BannerUCA.com

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

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

Method	Complaints about Medical Care or Part D Prescription Drugs – Contact Information
CALL	(877) 874-3930 Calls to this number are free. Hours of operation are 8 a.m. to 8 p.m., 7 days a week.
TTY	711 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 are 8 a.m. to 8 p.m., 7 days a week.
FAX	(866) 465-8340
WRITE	Banner – University Care Advantage 2701 E. Elvira Road Tucson, AZ 85756 Email: BUHPGrievances&Appeals@bannerhealth.com
MEDICARE WEBSITE	You can submit a complaint about Banner – University Care Advantage directly to Medicare. To submit an online complaint to Medicare go to https://www.medicare.gov/MedicareComplaintForm/home.aspx.

Where to send a request asking us to pay our share of the cost for medical care or a drug you have received

For more information on situations in which you may need to ask us for reimbursement or to pay a bill you have received from a provider, see Chapter 7 (*Asking us to pay our share of a bill you have received for covered medical services or drugs*).

Please note: If you send us a payment request 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, complaints))* for more information.

Method	Payment Request – Contact Information
CALL	(877) 874-3930 Calls to this number are free. Hours of operation are 8 a.m. to 8 p.m., 7 days a week.
TTY	711 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 are 8 a.m. to 8 p.m., 7 days a week.
FAX	(866) 465-8340
WRITE	Banner – University Care Advantage 2701 E. Elvira Road Tucson, AZ 85756
WEBSITE	www.BannerUCA.com

SECTION 2 Medicare
(how to get help and information directly from the Federal Medicare program)

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

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

Method	Medicare – Contact Information
CALL	1-800-MEDICARE, 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.

Method	Medicare – Contact Information
WEBSITE	https://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. You can also find Medicare contacts in your state. The Medicare website also has detailed information about your Medicare eligibility and enrollment options with the following tools: • **Medicare Eligibility Tool:** Provides Medicare eligibility status information. • **Medicare Plan Finder:** Provides personalized information about available Medicare prescription drug plans, Medicare health plans, and Medigap (Medicare Supplement Insurance) policies in your area. These tools provide an *estimate* of what your out-of-pocket costs might be in different Medicare plans. You can also use the website to tell Medicare about any complaints you have about Banner – University Care Advantage: • **Tell Medicare about your complaint:** You can submit a complaint about Banner – University Care Advantage directly to Medicare. To submit a complaint to Medicare, go to https://www.medicare.gov/MedicareComplaintForm/home.aspx. Medicare takes your complaints seriously and will use this information to help improve the quality of the Medicare program. If you don't have a computer, your local library or senior center may be able to help you visit this website using its computer. Or, you can call Medicare and tell them what information you are looking for. They will find the information on the website, print it out, and send it to you. (You can call Medicare at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.)

SECTION 3 State Health Insurance Assistance Program (free help, information, and answers to your questions about Medicare)

The State Health Insurance Assistance Program (SHIP) is a government program with trained counselors in every state. In Arizona, the SHIP is called Arizona State Health Insurance Assistance Program (Arizona SHIP).

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

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

Method	**Arizona Department of Economic Security Aging & Adult Administration, Arizona's State Health Insurance Assistance Program (Arizona SHIP)** – Contact Information
CALL	Local phone (602) 542-4446 Statewide hotline (800) 432-4040 (leave message)
TTY	711 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.
WRITE	Arizona SHIP 1789 W. Jefferson St. Site Code 950A Phoenix, AZ 85007
WEBSITE	des.az.gov

SECTION 4 Quality Improvement Organization (paid by Medicare to check on the quality of care for people with Medicare)

There is a designated Quality Improvement Organization for serving Medicare beneficiaries in each state. For Arizona, the Quality Improvement Organization is called Livanta BFCC-QIO Program.

Livanta BFCC-QIO Program 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. Livanta BFCC-QIO Program is an independent organization. It is not connected with our plan.

You should contact Livanta BFCC-QIO Program in any of these situations:

- You have a complaint about the quality of care you have received.

- You think coverage for your hospital stay is ending too soon.
- You think coverage for your home health care, skilled nursing facility care, or Comprehensive Outpatient Rehabilitation Facility (CORF) services are ending too soon.

Method	Livanta BFCC-QIO Program (Arizona's Quality Improvement Organization) – Contact Information
CALL	(877) 588-1123
TTY	(855) 887-6668 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.
FAX	833-868-4063
WRITE	Livanta BFCC-QIO Program 10820 Guilford Road Suite 202 Annapolis Junction, MD 20701
WEBSITE	www.livantaqio.com

SECTION 5 Social Security

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

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

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

Method	Social Security – Contact Information
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 Social Security's automated telephone services to get recorded information and conduct some business 24 hours a day.
TTY	1-800-325-0778 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free. Available 7:00 am to 7:00 pm, Monday through Friday.
WEBSITE	https://www.ssa.gov

SECTION 6 AHCCCS (Medicaid)
(a joint Federal and state program that helps with medical costs for some people with limited income and resources)

AHCCCS (Medicaid) is a joint Federal and state government program that helps with medical costs for certain people with limited incomes and resources.

In addition, there are programs offered through AHCCCS (Medicaid) that help people with Medicare pay their Medicare costs, such as their Medicare premiums. These "Medicare Savings Programs" help people with limited income and resources save money each year:

- **Qualified Medicare Beneficiary (QMB):** Helps pay Medicare Part A and Part B premiums, and other cost-sharing (like deductibles, coinsurance, and copayments). (Some people with QMB are also eligible for full AHCCCS (Medicaid) benefits (QMB+).)
- **Specified Low-Income Medicare Beneficiary (SLMB):** Helps pay Part B premiums. (Some people with SLMB are also eligible for full AHCCCS (Medicaid) benefits (SLMB+).)

If you have questions about the assistance you get from AHCCCS (Medicaid), contact AHCCCS (Medicaid).

Method	Arizona Health Cost Containment System (AHCCCS) (Arizona's Medicaid program) – Contact Information
CALL	1-855-432-7587 Hours of operation: Monday – Friday, 8 a.m. to 5 p.m.
TTY	1-800-367-8939 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.
WRITE	801 E. Jefferson Street Phoenix, AZ 85034
WEBSITE	www.azahcccs.gov

The Arizona Ombudsman – Citizens' Aide helps people enrolled in AHCCCS (Medicaid) with service or billing problems. They can help you file a grievance or appeal with our plan.

Method	Arizona Ombudsman – Citizens' Aide – Contact Information
CALL	(602) 277-7292 Toll Free (Outside Maricopa County): (800) 872-2879 Hours of operation: Monday-Friday, 8 a.m. to 5 p.m.
TTY	(602) 542-3323 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.
WRITE	7878 N. 16th Street Suite 235 Phoenix, AZ 85020 Email: ombuds@azoca.gov
WEBSITE	www.azoca.gov

The Arizona Long Term Care Ombudsman helps people get information about nursing homes and resolve problems between nursing homes and residents or their families.

Method	Arizona Long Term Care Ombudsman – Contact Information
CALL	(602) 542-6454 Hours of operation: Monday – Friday, 8 a.m. to 5 p.m.
TTY	711 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.
WRITE	1789 W. Jefferson St. Mail Drop 6288 Phoenix, AZ 85007
WEBSITE	des.az.gov

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

Medicare's "Extra Help" Program

Because you are eligible for AHCCCS (Medicaid), you qualify for and are getting "Extra Help" from Medicare to pay for your prescription drug plan costs. You do not need to do anything further to get this "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 (applications), 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 AHCCCS (Medicaid) Office (applications) (See Section 6 of this chapter for contact information).

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

- To request assistance in obtaining evidence, you or an individual acting on your behalf may contact our Customer Care Center (phone numbers are located on the back cover of this booklet). Or, if you have your evidence documentation, you may fax or mail to:

Mail:

Banner – University Care Advantage,
Attn: Pharmacy
2701 E. Elvira Road
Tucson, AZ 85756

Fax: (866) 349-0338 (Attn: Pharmacy)

- 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 our Customer Care Center if you have questions (phone numbers are printed on the back cover of this booklet).

What if you have coverage from an AIDS Drug Assistance Program (ADAP)?
What is the AIDS Drug Assistance Program (ADAP)?

The AIDS Drug Assistance Program (ADAP) helps ADAP-eligible individuals living with HIV/AIDS have access to life-saving HIV medications. Medicare Part D prescription drugs that are also covered by ADAP qualify for prescription cost-sharing assistance. In Arizona, the Arizona Department of Health Services administers ADAP. Note: To be eligible for the ADAP operating in your State, individuals must meet certain criteria, including proof of State residence and HIV status, low income as defined by the State, and uninsured/under-insured status.

If you are currently enrolled in an ADAP, it can continue to provide you with Medicare Part D prescription cost-sharing assistance for drugs on the ADAP formulary. In order to be sure you continue receiving this assistance, please notify your local ADAP enrollment worker of any changes in your Medicare Part D plan name or policy number. Arizona ADAP, 150 N. 18th Ave., Ste. 110, Phoenix, AZ 85007.

For information on eligibility criteria, covered drugs, or how to enroll in the program, please call (602) 364-3610 or (800) 334-1540. Or, you may email them at eligibility@siren.az.gov.

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

Most of our members get "Extra Help" from Medicare to pay for their prescription drug plan costs. If you get "Extra Help," the Medicare Coverage Gap Discount Program does not apply to you. If you get "Extra Help," you already have coverage for your prescription drug costs during the coverage gap.

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

If you think that you have reached the coverage gap and did not get a discount when you paid for your brand name drug, you should review your next *Part D Explanation of Benefits* (Part D EOB) notice. If the discount doesn't appear on your *Part D Explanation of Benefits*, you should contact us to make sure that your prescription records are correct and up-to-date. If we don't agree that you are owed a discount, you can appeal. You can get help filing an appeal from your State Health Insurance Assistance Program (SHIP) (telephone numbers are in Section 3 of this Chapter) or by calling 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

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.

If you receive your Medicare through the Railroad Retirement Board, it is important that you let them know if you move or change your mailing address.

Method	Railroad Retirement Board – Contact Information
CALL	1-877-772-5772 Calls to this number are free. If you press "0," you may speak with an RRB representative from 9:00 am to 3:30 pm, Monday, Tuesday, Thursday, and Friday, and from 9:00 am to 12:00 pm on Wednesday. If you press "1", you may access the automated RRB HelpLine and recorded information 24 hours a day, including weekends and holidays.
TTY	1-312-751-4701 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are *not* free.
WEBSITE	https://secure.rrb.gov/

SECTION 9 You can get assistance from Arizona Area Agency on Aging

The Area Agency on Aging is a non-profit agency that helps older adults, persons with disabilities, people with HIV/AIDS, and caregivers with programs and services.

Method	Arizona Area Agency on Aging – Contact Information
CALL	(Maricopa County): (602) 264-2255 (Pima County): (520) 790-0504 (Pinal and Gila County): (800) 293-9393 (La Paz, Yuma Counties): (928) 217-7114 (Cochise, Graham, Greenlee, Santa Cruz Counties): (520) 432-2528
HEARING IMPAIRED	TEXT (520) 775-1899 SMS (Short Message Service)
WRITE	Arizona Department of Economic Security (Maricopa County) Division of Aging and Adult Services (DAAS) 1789 W. Jefferson Street Site Code 950A Phoenix, AZ 85007
WEBSITE	des.az.gov

CHAPTER 3

Using the plan's coverage for your medical and other covered services

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

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

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

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

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

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

- **"Providers"** are doctors and other health care professionals licensed by the state to provide medical services and care. The term "providers" also includes hospitals and other health care facilities.
- **"Network providers"** are the doctors and other health care professionals, medical groups, hospitals, and other health care facilities that have an agreement with us to accept our payment and your cost-sharing amount as payment in full. We have arranged for these providers to deliver covered services to members in our plan. The providers in our network bill us directly for care they give you. When you see a network provider, you pay nothing or only your share of the cost for covered services.
- **"Covered services"** include all the medical care, health care services, supplies, and equipment that are covered by our plan. Your covered services for medical care are listed in the benefits chart in Chapter 4.

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

As a Medicare health plan, Banner – University Care Advantage must cover all services covered by Original Medicare and may offer other services in addition to those covered under Original Medicare, see Chapter 4, Section 2.1.

Banner – University Care Advantage will generally cover your medical 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).

- **The care you receive is considered medically necessary**. "Medically necessary" means that the services, supplies, or drugs are needed for the prevention, diagnosis, or treatment of your medical condition and meet accepted standards of medical practice.
- **You have a network primary care provider (a PCP) who is providing and overseeing your care.** As a member of our plan, you must choose a network PCP (for more information about this, see Section 2.1 in this chapter).
    - In most situations, your network 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 2.3 of this chapter.
    - Referrals from your PCP are not required for emergency care or urgently needed services. 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 2.2 of this chapter).
- **You 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 three exceptions:*
    - The plan covers emergency care or urgently needed services that you get from an out-of-network provider. For more information about this, and to see what emergency or urgently needed services means, see Section 3 in this chapter.
    - If you need medical care that Medicare or AHCCCS (Medicaid) 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. Your PCP should obtain prior authorization from our plan before seeking care outside our network. In this situation, we will cover these services as if you got the care from a network provider. For information about getting approval to see an out-of-network doctor, see Section 2.4 in this chapter.
    - The plan covers kidney dialysis services that you get at a Medicare-certified dialysis facility when you are temporarily outside the plan's service area.

SECTION 2 Use providers in the plan's network to get your medical care and other services

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 PCP. Your PCP is a physician or nurse practitioner who meets the 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. For example, in order for you to see a specialist, you usually need to get your PCP's approval first (this is called getting a "referral" to a specialist.) When you may need a service that is not covered by our plan, your PCP should submit a "prior authorization" to obtain this service.

How do you choose your PCP?

You may already have a PCP who is in our network of providers. We can help you if you do not know who your PCP is, or if you need help choosing or changing your PCP. You may choose another PCP by writing to us or by calling our Customer Care Center. Let us know you are a plan member needing to change your PCP.

You can find a list of our PCP's in the Provider Directory or on our website. Our Customer Care Center will also be able to give you more updated information, help you find a PCP near your home, and assist you if you need to find a doctor who speaks a language other than English. It is important that you choose a PCP who makes you feel comfortable. You should stay with that provider so you get the best possible care. 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.

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.

To change your PCP, call our customer Care Center. The PCP change will become effective on the 1st of the month following your phone call. When you call, be sure to tell our Customer Care Center 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). Our Customer Care Center 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. The Customer Care Center Representative will tell you when the change to your new PCP will take effect.

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

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

- Routine women's health care, which includes breast exams, screening mammograms (x-rays of the breast), Pap tests, and pelvic exams as long as you get them from a network provider
- Flu shots Hepatitis B vaccinations, and pneumonia vaccinations as long as you get them from a network provider
- Emergency services from network providers or from out-of-network providers
- Urgently needed services from network providers or from out-of-network providers when network providers are temporarily unavailable or inaccessible, 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. (If possible, please call our Customer Care Center before you leave the service area so we can help arrange for you to have maintenance dialysis while you are away. Phone numbers for our Customer Care Center are printed on the back cover of this booklet.)

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

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

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

For some types of referrals, your PCP may need to get approval in advance from our plan (this is called getting "prior authorization"). If a referral requires approval in advance, your provider will arrange for a prior authorization for these services. Our plan must review these requests. It may take up to 14 days to review this request. Your PCP's office will let you know if your authorization request is approved. You can call our Customer Care Center to find out the status. If your doctor's request is denied, our plan will let you know by mail. If you have a question about the denial, you may contact our Customer Care Center (address and phone numbers are printed on the back cover of this booklet). Please see Chapter 9, Section 6 for more information about filing an appeal for a denied 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 previously in this section). If you don't have a referral (approval in advance) before you get services from a specialist, your services may not be covered. 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. You may also need prior authorization from Banner – University Care Advantage if your specialist requests a medical procedure. Please see Chapter 4, Section 2.1 for more information about which services require prior authorization.

Our plan exclusively uses Sonora Quest laboratories for laboratory services for our members. If your PCP or specialist needs you to get lab work done, you must use Sonora Quest laboratories. It is very important to get a referral (approval in advance) from your doctor before you get lab work done. If you don't have a referral (approval in advance) before you get laboratory services, your services may not be covered. You also need to get prior authorization from Banner – University Care Advantage for laboratory or diagnostic services.

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

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

- Even though our network of providers may change during the year, Medicare requires that we furnish you with uninterrupted access to qualified doctors and specialists.
- We will make a good faith effort to provide you with at least 30 days' notice that your provider is leaving our plan so that you have time to select a new provider.
- We will assist you in selecting a new qualified provider to continue managing your health care needs.
- If you are undergoing medical treatment you have the right to request, and we will work with you to ensure, that the medically necessary treatment you are receiving is not interrupted.
- If you believe we have not furnished you with a qualified provider to replace your previous provider or that your care is not being appropriately managed, you have the right to file an appeal of our decision.
- If you find out your doctor or specialist is leaving your plan, please contact us so we can assist you in finding a new provider and managing your care.

If you would like some assistance with any of these or just have a question, please contact our Customer Care Center (phone numbers are printed on the back cover of this booklet).

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

You must receive your care from a network provider. In most cases, care you receive from an out-of-network provider (a provider who is not part of our plan's network) will be not covered.

There are three exceptions where you may obtain services from out-of-network providers:

- The plan covers emergency or urgently needed care that you get from out-of-network providers. For more information about emergency or urgently needed care, see Section 3 in this chapter.
- If you need medical care that Medicare or AHCCCS (Medicaid) 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. Authorization is required for out-of-network providers and your PCP will submit a prior authorization request to Banner – University Care Advantage. In this situation, we will cover these services as if you got the care from a network provider.
- Kidney dialysis services that you get at Medicare-certified dialysis facilities when you are temporarily outside the plan's service area.

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

Section 3.1 Getting care if you have a medical emergency

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

A **"medical emergency"** is when you, or any other prudent layperson with an average knowledge of health and medicine, believe that you have medical symptoms that require immediate medical attention to prevent loss of life, loss of a limb, or loss of function of a limb. The medical symptoms may be an illness, injury, severe pain, or a medical condition that is quickly getting worse.

If you have a medical emergency:

- **Get help as quickly as possible.** Call 911 for help or go to the nearest emergency room or hospital. Call for an ambulance if you need it. You do *not* need to get approval or a referral first from your PCP.
- **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. Please contact our Customer Care Center at (877) 874-3930. Hours of operation are 8 a.m. to 8 p.m., 7 days a week. TTY users should call 711.

What is covered if you have a medical emergency?

You may get covered emergency medical care whenever you need it, anywhere in the United States or its territories. Our plan covers ambulance services in situations where getting to the emergency room in any other way could endanger your health. 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 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 cover additional care *only* if you get the additional care in one of these two ways:

- You go to a network provider to get the additional care.
- – *or* – The additional care you get is considered "urgently needed services" and you follow the rules for getting 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 services

What are "urgently needed services"?

"Urgently needed services" are non-emergency, unforeseen medical illness, injury, or condition that requires immediate medical care. Urgently needed services may be furnished by network providers or by out-of-network providers when network providers are temporarily unavailable or inaccessible. The unforeseen condition could, for example, be an unforeseen flare-up of a known condition that you have.

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

You should always try to obtain urgently needed services from network providers. However, if providers are temporarily unavailable or inaccessible and it is not reasonable to wait to obtain care from your network provider when the network becomes available, we will cover urgently needed services that you get from an out-of-network provider.

If you are in a situation where you feel it is not reasonable to wait to obtain care from your network provider, please contact our plan's Customer Care Center at (877) 874-3930. TTY users call 711.

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

When you are outside the service area and cannot get care from a network provider, our plan will cover urgently needed services that you get from any provider.

Our plan covers neither emergency services, urgently needed services, nor any other services if you receive care outside of the United States and its territories.

Section 3.3 Getting care during a disaster

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

Please visit the following website: www.fema.gov/recovery-resources for information on how to obtain needed care during a disaster.

Generally, if you cannot use a network provider during a disaster, your plan will allow you to obtain care from out-of-network providers at in-network cost-sharing. If you cannot use a network pharmacy during a disaster, you may be able to fill your prescription drugs at an out-of-network pharmacy. Please see Chapter 5, Section 2.5 for more information.

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

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

If you have paid for your covered services, or if you have received a bill for the full cost of covered medical services, go to Chapter 7 (*Asking us to pay our share of a bill you have received for covered medical services or drugs*) for information about what to do.

Section 4.2 What should you do if services are not covered by our plan?

Banner – University Care Advantage covers all medical services that are medically necessary, are listed in the plan's Benefits Chart (this chart is in Chapter 4 of this booklet), and are obtained consistent with plan rules. You are responsible for paying the full cost of services that aren't covered by our plan, either because they are not plan covered services, or they were obtained out-of-network and were not authorized.

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. You also have the right to ask for this in writing. 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 (coverage decisions, appeals, complaints)*) 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 our Customer Care Center to get more information (phone numbers are printed on the back cover of this booklet).

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. If you are past your benefit limitation for the services, you may be responsible for the payment of the medical services. Any amount spent over the benefit limit for mandatory supplemental benefits does not apply to the out-of-pocket max. You can call our Customer Care Center when you want to know how much of your benefit limit you have already used.

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

Section 5.1 What is a "clinical research study"?

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

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

Once Medicare approves the study, someone who works on the study will contact you to explain more about the study and see if you meet the requirements set by the scientists who are running the study. You can participate in the study as long as you meet the requirements for the study

and you have a full understanding and acceptance of what is involved if you participate in the study.

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

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

Although you do not need to get our plan's permission to be in a clinical research study, **you do need to tell us before you start participating in a clinical research study.**

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

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

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

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

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 you will pay the same amount for the services you receive as part of the study as you would if you received these services from our plan.

> *Here's an example of how the cost-sharing works:* Let's say that you have a lab test that costs $100 as part of the research study. Let's also say that your share of the costs for this test is $20 under Original Medicare, but the test would be $10 under our plan's benefits. In this case, Original Medicare would pay $80 for the test and we would pay another $10. This means that you would pay $10, which is the same amount you would pay under our plan's benefits.

In order for us to pay for our share of the costs, you will need to submit a request for payment. With your request, you will need to send us a copy of your Medicare Summary Notices or other documentation that shows what services you received as part of the study and how much you owe. Please see Chapter 7 for more information about submitting requests for payment.

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 medical condition would normally require only one CT scan.

Do you want to know more?

You can get more information about joining a clinical research study by reading the publication "Medicare and Clinical Research Studies" on the Medicare website (https://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 covered in a "religious non-medical health care institution"

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

A religious non-medical health care institution is a facility that provides care for a condition that would ordinarily be treated in a hospital or skilled nursing facility. If getting care in a hospital or a skilled nursing facility is against a member's religious beliefs, we will instead provide coverage for care in a religious non-medical health care institution. 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 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. See Benefits Chart in Chapter 4, "*Inpatient Hospital Care".*

SECTION 7 Rules for ownership of durable medical equipment

Section 7.1 Will you own the durable medical equipment after making a certain number of payments under our plan?

Durable medical equipment (DME) includes items such as oxygen equipment and supplies, wheelchairs, walkers, powered mattress systems, crutches, diabetic supplies, speech generating devices, IV infusion pumps, nebulizers, and hospital beds ordered by a provider for use in the home. The member always owns certain items, such as prosthetics. In this section, we discuss other types of DME that you must rent.

In Original Medicare, people who rent certain types of DME own the equipment after paying copayments for the item for 13 months. As a member of Banner – University Care Advantage, however, you will not acquire ownership of rented DME items no matter how many copayments you make for the item while a member of our plan. Under certain limited circumstances we will transfer ownership of the DME item to you. Call our Customer Care Center (phone numbers are printed on the back cover of this booklet) to find out about the requirements you must meet and the documentation you need to provide.

Even if you made up to 12 consecutive payments for the DME item under Original Medicare before you joined our plan, you will not acquire ownership no matter how many copayments you make for the item while a member of our plan.

What happens to payments you made for durable medical equipment if you switch to Original Medicare?

If you did not acquire ownership of the DME item while in our plan, you will have to make 13 new consecutive payments after you switch to Original Medicare in order to own the item. Payments you made while in our plan do not count toward these 13 consecutive payments.

If you made fewer than 13 payments for the DME item under Original Medicare *before* you joined our plan, your previous payments also do not count toward the 13 consecutive payments. You will have to make 13 new consecutive payments after you return to Original Medicare in order to own the item. There are no exceptions to this case when you return to Original Medicare.

CHAPTER 4

Benefits Chart (what is covered and what you pay)

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

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

This chapter focuses on what services are covered and what you pay for these services. It includes a Benefits Chart that lists your covered services and shows how much you will pay for each covered service as a member of Banner – University Care Advantage. Later in this chapter, you can find information about medical services that are not covered. It also explains limits on certain services.

Section 1.1 Types of out-of-pocket costs you may pay for your covered services

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

- The **"deductible"** is the amount you must pay for medical services before our plan begins to pay its share. Members of Banner – University Care Advantage do not pay a deductible as long as your eligibility status as a QMB+ does not change during the year. If your AHCCCS (Medicaid) status changes during the year, please call AHCCCS (Medicaid) or our Customer Care Center to see how this may impact you.
- A **"copayment"** is the fixed amount you pay each time you receive certain medical services. You pay a copayment at the time you get the medical service. (The Benefits Chart in Section 2 tells you more about your copayments.)
- **"Coinsurance"** is the percentage you pay of the total cost of certain medical services. You pay a coinsurance at the time you get the medical service. (The Benefits Chart in Section 2 tells you more about your coinsurance.)

QMB members – you do not have any costs for Medicare-covered services, except your prescription copayments if you are enrolled in Medicare as a Qualified Medicare Beneficiary (QMB) and AHCCCS (Medicaid). Your coinsurance, deductibles and copayments (except for Part D prescription drugs) are paid by AHCCCS (Medicaid).

Non-QMB members – you may have costs if AHCCCS (Medicaid) does not cover cost-sharing for non-QMB enrollees. Your costs may include premiums, deductibles, copayments and coinsurance.

Grace Period

QMB members – if you lose your AHCCCS (Medicaid) eligibility, you can remain enrolled in this Medicare plan for up to 6 months. You must re-enroll in AHCCCS (Medicaid) before the end of the 6 month period to keep your Medicare benefits with this plan. During the 6 month period, if you do go to your provider, you will have out-of-pocket costs that your Medicare plan will not cover, you will be responsible for those costs until you regain your AHCCCS (Medicaid) eligibility. Your out-of-pocket costs may include premiums, deductibles, copayments and coinsurance. If you do not re-enroll in AHCCCS (Medicaid) during the 6 month period, you will be disenrolled from our plan. You will be enrolled in Original Medicare.

Non-QMB members – your Medicare cost-sharing will not change during the 6 month period. However, you may have out-of-pocket costs if AHCCCS (Medicaid) does not cover cost-sharing for non-QMB enrollees. Your out-of-pocket costs may include premiums, deductibles, copayments and coinsurance.

Section 1.2 What is the most you will pay for covered medical services?

Note: Because our members also get assistance from AHCCCS (Medicaid), very few members ever reach this out-of-pocket maximum. If you are eligible for Medicare cost-sharing assistance under AHCCCS (Medicaid), you are not responsible for paying any out-of-pocket costs toward the maximum out-of-pocket amount for covered Part A and Part B services.

Because you are enrolled in a Medicare Advantage Plan, there is a limit to how much you have to pay out-of-pocket each year for medical services that are covered by our plan (see the Medical Benefits Chart in Section 2, below). This limit is called the maximum out-of-pocket amount for medical services.

As a member of Banner – University Care Advantage, the most you will have to pay out-of-pocket for services in 2020 is $6,700. The amounts you pay for deductibles, copayments, and coinsurance for covered services count toward this maximum out-of-pocket amount. (The amounts you pay for your Part D prescription drugs do not count toward your maximum out-of-pocket amount.) If you reach the maximum out-of-pocket amount of $6,700, you will not have to pay any out-of-pocket costs for the rest of the year for covered services. However, you must continue to pay the Medicare Part B premium (unless your Part B premium is paid for you by AHCCCS (Medicaid) or another third party).

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

As a member of Banner – University Care Advantage, an important protection for you is that you only have to pay your cost-sharing amount when you get services covered by our plan. We do not allow providers to add additional separate charges, called "balance billing." This protection (that you never pay more than your cost-sharing amount) applies even if we pay the provider less than the provider charges for a service and even if there is a dispute and we don't pay certain provider charges.

Here is how this protection works.

- If your cost-sharing is a copayment (a set amount of dollars, for example, $15.00), then you pay only that amount for any covered services from a network provider.
- If your cost-sharing is a coinsurance (a percentage of the total charges), then you never pay more than that percentage. However, your cost depends on which type of provider you see:

- If you receive the covered services from a network provider, you pay the coinsurance percentage multiplied by the plan's reimbursement rate (as determined in the contract between the provider and the plan).
- If you receive the covered services from an out-of-network provider who participates with Medicare, you pay the coinsurance percentage multiplied by the Medicare payment rate for participating providers. (Remember, the plan covers services from out-of-network providers only in certain situations, such as when you get a referral.)
- If you receive the covered services from an out-of-network provider who does not participate with Medicare, you pay the coinsurance percentage multiplied by the Medicare payment rate for non-participating providers. (Remember, the plan covers services from out-of-network providers only in certain situations, such as when you get a referral.)

- If you believe a provider has "balance billed" you, call our Customer Care Center (phone numbers are printed on the back cover of this booklet).

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

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

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

- Your Medicare covered services must be provided according to the coverage guidelines established by Medicare.
- Your services (including medical care, services, supplies, and equipment) *must* be medically necessary. "Medically necessary" means that the services, supplies, or drugs are needed for the prevention, diagnosis, or treatment of your medical condition and meet accepted standards of medical practice.
- You receive your care from a network provider. In most cases, care you receive from an out-of-network provider will not be covered. Chapter 3 provides more information about requirements for using network providers and the situations when we will cover services from an out-of-network provider.
- You have a primary care provider (a PCP) who is providing and overseeing your care. 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.

Other important things to know about our coverage:

- You are covered by both Medicare and AHCCCS (Medicaid). Medicare covers health care and prescription drugs. AHCCCS (Medicaid) covers your cost-sharing for Medicare services, including emergency care, in-patient services, out-patient rehabilitation service, physician services, and skilled nursing facility care. AHCCCS (Medicaid) also covers services Medicare does not cover, like over-the-counter drugs and non-emergency medically necessary transportation.
- Like all Medicare health plans, we cover everything that Original Medicare covers. (If you want to know more about the coverage and costs of Original Medicare, look in your *Medicare & You 2020* Handbook. View it online at https://www.medicare.gov or ask for a copy by calling 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.)
- For all preventive services that are covered at no cost under Original Medicare, we also cover the service at no cost to you. However, if you also are treated or monitored for an existing medical condition during the visit when you receive the preventive service, a copayment will apply for the care received for the existing medical condition.
- Sometimes, Medicare adds coverage under Original Medicare for new services during the year. If Medicare adds coverage for any services during 2020, either Medicare or our plan will cover those services.
- If you are within our plan's 6-month period of deemed continued eligibility, we will continue to provide all Medicare Advantage plan-covered Medicare benefits. However, during this period, we will not continue to cover AHCCCS (Medicaid) benefits that are included under AHCCCS (Medicaid), nor will we pay the Medicare premiums or cost sharing for which the state would otherwise be liable had you not lost your AHCCCS (Medicaid) eligibility. Medicare cost sharing amounts for Medicare basic and supplemental benefits do not change during this period.

You will see this apple next to the preventive services in the benefits chart.

Benefits Chart

Services that are covered for you	**What you must pay** when you get these services
Abdominal aortic aneurysm screening A one-time screening ultrasound for people at risk. The plan only covers this screening if you have certain risk factors and if you get a referral for it from your physician, physician assistant, nurse practitioner, or clinical nurse specialist.	There is no coinsurance, copayment, or deductible for members eligible for this preventive screening.
Ambulance services* • Covered ambulance services include fixed wing, rotary wing, and ground ambulance services, to the nearest appropriate facility that can provide care only if they are furnished to a member whose medical condition is such that other means of transportation could endanger the person's health or if authorized by the plan. • Non-emergency transportation by ambulance is appropriate if it is documented that the member's condition is such that other means of transportation could endanger the person's health and that transportation by ambulance is medically required.	0% or 20% coinsurance for Medicare-covered ambulance services and non-emergency transportation.◊ Cost-sharing would apply for one-way trips. Prior authorization is required for non-emergency Medicare-covered ambulance services. ◊*Your cost-sharing is determined by your level of Medicaid eligibility. Contact your Medicaid plan.*

Services that are covered for you	**What you must pay** when you get these services
Annual wellness visit If you've had Part B for longer than 12 months, you can get an annual wellness visit to develop or update a personalized prevention plan based on your current health and risk factors. This is covered once every 12 months. **Note**: Your first annual wellness visit can't take place within 12 months of your "Welcome to Medicare" preventive visit. However, you don't need to have had a "Welcome to Medicare" visit to be covered for annual wellness visits after you've had Part B for 12 months.	There is no coinsurance, copayment, or deductible for the annual wellness visit.
Bone mass measurement For qualified individuals (generally, this means people at risk of losing bone mass or at risk of osteoporosis), the following services are covered every 24 months or more frequently if medically necessary: procedures to identify bone mass, detect bone loss, or determine bone quality, including a physician's interpretation of the results.	There is no coinsurance, copayment, or deductible for Medicare-covered bone mass measurement.
Breast cancer screening (mammograms) Covered services include: • One baseline mammogram between the ages of 35 and 39 • One screening mammogram every 12 months for women age 40 and older • Clinical breast exams once every 24 months	There is no coinsurance, copayment, or deductible for covered screening mammograms.

Services that are covered for you	**What you must pay** when you get these services
Cardiac rehabilitation services* Comprehensive programs of cardiac rehabilitation services that include exercise, education, and counseling are covered for members who meet certain conditions with a doctor's referral. The plan also covers intensive cardiac rehabilitation programs that are typically more rigorous or more intense than cardiac rehabilitation programs.	0% or 20% coinsurance applies to Medicare-covered Cardiac Rehabilitation Services and Medicare-covered Intensive Cardiac Rehabilitation Services.◊ Prior authorization is required. ◊*Your cost-sharing is determined by your level of Medicaid eligibility. Contact your Medicaid plan.*
Cardiovascular disease risk reduction visit (therapy for cardiovascular disease) We cover one visit per year with your primary care doctor to help lower your risk for cardiovascular disease. During this visit, your doctor may discuss aspirin use (if appropriate), check your blood pressure, and give you tips to make sure you're eating healthy.	There is no coinsurance, copayment, or deductible for the intensive behavioral therapy cardiovascular disease preventive benefit.
Cardiovascular disease testing Blood tests for the detection of cardiovascular disease (or abnormalities associated with an elevated risk of cardiovascular disease) once every 5 years (60 months)	There is no coinsurance, copayment, or deductible for cardiovascular disease testing that is covered once every 5 years.
Cervical and vaginal cancer screening Covered services include: • For all women: Pap tests and pelvic exams are covered once every 24 months • If you are at high risk of cervical or vaginal cancer or you are of childbearing age and have had an abnormal Pap test within the past 3 years: one Pap test every 12 months	There is no coinsurance, copayment, or deductible for Medicare-covered preventive Pap and pelvic exams.

Services that are covered for you	**What you must pay** when you get these services
Chiropractic services Covered services include: • Manual manipulation of the spine to correct subluxation	0% or 20% coinsurance applies to Medicare-covered Chiropractic Services.◊
• Routine chiropractic care: 6 routine non-Medicare visits allowed per calendar year	0% coinsurance for routine chiropractic care. ◊*Your cost-sharing is determined by your level of Medicaid eligibility. Contact your Medicaid plan.*
Colorectal cancer screening For people 50 and older, the following are covered: • Flexible sigmoidoscopy (or screening barium enema as an alternative) every 48 months One of the following every 12 months: • Guaiac-based fecal occult blood test (gFOBT) • Fecal immunochemical test (FIT) DNA based colorectal screening every 3 years For people at high risk of colorectal cancer, we cover: • Screening colonoscopy (or screening barium enema as an alternative) every 24 months For people not at high risk of colorectal cancer, we cover: • Screening colonoscopy every 10 years (120 months), but not within 48 months of a screening sigmoidoscopy	There is no coinsurance, copayment, or deductible for a Medicare-covered colorectal cancer screening exam. 0% or 20% coinsurance for barium enema.◊ ◊*Your cost-sharing is determined by your level of Medicaid eligibility. Contact your Medicaid plan.*

Services that are covered for you	**What you must pay** when you get these services
Dental services*	
In general, preventive dental services (such as cleaning, routine dental exams, and dental x-rays) are not covered by Original Medicare. We cover: **Preventative Dental Services** • Office visit includes combined exam and cleaning (for up to 1 every six months, maximum 2 per year). • Oral exam (for up to 1 every six months) • Cleaning (for up to 1 every six months) • Fluoride treatment (for up to 1 every year; treatment must be performed during a preventative office visit) • Dental x-ray(s) (for up to 1 set of x-rays every year; must be taken during a preventative office visit.) Authorization and/or referrals are not required for preventative dental services. **Comprehensive Dental Services*** • Non-routine Services; Diagnostic Services; Restorative Services; Endodontics, Other Oral/Maxillofacial Surgery, Other Services • Certain comprehensive services such as filling, removal or replacement of teeth. Prior authorization required for comprehensive dental services. Limitations and exclusions apply to the above benefits. Please contact our Customer Care Center for benefit details, or you can go online to www.BannerUCA.com.	0% or 20% coinsurance for Medicare-covered dental services (this does not include services in connection with care, treatment, filling, removal, or replacement of teeth).◊ There is no coinsurance, co-payment, or deductible for plan covered dental services not covered under original Medicare. Our plan pays $3,000 for most dental services (preventative and certain comprehensive services) every year. Cost of all visits will be deducted from yearly coverage amount. You must use BUCA network providers for these services. ◊*Your cost-sharing is determined by your level of Medicaid eligibility. Contact your Medicaid plan.*
Depression screening We cover one screening for depression per year. The screening must be done in a primary care setting that can provide follow-up treatment and/or referrals.	There is no coinsurance, copayment, or deductible for an annual depression screening visit.

Services that are covered for you	**What you must pay** when you get these services
Diabetes screening We cover this screening (includes fasting glucose tests) if you have any of the following risk factors: high blood pressure (hypertension), history of abnormal cholesterol and triglyceride levels (dyslipidemia), obesity, or a history of high blood sugar (glucose). Tests may also be covered if you meet other requirements, like being overweight and having a family history of diabetes. Based on the results of these tests, you may be eligible for up to two diabetes screenings every 12 months.	There is no coinsurance, copayment, or deductible for the Medicare covered diabetes screening tests.
Diabetes self-management training, diabetic services and supplies For all people who have diabetes (insulin and non-insulin users). Covered services include: • Supplies to monitor your blood glucose: Blood glucose monitor, blood glucose test strips, lancet devices and lancets, and glucose-control solutions for checking the accuracy of test strips and monitors • For people with diabetes who have severe diabetic foot disease: One pair per calendar year of therapeutic custom-molded shoes (including inserts provided with such shoes) and two additional pairs of inserts, or one pair of depth shoes and three pairs of inserts (not including the non-customized removable inserts provided with such shoes). Coverage includes fitting. • Diabetes self-management training is covered under certain condition* Prior Authorization is required for Medicare-covered Diabetes Self-Management Training. Referral not required. Diabetic supplies and services are limited from specified manufacturers.* **Prior authorization required.**	0% or 20% coinsurance for the Medicare-covered Diabetes Self-Management Training.* 0% or 20% coinsurance for Medicare-covered Diabetic Supplies and Therapeutic Shoes or Inserts.◊ ◊*Your cost-sharing is determined by your level of Medicaid eligibility. Contact your Medicaid plan.*

Services that are covered for you	**What you must pay** when you get these services
Durable medical equipment (DME) and related supplies* (For a definition of "durable medical equipment," see Chapter 12 of this booklet.) Covered items include, but are not limited to: wheelchairs, crutches, powered mattress systems, diabetic supplies, hospital beds ordered by a provider for use in the home, IV infusion pumps, speech generating devices, oxygen equipment, nebulizers, and walkers. We cover all medically necessary DME covered by Original Medicare. If our supplier in your area does not carry a particular brand or manufacturer, you may ask them if they can special order it for you. There are no preferred vendors/manufacturers for Durable Medical Equipment (DME).	0% or 20% coinsurance for Medicare-covered benefits.◊ ◊*Your cost-sharing is determined by your level of Medicaid eligibility. Contact your Medicaid plan.*
Emergency care Emergency care refers to services that are: • Furnished by a provider qualified to furnish emergency services, and • Needed to evaluate or stabilize an emergency medical condition. A medical emergency is when you, or any other prudent layperson with an average knowledge of health and medicine, believe that you have medical symptoms that require immediate medical attention to prevent loss of life, loss of a limb, or loss of function of a limb. The medical symptoms may be an illness, injury, severe pain, or a medical condition that is quickly getting worse. Cost sharing for necessary emergency services furnished out-of-network is the same as for such services furnished in-network. Coverage is limited to the U.S. and its territories.	0% to 20% coinsurance (up to $90 per visit) for Medicare-covered benefits.◊ If you are admitted to the hospital within 3 days, you do not have to pay your share of the cost for emergency care. 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 *or* you must have your inpatient care at the out-of-network hospital authorized by the plan and your cost is the cost-

Services that are covered for you	**What you must pay** when you get these services
Emergency care (continued)	sharing you would pay at a network hospital. ◊*Your cost-sharing is determined by your level of Medicaid eligibility. Contact your Medicaid plan.*
Hearing services*	
Diagnostic hearing and balance evaluations performed by your PCP to determine if you need medical treatment are covered as outpatient care when furnished by a physician, audiologist, or other qualified provider. • Routine hearing exam (1 per year) • Fitting and evaluation for hearing aid (up to 1 every three years) • Hearing aids (both ears combined)*	0% to 20% coinsurance for Medicare-covered benefits for exam to diagnose/treat hearing and balance issues.◊ There is no deductible, copayment or coinsurance for annual Routine Hearing exam or Fitting/Evaluation for hearing aids. No prior authorization or referral required. Our plan pays up to $2,000 every three years for Hearing Aids. Prior authorization required for hearing aids. Referral required by certified physician or audiologist for Hearing Aids. Cost of all exams-including annual hearing-will deduct from total coverage amount. You must use BUCA network providers for these services.

Services that are covered for you	**What you must pay** when you get these services
Hearing services* (continued)	◊*Your cost-sharing is determined by your level of Medicaid eligibility. Contact your Medicaid plan.*
HIV screening For people who ask for an HIV screening test or who are at increased risk for HIV infection, we cover: • One screening exam every 12 months For women who are pregnant, we cover: • Up to three screening exams during a pregnancy	There is no coinsurance, copayment, or deductible for members eligible for Medicare-covered preventive HIV screening.
Home health agency care* Prior to receiving home health services, a doctor must certify that you need home health services and will order home health services to be provided by a home health agency. You must be homebound, which means leaving home is a major effort. Covered services include, but are not limited to: • Part-time or intermittent skilled nursing and home health aide services (To be covered under the home health care benefit, your skilled nursing and home health aide services combined must total fewer than 8 hours per day and 35 hours per week) • Physical therapy, occupational therapy, and speech therapy • Medical and social services • Medical equipment and supplies	There is no coinsurance, co-payment, or deductible for the Medicare-covered benefits. Prior authorization and referral are required.
Hospice care You may receive care from any Medicare-certified hospice program. You are eligible for the hospice benefit when your doctor and the hospice medical director have given you a terminal prognosis certifying that you're terminally ill and have 6 months or less to live if your illness runs its normal course. Your hospice doctor can be a network provider or an out-of-network provider. Covered services include: • Drugs for symptom control and pain relief	When you enroll in a Medicare-certified hospice program, your hospice services and your Part A and Part B services related to your terminal prognosis are paid for by Original Medicare, not Banner –

Services that are covered for you	**What you must pay** when you get these services
Hospice care (continued) • Short-term respite care • Home care For hospice services and for services that are covered by Medicare Part A or B and are related to your terminal prognosis: Original Medicare (rather than our plan) will pay for your hospice services related to your terminal prognosis. While you are in the hospice program, your hospice provider will bill Original Medicare for the services that Original Medicare pays for. For services that are covered by Medicare Part A or B and are not related to your terminal prognosis: If you need non-emergency, non-urgently needed services that are covered under Medicare Part A or B and that are not related to your terminal prognosis, your cost for these services depends on whether you use a provider in our plan's network: • If you obtain the covered services from a network provider, you only pay the plan cost-sharing amount for in-network services • If you obtain the covered services from an out-of-network provider, you pay the cost-sharing under Fee-for-Service Medicare (Original Medicare) For services that are covered by Banner – University Care Advantage but are not covered by Medicare Part A or B: Banner – University Care Advantage will continue to cover plan-covered services that are not covered under Part A or B whether or not they are related to your terminal prognosis. You pay your plan cost-sharing amount for these services. For drugs that may be covered by the plan's Part D benefit: Drugs are never covered by both hospice and our plan at the same time. For more information, please see Chapter 5, Section 9.4 (*What if you're in Medicare-certified hospice*) **Note:** If you need non-hospice care (care that is not related to your terminal prognosis), you should contact us to arrange the services. Our plan covers hospice consultation services (one time only) for a terminally ill person who hasn't elected the hospice benefit.	University Care Advantage.

Services that are covered for you	**What you must pay** when you get these services
Immunizations Covered Medicare Part B services include: • Pneumonia vaccine • Flu shots, once each flu season in the fall and winter, with additional flu shots if medically necessary • Hepatitis B vaccine if you are at high or intermediate risk of getting Hepatitis B • Other vaccines if you are at risk and they meet Medicare Part B coverage rules We also cover some vaccines under our Part D prescription drug benefit.	There is no coinsurance, copayment, or deductible for the pneumonia, influenza, and Hepatitis B vaccines.
Inpatient hospital care* Includes inpatient acute, inpatient rehabilitation, long-term care hospitals and other types of inpatient hospital services. Inpatient hospital care starts the day you are formally admitted to the hospital with a doctor's order. The day before you are discharged is your last inpatient day. Covered services include but are not limited to: • Semi-private room (or a private room if medically necessary) • Meals including special diets • Regular nursing services • Costs of special care units (such as intensive care or coronary care units) • Drugs and medications • Lab tests • X-rays and other radiology services • Necessary surgical and medical supplies • Use of appliances, such as wheelchairs • Operating and recovery room costs • Physical, occupational, and speech language therapy • Inpatient substance abuse services • Under certain conditions, the following types of transplants are covered: corneal, kidney, kidney-pancreatic, heart, liver, lung, heart/lung, bone marrow, stem cell, and intestinal/multivisceral. If you need a transplant, we will arrange to have your case reviewed by a Medicare-approved transplant center that will decide whether you are a	In 2019, the amounts (◊) for each benefit period were $0 or: • Medicare deductible amount $1,364 • $0 coinsurance for each benefit period days 1 through 60 • $341 copay per day for days 61through 90 • $682 copay per day for 60 lifetime reserve days These amounts may change for 2020. BUCA will notify you of the 2020 Medicare Inpatient cost-sharing amounts when they are announced by the Federal government. A benefit period begins the day you go into a hospital. The benefit period ends when you haven't received any inpatient hospital care for 60 days in a row. If you go into a hospital after

Services that are covered for you	**What you must pay** when you get these services
Inpatient hospital care* (continued) candidate for a transplant. Transplant providers may be local or outside of the service area. If our in-network transplant services are outside the community pattern of care, you may choose to go locally as long as the local transplant providers are willing to accept the Original Medicare rate. If Banner – University Care Advantage provides transplant services at a location outside the pattern of care for transplants in your community and you choose to obtain transplants at this distant location, we will arrange or pay for appropriate lodging and transportation costs for you and a companion. • Blood - including storage and administration. Coverage of whole blood and packed red cells begins only with the fourth pint of blood that you need - you must either pay the costs for the first 3 pints of blood you get in a calendar year or have the blood donated by you or someone else. All other components of blood are covered beginning with the first pint used. • Physician services **Note:** To be an inpatient, your provider must write an order to admit you formally as an inpatient of the hospital. Even if you stay in the hospital overnight, you might still be considered an "outpatient." If you are not sure if you are an inpatient or an outpatient, you should ask the hospital staff. You can also find more information in a Medicare fact sheet called "Are You a Hospital Inpatient or Outpatient? If You Have Medicare – Ask!" This fact sheet is available on the Web at https://www.medicare.gov/sites/default/files/2018-09/11435-Are-You-an-Inpatient-or-Outpatient.pdf or by calling 1-800-MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048. You can call these numbers for free, 24 hours a day, 7 days a week.	one benefit period has ended, a new benefit period begins. There is no limit to the number of benefit periods. If you get authorized inpatient care at an out-of-network hospital after your emergency condition is stabilized, your cost is the cost-sharing you would pay at a network hospital.◊ Prior Authorization and referral is required for inpatient services. ◊*Your cost-sharing is determined by your level of Medicaid eligibility. Contact your Medicaid plan.*

Services that are covered for you	**What you must pay** when you get these services
Inpatient mental health care*	
• Covered services include mental health care services that require a hospital stay. Our plan covers up to 190 days in a lifetime for inpatient mental health care in a psychiatric hospital. The 190-day limit does not apply to inpatient mental health services provided in a general hospital.	In 2019, the amounts (◊) for each benefit period were $0 or: • Medicare deductible amount $1,364 • 0% coinsurance for each benefit period days 1 through 60 • $341 co-pay per day for days 61through 90 • $682 co-pay per day for 60 lifetime reserve days These amounts may change for 2020. BUCA will notify you of the 2020 Medicare Inpatient cost-sharing amounts when they are announced by the Federal government. A benefit period begins the day you go into a hospital. The benefit period ends when you haven't received any inpatient hospital care for 60 days in a row. If you go into a hospital after one benefit period has ended, a new benefit period begins. There is no limit to the number of benefit periods. A referral and prior authorization is required for Inpatient mental health care admissions. ◊*Your cost-sharing is determined by your level of Medicaid eligibility. Contact your Medicaid plan.*

Services that are covered for you	**What you must pay** when you get these services
Inpatient stay: Covered services received in a hospital or SNF during a non-covered inpatient stay If you have exhausted your inpatient benefits or if the inpatient stay is not reasonable and necessary, we will not cover your inpatient stay. However, in some cases, we will cover certain services you receive while you are in the hospital or the skilled nursing facility (SNF). Covered services include but are not limited to: • Physician services • Diagnostic tests (like lab tests) • X-ray, radium, and isotope therapy including technician materials and services • Surgical dressings • Splints, casts and other devices used to reduce fractures and dislocations • Prosthetics and orthotics devices (other than dental) that replace all or part of an internal body organ (including contiguous tissue), or all or part of the function of a permanently inoperative or malfunctioning internal body organ, including replacement or repairs of such devices • Leg, arm, back, and neck braces; trusses; and artificial legs, arms, and eyes including adjustments, repairs, and replacements required because of breakage, wear, loss, or a change in the patient's physical condition • Physical therapy, speech therapy, and occupational therapy	0% to 20% coinsurance for Medicare-covered outpatient hospital services.◊ Coinsurance may apply for these services. Please review the benefits in this chart for information on these covered services. For example, see "Prosthetic devices and related supplies" section for braces and artificial limbs. Prior authorization may apply. ◊*Your cost-sharing is determined by your level of Medicaid eligibility. Contact your Medicaid plan.*
Medical nutrition therapy This benefit is for people with diabetes, renal (kidney) disease (but not on dialysis), or after a kidney transplant when ordered by your doctor. We cover 3 hours of one-on-one counseling services during your first year that you receive medical nutrition therapy services under Medicare (this includes our plan, any other Medicare Advantage plan, or Original Medicare), and 2 hours each year after that. If your condition, treatment, or diagnosis changes, you may be able to receive more hours of treatment with a physician's order. A physician must prescribe these services and renew their order yearly if your treatment is needed into the next calendar year.	There is no coinsurance, copayment, or deductible for members eligible for Medicare-covered medical nutrition therapy services.

Services that are covered for you	**What you must pay** when you get these services
Medicare Diabetes Prevention Program (MDPP) MDPP services will be covered for eligible Medicare beneficiaries under all Medicare health plans. MDPP is a structured health behavior change intervention that provides practical training in long-term dietary change, increased physical activity, and problem-solving strategies for overcoming challenges to sustaining weight loss and a healthy lifestyle.	There is no coinsurance, copayment, or deductible for the MDPP benefit.
Medicare Part B prescription drugs* These drugs are covered under Part B of Original Medicare. Members of our plan receive coverage for these drugs through our plan. Covered drugs include: • Drugs that usually aren't self-administered by the patient and are injected or infused while you are getting physician, hospital outpatient, or ambulatory surgical center services • Drugs you take using durable medical equipment (such as nebulizers) that were authorized by the plan • Clotting factors you give yourself by injection if you have hemophilia • Immunosuppressive drugs, if you were enrolled in Medicare Part A at the time of the organ transplant • Injectable osteoporosis drugs, if you are homebound, have a bone fracture that a doctor certifies was related to post-menopausal osteoporosis, and cannot self-administer the drug • Antigens • Certain oral anti-cancer drugs and anti-nausea drugs • Certain drugs for home dialysis, including heparin, the antidote for heparin when medically necessary, topical anesthetics, and erythropoiesis-stimulating agents (such as Epogen®, Procrit®, Epoetin Alfa, Aranesp®, or Darbepoetin Alfa) • Intravenous Immune Globulin for the home treatment of primary immune deficiency diseases Chapter 5 explains the Part D prescription drug benefit, including rules you must follow to have prescriptions covered. What you pay for your Part D prescription drugs through our plan is explained in Chapter 6.	0% or 20% of the cost for Part B drugs such as chemotherapy drugs.◊ 0% or 20% coinsurance for other Part B drugs.◊ Note: These services require prior authorization. ◊*Your cost-sharing is determined by your level of Medicaid eligibility. Contact your Medicaid plan.*

Services that are covered for you	**What you must pay** when you get these services
Obesity screening and therapy to promote sustained weight loss If you have a body mass index of 30 or more, we cover intensive counseling to help you lose weight. This counseling is covered if you get it in a primary care setting, where it can be coordinated with your comprehensive prevention plan. Talk to your primary care doctor or practitioner to find out more.	There is no coinsurance, copayment, or deductible for preventive obesity screening and therapy.
Opioid Treatment Program Services Opioid use disorder treatment services are covered under Part B of Original Medicare. Members of our plan receive coverage for these services through our plan. Covered services include: • FDA-approved opioid agonist and antagonist treatment medications and the dispensing and administration of such medications, if applicable • Substance use counseling • Individual and group therapy • Toxicology testing	0% to 20% coinsurance for Medicare-covered opioid treatment services.◊ Referral required. ◊*Your cost-sharing is determined by your level of Medicaid eligibility. Contact your Medicaid plan.*
Outpatient diagnostic tests and therapeutic services and supplies* Covered services include, but are not limited to: • X-rays • Radiation (radium and isotope) therapy including technician materials and supplies. • Surgical supplies, such as dressings • Splints, casts and other devices used to reduce fractures and dislocations • Laboratory tests • Blood - including storage and administration. Coverage of whole blood and packed red cells begins only with the fourth pint of blood that you need - you must either pay the costs for the first 3 pints of blood you get in a calendar year or have the blood donated by you or someone else. All other components of blood are covered beginning with the first pint used. • Other outpatient diagnostic tests	0% or 20% coinsurance for diagnostic tests and procedures.◊ 0% coinsurance for lab services.◊ 0% to 20% coinsurance outpatient x-rays.◊ 0% to 20% coinsurance for therapeutic radiology services (such as radiation treatment for cancer).◊ A referral and authorization is required for outpatient diagnostic tests and therapeutic services and

Services that are covered for you	**What you must pay** when you get these services
Outpatient diagnostic tests and therapeutic services and supplies* (continued)	supplies. ◊*Your cost-sharing is determined by your level of Medicaid eligibility. Contact your Medicaid plan.*
Outpatient Hospital Observation* Observation services are hospital outpatient services given to determine if you need to be admitted as an inpatient or can be discharged. For outpatient hospital observation services to be covered, they must meet the Medicare criteria and be considered reasonable and necessary. Observation services are covered only when provided by the order of a physician or another individual authorized by state licensure law and hospital staff bylaws to admit patients to the hospital or order outpatient tests. **Note:** Unless the provider has written an order to admit you as an inpatient to the hospital, you are an outpatient and pay the cost-sharing amounts for outpatient hospital services. Even if you stay in the hospital overnight, you might still be considered an "outpatient." If you are not sure if you are an outpatient, you should ask the hospital staff. You can also find more information in a Medicare fact sheet called "Are You a Hospital Inpatient or Outpatient? If You Have Medicare – Ask!" This fact sheet is available on the Web at https://www.medicare.gov/sites/default/files/2018-09/11435-Are-You-an-Inpatient-or-Outpatient.pdf or by calling 1-800-MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048. You can call these numbers for free, 24 hours a day, 7 days a week.	0% to 20% coinsurance for Medicare-covered benefits.◊ A referral and authorization is required for outpatient hospital services. ◊*Your cost-sharing is determined by your level of Medicaid eligibility. Contact your Medicaid plan.*

Services that are covered for you	**What you must pay** when you get these services
Outpatient hospital services* We cover medically-necessary services you get in the outpatient department of a hospital for diagnosis or treatment of an illness or injury. Covered services include, but are not limited to: • Services in an emergency department or outpatient clinic, such as observation services or outpatient surgery • Laboratory and diagnostic tests billed by the hospital • Mental health care, including care in a partial-hospitalization program, if a doctor certifies that inpatient treatment would be required without it • X-rays and other radiology services billed by the hospital • Medical supplies such as splints and casts • Certain drugs and biologicals that you can't give yourself **Note:** Unless the provider has written an order to admit you as an inpatient to the hospital, you are an outpatient and pay the cost-sharing amounts for outpatient hospital services. Even if you stay in the hospital overnight, you might still be considered an "outpatient." If you are not sure if you are an outpatient, you should ask the hospital staff. You can also find more information in a Medicare fact sheet called "Are You a Hospital Inpatient or Outpatient? If You Have Medicare – Ask!" This fact sheet is available on the Web at https://www.medicare.gov/sites/default/files/2018-09/11435-Are-You-an-Inpatient-or-Outpatient.pdf or by calling 1-800-MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048. You can call these numbers for free, 24 hours a day, 7 days a week.	0% or 20% coinsurance for Medicare-covered benefits.◊ A referral and authorization is required for outpatient hospital services. ◊*Your cost-sharing is determined by your level of Medicaid eligibility. Contact your Medicaid plan.*
Outpatient mental health care* Covered services include: Mental health services provided by a state-licensed psychiatrist or doctor, clinical psychologist, clinical social worker, clinical nurse specialist, nurse practitioner, physician assistant, or other Medicare-qualified mental health care professional as allowed under applicable state laws. Referral required for Mental Health Specialty Services provided by a Non-Physician.	0% or 20% coinsurance for outpatient group therapy visit.◊ 0% or 20% coinsurance for outpatient individual therapy visit.◊ A referral and prior authorization is required

Services that are covered for you	**What you must pay** when you get these services
Outpatient mental health care* (continued)	for outpatient mental health care services. ◊*Your cost-sharing is determined by your level of Medicaid eligibility. Contact your Medicaid plan.*
Outpatient rehabilitation services* Covered services include: physical therapy, occupational therapy, and speech language therapy. Outpatient rehabilitation services are provided in various outpatient settings, such as hospital outpatient departments, independent therapist offices, and Comprehensive Outpatient Rehabilitation Facilities (CORFs).	0% or 20% coinsurance for occupational therapy/ Physical therapy / Speech and language therapy visit.◊ A referral and prior authorization is required for outpatient rehabilitation services. ◊*Your cost-sharing is determined by your level of Medicaid eligibility. Contact your Medicaid plan.*

Services that are covered for you	**What you must pay** when you get these services
Outpatient substance abuse services*	
Medicare-covered Individual Sessions; Medicare-covered Group Sessions	0% or 20% coinsurance for outpatient individual therapy.◊ 0% or 20% coinsurance for outpatient group therapy visit.◊ A referral and prior authorization is required for Outpatient substance abuse services. ◊*Your cost-sharing is determined by your level of Medicaid eligibility. Contact your Medicaid plan.*
Outpatient surgery, including services provided at hospital outpatient facilities and ambulatory surgical centers*	
Note: If you are having surgery in a hospital facility, you should check with your provider about whether you will be an inpatient or outpatient. Unless the provider writes an order to admit you as an inpatient to the hospital, you are an outpatient and pay the cost-sharing amounts for outpatient surgery. Even if you stay in the hospital overnight, you might still be considered an "outpatient."	0% or 20% coinsurance for ambulatory surgical center.◊ 0% or 20% coinsurance for outpatient surgery.◊ A referral and prior authorization is required for outpatient surgery services. ◊*Your cost-sharing is determined by your level of Medicaid eligibility. Contact your Medicaid plan.*

Services that are covered for you	**What you must pay** when you get these services
Over-the-counter card Covered services include: • $50 per month to be used at participating stores. • Funds provided through a loyalty card. • Items available for purchase include over-the-counter medicines and health-related items. • Nicotine Replacement Therapy (NRT) is available under this benefit. Please visit our website to see our list of covered over-the-counter items.	Unused monthly amount does not rollover into following month.
Partial hospitalization services* "Partial hospitalization" is a structured program of active psychiatric treatment provided as a hospital outpatient service or by a community mental health center, that is more intense than the care received in your doctor's or therapist's office and is an alternative to inpatient hospitalization. **Note**: Because there are no community mental health centers in our network, we cover partial hospitalization only as a hospital outpatient service.	0% or 20% coinsurance for partial hospitalization services.◊ A referral and prior authorization is required for partial hospitalization services. ◊*Your cost-sharing is determined by your level of Medicaid eligibility. Contact your Medicaid plan.*
Physician/Practitioner services, including doctor's office visits Covered services include: • Medically-necessary medical care or surgery services furnished in a physician's office, certified ambulatory surgical center, hospital outpatient department, or any other location • Consultation, diagnosis, and treatment by a specialist • Basic hearing and balance exams performed by your PCP, if your doctor orders it to see if you need medical treatment • Certain telehealth services including consultation, diagnosis, and treatment by a physician or practitioner for	0% or 20% coinsurance for Medicare-covered visits.◊ Authorization is required for some services. Please refer to the benefit section in Chapter 4 for more information. ◊*Your cost-sharing is determined by your level of Medicaid eligibility.*

Services that are covered for you	**What you must pay** when you get these services
Physician/Practitioner services, including doctor's office visits (continued) patients in certain rural areas or other locations approved by Medicare • Telehealth services for monthly ESRD-related visits for home dialysis members in a hospital-based or critical access hospital-based renal dialysis center, renal dialysis facility, or the member's home • Telehealth services for diagnosis, evaluation or treatment of symptoms of an acute stroke • Brief virtual (for example, via telephone or video chat) 5-10 minute check-ins with your doctor—if you are an established patient and the virtual check-in is not related to an office visit within the previous 7 days, nor leads to an office visit within the next 24 hours or soonest available appointment • Remote evaluation of pre-recorded video and/or images you send to your doctor, including your doctor's interpretation and follow-up within 24 hours—if you are an established patient and the remote evaluation is not related to an office visit within the previous 7 days, nor leads to an office visit within the next 24 hours or soonest available appointment • Consultation your doctor has with other physicians via telephone, internet, or electronic health record assessment—if you are an established patient • Second opinion by another network provider prior to surgery • Non-routine dental care (covered services are limited to surgery of the jaw or related structures, setting fractures of the jaw or facial bones, extraction of teeth to prepare the jaw for radiation treatments of neoplastic cancer disease, or services that would be covered when provided by a physician)	*Contact your Medicaid plan.*

Services that are covered for you	**What you must pay** when you get these services
Podiatry services* Covered services include: • Diagnosis and the medical or surgical treatment of injuries and diseases of the feet (such as hammer toe or heel spurs) • Routine foot care for members with certain medical conditions affecting the lower limbs • 6 routine visits per year for routine foot care. (Routine visits require prior authorization and referral)	0% or 20% coinsurance for foot exams and treatment if you have diabetes-related nerve damage and/or meet certain conditions.◊ $0 copay for routine podiatry services. A referral and prior authorization required for Podiatry services. ◊*Your cost-sharing is determined by your level of Medicaid eligibility. Contact your Medicaid plan.*
Prostate cancer screening exams For men age 50 and older, covered services include the following - once every 12 months: • Digital rectal exam • Prostate Specific Antigen (PSA) test	There is no coinsurance, copayment, or deductible for an annual PSA test. 0% or 20% coinsurance for digital rectal exam.◊ ◊*Your cost-sharing is determined by your level of Medicaid eligibility. Contact your Medicaid plan.*
Prosthetic devices and related supplies* Devices (other than dental) that replace all or part of a body part or function. These include, but are not limited to: colostomy bags and supplies directly related to colostomy care, pacemakers, braces, prosthetic shoes, artificial limbs, and breast prostheses (including a surgical brassiere after a mastectomy). Includes certain supplies related to prosthetic devices, and repair and/or replacement of prosthetic devices. Also includes	0% or 20% coinsurance for prosthetic devices.◊ 0% or 20% coinsurance for related medical supplies.◊ A referral and prior authorization is required for Prosthetic devices and

Services that are covered for you	**What you must pay** when you get these services
Prosthetic devices and related supplies* (continued) some coverage following cataract removal or cataract surgery – see "Vision Care" later in this section for more detail.	related supplies. ◊*Your cost-sharing is determined by your level of Medicaid eligibility. Contact your Medicaid plan.*
Pulmonary rehabilitation services* Comprehensive programs of pulmonary rehabilitation are covered for members who have moderate to very severe chronic obstructive pulmonary disease (COPD) and an order for pulmonary rehabilitation from the doctor treating the chronic respiratory disease.	0% or 20% coinsurance for Medicare-covered Pulmonary Rehabilitation Services.◊ A referral and prior authorization is required for Pulmonary rehabilitation services. ◊*Your cost-sharing is determined by your level of Medicaid eligibility. Contact your Medicaid plan*
Screening and counseling to reduce alcohol misuse We cover one alcohol misuse screening for adults with Medicare (including pregnant women) who misuse alcohol, but aren't alcohol dependent. If you screen positive for alcohol misuse, you can get up to 4 brief face-to-face counseling sessions per year (if you're competent and alert during counseling) provided by a qualified primary care doctor or practitioner in a primary care setting.	There is no coinsurance, copayment, or deductible for the Medicare-covered screening and counseling to reduce alcohol misuse preventive benefit.

Services that are covered for you	**What you must pay** when you get these services
Screening for lung cancer with low dose computed tomography (LDCT) For qualified individuals, a LDCT is covered every 12 months. **Eligible members are**: people aged 55 – 77 years who have no signs or symptoms of lung cancer, but who have a history of tobacco smoking of at least 30 pack-years and who currently smoke or have quit smoking within the last 15 years, who receive a written order for LDCT during a lung cancer screening counseling and shared decision making visit that meets the Medicare criteria for such visits and be furnished by a physician or qualified non-physician practitioner. *For LDCT lung cancer screenings after the initial LDCT screening:* the member must receive a written order for LDCT lung cancer screening, which may be furnished during any appropriate visit with a physician or qualified non-physician practitioner. If a physician or qualified non-physician practitioner elects to provide a lung cancer screening counseling and shared decision making visit for subsequent lung cancer screenings with LDCT, the visit must meet the Medicare criteria for such visits.	There is no coinsurance, copayment, or deductible for the Medicare covered counseling and shared decision making visit or for the LDCT.
Screening for sexually transmitted infections (STIs) and counseling to prevent STIs We cover sexually transmitted infection (STI) screenings for chlamydia, gonorrhea, syphilis, and Hepatitis B. These screenings are covered for pregnant women and for certain people who are at increased risk for an STI when the tests are ordered by a primary care provider. We cover these tests once every 12 months or at certain times during pregnancy. We also cover up to 2 individual 20 to 30 minute, face-to-face high-intensity behavioral counseling sessions each year for sexually active adults at increased risk for STIs. We will only cover these counseling sessions as a preventive service if they are provided by a primary care provider and take place in a primary care setting, such as a doctor's office.	There is no coinsurance, copayment, or deductible for the Medicare-covered screening for STIs and counseling for STIs preventive benefit.

Services that are covered for you	**What you must pay** when you get these services
Services to treat kidney disease*	
Covered services include: • Kidney disease education services to teach kidney care and help members make informed decisions about their care. For members with stage IV chronic kidney disease when referred by their doctor, we cover up to six sessions of kidney disease education services per lifetime. • 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 as an inpatient 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) Certain drugs for dialysis are covered under your Medicare Part B drug benefit. For information about coverage for Part B Drugs, please go to the section, "Medicare Part B prescription drugs."	0% or 20% coinsurance for Medicare-covered kidney disease education services.◊ 0% or 20% coinsurance for renal dialysis.◊ A referral and prior authorization required for renal dialysis. A referral is required for kidney disease education services. ◊*Your cost-sharing is determined by your level of Medicaid eligibility. Contact your Medicaid plan.*

Services that are covered for you	**What you must pay** when you get these services
Skilled nursing facility (SNF) care*	
(For a definition of "skilled nursing facility care," see Chapter 12 of this booklet. Skilled nursing facilities are sometimes called "SNFs.") Covered services include but are not limited to: • Semiprivate room (or a private room if medically necessary) • Meals, including special diets • Skilled nursing services • Physical therapy, occupational therapy, and speech therapy • Drugs administered to you as part of your plan of care (This includes substances that are naturally present in the body, such as blood clotting factors.) • Blood - including storage and administration. Coverage of whole blood and packed red cells begins only with the fourth pint of blood that you need – you must either pay the costs for the first 3 pints of blood you get in a calendar year or have the blood donated by you or someone else. All other components of blood are covered beginning with the first pint used. • Medical and surgical supplies ordinarily provided by SNFs • Laboratory tests ordinarily provided by SNFs • X-rays and other radiology services ordinarily provided by SNFs • Use of appliances such as wheelchairs ordinarily provided by SNFs • Physician/Practitioner services Generally, you will get your SNF care from network facilities. However, under certain conditions listed below, you may be able to get your care from a facility that isn't a network provider, if the facility accepts our plan's amounts for payment. • A nursing home or continuing care retirement community where you were living right before you went to the hospital (as long as it provides skilled nursing facility care) • A SNF where your spouse is living at the time you leave the hospital	In 2020, the amounts (◊) for each benefit period are $0 or: • Days 1–20: $0 for each benefit period. • Days 21–100: $178 coinsurance per day of each benefit period. • Days 101 and beyond: all costs. A benefit period begins the day you go into a skilled nursing facility. The benefit period ends when you haven't received any skilled care in a SNF for 60 days in a row. If you go into a skilled nursing facility after one benefit period has ended, a new benefit period begins. There is no limit to the number of benefit periods. A referral and prior authorization is required for Skilled Nursing facility services. ◊*Your cost-sharing is determined by your level of Medicaid eligibility. Contact your Medicaid plan.*

Services that are covered for you	**What you must pay** when you get these services
Smoking and tobacco use cessation (counseling to stop smoking or tobacco use) If you use tobacco, but do not have signs or symptoms of tobacco-related disease: We cover two counseling quit attempts within a 12-month period as a preventive service with no cost to you. Each counseling attempt includes up to four face-to-face visits. If you use tobacco and have been diagnosed with a tobacco-related disease or are taking medicine that may be affected by tobacco: We cover cessation counseling services. We cover two counseling quit attempts within a 12-month period; however, you will pay the applicable cost-sharing. Each counseling attempt includes up to four face-to-face visits.	There is no coinsurance, copayment, or deductible for the Medicare-covered smoking and tobacco use cessation preventive benefits.
Supervised Exercise Therapy (SET) SET is covered for members who have symptomatic peripheral artery disease (PAD) and a referral for PAD from the physician responsible for PAD treatment. Up to 36 sessions over a 12-week period are covered if the SET program requirements are met. The SET program must: • Consist of sessions lasting 30-60 minutes, comprising a therapeutic exercise-training program for PAD in patients with claudication • Be conducted in a hospital outpatient setting or a physician's office • Be delivered by qualified auxiliary personnel necessary to ensure benefits exceed harms, and who are trained in exercise therapy for PAD • Be under the direct supervision of a physician, physician assistant, or nurse practitioner/clinical nurse specialist who must be trained in both basic and advanced life support techniques SET may be covered beyond 36 sessions over 12 weeks for an additional 36 sessions over an extended period of time if deemed medically necessary by a health care provider.	0% or 20% coinsurance.◊ ◊*Your cost-sharing is determined by your level of Medicaid eligibility. Contact your Medicaid plan.*

Services that are covered for you	**What you must pay** when you get these services
Urgently needed services Urgently needed services are provided to treat a non-emergency, unforeseen medical illness, injury, or condition that requires immediate medical care. Urgently needed services may be furnished by network providers or by out-of-network providers when network providers are temporarily unavailable or inaccessible. Cost sharing for necessary urgently needed services furnished out-of-network is the same as for such services furnished in-network. Coverage limited to the U.S. and its territories.	0% or 20% coinsurance (up to $65 per visit).◊ ◊*Your cost-sharing is determined by your level of Medicaid eligibility. Contact your Medicaid plan.*
Vision care* Covered services include: • Outpatient physician services for the diagnosis and treatment of diseases and injuries of the eye, including treatment for age-related macular degeneration. Original Medicare doesn't cover routine eye exams (eye refractions) for eyeglasses/contacts • For people who are at high risk of glaucoma, we will cover one glaucoma screening each year. People at high risk of glaucoma include: people with a family history of glaucoma, people with diabetes, African-Americans who are age 50 and older, and Hispanic Americans who are 65 or older • For people with diabetes, screening for diabetic retinopathy is covered once per year • One pair of eyeglasses or contact lenses after each cataract surgery that includes insertion of an intraocular lens (If you have two separate cataract operations, you cannot reserve the benefit after the first surgery and purchase two eyeglasses after the second surgery.) We cover*: • One routine eye exam covered per year. Cost of annual routine visit will not be deducted from total coverage amount for vision related benefits. Office visit cost share may apply if other physician services are performed in conjunction with eye exam.	0% or 20% coinsurance for Medicare-covered exam to diagnose and treat diseases and conditions of the eye (including yearly glaucoma screening).◊ 0% or 20% coinsurance for eyeglasses or contact lenses after cataract surgery.◊ There is no deductible, copayment or coinsurance for annual Routine eye exam. Referral and prior authorization required for eye exam. Our plan pays up to $225 every year for contact lenses and fitting fee or eyeglasses (frames and/or lenses). Prior authorization required for Medicare-covered

Services that are covered for you	**What you must pay** when you get these services
Vision care* (continued) • Glasses and contact lenses. Glasses include lenses and frames, up to one pair every year. Contacts include hardware and fitting fee, up to coverage amount. Coverage includes receipt of glasses and contacts in one coverage period.	eyewear (glasses or contacts). You must use BUCA network providers for these services. ◊*Your cost-sharing is determined by your level of Medicaid eligibility. Contact your Medicaid plan.*
"Welcome to Medicare" Preventive Visit The plan covers the one-time "Welcome to Medicare" preventive visit. The visit includes a review of your health, as well as education and counseling about the preventive services you need (including certain screenings and shots), and referrals for other care if needed. **Important:** We cover the "Welcome to Medicare" preventive visit only within the first 12 months you have Medicare Part B. When you make your appointment, let your doctor's office know you would like to schedule your "Welcome to Medicare" preventive visit.	There is no coinsurance, copayment, or deductible for the "Welcome to Medicare" preventive visit. 0% to 20% coinsurance for Medicare-covered EKG following Welcome Visit.◊ Referral and prior authorization required for EKG. ◊*Your cost-sharing is determined by your level of Medicaid eligibility. Contact your Medicaid plan.*

SECTION 3 What services are not covered by Medicare?

Section 3.1 Services *not* covered by Medicare (Medicare exclusions)

This section tells you what services are "excluded" by Medicare. Excluded means that Medicare doesn't cover these services.

The chart below describes some services and items that aren't covered by Medicare under any conditions or are covered by Medicare only under specific conditions.

Medicare won't pay for the excluded medical services listed in the chart below except under the specific conditions listed. The only exception: we will pay if a service in the chart below is found upon appeal to be a medical service that we should have paid for or covered because of your specific situation. (For information about appealing a decision we have made to not cover a medical service, go to Chapter 9, Section 6.3 in this booklet.)

All exclusions or limitations on services are described in the Benefits Chart or in the chart below.

Services not covered by Medicare	**Not covered under any condition**	**Covered only under specific conditions**
Services considered not reasonable and necessary, according to the standards of Original Medicare	✓	
Experimental medical and surgical procedures, equipment and medications Experimental procedures and items are those items and procedures determined by our plan and Original Medicare to not be generally accepted by the medical community.		✓ May be covered by Original Medicare under a Medicare-approved clinical research study or by our plan (See Chapter 3, Section 5 for more information on clinical research studies.)
Private room in a hospital		✓ Covered only when medically necessary
Personal items in your room at a hospital or a skilled nursing facility, such as a telephone or a television	✓	
Full-time nursing care in your home	✓	
*Custodial care is care provided in a nursing home, hospice, or other facility setting when you do not require skilled medical care or skilled nursing care.	✓	

Services not covered by Medicare	Not covered under any condition	Covered only under specific conditions
Homemaker services include basic household assistance, including light housekeeping or light meal preparation.	✓	
Fees charged for care by your immediate relatives or members of your household	✓	
Cosmetic surgery or procedures		✓ • Covered in cases of an accidental injury or for improvement of the functioning of a malformed body member • Covered for all stages of reconstruction for a breast after a mastectomy, as well as for the unaffected breast to produce a symmetrical appearance
Home-delivered meals	✓	
Orthopedic shoes		✓ If shoes are part of a leg brace and are included in the cost of the brace, or the shoes are for a person with diabetic foot disease.
Supportive devices for the feet		✓ Orthopedic or therapeutic shoes for people with diabetic foot disease
Radial keratotomy, LASIK surgery, and other low vision aids	✓	
Reversal of sterilization procedures and or non-prescription contraceptive supplies	✓	
Acupuncture	✓	

Services not covered by Medicare	Not covered under any condition	Covered only under specific conditions
Naturopath services (uses natural or alternative treatments)	✓	

*Custodial care is personal care that does not require the continuing attention of trained medical or paramedical personnel, such as care that helps you with activities of daily living, such as bathing or dressing.

Dental Benefits Covered Codes

Coverage Codes for Preventive and Diagnostic benefits:

D0120 periodic oral evaluation - established patient; D0140 limited oral evaluation - problem focused; D0150 comprehensive oral evaluation - new or established patient; D0210 intraoral - complete series of radiographic images; D0220 intraoral - periapical first radiographic image; D0230 intraoral - periapical each additional radiographic image; D0272 bitewings - two radiographic images; D0274 bitewings - four radiographic images; D0330 panoramic radiographic image; D1110 prophylaxis - adult; D1120 prophylaxis - child; D1208 topical application of fluoride - excluding varnish

Coverage codes for comprehensive dental benefits:

Restorative:

D2140 amalgam - one surface, primary or permanent; D2150 amalgam - two surfaces, primary or permanent; D2160 amalgam - three surfaces, primary or permanent; D2161 amalgam - four or more surfaces, primary or permanent; D2330 resin based composite - one surface, anterior; D2331 resin based composite - two surfaces, anterior; D2332 resin based composite - three surfaces, anterior; D2335 resin based composite - four or more surfaces or involving incisal angle (interior); D2390 resin based composite crown, anterior; D2391 resin base composite - one surface, posterior; D2392 resin base composite - two surfaces, posterior; D2393 resin base composite - three surfaces, posterior; D2394 resin base composite - four or more surfaces, posterior; D2710 crown - resin based composite (indirect); D2740 crown - porcelain/ceramic substrate; D2750 crown - porcelain fused to high noble metal; D2751 crown - porcelain fused to predominantly base metal; D2752 crown - porcelain fused to noble metal; D2783 crown - three-quarter porcelain/ceramic; D2790 crown - forecast high noble metal; D2791 crown - full cast predominantly based metal; D2792 crown - forecast noble metal; D2920 recement or re-bond crown; D2930 prefabricated stainless steel crown - primary tooth; D2931 prefabricated stainless steel crown - permanent tooth; D2940 protective restoration; D2950 core buildup, including any pins when required; D2954 prefabricated post and core in addition to crown

Root Canal:

D3220 therapeutic pulpotomy (excluding final restoration) - removal of pulp coronal to the dentinocemental junction and application of medicament; D3310 endodontic therapy, anterior tooth (excluding final restoration); D3320 endodontic therapy, bicuspid tooth (excluding

final restoration); D3330 endodontic therapy, molar (excluding final restoration); D3346 retreatment of previous root canal therapy - anterior; D3347 retreatment of previous root canal therapy - bicuspid; D3348 retreatment of previous root canal therapy - molar

Periodontal:

D4260 osseous surgery (including elevation or a full thickness flap and closure) - four or more contiguous teeth or tooth bounded spaces per quadrant; D4261 osseous surgery (including elevation of a full thickness flap and closure) - 1 to 3 contiguous teeth or tooth bounded spaces per quadrant; D4341 periodontal scaling and root planing - four or more teeth per quadrant; D4342 Dental scaling and root planing - 1 to 3 teeth per quadrant; D4355 full mouth debridement to enable comprehensive evaluation and diagnosis; D4910 periodontal maintenance procedures;

Dentures:

D5110 complete denture - maxillary; D5120 complete denture - mandibular; D5130 immediate denture maxillary; D5140 immediate denture - mandibular; D5211 maxillary partial denture - resin base (including any conventional clasps, rests and teeth); D5212 mandibular partial denture - resin base (including any conventional clasps, rests and teeth); D5213 maxillary partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth); D5214 mandibular partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth); D5225 maxillary partial denture - flexible base; D5226 mandibular partial denture - flexible base; D5410 adjust complete denture - maxillary; D5411 adjust complete denture - mandibular; D5421 adjust partial denture - maxillary; D5422 adjust partial denture - mandibular; D5511 repair broken mandibular denture base; D5512 repair broken maxillary denture base; D5520 replace missing or broken teeth - complete denture (each tooth); D5611 repair partial resin mandibular denture base; D5612 repair partial resin maxillary denture base; D5621 repair cast framework mandibular; D5622 repair cast framework maxillary; D5630 repair or replace broken clasp; D5640 replace broken teeth - per tooth; D5650 and tooth to existing partial denture; D5660 add clasp to existing partial denture; D5730 reline complete maxillary denture (chairside); D5731 reline complete mandibular denture (chairside); D5740 reline maxillary partial denture (chairside); D5741 reline mandibular partial denture (chairside); D5750 reline complete maxillary denture (laboratory); D5751 reline complete mandibular denture (laboratory); D5760 reline maxillary partial denture (laboratory); D5761 reline mandibular partial denture (laboratory)

Bridgework:

D6210 pontic - cast high noble metal; D6211 pontic - cast base metal; D6212 pontic - cast noble metal; D6240 pontic - porcelain fused - high noble; D6240 pontic - porcelain fused to base metal; D6242 pontic - porcelain fused - noble metal; D6740 retainer crown - porcelain/ceramic; D6750 crown - porcelain fused high noble; D6751 crown - porcelain fused to base metal; D6752 crown - porcelain fused noble metal; D6790 crown - full cast high noble; D6791 crown - full cast base metal; D6792 crown - full cast noble metal; D6930 recement or re-bond fixed partial denture

Surgery and extractions:

D7140 extraction, erupted tooth or exposed root (elevation and/or forceps removal);

D7210 surgical removal of erupted tooth requiring removal of bone and/or sectioning of tooth, and including elevation of mucoperiosteal flap if indicated; D7250 surgical removal of residual tooth roots (cutting procedure); D7310 alveoloplasty in conjunction with extractions - four or more teeth or tooth spaces, per quadrant; D7311 alveoloplasty in conjunction with extractions - 1 to 3 teeth or tooth spaces, per quadrant; D7471 removal of exostosis - per site; D7472 removal of torus palatinus; D7473 removal of torus mandibularis; D7485 surgical reduction of osseous tuberosity;

Adjunctive:

D9110 palliative (emergency) treatment of dental pain - minor procedure; D9230 inhalation of nitrous oxide/analgesia, anxiolysis.

Our plan does not cover the following:

- Dental implants
- Cost for missing dental appointments
- Dental procedures received from an out-of-network provider
- Dental procedures not listed in the above list of dental benefit codes
- Dental procedures solely for cosmetic/aesthetic reasons
- Dental procedures that are inconsistent with the ADA guidelines as indicated in the DentaQuest Provider Manual

Limitations and exclusions apply to the above benefits. If you have questions, please contact our Customer Care Center for benefit details, or you can go online to www.BannerUCA.com.

CHAPTER 5

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

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

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How can you get information about your drug costs?

Because you are eligible for AHCCCS (Medicaid), you qualify for and are getting "Extra Help" from Medicare to pay for your prescription drug plan costs. Because you are in the "Extra Help" program, **some information in this *Evidence of Coverage* about the costs for Part D prescription drugs may not apply to you.** We have sent you a separate insert, called the "Evidence of Coverage Rider for People Who Get Extra Help Paying for Prescription Drugs" (also known as the "Low Income Subsidy Rider" or the "LIS Rider"), which tells you about your drug coverage. If you don't have this insert, please call our Customer Care Center and ask for the "LIS Rider." (Phone numbers for our Customer Care Center are printed on the back cover of this booklet.)

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**.

In addition to your coverage for Part D drugs, Banner – University Care Advantage also covers some drugs under the plan's medical benefits. Through its coverage of Medicare Part A benefits, our plan generally covers drugs you are given during covered stays in the hospital or in a skilled nursing facility. Through its coverage of Medicare Part B benefits, our plan covers drugs including certain chemotherapy drugs, certain drug injections you are given during an office visit, and drugs you are given at a dialysis facility. Chapter 4 (*Medical Benefits Chart, what is covered and what you pay*) tells about the benefits and costs for drugs during a covered hospital or skilled nursing facility stay, as well as your benefits and costs for Part B drugs.

Your drugs may be covered by Original Medicare if you are in Medicare hospice. Our plan only covers Medicare Parts A, B, and D services and drugs that are unrelated to your terminal prognosis and related conditions and therefore not covered under the Medicare hospice benefit. For more information, please see Section 9.4 (*What if you're in Medicare-certified hospice*). For information on hospice coverage, see the hospice section of Chapter 4 (*Medical Benefits Chart, what is covered and what you pay*).

The following sections discuss coverage of your drugs under the plan's Part D benefit rules. Section 9, *Part D drug coverage in special situations* includes more information on your Part D coverage and Original Medicare.

In addition to the drugs covered by Medicare, some prescription drugs are covered for you under your AHCCCS (Medicaid) benefits. You can learn more about prescription drug coverage under your AHCCCS (Medicaid) benefits by contacting your AHCCCS (Medicaid) health plan or the AHCCCS (Medicaid) office listed in Chapter 2.

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

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

- You must have a provider (a doctor, dentist or other prescriber) write your prescription.
- Your prescriber must either accept Medicare or file documentation with CMS showing that he or she is qualified to write prescriptions, or your Part D claim will be denied. You should ask your prescribers the next time you call or visit if they meet this condition. If not, please be aware it takes time for your prescriber to submit the necessary paperwork to be processed.
- You generally must use a network pharmacy to fill your prescription. (See Section 2, *Fill your prescriptions at a network pharmacy or through the plan's mail-order service.*)
- Your drug must be on the plan's *List of Covered Drugs (Formulary)* (we call it the "Drug List" for short). (See Section 3, *Your drugs need to be on the plan's "Drug List*.")
- Your drug must be used for a medically accepted indication. A "medically accepted indication" is a use of the drug that is either approved by the Food and Drug Administration or supported by certain reference books. (See Section 3 for more information about a medically accepted indication.)

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

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

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

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

Section 2.2 Finding network pharmacies

How do you find a network pharmacy in your area?

To find a network pharmacy, you can look in your *Pharmacy Directory*, visit our website (www.BannerUCA.com), or call our Customer Care Center (phone numbers are printed on the back cover of this booklet).

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 provider 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 our Customer Care Center (phone numbers are printed on the back cover of this booklet) or use the *Pharmacy Directory*. You can also find information on our website at www.BannerUCA.com.

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 (LTC) facility. Usually, a long-term care facility (such as a nursing home) has its own pharmacy. If you are in an LTC facility, we must ensure that you are able to routinely receive your Part D benefits through our network of LTC pharmacies, which is typically the pharmacy that the LTC facility uses. If you have any difficulty accessing your Part D benefits in an LTC facility, please contact our Customer Care Center.
- 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 drugs that are restricted by the FDA to certain locations or that require special handling, provider coordination, or education on their use. (Note: This scenario should happen rarely.)

To locate a specialized pharmacy, look in your *Pharmacy Directory* or call our Customer Care Center (phone numbers are printed on the back cover of this booklet).

Section 2.3 Using the plan's mail-order services

You can use the plan's network mail-order services. Generally, the drugs provided through mail order are drugs that you take on a regular basis, for a chronic or long-term medical condition.

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

To get information about filling your prescriptions by mail, call our Customer Care Center (phone numbers are printed on the back cover of this booklet.)

Usually a mail-order pharmacy order will get to you in no more than 14 days. If for some reason your order cannot be delivered within 14 days, please call our Customer Care Center (phone numbers are printed on the back cover of this booklet.)

New prescriptions the pharmacy receives directly from your doctor's office.
After the pharmacy receives a prescription from a health care provider, it will contact you to see if you want the medication filled immediately or at a later time. This will give you an opportunity to make sure that the pharmacy is delivering the correct drug (including strength, amount, and form) and, if needed, allow you to stop or delay the order before you are billed and it is shipped. It is important that you respond each time you are contacted by the pharmacy, to let them know what to do with the new prescription and to prevent any delays in shipping.

Refills on mail-order prescriptions. For refills, please contact your pharmacy 14 days before you think the drugs you have on hand will run out to make sure your next order is shipped to you in time.

So the pharmacy can reach you to confirm your order before shipping, please make sure to let the pharmacy know the best ways to contact you. Please contact Postal Prescription Services (PPS) at (800) 552-6694 or online at www.ppsrx.com.

Section 2.4 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 (also called an "extended supply") of "maintenance" drugs on our plan's Drug List. (Maintenance drugs are drugs that you take on a regular basis, for a chronic or long-term medical condition.) You may order this supply through mail order (see Section 2.3) or you may go to a retail pharmacy.

1. **Some retail pharmacies** in our network allow you to get a long-term supply of maintenance drugs. Some of these retail pharmacies agree to accept a lower cost-sharing amount for a long-term supply of maintenance drugs. Other retail pharmacies may not agree to accept the lower cost-sharing amounts for a long-term supply of maintenance drugs. In this case you will be responsible for the difference in price. Your *Pharmacy Directory* tells you which pharmacies in our network can give you a long-term supply of maintenance drugs. You can also call our Customer Care Center for more information (phone numbers are printed on the back cover of this booklet).
2. You can use the plan's network **mail-order services.** Our plan's mail-order service requires you to order a 90-day supply. See Section 2.3 for more information about using our mail-order services.

Section 2.5 When can you use a pharmacy that is not in the plan's network?

Your prescription may be covered in certain situations

Generally, we cover drugs filled at an out-of-network pharmacy *only* when you are not able to use a network pharmacy. To help you, we have network pharmacies outside of our service area where you can get your prescriptions filled as a member of our plan. If you cannot use a network pharmacy, here are the circumstances when we would cover prescriptions filled at an out-of-network pharmacy:

- We will cover prescriptions that are filled at an out-of-network pharmacy if the prescriptions are related to the care for a medical emergency or urgently needed care.
- If you are traveling within the U.S., but outside our coverage area, you may become ill or lose or run out of prescription drugs, we will cover prescriptions that are filled at an out-of-network pharmacy if a network pharmacy is not available.
- If the Governor of your state, the U.S. Secretary of Health and Human Services, or the President of the United States declares a state of disaster or emergency in your geographic area, we will cover prescriptions that are filled at an out-of-network pharmacy if a network pharmacy is not available.

In these situations, **please check first with our Customer Care Center** to see if there is a network pharmacy nearby. (Phone numbers for our Customer Care Center are printed on the back cover of this booklet.) You may be required to pay the difference between what you pay for the drug at the out-of-network pharmacy and the cost that we would cover at an in-network pharmacy.

How do you ask for reimbursement from the plan?

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

SECTION 3 Your drugs need to be on the plan's "Drug List"

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

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

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

The Drug List includes the drugs covered under Medicare Part D (earlier in this chapter, Section 1.1 explains about Part D drugs). In addition to the drugs covered by Medicare, some prescription drugs are covered for you under your AHCCCS (Medicaid) benefits. You can either contact your AHCCCS (Medicaid) health plan or the AHCCCS (Medicaid) office for more information on your drug coverage. Phone numbers for the AHCCCS (Medicaid) are in Chapter 2, Section 6 of this booklet.

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

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

The Drug List includes both brand name and generic drugs

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

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 7.1 in this chapter).
- In other cases, we have decided not to include a particular drug on our Drug List.

Section 3.2 How can you find out if a specific drug is on the Drug List?

You have 3 ways to find out:

1. Check the most recent Drug List we provided electronically.
2. Visit the plan's website (www.BannerUCA.com). The Drug List on the website is always the most current.
3. Call our Customer Care Center 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 our Customer Care Center are printed on the back cover of this booklet.)

SECTION 4 There are restrictions on coverage for some drugs

Section 4.1 Why do some drugs have restrictions?

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

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

If there is a restriction for your drug, it usually means that you or your provider will have to take extra steps in order for us to cover the drug. If you want us to waive the restriction for you, you will need to use the coverage decision process and ask us to make an exception. We may or may not agree to waive the restriction for you. (See Chapter 9, Section 7.2 for information about asking for exceptions.)

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

Section 4.2 What kinds of restrictions?

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

Restricting brand name drugs when a generic version is available

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

Getting plan approval in advance

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

Trying a different drug first

This requirement encourages you to try less costly but just as effective drugs before the plan covers another drug. For example, if Drug A and Drug B treat the same medical condition and Drug A is less costly, 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 by limiting 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 4.3 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 our Customer Care Center (phone numbers are printed on the back cover of this booklet) or check our website (www.BannerUCA.com).

If there is a restriction for your drug, it usually means that you or your provider will have to take extra steps in order for us to cover the drug. If there is a restriction on the drug you want to take, you should contact our Customer Care Center to learn what you or your provider would need to do to get coverage for the drug. If you want us to waive the restriction for you, you will need to use the coverage decision process and ask us to make an exception. We may or may not agree to waive the restriction for you. (See Chapter 9, Section 7.2 for information about asking for exceptions.)

SECTION 5 What if one of your drugs is not covered in the way you'd like it to be covered?

Section 5.1 There are things you can do if your drug is not covered in the way you'd like it to be covered

We hope that your drug coverage will work well for you. But it's possible that there could be a prescription drug you are currently taking, or one that you and your provider think you should be taking, that is not on our formulary or is on our formulary with restrictions. 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.
- The drug is covered, but there are extra rules or restrictions on coverage for that drug. As explained in Section 4, 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. In some cases, you may want us to waive the restriction for you.

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

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

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

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

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

You may be able to get a temporary supply

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

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

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

- The drug you have been taking is **no longer on the plan's Drug List**.
- -- or -- the drug you have been taking is **now restricted in some way** (Section 4 in this chapter tells about restrictions).

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

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

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

- **For those members who have been in the plan for more than 90 days and reside in a long-term care (LTC) facility and need a supply right away:**

  We will cover one 31-day supply of a particular drug, or less if your prescription is written for fewer days. This is in addition to the above temporary supply situation.

- **For those members with level of care changes:**

  If you are a resident of a long-term care facility, we will allow you to refill your prescription until we have provided you with 31-day transition supply, consistent with dispensing increment, (unless you have a prescription written for fewer days). If you need a drug that is not on our formulary or if your ability to get your drugs is limited, but you are past the first 90 days of membership in our plan, we will cover a 31-day emergency supply of that drug (unless you have a prescription for fewer days) while you pursue a formulary exception.

  You may have to fill new prescriptions for the drugs you were taking if you have a level of care change such as:
  - Members who are discharged from a hospital to home
  - Members who end their skilled nursing facility Medicare Part A stay (where payments include all pharmacy charges) and who need to revert to their Part D plan formulary
  - Members who give up hospice status to revert to standard Medicare Part A and B benefits
  - Members who end a long-term care facility stay and return to the community
  - Members who are discharged from psychiatric hospitals with drug regimens that are highly individualized

To ask for a temporary supply, call our Customer Care Center (phone numbers are printed on the back cover of this booklet).

During the time when you are getting a temporary supply of a drug, you should talk with your provider to decide what to do when your temporary supply runs out. You can either switch to a different drug covered by the plan or ask the plan to make an exception for you and cover your current drug. The sections below tell you more about these options.

You can change to another drug

Start by talking with your provider. Perhaps there is a different drug covered by the plan that might work just as well for you. You can call our Customer Care Center to ask for a list of covered drugs that treat the same medical condition. This list can help your provider find a covered drug that might work for you. (Phone numbers for our Customer Care Center are printed on the back cover of this booklet.)

You can ask for an exception

You and your provider can ask the plan to make an exception for you and cover the drug in the way you would like it to be covered. If your provider says that you have medical reasons that justify asking us for an exception, your provider can help you request an exception to the rule. 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 next year. You can ask for an exception before next year and we will give you an answer within 72 hours after we receive your request (or your prescriber's supporting statement). If we approve your request, we will authorize the coverage before the change takes effect.

If you and your provider want to ask for an exception, Chapter 9, Section 7.4 tells what to do. It explains the procedures and deadlines that have been set by Medicare to make sure your request is handled promptly and fairly.

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

Section 6.1 The Drug List can change during the year

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

- **Add or remove drugs from the Drug List**. New drugs become available, including new generic drugs. Perhaps the government has given approval to a new use for an existing drug. Sometimes, a drug gets recalled and we decide not to cover it. Or we might remove a drug from the list because it has been found to be ineffective.
- **Add or remove a restriction on coverage for a drug** (for more information about restrictions to coverage, see Section 4 in this chapter).
- **Replace a brand name drug with a generic drug.**

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

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

Information on changes to drug coverage

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

Do changes to your drug coverage affect you right away?

Changes that can affect you this year: In the below cases, you will be affected by the coverage changes during the current year:

- **A new generic drug replaces a brand name drug on the Drug List (or we change cost-sharing tier or add new restrictions to the brand name drug)**
    - We may immediately remove a brand name drug on our Drug List if we are replacing it with a newly approved generic version of the same drug that will appear on the same or lower cost sharing tier and with the same or fewer restrictions. Also, when adding the new generic drug, we may decide to keep the brand name drug on our Drug List, but immediately move it to a higher cost-sharing tier or add new restrictions.
    - We may not tell you in advance before we make that change—even if you are currently taking the brand name drug
    - You or your prescriber can ask us 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 (coverage decisions, appeals, complaints)).*
    - If you are taking the brand name drug at the time we make the change, we will provide you with information about the specific change(s) we made. This will

also include information on the steps you may take to request an exception to cover the brand name drug. You may not get this notice before we make the change.

- **Unsafe drugs and other drugs on the Drug List that are withdrawn from the market**
  - Once in a while, a drug may be suddenly withdrawn because it has been found to be unsafe or removed from the market for another reason. If this happens, we will immediately remove the drug from the Drug List. If you are taking that drug, we will let you know of this change right away.
  - Your prescriber will also know about this change, and can work with you to find another drug for your condition.
- **Other changes to drugs on the Drug List**
  - We may make other changes once the year has started that affect drugs you are taking. For instance, we might add a generic drug that is not new to the market to replace a brand name drug or change the cost-sharing tier or add new restrictions to the brand name drug. We also might make changes based on FDA boxed warnings or new clinical guidelines recognized by Medicare. We must give you at least 30 days' advance notice of the change or give you notice of the change and a 31-day refill of the drug you are taking at a network pharmacy.
  - After you receive notice of the change, you should be working with your prescriber to switch to a different drug that we cover.
  - Or you or your prescriber can ask us to make an exception and continue to cover the 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 (coverage decisions, appeals, complaints).*

Changes to drugs on the Drug List that will not affect people currently taking the drug: For changes to the Drug List that are not described above, if you are currently taking the drug the following types of changes will not affect you until January 1 of the next year if you stay in the plan:

- If we put a new restriction on your use of the drug
- If we remove your drug from the Drug List

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

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

Section 7.1 Types of drugs we do not cover

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

We won't pay for the drugs that are listed in this section. The only exception: If the requested drug is found upon appeal to be a drug that is not excluded under Part D and we should have paid for or covered it because of your specific situation. (For information about appealing a decision we have made to not cover a drug, go to Chapter 9, Section 7.5 in this booklet.) If the drug excluded by our plan is also excluded by AHCCCS (Medicaid), you must pay for it yourself.

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 for cancer, the National Comprehensive Cancer Network and Clinical Pharmacology or their successors. If the use is not supported by any of these reference books, then our plan cannot cover its "off-label use."

Also, by law, the categories of drugs listed below are not covered by Medicare. However, some of these drugs may be covered for you under your AHCCCS (Medicaid) drug coverage. For more information on prescription drug coverage under AHCCCS (Medicaid), please contact AHCCCS (Medicaid) or view your AHCCCS (Medicaid) formulary. Phone numbers for AHCCCS (Medicaid) are in Chapter 2, Section 6 of the booklet.

- Non-prescription drugs (also called over-the-counter drugs)
- Drugs when used to promote fertility
- Drugs when used for the relief of cough or cold symptoms
- Drugs when used for cosmetic purposes or to promote hair growth
- Prescription vitamins and mineral products, except prenatal vitamins and fluoride preparations
- Drugs when used for the treatment of sexual or erectile dysfunction

- Drugs when used for treatment of anorexia, weight loss, or weight gain
- 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 8 Show your plan membership card when you fill a prescription

Section 8.1 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 the costs of your covered prescription drug. You will need to pay the pharmacy *your* share of the cost when you pick up your prescription.

Section 8.2 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.)

SECTION 9 Part D drug coverage in special situations

Section 9.1 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.

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

Usually, a long-term care (LTC) facility (such as a nursing home) has its own pharmacy, or a pharmacy that supplies drugs for all of its residents. If you are a resident of a long-term care

facility, you may get your prescription drugs through the facility's pharmacy as long as it is part of our network.

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

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

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

During the time when you are getting a temporary supply of a drug, you should talk with your provider to decide what to do when your temporary supply runs out. Perhaps there is a different drug covered by the plan that might work just as well for you. Or you and your provider can ask the plan to make an exception for you and cover the drug in the way you would like it to be covered. If you and your provider want to ask for an exception, Chapter 9, Section 7.4 tells what to do.

Section 9.3 What if you're in Medicare-certified hospice?

Drugs are never covered by both hospice and our plan at the same time. If you are enrolled in Medicare hospice and require an anti-nausea, laxative, pain medication or antianxiety drug that is not covered by your hospice because it is unrelated to your terminal illness and related conditions, our plan must receive notification from either the prescriber or your hospice provider that the drug is unrelated before our plan can cover the drug. To prevent delays in receiving any unrelated drugs that should be covered by our plan, you can ask your hospice provider or prescriber to make sure we have the notification that the drug is unrelated before you ask a pharmacy to fill your prescription.

In the event you either revoke your hospice election or are discharged from hospice, our plan should cover all your drugs. To prevent any delays at a pharmacy when your Medicare hospice benefit ends, you should bring documentation to the pharmacy to verify your revocation or discharge. See the previous parts of this section that tell about the rules for getting drug coverage under Part D Chapter 6 (*What you pay for your Part D prescription drugs*) gives more information about drug coverage and what you pay.

SECTION 10 Programs on drug safety and managing medications

Section 10.1 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
- Unsafe amounts of opioid pain medications

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

Section 10.2 Medication Therapy Management (MTM) program to help members manage their medications

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

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

get a personal medication list that will include all the medications you're taking and why you take them.

It's a good idea to have your medication review before your yearly "Wellness" visit, so you can talk to your doctor about your action plan and medication list. Bring your action plan and medication list with you to your visit or anytime you talk with your doctors, pharmacists, and other health care providers. Also, keep your medication list with you (for example, with your ID) in case you go to the hospital or emergency room.

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 you from the program. If you have any questions about these programs, please contact our Customer Care Center (phone numbers are printed on the back cover of this booklet).

CHAPTER 6

What you pay for your Part D prescription drugs

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

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How can you get information about your drug costs?

Because you are eligible for AHCCCS (Medicaid), you qualify for and are getting "Extra Help" from Medicare to pay for your prescription drug plan costs. Because you are in the "Extra Help" program, **some information in this *Evidence of Coverage* about the costs for Part D prescription drugs may not apply to you.** We have sent you a separate insert, called the "Evidence of Coverage Rider for People Who Get Extra Help Paying for Prescription Drugs" (also known as the "Low Income Subsidy Rider" or the "LIS Rider"), which tells you about your drug coverage. If you don't have this insert, please call our Customer Care Center and ask for the "LIS Rider." (Phone numbers for our Customer Care Center are printed on the back cover of this booklet.)

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, not all drugs are Part D drugs – some drugs are excluded from Part D coverage by law. Some of the drugs excluded from Part D coverage are covered under Medicare Part A or Part B or under AHCCCS (Medicaid).

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.
    - If you need a copy of the Drug List, call our Customer Care Center (phone numbers are printed on the back cover of this booklet). You can also find the Drug List on our website at www.BannerUCA.com. The Drug List on the website is always the most current.
- **Chapter 5 of this booklet.** Chapter 5 gives the details about your prescription drug coverage, including rules you need to follow when you get your covered drugs. Chapter 5 also tells which types of prescription drugs are not covered by our plan.
- **The plan's *Pharmacy Directory.*** In most situations you must use a network pharmacy to get your covered drugs (see Chapter 5 for the details). The *Pharmacy Directory* has a list of pharmacies in the plan's network. It also tells you which pharmacies in our network can give you a long-term supply of a drug (such as filling a prescription for a three-month's supply).

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

To understand the payment information we give you in this chapter, you need to know about the types of out-of-pocket costs you may pay for your covered services. The amount that you pay for a drug is called "cost-sharing," and there are three ways you may be asked to pay.

- The **"deductible"** is the amount you must pay for drugs before our plan begins to pay its share.
- **"Copayment"** means that you pay a fixed amount each time you fill a prescription.
- **"Coinsurance"** means that you pay a percent of the total cost of the drug each time you fill a prescription.

SECTION 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 drug payment stages for Banner – University Care Advantage members?

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

Stage 1 *Yearly Deductible Stage*	**Stage 2** *Initial Coverage Stage*	**Stage 3** *Coverage Gap Stage*	**Stage 4** *Catastrophic Coverage Stage*
If you receive "Extra Help" to pay your prescription drugs, your deductible amount will be either $0 or $89, depending on the level of "Extra Help" you receive. (Look at the separate insert, the "LIS Rider," for your deductible amount.) *If your deductible is $0:* This payment stage does not apply to you. *If your deductible is $89:* **You pay the full cost** of your drugs until you have paid $89 for your drugs. (Details are in Section 4 of this chapter.)	During this stage, the plan pays its share of the cost of your drugs and **you pay your share of the cost.** After you (or others on your behalf) have met your deductible, the plan pays its share of the costs of your drugs and you pay your share. You stay in this stage until your year-to-date **"out-of-pocket costs"** (your payments) reach $6,350. (Details are in Section 5 of this chapter.)	Because there is no coverage gap for the plan, this payment stage does not apply to you.	During this stage, **the plan will pay most of the costs** of your drugs for the rest of the calendar year (through December 31, 2020). (Details are in Section 7 of this chapter.)

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

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

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

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

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

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

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

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

- **Show your membership card when you get a prescription filled.** To make sure we know about the prescriptions you are filling and what you are paying, show your plan membership card every time you get a prescription filled.
- **Make sure we have the information we need.** There are times you may pay for prescription drugs when we will not automatically get the information we need to keep track of your out-of-pocket costs. To help us keep track of your out-of-pocket costs, you may give us copies of receipts for drugs that you have purchased. (If you are billed for a covered drug, you can ask our plan to pay our share of the cost for the drug. For instructions on how to do this, go to Chapter 7, Section 2 of this booklet.) Here are some types of situations when you may want to give us copies of your drug receipts to be sure we have a complete record of what you have spent for your drugs:
    - When you purchase a covered drug at a network pharmacy at a special price or using a discount card that is not part of our plan's benefit
    - When you made a copayment for drugs that are provided under a drug manufacturer patient assistance program
    - Any time you have purchased 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 an AIDS drug assistance program (ADAP), 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 a *Part D Explanation of Benefits* (a Part D EOB) 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 our Customer Care Center (phone numbers are printed on the back cover of this booklet). Be sure to keep these reports. They are an important record of your drug expenses.

SECTION 4 During the Deductible Stage, you pay the full cost of your drugs

Section 4.1 You stay in the Deductible Stage until you have paid $435 for your drugs

Most of our members get "Extra Help" with their prescription drug costs, so the Deductible Stage does not apply to many of them. If you receive "Extra Help," your deductible amount depends on the level of "Extra Help" you receive – you will either:

- Not pay a deductible
- --or-- Pay a deductible of $89.

Look at the separate insert (the "LIS Rider") for information about your deductible amount.

If you do not receive "Extra Help," the Deductible Stage is the first payment stage for your drug coverage. This stage begins when you fill your first prescription in the year. When you are in this payment stage, **you must pay the full cost of your drugs** until you reach the plan's deductible amount, which is $435 for 2020.

- Your **"full cost"** is usually lower than the normal full price of the drug, since our plan has negotiated lower costs for most drugs.
- The **"deductible"** is the amount you must pay for your Part D prescription drugs before the plan begins to pay its share.

Once you have paid $435 for your drugs, you leave the Deductible Stage and move on to the next drug payment stage, which is the Initial Coverage Stage.

SECTION 5 During the Initial Coverage Stage, the plan pays its share of your drug costs and you pay your share

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

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

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 *Pharmacy Directory*.

Section 5.2 A table that shows your costs for a one-*month* supply of a drug

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

- **"Copayment"** means that you pay a fixed amount each time you fill a prescription.
- **"Coinsurance"** means that you pay a percent of the total cost of the drug each time you fill a prescription.

As shown in the table below, the amount of the copayment or coinsurance depends on which cost-sharing tier your drug is in. Please note:

- If your covered drug costs less than the copayment amount listed in the chart, you will pay that lower price for the drug. You pay *either* the full price of the drug *or* the copayment amount, *whichever is lower*.

- We cover prescriptions filled at out-of-network pharmacies in only limited situations. Please see Chapter 5, Section 2.5 for information about when we will cover a prescription filled at an out-of-network pharmacy.

Your share of the cost when you get a *one-month* supply of a covered Part D prescription drug:

Tier	Standard retail cost-sharing (in-network) (up to a 31-day supply)	Long-term care (LTC) cost-sharing (up to a 31-day supply)	Out-of-network cost-sharing (Coverage is limited to certain situations; see Chapter 5 for details.) (up to a 31-day supply)
Generic and brand name drugs treated as generic	$0 copay or $1.30 copay or $3.60 copay or 15% coinsurance per prescription	$0 copay or $1.30 copay or $3.60 copay or 15% coinsurance per prescription	$0 copay or $1.30 copay or $3.60 copay or 15% coinsurance per prescription
Brand name drugs and all other drugs	$0 copay or $3.90 copay or $8.95 copay or 15% coinsurance per prescription	$0 copay or $3.90 copay or $8.95 copay or 15% coinsurance per prescription	$0 copay or $3.90 copay or $8.95 copay or 15% coinsurance per prescription
You are receiving "Extra Help" so your co-payment depends on income and institutional status. If you are not receiving "Extra Help" from Medicare, you will pay a higher amount for your prescription drugs.			

Section 5.3 If your doctor prescribes less than a full month's supply, you may not have to pay the cost of the entire month's supply

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

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

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

- If you are responsible for a copayment for the drug, your copay will be based on the number of days of the drug that you receive. We will calculate the amount you pay per day for your drug (the "daily cost-sharing rate") and multiply it by the number of days of the drug you receive.
    - Here's an example: Let's say the copay for your drug for a full month's supply (a 31-day supply) is $31. This means that the amount you pay per day for your drug is $1. If you receive a 7 days' supply of the drug, your payment will be $1 per day multiplied by 7 days, for a total payment of $7.

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

Section 5.4 A table that shows your costs for a *long-term* (90-day) supply of a drug

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

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

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

Tier	Standard retail cost-sharing (in-network) (90-day supply)	Mail-order cost-sharing (90-day supply)
Generic and brand name drugs treated as generic	$0 copay or $1.30 copay or $3.60 copay or 15% coinsurance per prescription	$0 copay or $1.30 copay or $3.60 copay or 15% coinsurance per prescription
Brand name drugs and all other drugs	$0 copay or $3.90 copay or $8.95 copay or 15% coinsurance per prescription	$0 copay or $3.90 copay or $8.95 copay or 15% coinsurance per prescription
You are receiving "Extra Help" so your co-payment depends on income and institutional status. If you are not receiving "Extra Help" from Medicare, you will pay a higher amount for your prescription drugs.		

Section 5.5 You stay in the Initial Coverage Stage until your out-of-pocket costs for the year reach $6,350

You stay in the Initial Coverage Stage until the total amount for the prescription drugs you have filled and refilled reaches the **$6,350 limit for the Initial Coverage Stage**.

Your total drug cost is based on adding together what you have paid and what any Part D 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. (See Section 6.2 for more information about how Medicare calculates your out-of-pocket costs.) This includes:
  - The total amount you paid when you were in the Deductible Stage, which is either $0 or $89
  - 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. (If you were enrolled in a different Part D plan at any time during 2020, the amount that plan paid during the Initial Coverage Stage also counts toward your total drug costs.)

You stay in the Initial Coverage Stage until your total out-of-pocket costs reach $6,350. Medicare has rules about what counts and what does *not* count as your out-of-pocket costs. (See Section 5.6 for information about how Medicare counts your out-of-pocket costs.) When you reach an out-of-pocket limit of $6,350 you leave the Initial Coverage Gap and move on to the Catastrophic Coverage Stage.

The *Part D Explanation of Benefits* (Part D EOB) that we send to you will help you keep track of how much you and the plan, as well as any third parties, have spent on your behalf during the year. Many people do not reach the $6,350 limit in a year.

We will let you know if you reach this $6,350 amount. If you do reach this amount, you will leave the Initial Coverage Stage and move on to the Catastrophic Coverage Stage.

Section 5.6 How Medicare calculates your out-of-pocket costs for prescription drugs

Medicare has rules about what counts and what does *not* count as your out-of-pocket costs. When you reach an out-of-pocket limit of $6,350, you leave the Initial Coverage Stage and move on to the Catastrophic Coverage Stage.

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

These payments <u>are included</u> in your out-of-pocket costs

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

- The amount you pay for drugs when you are in any of the following drug payment stages:
  - The Deductible Stage
  - The Initial Coverage Stage
- Any payments you made during this calendar year as a member of a different Medicare prescription drug plan before you joined our plan

It matters who pays:

- If you make these payments **yourself**, they are included in your out-of-pocket costs.
- These payments are *also included* if they are made on your behalf by **certain other individuals or organizations.** This includes payments for your drugs made by a friend or relative, by most charities, by AIDS drug assistance programs, or by the

Indian Health Service. Payments made by Medicare's "Extra Help" Program are also included.

Moving on to the Catastrophic Coverage Stage:

When you (or those paying on your behalf) have spent a total of $6,350 in out-of-pocket costs within the calendar year, you will move from the Initial Coverage Stage to the Catastrophic Coverage Stage.

These payments <u>are not included</u> in your out-of-pocket costs

When you add up your out-of-pocket costs, you **<u>are not allowed to include</u>** any of these types of payments for prescription drugs:

- Drugs you buy outside the United States and its territories.
- Drugs that are not covered by our plan.
- Drugs you get at an out-of-network pharmacy that do not meet the plan's requirements for out-of-network coverage.
- Drugs covered by AHCCCS (Medicaid) only.
- Non-Part D drugs, including prescription drugs covered by Part A or Part B and other drugs excluded from coverage by Medicare.
- Payments you make toward prescription drugs not normally covered in a Medicare Prescription Drug Plan.
- Payments made by the plan for your brand or generic drugs while in the Coverage Gap.
- Payments for your drugs that are made by group health plans including employer health plans.
- Payments for your drugs that are made by certain insurance plans and government-funded health programs such as TRICARE and Veterans Affairs.
- Payments for your drugs made by a third-party with a legal obligation to pay for prescription costs (for example, workers' compensation).

Reminder: If any other organization such as the ones listed above pays part or all of your out-of-pocket costs for drugs, you are required to tell our plan. Call our Customer Care Center to let us know (phone numbers are printed on the back cover of this booklet).

How can you keep track of your out-of-pocket total?

- **We will help you**. The *Part D Explanation of Benefits* (Part D EOB) report we send to you includes the current amount of your out-of-pocket costs (Section 3 in this chapter tells about this report). When you reach a total of $6,350 in out-of-pocket costs for the year, this report will tell you that you have left the Initial Coverage Stage and have moved on to the Catastrophic Coverage Stage.

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

SECTION 6 There is no coverage gap for Banner – University Care Advantage

Section 6.1 You do not have a coverage gap for your Part D drugs

There is no coverage gap for Banner – University Care Advantage. Once you leave the Initial Coverage Stage, you move on to the Catastrophic Coverage Stage. See Section 7 for information about your coverage in the Catastrophic Coverage Stage.

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

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

You qualify for the Catastrophic Coverage Stage when your out-of-pocket costs have reached the $6,350 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.

If you receive "Extra Help" to pay for your prescription drugs, your costs for covered drugs will depend on the level of "Extra Help" you receive. During this stage, your share of the cost for a covered drug will be either:

- $0; *or*
- A coinsurance or a copayment, whichever is the *larger* amount:
  - – *either* – Coinsurance of 5% of the cost of the drug
  - –*or* – $3.60 for a generic drug or a drug that is treated like a generic and $8.95 for all other drugs.
  - **Our plan pays the rest** of the cost.

Look at the separate insert (the "LIS Rider") for information about your costs during the Catastrophic Coverage Stage.

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

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

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

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

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

What do you pay for a Part D vaccination?

What you pay for a Part D vaccination depends on three things:

1. **The type of vaccine** (what you are being vaccinated for).
    - Some vaccines are considered medical benefits. You can find out about your coverage of these vaccines by going to Chapter 4, *Benefits Chart (what is covered and what you pay)*.
    - Other vaccines are considered Part D drugs. You can find these vaccines listed in the plan's *List of Covered Drugs (Formulary).*
2. **Where you get the vaccine medication.**
3. **Who gives you the vaccine.**

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 vaccine, you will have to pay the entire cost for both the vaccine medication and for getting the vaccine. You can ask our plan to pay you back for our share of the cost.
- Other times, when you get the vaccine medication or the vaccine, you will pay only your share of the cost.

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

Situation 1: You buy the Part D vaccine at the pharmacy and you get your vaccine 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 and the cost of giving you the vaccine.
- Our plan will pay the remainder of the costs.

Situation 2: You get the Part D vaccination at your doctor's office.

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

Situation 3: You buy the Part D vaccine at your pharmacy, and then take it to your doctor's office where they give you the vaccine.

- You will have to pay the pharmacy the amount of your copayment for the vaccine itself.
- When your doctor gives you the vaccine, you will pay the entire cost for this service. You can then ask our plan to pay you back for our share of the cost by using the procedures described in Chapter 7 of this booklet.
- You will be reimbursed the amount charged by the doctor for administering the vaccine.

Section 8.2 You may want to call us at our Customer Care Center 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 our Customer Care Center whenever you are planning to get a vaccination. (Phone numbers for our Customer Care Center are printed on the back cover of this booklet.)

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

CHAPTER 7

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

Chapter 7. Asking us to pay our share of a bill you have received for covered medical services or drugs

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SECTION 1 Situations in which you should ask us to pay for your covered services or drugs

Section 1.1 If you pay for your covered services or drugs, or if you receive a bill, you can ask us for payment

Our network providers bill the plan directly for your covered services and drugs. If you get a bill for the full cost of medical care or drugs you have received, you should send this bill to us so that we can pay it. When you send us the bill, we will look at the bill and decide whether the services should be covered. If we decide they should be covered, we will pay the provider directly.

If you have already paid for services or drugs covered by the plan, you can ask our plan to pay you back (paying you back is often called "reimbursing" you). It is your right to be paid back by our plan whenever you've paid more than your share of the cost for medical services or drugs that are covered by our plan. When you send us a bill you have already paid, we will look at the bill and decide whether the services or drugs should be covered. If we decide they should be covered, we will pay you back for the services or drugs.

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

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

You can receive emergency services from any provider, whether or not the provider is a part of our network. When you receive emergency or urgently needed services from a provider who is not part of our network, you should ask the provider to bill the plan.

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

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

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

- If you are eligible for Medicare cost-sharing assistance under AHCCCS (Medicaid*),* we do not allow providers to bill you for covered services. We pay our providers directly,

and we protect you from any charges. This is true even if we pay the provider less than the provider charges for a service. For more information about "balance billing," go to Chapter 4, Section 1.3.

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

3. If you are retroactively enrolled in our plan

Sometimes a person's enrollment in the plan is retroactive. (Retroactive means that the first day of their enrollment has already passed. The enrollment date may even have occurred last year.)

If you were retroactively enrolled in our plan and you paid out-of-pocket for any of your covered services or drugs after your enrollment date, you can ask us to pay you back for our share of the costs. You will need to submit paperwork for us to handle the reimbursement. Please contact our Customer Care Center for additional information about how to ask us to pay you back and deadlines for making your request. (Phone numbers for our Customer Care Center are printed on the back cover of this booklet.)

4. 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, 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. (We cover prescriptions filled at out-of-network pharmacies only in a few special situations. Please go to Chapter 5, Section 2.5 to learn more.) Save your receipt and send a copy to us when you ask us to pay you back for our share of the cost.

5. When you pay the full cost for a 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 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.

6. When you pay the full cost for a prescription in other situations

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

- For example, the 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 of the drug.

When you send us a request for payment, we will review your request and decide whether the service or drug should be covered. This is called making a "coverage decision." If we decide it should be covered, we will pay for our share of the cost for the service or drug. If we deny your request for payment, you can appeal our decision. Chapter 9 of this booklet (*What to do if you have a problem or complaint (coverage decisions, appeals, complaints)*) has information about how to make an appeal.

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

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

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

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

Banner – University Care Advantage
Attn: Customer Care Center
2701 E. Elvira Road
Tucson, AZ 85756

Contact our Customer Care Center if you have any questions (phone numbers are printed on the back cover of this booklet). If you don't know what you should have paid, or you receive bills and you don't know what to do about those bills, we can help. You can also call if you want to give us more information about a request for payment you have already sent to us.

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

- If we decide that the medical care or drug is covered and you followed all the rules for getting the care or drug, we will pay for our share of the cost for the service. If you have already paid for the service or drug, we will mail your reimbursement of our share of the cost to you. If you have not paid for the service or drug yet, we will mail the payment directly to the provider. (Chapter 3 explains the rules you need to follow for getting your medical services covered. Chapter 5 explains the rules you need to follow for getting your Part D prescription drugs covered.)
- If we decide that the medical care or drug is *not* covered, or you did *not* follow all the rules, we will not pay for our share of the cost of the care or drug. 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 all or part of 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 or you don't agree with the amount we are paying, you can make an appeal. If you make an appeal, it means you are asking us to change the decision we made when we turned down your request for payment.

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 formal 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 5 of Chapter 9. Section 5 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 5, 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 medical service, go to Section 6.3 in Chapter 9.
- If you want to make an appeal about getting paid back for a drug, go to Section 7.5 of Chapter 9.

SECTION 4 Other situations in which you should save your receipts and send copies to us

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

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

Below is an example of a situation when you should send us copies of 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, we will not pay for any share of these drug costs. But sending a copy of the receipt allows us to calculate your out-of-pocket costs correctly and may help you qualify for the Catastrophic Coverage Stage more quickly.

Since you are not asking for payment in the case described above, this situation is not considered a coverage decision. Therefore, you cannot make an appeal if you disagree with our decision.

CHAPTER 8

Your rights and responsibilities

Chapter 8. Your rights and responsibilities

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

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

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

Our plan has people and free interpreter services available to answer questions from disabled and non-English speaking members. We can also give you information in Braille, in large print, or other alternate formats at no cost if you need it. We are required to give you information about the plan's benefits in a format that is accessible and appropriate for you. To get information from us in a way that works for you, please call our Customer Care Center (phone numbers are printed on the back cover of this booklet) or contact Anna Mayer.

If you have any trouble getting information from our plan in a format that is accessible and appropriate for you, please call to file a grievance with our Customer Care Center at (877) 874-3930. You may also file a complaint with Medicare by calling 1-800-MEDICARE (1-800-633-4227) or directly with the Office for Civil Rights. Contact information is included in this Evidence of Coverage or with this mailing, or you may contact our Customer Care Center for additional information.

Sección 1.1 Debemos proporcionar información de una manera que le vaya bien a usted (en idiomas que no sean el inglés, en Braille, en letras grandes, o en otros formatos alternos, etc.)

Para recibir información nuestra de una manera que le vaya bien a usted, llame a nuestro Centro de Atención al Cliente (los números de teléfono están impresos en la cubierta trasera de este manual).

Nuestro plan tiene servicios de interpretación de idiomas gratuitos para contestar preguntas de miembros con discapacidades y miembros que no hablan inglés. También podemos darle información en Braille, en letras grandes, o en otros formatos alternos sin costo si lo necesita. Se nos requiere que le demos información acerca de los beneficios del plan en un formato que sea accesible y apropiada para usted. Para obtener información de nosotros de una forma que sea adecuada para usted, llame a nuestro Centro de Atención al Cliente (los números de teléfono están impresos en la cubierta trasera de este manual) o comuníquese con Anna Mayer.

Si tiene problemas para recibir información de nuestro plan en un formato que es accesible y apropiado para usted, llame para presentar un agravio con nuestro Centro de Atención al Cliente al (877) 874-3930. También puede presentar una queja con Medicare llamando al 1-800-MEDICARE (1-800-633-4227), o directamente con la Oficina de Derechos Civiles. La

información de contacto está incluida en esta Evidencia de Cobertura o con este paquete, o puede comunicarse con nuestro Centro de Atención al Cliente.

Section 1.2 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 our Customer Care Center to learn which doctors are accepting new patients (phone numbers are printed on the back cover of this booklet). 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.

If you think that you are not getting your medical care or Part D drugs within a reasonable amount of time, Chapter 9, Section 11 of this booklet tells what you can do. (If we have denied coverage for your medical care or drugs and you don't agree with our decision, Chapter 9, Section 5 tells what you can do.)

Section 1.3 We must protect the privacy of your personal health information

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

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

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 work with your health care provider to decide whether the changes should be made.

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

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

Section 1.4 We must give you information about the plan, its network of providers, and your covered services

As a member of Banner – University Care Advantage, 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 our Customer Care Center (phone numbers are printed on the back cover of this booklet):

- **Information about our plan**. This includes, for example, information about the plan's financial condition. It also includes information about the number of appeals made by members and the plan's performance ratings, including how it has been rated by plan members and how it compares to other Medicare health plans.
- **Information about our network providers including our network pharmacies.**
    - For example, you have the right to get information from us about the qualifications of the providers and pharmacies in our network and how we pay the providers in our network.

  - For a list of the providers and pharmacies in the plan's network, see the Provider Directory and Pharmacy Directory.
  - For more detailed information about our providers or pharmacies, you can call our Customer Care Center (phone numbers are printed on the back cover of this booklet) or visit our website at www.BannerUCA.com.

- **Information about your coverage and the rules you must follow when using your coverage.**
  - In Chapters 3 and 4 of this booklet, we explain what medical services are covered for you, any restrictions to your coverage, and what rules you must follow to get your covered medical services.
  - To get the details on your Part D prescription drug coverage, see Chapters 5 and 6 of this booklet plus the plan's *List of Covered Drugs (Formulary).* These chapters, together with the *List of Covered Drugs (Formulary)*, tell you what drugs are covered and explain the rules you must follow and the restrictions to your coverage for certain drugs.
  - If you have questions about the rules or restrictions, please call our Customer Care Center (phone numbers are printed on the back cover of this booklet).
- **Information about why something is not covered and what you can do about it.**
  - If a medical service or Part D drug is not covered for you, or if your coverage is restricted in some way, you can ask us for a written explanation. You have the right to this explanation even if you received the medical service or drug from an out-of-network provider or pharmacy.
  - If you are not happy or if you disagree with a decision we make about what medical care or Part D drug is covered for you, you have the right to ask us to change the decision. You can ask us to change the decision by making an appeal. For details on what to do if something is not covered for you in the way you think it should be covered, see Chapter 9 of this booklet. It gives you the details about how to make an appeal if you want us to change our decision. (Chapter 9 also tells about how to make a complaint about quality of care, waiting times, and other concerns.)
  - If you want to ask our plan to pay our share of a bill you have received for medical care or a Part D prescription drug, see Chapter 7 of this booklet.

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

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

You have the right to get full information from your doctors and other health care providers 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.

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

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

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

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

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

- **Get the form.** If you want to have an advance directive, you can get a form from your lawyer, from a social worker, or from some office supply stores. You can sometimes get advance directive forms from organizations that give people information about Medicare.

You can also contact our Customer Care Center to ask for the forms (phone numbers are printed on the back cover of this booklet).

- **Fill it out and sign it.** Regardless of where you get this form, keep in mind that it is a legal document. You should consider having a lawyer help you prepare it.
- **Give copies to appropriate people.** You should give a copy of the form to your doctor and to the person you name on the form as the one to make decisions for you if you can't. You may want to give copies to close friends or family members as well. Be sure to keep a copy at home.

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

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

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

What if your instructions are not followed?

If you have signed an advance directive, and you believe that a doctor or hospital did not follow the instructions in it, you may file a complaint with the Arizona Medical Board at (877) 255-2212.

Section 1.6 You have the right to make complaints and to ask us to reconsider decisions we have made

If you have any problems or concerns about your covered services or care, Chapter 9 of this booklet tells what you can do. It gives the details about how to deal with all types of problems and complaints. What you need to do to follow up on a problem or concern depends on the situation. You might need to ask our plan to make a coverage decision for you, make an appeal to us to change a coverage decision, or make a complaint. Whatever you do – ask for a coverage decision, make an appeal, or make a complaint – **we are required to treat you fairly**.

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 our Customer Care Center (phone numbers are printed on the back cover of this booklet).

Section 1.7 What can you do if you believe 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 believe you have been treated unfairly or your rights have not been respected due to your race, disability, religion, sex, health, ethnicity, creed (beliefs), age, or national origin, you should call the Department of Health and Human Services' **Office for Civil Rights** at 1-800-368-1019 or TTY 1-800-537-7697, or call your local Office for Civil Rights.

Is it about something else?

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

- You can **call our Customer Care Center** (phone numbers are printed on the back 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.
- Or, **you can call Medicare** at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

Section 1.8 How to get more information about your rights

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

- You can **call our Customer Care Center** (phone numbers are printed on the back cover of this booklet).
- You can **call the State Health Insurance Assistance Program**. For details about this organization and how to contact it, go to Chapter 2, Section 3.
- You can contact **Medicare**.
    - You can visit the Medicare website to read or download the publication "Medicare Rights & Protections." (The publication is available at: https://www.medicare.gov/Pubs/pdf/11534-Medicare-Rights-and-Protections.pdf.)
    - Or, you can call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY 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 our Customer Care Center (phone numbers are printed on the back cover of this booklet). We're here to help.

- **Get familiar with your covered services and the rules you must follow to get these covered services**. Use this Evidence of Coverage booklet to learn what is covered for you and the rules you need to follow to get your covered services.
    - Chapters 3 and 4 give the details about your medical services, including what is covered, what is not covered, rules to follow, and what you pay.
    - 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 our Customer Care Center to let us know (phone numbers are printed on the back cover of this booklet).
    - We are required to follow rules set by Medicare and AHCCCS (Medicaid) to make sure that you are using all of your coverage in combination when you get your covered services from our plan. This is called "**coordination of benefits**" because it involves coordinating the health and drug benefits you get from our plan with any other health and drug benefits available to you. We'll help you coordinate your benefits. (For more information about coordination of benefits, go to Chapter 1, Section 7.)
- **Tell your doctor and other health care providers that you are enrolled in our plan.** Show your plan membership card and your AHCCCS (Medicaid) card whenever you get your medical care or Part D prescription drugs.
- **Help your doctors and other providers help you by giving them information, asking questions, and following through on your care.**
    - To help your doctors and other health providers give you the best care, learn as much as you are able to about your health problems and give them the information they need about you and your health. Follow the treatment plans and instructions that you and your doctors agree upon.
    - Make sure your doctors know all of the drugs you are taking, including over-the-counter drugs, vitamins, and supplements.
    - If you have any questions, be sure to ask. Your doctors and other health care providers are supposed to explain things in a way you can understand. If you ask a question and you don't understand the answer you are given, ask again.

- **Be considerate.** We expect all our members to respect the rights of other patients. We also expect you to act in a way that helps the smooth running of your doctor's office, hospitals, and other offices.
- **Pay what you owe**. As a plan member, you are responsible for these payments:
    - In order to be eligible for our plan, you must have Medicare Part A and Medicare Part B. For most Banner – University Care Advantage members, AHCCCS (Medicaid) pays for your Part A premium (if you don't qualify for it automatically) and for your Part B premium. If AHCCCS (Medicaid) is not paying your Medicare premiums for you, you must continue to pay your Medicare premiums to remain a member of the plan.
    - For most of your medical services or drugs covered by the plan, you must pay your share of the cost when you get the service or drug. This will be a copayment (a fixed amount) or coinsurance (a percentage of the total cost). Chapter 4 tells what you must pay for your medical services. Chapter 6 tells what you must pay for your Part D prescription drugs.
    - 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.
        - If you disagree with our decision to deny coverage for a service or drug, you can make an appeal. Please see Chapter 9 of this booklet for information about how to make an appeal.
    - If you are required to pay a late enrollment penalty, you must pay the penalty to keep your prescription drug coverage.
    - If you are required to pay the extra amount for Part D because of your higher income (as reported on your last tax return), you must pay the extra amount directly to the government to remain a member of the plan.
- **Tell us if you move.** If you are going to move, it's important to tell us right away. Call our Customer Care Center (phone numbers are printed on the back 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 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.
    - If you move, it is also important to tell Social Security (or the Railroad Retirement Board). You can find phone numbers and contact information for these organizations in Chapter 2.
- **Call our Customer Care Center 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 our Customer Care Center are printed on the back 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, complaints)

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

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BACKGROUND

SECTION 1 Introduction

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

This chapter explains the processes for handling problems and concerns. The process you use to handle your problem depends on two things:

1. Whether your problem is about benefits covered by **Medicare** or **Medicaid**. If you would like help deciding whether to use the Medicare process or the Medicaid process, or both, please contact our Customer Care Center (phone numbers are printed on the back cover of this booklet).

2. The type of problem you are having:
    - For some types of problems, you need to use the **process for coverage decisions and appeals**.
    - For other types of problems, you need to use the **process for making complaints**.

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

Which one do you use? 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” or “at-risk 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.

Get help from an independent government organization

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

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

You can also get help and information from Medicare

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

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

You can get help and information from AHCCCS (Medicaid)

For more information on AHCCCS (Medicaid) you can call the AHCCCS Applicant and Customer Care Center at 1(855) HEA-PLUS (1-855-432-7587), Monday through Friday 8 a.m. - 5 p.m. AZ Relay Service for the hearing impaired: 1-800-367-8939. If you are experiencing any delays or need help in accessing behavioral health services, call the AHCCCS Clinical Resolution Unit at 1-800-867-5808. For AHCCCS (Medicaid) mailing address and website information, please see Chapter 2, section 6 in the front of this booklet.

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

Section 3.1 Should you use the process for Medicare benefits or Medicaid benefits?

Because you have Medicare and get assistance from Medicaid, you have different processes that you can use to handle your problem or complaint. Which process you use depends on whether the problem is about Medicare benefits or Medicaid benefits. If your problem is about a benefit covered by Medicare, then you should use the Medicare process. If your problem is about a benefit covered by Medicaid, then you should use the Medicaid process. If you would like help deciding whether to use the Medicare process or the Medicaid process, please contact our Customer Care Center (phone numbers are printed on the back cover of this booklet).

The Medicare process and Medicaid process are described in different parts of this chapter. To find out which part you should read, use the chart below.

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

Is your problem about Medicare benefits or Medicaid benefits?

(If you would like help deciding whether your problem is about Medicare benefits or Medicaid benefits, please contact our Customer Care Center. Phone numbers for our Customer Care Center are printed on the back cover of this booklet.)

My problem is about **Medicare** benefits.

Go to the next section of this chapter, **Section 4, "Handling problems about Medicare your benefits."**

My problem is about **Medicaid** coverage.

Skip ahead to **Section 12** of this chapter, **"Handling problems about your Medicaid benefits."**

PROBLEMS ABOUT YOUR MEDICARE BENEFITS

SECTION 4 Handling problems about your Medicare benefits

Section 4.1 Should you use the process for coverage decisions and appeals? Or should you use the process for making complaints?

If you have a problem or concern, you only need to read the parts of this chapter that apply to your situation. The chart below will help you find the right section of this chapter for problems or complaints about **benefits covered by Medicare**.

To figure out which part of this chapter will help with your problem or concern about your **Medicare** benefits, use this chart:

Is your problem or concern about your benefits or coverage?

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

Yes. My problem is about benefits or coverage.

Go on to the next section of this chapter, **Section 5, "A guide to the basics of coverage decisions and appeals."**

No. My problem is not about benefits or coverage.

Skip ahead to **Section 11** at the end of this chapter: **"How to make a complaint about quality of care, waiting times, customer service or other concerns."**

SECTION 5 A guide to the basics of coverage decisions and appeals

Section 5.1 Asking for coverage decisions and making appeals: the big picture

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

Asking for coverage decisions

A coverage decision is a decision we make about your benefits and coverage or about the amount we will pay for your medical services or drugs. We are making a coverage decision whenever we decide what is covered for you and how much we pay. For example, your plan network doctor makes a (favorable) coverage decision for you whenever you receive medical care from him or her or if your network doctor refers you to a medical specialist. You or your doctor can also contact us and ask for a coverage decision if your doctor is unsure whether we will cover a particular medical service or refuses to provide medical care you think that you need. In other words, if you want to know if we will cover a medical service before you receive it, you can ask us to make a coverage decision for you.

In some cases, we might decide a service or drug is not covered or is no longer covered by Medicare for you. If you disagree with this coverage decision, you can make an appeal.

Making an appeal

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

When you appeal a decision for the first time, this is called a Level 1 Appeal. In this appeal, we review the coverage decision we made to check to see if we were following all of the rules properly. Your appeal is handled by different reviewers than those who made the original unfavorable decision. When we have completed the review we give you our decision. Under certain circumstances, which we discuss later, you can request an expedited or "fast coverage decision" or fast appeal of a coverage decision.

If we say no to all or part of your Level 1 Appeal, you can go on to a Level 2 Appeal. The Level 2 Appeal is conducted by an independent organization that is not connected to us. (In some situations, your case will be automatically sent to the independent organization for a Level 2 Appeal. In other situations, you will need to ask for a Level 2 Appeal.) If you are not satisfied with the decision at the Level 2 Appeal, you may be able to continue through additional levels of appeal.

Section 5.2 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 our Customer Care Center** (phone numbers are printed on the back cover of this booklet).
- To **get free help from an independent organization** that is not connected with our plan, contact your State Health Insurance Assistance Program (see Section 2 of this chapter).
- **Your doctor can make a request for you.**
    - For medical care, your doctor can request a coverage decision or a Level 1 Appeal on your behalf. If your appeal is denied at Level 1, it will be automatically forwarded to Level 2. To request any appeal after Level 2, your doctor must be appointed as your representative.
    - For Part D prescription drugs, your doctor or other prescriber can request a coverage decision or a Level 1 or Level 2 Appeal on your behalf. To request any appeal after Level 2, your doctor or other prescriber must be appointed as your representative.
- **You can ask someone to act on your behalf.** If you want to, you can name another person to act for you as your "representative" to ask for a coverage decision or make an appeal.
    - There may be someone who is already legally authorized to act as your representative under State law.
    - If you want a friend, relative, your doctor or other provider, or other person to be your representative, call our Customer Care Center (phone numbers are printed on the back cover of this booklet) and ask for the "Appointment of Representative" form. (The form is also available on Medicare's website at https://www.cms.hhs.gov/cmsforms/downloads/cms1696.pdf or on our website at www.BannerUCA.com.) The form gives that person permission to act on your behalf. It must be signed by you and by the person who you would like to act on your behalf. You must give us a copy of the signed form.
- **You also have the right to hire a lawyer to act for you.** You may contact your own lawyer, or get the name of a lawyer from your local bar association or other referral service. There are also groups that will give you free legal services if you qualify. However, **you are not required to hire a lawyer** to ask for any kind of coverage decision or appeal a decision.

Section 5.3 Which section of this chapter gives the details for your situation?

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

- **Section 6** of this chapter: "Your medical care: How to ask for a coverage decision or make an appeal"
- **Section 7** of this chapter: "Your Part D prescription drugs: How to ask for a coverage decision or make an appeal"
- **Section 8** of this chapter: "How to ask us to cover a longer inpatient hospital stay if you think the doctor is discharging you too soon"
- **Section 9** of this chapter: "How to ask us to keep covering certain medical services if you think your coverage is ending too soon" (*Applies to these services only*: home health care, skilled nursing facility care, and Comprehensive Outpatient Rehabilitation Facility (CORF) services)

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

SECTION 6 Your medical care: How to ask for a coverage decision or make an appeal

Have you read Section 5 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 what to do if you have problems getting coverage for medical care or if you want us to pay you back for our share of the cost of your care

This section is about your benefits for medical care and services. These benefits are described in Chapter 4 of this booklet: *Benefits Chart (what is covered and what you pay*). To keep things simple, we generally refer to "medical care coverage" or "medical care" in the rest of this section, instead of repeating "medical care or treatment or services" every time. The term "medical care" includes medical items and services as well as Medicare Part B prescription drugs. In some cases, different rules apply to a request for a Part B prescription drug. In those

cases, we will explain how the rules for Part B prescription drugs are different from the rules for medical items and services.

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

1. You are not getting certain medical care you want, and you believe that this care is covered by our plan.
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 medical care or services that you believe should be covered by the plan, and you want to ask our plan to reimburse you for this care.
5. You are being told that coverage for certain medical care you have been getting that we previously approved will be reduced or stopped, and you believe that reducing or stopping this care could harm your health.
    - 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 8: *How to ask us to cover a longer inpatient hospital stay if you think the doctor is discharging you too soon.*
        - Chapter 9, Section 9: *How to ask us to keep covering certain medical services if you think your coverage is ending too soon.* This section is about three services only: home health care, skilled nursing facility care, and Comprehensive Outpatient Rehabilitation Facility (CORF) services.
    - For *all other* situations that involve being told that medical care you have been getting will be stopped, use this section (Section 6) as your guide for what to do.

Which of these situations are you in?

If you are in this situation:	This is what you can do:
Do you want to find out whether we will cover the medical care or services you want?	You can ask us to make a coverage decision for you. Go to the next section of this chapter, **Section 6.2**.
Have we already told you that we will not cover or pay for a medical service in the way that you want it to be covered or paid for?	You can make an **appeal**. (This means you are asking us to reconsider.) Skip ahead to **Section 6.3** of this chapter.
Do you want to ask us to pay you back for medical care or services you have already received and paid for?	You can send us the bill. Skip ahead to **Section 6.5** of this chapter.

Section 6.2 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."**

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

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

How to request coverage for the medical care you want

- Start by calling, writing, or faxing our plan to make your request for us to authorize or provide coverage for the medical care you want. You, your doctor, or your representative can do this.

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

Generally, we use the standard deadlines for giving you our decision

When we give you our decision, we will use the "standard" deadlines unless we have agreed to use the "fast" deadlines. **A standard coverage decision means we will give you an answer within 14 calendar days** after we receive your request **for a medical item or service.** If your request is for a **Medicare Part B prescription drug, we will give you an answer within 72 hours** after we receive your request.

- **However,** for a request **for a medical item or service, we can take up to 14 more calendar days** if you ask for more time, or if we need information (such as medical records from out-of-network providers) that may benefit you. If we decide to take extra days to make the decision, we will tell you in writing. We can't take extra time to make a decision if your request is for a Medicare Part B prescription drug.
- If you believe we should *not* take extra days, you can file a "fast complaint" about our decision to take extra days. When you file a fast complaint, we will give you an answer to your complaint within 24 hours. (The process for making a complaint is different from the process for coverage decisions and appeals. For more information about the process for making complaints, including fast complaints, see Section 11 of this chapter.)

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

- **A fast coverage decision means we will answer within 72 hours if your request is for a medical item or service. If your request is for a Medicare Part B prescription drug, we will answer within 24 hours.**
    - **However,** for a request **for a medical item or service, we can take up to 14 more calendar days** if we find that some information that may benefit you is missing (such as medical records from out-of-network providers), or if you need time to get information to us for the review. If we decide to take extra days, we will tell you in writing. We can't take extra time to make a decision if your request is for a Medicare Part B prescription drug.
    - If you believe we should *not* take extra days, you can file a "fast complaint" about our decision to take extra days. (For more information about the process for making complaints, including fast complaints, see Section 11 of this chapter.) We will call you as soon as we make the decision.
- **To get a fast coverage decision, you must meet two requirements:**
    - You can get a fast coverage decision *only* if you are asking for coverage for medical care *you have not yet received*. (You cannot get a fast coverage decision if your request is about payment for medical care you have already received.)

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

- **If your doctor tells us that your health requires a "fast coverage decision," we will automatically agree to give you a fast coverage decision.**
- If you ask for a fast coverage decision on your own, without your doctor's support, we will decide whether your health requires that we give you a fast coverage decision.
  - If we decide that your medical condition does not meet the requirements for a fast coverage decision, we will send you a letter that says so (and we will use the standard deadlines instead).
  - This letter will tell you that if your doctor asks for the fast coverage decision, we will automatically give a fast coverage decision.
  - The letter will also tell how you can file a "fast complaint" about our decision to give you a standard coverage decision instead of the fast coverage decision you requested. (For more information about the process for making complaints, including fast complaints, see Section 11 of this chapter.)

Step 2: We consider your request for medical care coverage and give you our answer.

Deadlines for a "fast" coverage decision

- Generally, for a fast coverage decision on a request for a medical item or service, we will give you our answer **within 72 hours**. If your request is for a Medicare Part B prescription drug, we will answer **within 24 hours**.
  - As explained above, we can take up to 14 more calendar days under certain circumstances. If we decide to take extra days to make the coverage decision, we will tell you in writing. We can't take extra time to make a decision if your request is for a Medicare Part B prescription drug.
  - If you believe we should *not* take extra days, you can file a "fast complaint" about our decision to take extra days. When you file a fast complaint, we will give you an answer to your complaint within 24 hours. (For more information about the process for making complaints, including fast complaints, see Section 11 of this chapter.)
  - If we do not give you our answer within 72 hours (or if there is an extended time period, by the end of that period), or 24 hours if your request is for a Part B prescription drug, you have the right to appeal. Section 6.3 below tells how to make an appeal.
- **If our answer is yes to part or all of what you requested,** we must authorize or provide the medical care coverage we have agreed to provide within 72 hours after we received your request. If we extended the time needed to make our coverage

decision on your request for a medical item or service, we will authorize or provide the coverage by the end of that extended period.

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

Deadlines for a "standard" coverage decision

- Generally, for a standard coverage decision on your request for a medical item or service, we will give you our answer **within 14 calendar days of receiving your request.** If your request is for a Medicare Part B prescription drug, we will give you an answer **within 72 hours** of receiving your request.
    - For a request for a medical item or service, we can take up to 14 more calendar days ("an extended time period") under certain circumstances. If we decide to take extra days to make the coverage decision, we will tell you in writing. We can't take extra time to make a decision if your request is for a Medicare Part B prescription drug.
    - If you believe we should *not* take extra days, you can file a "fast complaint" about our decision to take extra days. When you file a fast complaint, we will give you an answer to your complaint within 24 hours. (For more information about the process for making complaints, including fast complaints, see Section 11 of this chapter.)
    - If we do not give you our answer within 14 calendar days (or if there is an extended time period, by the end of that period), or 72 hours if your request is for a Part B prescription drug, you have the right to appeal. Section 6.3 below tells how to make an appeal.
- **If our answer is yes to part or all of what you requested,** we must authorize or provide the coverage we have agreed to provide within 14 calendar days, or 72 hours if your request is for a Part B prescription drug, after we received your request. If we extended the time needed to make our coverage decision on your request for a medical item or service, we will authorize or provide the coverage by the end of that extended period.
- **If our answer is no to part or all of what you requested**, we will send you a written statement that explains why we said no.

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

- If we say no, you have the right to ask us to reconsider – and perhaps change – this decision by making an appeal. Making an appeal means making another try to get the medical care coverage you want.
- If you decide to make an appeal, it means you are going on to Level 1 of the appeals process (see Section 6.3 below).

Section 6.3 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
An appeal to the plan about a medical care coverage decision is called a plan **"reconsideration."**

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

What to do

- **To start an appeal you, your doctor, or your representative, must contact us.** For details on how to reach us for any purpose related to your appeal, go to Chapter 2, Section 1 and look for the section called *How to contact us when you are making an appeal about your medical care.*
- **If you are asking for a standard appeal, make your standard appeal in writing by submitting a request.** You may also ask for an appeal by calling us at the phone number shown in Chapter 2, Section 1 (*How to contact us when you are making an appeal about your medical care*).
    - If you have someone appealing our decision for you other than your doctor, your appeal must include an Appointment of Representative form authorizing this person to represent you. (To get the form, call our Customer Care Center (phone numbers are printed on the back cover of this booklet) and ask for the "Appointment of Representative" form. It is also available on Medicare's website at https://www.cms.hhs.gov/cmsforms/downloads/cms1696.pdf or on our website at www.BannerUCA.com.) While we can accept an appeal request without the form, we cannot begin or complete our review until we receive it. If we do not receive the form within 44 calendar days after receiving your appeal request (our deadline for making a decision on your appeal), your appeal request will be dismissed. If this happens, we will send you a written notice explaining your right to ask the Independent Review Organization to review our decision to dismiss your appeal.
- **If you are asking for a fast appeal, make your appeal in writing or call us** at the phone number shown in Chapter 2, Section 1 (*How to contact us when you are making an appeal about your medical care*).
- **You must make your appeal request within 60 calendar days** from the date on the written notice we sent to tell you our answer to your request for a coverage decision. If you miss this deadline and have a good reason for missing it, we may give you more time to make your appeal. Examples of good cause for missing the

deadline may include if you had a serious illness that prevented you from contacting us or if we provided you with incorrect or incomplete information about the deadline for requesting an appeal.

- **You can ask for a copy of the information 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.
  - 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 a request by calling us)

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

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

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

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

Deadlines for a "fast" appeal

- When we are using the fast deadlines, we must give you our answer **within 72 hours after we receive your appeal**. We will give you our answer sooner if your health requires us to do so.
  - However, if you ask for more time, or if we need to gather more information that may benefit you, we **can take up to 14 more calendar days** if your request is for a medical item or service**.** If we decide to take extra days to make the

decision, we will tell you in writing. We can't take extra time to make a decision if your request is for a Medicare Part B prescription drug.

- If we do not give you an answer within 72 hours (or by the end of the extended time period if we took extra days), we are required to automatically send your request on to Level 2 of the appeals process, where it will be reviewed by an independent organization. Later in this section, we tell you about this organization and explain what happens at Level 2 of the appeals process.

- **If our answer is yes to part or all of what you requested,** we must authorize or provide the coverage we have agreed to provide within 72 hours after we receive your appeal.
- **If our answer is no to part or all of what you requested,** we will automatically send your appeal to the Independent Review Organization for a Level 2 Appeal.

Deadlines for a "standard" appeal

- If we are using the standard deadlines, we must give you our answer on a request for a medical item or service **within 30 calendar days** after we receive your appeal if your appeal is about coverage for services you have not yet received. If your request is for a Medicare Part B prescription drug, we will give you our answer **within 7 calendar days** after we receive your appeal if your appeal is about coverage for a Part B prescription drug you have not yet received. We will give you our decision sooner if your health condition requires us to.
  - However, if you ask for more time, or if we need to gather more information that may benefit you, **we can take up to 14 more calendar days** if your request is for a medical item or service. If we decide to take extra days to make the decision, we will tell you in writing. We can't take extra time to make a decision if your request is for a Medicare Part B prescription drug.
  - If you believe we should *not* take extra days, you can file a "fast complaint" about our decision to take extra days. When you file a fast complaint, we will give you an answer to your complaint within 24 hours. (For more information about the process for making complaints, including fast complaints, see Section 11 of this chapter.)
  - If we do not give you an answer by the applicable deadline above (or by the end of the extended time period if we took extra days on your request for a medical item or service), 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 talk 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 calendar days, or **within 7 calendar days** if your request is for a Medicare Part B prescription drug, after we receive your appeal.

- **If our answer is no to part or all of what you requested**, we will automatically send your appeal to the Independent Review Organization for a Level 2 Appeal.

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

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

Section 6.4 Step-by-step: How a Level 2 Appeal is done

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

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

Step 1: The Independent Review Organization reviews your appeal.

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

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

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

- However, if your request is for a medical item or service and the Independent Review Organization needs to gather more information that may benefit you, **it can take up to 14 more calendar days**. The Independent Review Organization can't take extra time to make a decision if your request is for a Medicare Part B prescription drug.

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

- If you had a standard appeal to our plan at Level 1, you will automatically receive a standard appeal at Level 2. If your request is for a medical item or service, the review organization must give you an answer to your Level 2 Appeal **within 30 calendar days** of when it receives your appeal. If your request is for a Medicare Part B prescription drug, the review organization must give you an answer to your Level 2 Appeal **within 7 calendar days** of when it receives your appeal.
- However, if your request is for a medical item or service and the Independent Review Organization needs to gather more information that may benefit you, **it can take up to 14 more calendar days**. The Independent Review Organization can't take extra time to make a decision if your request is for a Medicare Part B prescription drug.

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

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

- **If the review organization says yes to part or all of a request for a medical item or service,** we must authorize the medical care coverage within 72 hours or provide the service within 14 calendar days after we receive the decision from the review organization for standard requests or within 72 hours from the date we receive the decision from the review organization for expedited requests.
- **If the review organization says yes to part or all of a request for a Medicare Part B prescription drug,** we must authorize or provide the Part B prescription drug under dispute within **72 hours** after we receive the decision from the review organization for **standard requests** or within **24 hours** from the date we receive the decision from the review organization for **expedited requests.**
- **If this organization says no to part or all of your appeal**, it means they agree with 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.")
    - If the Independent Review Organization "upholds the decision" you have the right to a Level 3 Appeal. However, to make another appeal at Level 3, the dollar value of the medical care coverage you are requesting must meet a certain minimum. If the dollar value of the coverage you are requesting is too low, you cannot make another appeal, which means that the decision at Level 2 is final. The written notice you get from the Independent Review

Organization will tell you how to find out the dollar amount to continue the appeals process.

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

- There are three additional levels in the appeals process after Level 2 (for a total of five levels of appeal).
- If your Level 2 Appeal is turned down and you meet the requirements to continue with the appeals process, you must decide whether you want to go on to Level 3 and make a third appeal. The details on how to do this are in the written notice you got after your Level 2 Appeal.
- The Level 3 Appeal is handled by an Administrative Law Judge or attorney adjudicator. Section 10 in this chapter tells more about Levels 3, 4, and 5 of the appeals process.

Section 6.5 What if you are asking us to pay you back for our share of a bill you have received for medical care?

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

Asking for reimbursement is asking for a coverage decision from us

If you send us the paperwork that asks for reimbursement, you are asking us to make a coverage decision (for more information about coverage decisions, see Section 5.1 of this chapter). To make this coverage decision, we will check to see if the medical care you paid for is a covered service (see Chapter 4: *Benefits Chart (what is covered and what you pay)*). We will also check to see if you followed all the rules for using your coverage for medical care (these rules are given in Chapter 3 of this booklet: *Using the plan's coverage for your medical services*).

We will say yes or no to your request

- If the medical care you paid for is covered and you followed all the rules, we will send you the payment for our share of the cost of your medical care within 60 calendar days after we receive your request. Or, if you haven't paid for the services, we will send the payment directly to the provider. When we send the payment, it's the same as saying *yes* to your request for a coverage decision.)
- If the medical care is *not* covered, or you did *not* follow all the rules, we will not send payment. Instead, we will send you a letter that says we will not pay for the services and

the reasons why in detail. (When we turn down your request for payment, it's the same as saying *no* to your request for a coverage decision.)

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

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

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

- If you make an appeal for reimbursement, we must give you our answer within 60 calendar days after we receive your appeal. (If you are asking us to pay you back for medical care you have already received and paid for yourself, you are not allowed to ask for a fast appeal.)
- If the Independent Review Organization reverses our decision to deny payment, we must send the payment you have requested to you or to the provider within 30 calendar days. If the answer to your appeal is yes at any stage of the appeals process after Level 2, we must send the payment you requested to you or to the provider within 60 calendar days.

SECTION 7 Your Part D prescription drugs: How to ask for a coverage decision or make an appeal

Have you read Section 5 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 7.1 This section tells you what to do if you have problems getting a Part D drug or you want us to pay you back for a Part D drug

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

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

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

Part D coverage decisions and appeals

As discussed in Section 5 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
An initial coverage decision about your Part D drugs 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 (Formulary)*
  - Asking us to waive a restriction on the plan's coverage for a drug (such as limits on the amount of the drug you can get)
- You ask us whether a drug is covered for you and whether you meet the requirements for coverage. (For example, when your drug is on the plan's *List of Covered Drugs (Formulary)* but we require you to get approval from us before we will cover it for you.)
  - *Please note:* If your pharmacy tells you that your prescription cannot be filled as written, you will get a written notice explaining how to contact us to ask for a coverage decision.
- 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 the chart below to help you determine which part has information for your situation:

Which of these situations are you in?

If you are in this situation:	This is what you can do:
Do you need a drug that isn't on our Drug List or need us to waive a rule or restriction on a drug we cover?	You can ask us to make an exception. (This is a type of coverage decision.) Start with **Section 7.2** of this chapter.
Do you want us to cover a drug on our Drug List and you believe you meet any plan rules or restrictions (such as getting approval in advance) for the drug you need?	You can ask us for a coverage decision. Skip ahead to **Section 7.4** of this chapter.
Do you want to ask us to pay you back for a drug you have already received and paid for?	You can ask us to pay you back. (This is a type of coverage decision.) Skip ahead to **Section 7.4** of this chapter.
Have we already told you that we will not cover or pay for a drug in the way that you want it to be covered or paid for?	You can make an appeal. (This means you are asking us to reconsider.) Skip ahead to **Section 7.5** of this chapter.

Section 7.2 What is an exception?

If a drug is not covered in the way you would like it to be covered, you can ask us 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 two 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 *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 all of our drugs. You cannot

ask for an exception to the copayment or coinsurance amount we require you to pay for the drug.

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

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.

Section 7.3 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 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.

We 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 7.5 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 7.4 Step-by-step: How to ask for a coverage decision, including an exception

Step 1: You ask us 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 coverage decision." You cannot ask for a fast coverage 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 us to make your request. You, your representative, or your doctor (or other prescriber) can do this. You can also access the coverage decision process through our website. For the details, go to Chapter 2, Section 1 and look for the section called *How to contact us when you are asking for a coverage decision about your 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 5 of this chapter tells how you can give written permission to someone else to act as your representative. You can also have a lawyer act on your behalf.
- **If you want to ask us to pay you back for a drug,** start by reading Chapter 7 of this booklet: *Asking us to pay our share of a bill you have received for covered medical services or drugs.* Chapter 7 describes the situations in which you may need to ask for reimbursement. It also tells how to send us the paperwork that asks us to pay you back for our share of the cost of a drug you have paid for.
- **If you are requesting an exception, provide the "supporting statement."** Your doctor or other prescriber must give us the medical reasons for the drug exception you are requesting. (We call this the "supporting statement.") Your doctor or other prescriber can fax or mail the statement to us. Or your doctor or other prescriber can tell us on the phone and follow up by faxing or mailing a written statement if necessary. See Sections 6.2 and 6.3 for more information about exception requests.
- **We must accept any written request,** including a request submitted on the CMS Model Coverage Determination Request Form, which is available on our website.

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

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

- When we give you our decision, we will use the "standard" deadlines unless we have agreed to use the "fast" deadlines. A standard coverage decision means we will give you an answer within 72 hours after we receive your doctor's statement. A fast coverage decision means we will answer within 24 hours after we receive your doctor's statement.
- **To get a fast coverage decision, you must meet two requirements:**
  - You can get a fast coverage decision *only* if you are asking for a *drug you have not yet received*. (You cannot get a fast coverage decision if you are asking us to pay you back for a drug you have already bought.)
  - You can get a fast coverage decision *only* if using the standard deadlines could *cause serious harm to your health or hurt your ability to function.*
- **If your doctor or other prescriber tells us that your health requires a "fast coverage decision," we will automatically agree to give you a fast coverage decision.**
- If you ask for a fast coverage decision on your own (without your doctor's or other prescriber's support), we will decide whether your health requires that we give you a fast coverage decision.
  - If we decide that your medical condition does not meet the requirements for a fast coverage decision, we will send you a letter that says so (and we will use the standard deadlines instead).
  - This letter will tell you that if your doctor or other prescriber asks for the fast coverage decision, we will automatically give a fast coverage decision.
  - The letter will also tell how you can file a complaint about our decision to give you a standard coverage decision instead of the fast coverage decision you requested. It tells how to file a "fast" complaint, which means you would get our answer to your complaint within 24 hours of receiving the complaint. (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 11 of this chapter.)

Step 2: We consider 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 talk about this review organization and explain what happens at Appeal Level 2.

- **If our answer is yes to part or all of what you requested,** we 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. We will also tell you how to appeal.

Deadlines for a "standard" coverage decision about a 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 talk about this review organization and explain what happens at Appeal Level 2.
- **If our answer is yes to part or all of what you requested –**
  - 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. We will also tell you how to appeal.

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 talk about this review organization and explain what happens at Appeal Level 2.
- **If our answer is yes to part or all of what you requested,** we are also required to make payment to you within 14 calendar days after we receive your request.
- **If our answer is no to part or all of what you requested**, we will send you a written statement that explains why we said no. We will also tell you how to appeal.

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

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

Section 7.5 Step-by-step: How to make a Level 1 Appeal (how to ask for a review of a coverage decision made by our plan)

Legal Terms
An appeal to the plan about a Part D drug coverage decision is called a plan **"redetermination."**

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

What to do

- **To start your appeal, you (or your representative or your doctor or other prescriber) must contact us.**
  - For details on how to reach us by phone, fax, or mail, or on our website for any purpose related to your appeal, go to Chapter 2, Section 1, and look for the section called *How to contact us when you are making an appeal about your Part D prescription drugs.*
- **If you are asking for a standard appeal, make your appeal by submitting a written request.**
- **If you are asking for a fast appeal, you may make your appeal in writing or you may call us at the phone number shown in Chapter 2, Section 1** *(How to contact our plan when you are making an appeal about your Part D prescription drugs)*.
- **We must accept any written request,** including a request submitted on the CMS Model Coverage Determination Request Form, which is available on our website.
- **You must make your appeal request within 60 calendar days** from the date on the written notice we sent to tell you our answer to your request for a coverage decision. If you miss this deadline and have a good reason for missing it, we may give you more time to make your appeal. Examples of good cause for missing the deadline may include if you had a serious illness that prevented you from contacting us or if we provided you with incorrect or incomplete information about the deadline for requesting an appeal.

- **You can ask for a copy of the information in your appeal and add more information.**
  - You have the right to ask us for a copy of the information regarding your appeal.
  - 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 redetermination."**

- If you are appealing a decision we 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 coverage decision" in Section 7.4 of this chapter.

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

- When we are reviewing your appeal, we take another careful look at all of the information about your 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 talk 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 for a drug you have not received yet. 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 you believe your health requires it, you should ask for "fast" appeal.

  - 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.
- If you are requesting that we pay you back for a drug you have already bought, we must give you our answer **within 14 calendar days** after we receive your request.
  - If we do not give you a decision within 14 calendar days, we are required to send your request on to Level 2 of the appeals process, where it will be reviewed by an independent organization. Later in this section, we talk about this review organization and explain what happens at Appeal Level 2.
- **If our answer is yes to part or all of what you requested,** we are also required to make payment to you within 30 calendar days after we receive your request.
- **If our answer is no to part or all of what you requested**, we will send you a written statement that explains why we said no. We will also tell you how to appeal.

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

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

Section 7.6 Step-by-step: How to make a Level 2 Appeal

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

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 (or your representative or your doctor or other prescriber) must contact the Independent Review Organization and ask for a review of your case.

- If we say 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**.
- 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 independent organization that is hired by Medicare**. This organization is not connected with us and it is not a government agency. This organization is a company chosen by Medicare to review our decisions about your Part D benefits with us.
- 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 it is for a drug you have not received yet. If you are requesting that we pay you back for a drug you have already bought, the review organization must give you an answer to your level 2 appeal within 14 calendar days after it receives your request.
- **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 **send payment to you within 30 calendar days** after we receive the decision from the review organization.

What if the review organization says no to your appeal?

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

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

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

- There are three additional levels in the appeals process after Level 2 (for a total of five levels of appeal).
- If your Level 2 Appeal is turned down and you meet the requirements to continue with the appeals process, you must decide whether you want to go on to Level 3 and make a third appeal. If you decide to make a third appeal, the details on how to do this are in the written notice you got after your second appeal.
- The Level 3 Appeal is handled by an Administrative Law Judge or attorney adjudicator. Section 10 in this chapter tells more about Levels 3, 4, and 5 of the appeals process.

SECTION 8 How to ask us to cover a longer inpatient hospital stay if you think the doctor is discharging you too soon

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

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

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

Section 8.1 During your inpatient hospital stay, you will get a written notice from Medicare that tells about your rights

During your covered 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 (for example, a caseworker or nurse) must give it to you within two days after you are admitted. If you do not get the notice, ask any hospital employee for it. If you need help, please call our Customer Care Center (phone numbers are printed on the back cover of this booklet). 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.

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
   - Your right to appeal your discharge decision if you think you are being discharged from the hospital too soon

Legal Terms
The written notice from Medicare tells you how you can **"request an immediate review."** Requesting an immediate review is a formal, legal way to ask for a delay in your discharge date so that we will cover your hospital care for a longer time. (Section 8.2 below tells you how you can request an immediate review.)

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

3. **Keep your copy** of the signed notice so you will have the information about making an appeal (or reporting a concern about quality of care) handy if you need it.
   - If you sign the notice more than two days before the day you leave the hospital, you will get another copy before you are scheduled to be discharged.
   - To look at a copy of this notice in advance, you can call our Customer Care Center (phone numbers are printed on the back cover of this booklet) or 1-800 MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048. You can also see it online at https://www.cms.gov/Medicare/Medicare-General-Information/BNI/HospitalDischargeAppealNotices.html

Section 8.2 Step-by-step: How to make a Level 1 Appeal to change your hospital discharge date

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

- **Follow the process.** Each step in the first two levels of the appeals process is explained below.
- **Meet the deadlines.** The deadlines are important. Be sure that you understand and follow the deadlines that apply to things you must do.

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

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

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

A "fast review" is also called an "immediate 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 About Your Rights*) tells you how to reach this organization. (Or find the name, address, and phone number of the Quality Improvement Organization for your state in Chapter 2, Section 4, of this booklet.)

Act quickly:

- To make your appeal, you must contact the Quality Improvement Organization *before* you leave the hospital and **no later than your planned discharge date.** (Your "planned discharge date" is the date that has been set for you to leave the hospital.)
    - If you meet this deadline, you are allowed to stay in the hospital *after* your discharge date *without paying for it* while you wait to get the decision on your appeal from the Quality Improvement Organization.
    - If you do *not* meet this deadline, and you decide to stay in the hospital after your planned discharge date, *you may have to pay all of the costs* for hospital care you receive after your planned discharge date.
- If you miss the deadline for contacting the Quality Improvement Organization about your appeal, you can make your appeal directly to our plan instead. For details about this other way to make your appeal, see Section 8.4.

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**."

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

What happens during this review?

- Health professionals at the Quality Improvement Organization (we will call them "the reviewers" for short) will ask you (or your representative) why you believe coverage for the services should continue. You don't have to prepare anything in writing, but you may do so if you wish.
- The reviewers will also look at your medical information, talk with your doctor, and review information that the hospital and we have 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 in detail the reasons why your doctor, the hospital, and we think it is right (medically appropriate) for you to be discharged on that date.

Legal Terms
This written explanation is called the "**Detailed Notice of Discharge."** You can get a sample of this notice by calling our Customer Care Center (phone numbers are printed on the back cover of this booklet) or 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. (TTY users should call 1-877-486-2048.) Or you can see a sample notice online at https://www.cms.gov/Medicare/Medicare-General-Information/BNI/HospitalDischargeAppealNotices.html

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

What happens if the answer is yes?

- If the review organization says *yes* to your appeal, **we must keep providing your covered inpatient hospital services for as long as these services are medically necessary.**
- You will have to keep paying your share of the costs (such as deductibles or copayments, if these apply). In addition, there may be limitations on your covered hospital services. (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. If this happens, **our coverage for your inpatient hospital services will end** at noon on the day *after* the Quality Improvement Organization gives you its answer to your appeal.
- If the review organization says *no* to your appeal and you decide to stay in the hospital, then **you may have to pay the full cost** of hospital care you receive after noon on the day after the Quality Improvement Organization gives you its answer to your appeal.

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

- If the Quality Improvement Organization has 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 8.3 Step-by-step: How to make a Level 2 Appeal to change your hospital discharge date

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

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

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

- You must ask for this review **within 60 calendar days** after the day the Quality Improvement Organization said *no* to your Level 1 Appeal. You can ask for this

review only if you stayed in the hospital after the date that your coverage for the care ended.

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

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

Step 3: Within 14 calendar days of receipt of your request for a second review, the Quality Improvement Organization reviewers will decide on your appeal and tell you their decision.

If the review organization says yes:

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

If the review organization says no:

- It means they agree with the decision they made on your Level 1 Appeal and will not change it.
- The notice you get will tell you in writing what you can do if you wish to continue with the review process. It will give you the details about how to go on to the next level of appeal, which is handled by an Administrative Law Judge or attorney adjudicator.

Step 4: If the answer is no, you will need to decide whether you want to take your appeal further 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 an Administrative Law Judge or attorney adjudicator.
- Section 10 in this chapter tells more about Levels 3, 4, and 5 of the appeals process.

Section 8.4 What if you miss the deadline for making your Level 1 Appeal?

You can appeal to us instead

As explained above in Section 8.2, you must act quickly to contact the Quality Improvement Organization to start your first appeal of your hospital discharge. ("Quickly" means before you leave the hospital and no later than your planned discharge date.) If you miss the deadline for contacting this organization, there is another way to make your appeal.

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

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

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

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

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

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

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

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

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

- **If we say yes to your fast appeal,** it means we have agreed with you that you still need to be in the hospital after the discharge date, and will keep providing your

covered inpatient hospital services for as long as it is medically necessary. It also means that we have agreed to reimburse you for our share of the costs of care you have received since the date when we said your coverage would end. (You must pay your share of the costs and there may be coverage limitations that apply.)

- **If we say no to your fast appeal,** we are saying that your planned discharge date was medically appropriate. Our coverage for your inpatient hospital services ends as of the day we said coverage would end.
  - If you stayed in the hospital *after* your planned discharge date, then **you may have to pay the full cost** of hospital care you received after the planned discharge date.

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

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

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

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

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 11 of this chapter tells how to make a complaint.)

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

- **The Independent Review Organization is an independent organization that is hired by Medicare**. This organization is not connected with our plan and it is not a government agency. This organization is a company chosen by Medicare to handle the job of being the Independent Review Organization. Medicare oversees its work.
- Reviewers at the Independent Review Organization will take a careful look at all of the information related to your appeal of your hospital discharge.
- **If this organization says *yes* to your appeal,** then we must reimburse you (pay you back) for our share of the costs of hospital care you have received since the date of your planned discharge. We must also continue the plan's coverage of your inpatient hospital services for as long as it is medically necessary. You must continue to pay your share of the costs. If there are coverage limitations, these could limit how much we would reimburse or how long we would continue to cover your services.
- **If this organization says *no* to your appeal,** it means they agree with us that your planned hospital discharge date was medically appropriate.
    - 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 an Administrative Law Judge or attorney adjudicator.

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

- There are three additional levels in the appeals process after Level 2 (for a total of five levels of appeal). If reviewers say no to your Level 2 Appeal, you decide whether to accept their decision or go on to Level 3 and make a third appeal.
- Section 10 in this chapter tells more about Levels 3, 4, and 5 of the appeals process.

SECTION 9 How to ask us to keep covering certain medical services if you think your coverage is ending too soon

Section 9.1 *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: *Benefits Chart (what is covered and what you pay)*.

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

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

Section 9.2 We will tell you in advance when your coverage will be ending

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

Legal Terms
In telling you what you can do, the written notice is telling how you can request a **"fast-track appeal."** Requesting a fast-track appeal is a formal, legal way to request a change to our coverage decision about when to stop your care. (Section 9.3 below tells how you can request a fast-track appeal.)

Legal Terms
The written notice is called the "**Notice of Medicare Non-Coverage."** To get a sample copy, call our Customer Care Center (phone numbers are printed on the back cover of this booklet) or 1-800-MEDICARE (1-800-633-4227, 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.). Or see a copy online at https://www.cms.gov/Medicare/Medicare-General-Information/BNI/MAEDNotices.html

2. **You must sign the written notice to show that you received it.**
    - You or someone who is acting on your behalf must sign the notice. (Section 5 tells how you can give written permission to someone else to act as your representative.)
    - Signing the notice shows *only* that you have received the information about when your coverage will stop. **Signing it does not mean you agree** with the plan that it's time to stop getting the care.

Section 9.3 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 11 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 our Customer Care Center (phone numbers are printed on the back cover of this booklet). Or call your State Health Insurance Assistance Program, a government organization that provides personalized assistance (see Section 2 of this chapter).

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

Step 1: Make your Level 1 Appeal: contact the Quality Improvement Organization for 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 for a "fast-track appeal" (to do an independent review) of whether it is medically appropriate for us to end coverage for your medical services.

Your deadline for contacting this organization.

- You must contact the Quality Improvement Organization to start your appeal *no later than noon of the day after you receive the written notice telling you when we will stop covering your care*.
- If you miss the deadline for contacting the Quality Improvement Organization about your appeal, you can make your appeal directly to us instead. For details about this other way to make your appeal, see Section 9.5.

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 us of your appeal, and you will also get a written notice from us that explains in detail our reasons for ending our coverage for your services.

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

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

What happens if the reviewers say yes to your appeal?

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

What happens if the reviewers say no to your appeal?

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

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

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

Section 9.4 Step-by-step: How to make a Level 2 Appeal to have our plan cover your care for a longer time

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

skilled nursing facility care, or Comprehensive Outpatient Rehabilitation Facility (CORF) services *after* the date when we said your coverage would end.

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

Step 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 of receipt of your appeal request, reviewers will decide on your appeal and tell you their decision.

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

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

What happens if the review organization says no?

- It means they agree with the decision we made to your Level 1 Appeal and will not change it.
- The notice you get will tell you in writing what you can do if you wish to continue with the review process. It will give you the details about how to go on to the next level of appeal, which is handled by an Administrative Law Judge or attorney adjudicator.

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

- There are three additional levels of appeal after Level 2, for a total of five levels of appeal. If 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 an Administrative Law Judge or attorney adjudicator.

- Section 10 in this chapter tells more about Levels 3, 4, and 5 of the appeals process.

Section 9.5 What if you miss the deadline for making your Level 1 Appeal?

You can appeal to us 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 us, asking for a "fast review." A fast review is an appeal that uses the fast deadlines instead of the standard deadlines.

Here are the steps for a Level 1 Alternate Appeal:

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

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

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

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

- During this review, we take another look at all of the information about your case. We check to see if we were following all the rules when we set the date for ending the plan's coverage for services you were receiving.
- We will use the "fast" deadlines rather than the standard deadlines for giving you the answer to this review.

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

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

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

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

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

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

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

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

- We are required to send the information for your Level 2 Appeal to the Independent Review Organization within 24 hours of when we tell you that we are saying no to your first appeal. (If you think we are not meeting this deadline or other deadlines, you can make a complaint. The complaint process is different from the appeal process. Section 11 of this chapter tells how to make a complaint.)

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

- **The Independent Review Organization is an independent organization that is hired by Medicare**. This organization is not connected with our plan and it is not a government agency. This organization is a company chosen by Medicare to handle the job of being the Independent Review Organization. Medicare oversees its work.
- Reviewers at the Independent Review Organization will take a careful look at all of the information related to your appeal.
- **If this organization says *yes* to your appeal,** then we must reimburse you (pay you back) for our share of the costs of care you have received since the date when we said your coverage would end. We must also continue to cover the care for as long as it is medically necessary. You must continue to pay your share of the costs. If there are coverage limitations, these could limit how much we would reimburse or how long we would continue to cover your services.
- **If this organization says *no* to your appeal,** it means they agree with the decision our plan made to your first appeal and will not change it.
    - The notice you get from the Independent Review Organization will tell you in writing what you can do if you wish to 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 an Administrative Law Judge or attorney adjudicator.
- Section 10 in this chapter tells more about Levels 3, 4, and 5 of the appeals process.

SECTION 10 Taking your appeal to Level 3 and beyond

Section 10.1 Levels of Appeal 3, 4, and 5 for Medical Service Appeals

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

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

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

Level 3 Appeal	**A judge (called an Administrative Law Judge) or an attorney adjudicator who works for the Federal government** will review your appeal and give you an answer.

- **If the Administrative Law Judge or attorney adjudicator says yes to your appeal, the appeals process *may* or *may not* be over** - 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 calendar days after receiving the Administrative Law Judge's or attorney adjudicator's decision.
  - If we decide to appeal the decision, we will send you a copy of the Level 4 Appeal request with any accompanying documents. We may wait for the Level 4 Appeal decision before authorizing or providing the service in dispute.
- **If the Administrative Law Judge or attorney adjudicator says no to your appeal, the appeals process *may* or *may not* be over**.
  - If you decide to accept this decision that turns down your appeal, the appeals process is over.
  - If you do not want to accept the decision, you can continue to the next level of the review process. If the Administrative Law Judge or attorney adjudicator 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** (Council) will review your appeal and give you an answer. The Council is part of the Federal government.

- **If the answer is yes, or if the Council denies our request to review a favorable Level 3 Appeal decision, the appeals process *may* or *may not* be over** - 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 calendar days after receiving the Council's decision.
  - If we decide to appeal the decision, we will let you know in writing.
- **If the answer is no or if the Council denies the review request, the appeals process *may* or *may not* be over**.
  - If you decide to accept this decision that turns down your appeal, the appeals process is over.

- If you do not want to accept the decision, you might be able to continue to the next level of the review process. If the Council says no to your appeal, the notice you get will tell you whether the rules allow you to go on to a Level 5 Appeal. If the rules allow you to go on, the written notice will also tell you who to contact and what to do next if you choose to continue with your appeal.

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

- This is the last step of the appeals process.

Section 10.2 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 value of the drug you have appealed meets a certain dollar amount, you may be able to go on to additional levels of appeal. If the dollar amount is less, you cannot appeal any further. 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 (called an Administrative Law Judge) or attorney adjudicator who works for the Federal** government will review your appeal and give you an answer.

- **If the answer is yes, the appeals process is over**. What you asked for in the appeal has been approved. We must **authorize or provide the drug coverage** that was approved by the Administrative Law Judge or attorney adjudicator **within 72 hours (24 hours for expedited appeals) or make payment no later than 30 calendar days** after we receive the decision.
- **If the answer is no, the appeals process *may* or *may not* be over**.
  - If you decide to accept this decision that turns down your appeal, the appeals process is over.
  - If you do not want to accept the decision, you can continue to the next level of the review process. If the Administrative Law Judge or attorney adjudicator 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** (Council) will review your appeal and give you an answer. The Council is part of the Federal government.

- **If the answer is yes, the appeals process is over**. What you asked for in the appeal has been approved. We must **authorize or provide the drug coverage** that was approved by the Council **within 72 hours (24 hours for expedited appeals) or make payment no later than 30 calendar days** after we receive the decision.
- **If the answer is no, the appeals process *may* or *may not* be over**.
  - If you decide to accept this decision that turns down your appeal, the appeals process is over.
  - If you do not want to accept the decision, you might be able to continue to the next level of the review process. If the Council says no to your appeal or denies your request to review the appeal, the notice you get will tell you whether the rules allow you to go on to a Level 5 Appeal. If the rules allow you to go on, the written notice will also tell you who to contact and what to do next if you choose to continue with your appeal.

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

- This is the last step of the appeals process.

SECTION 11 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 5 of this chapter.

Section 11.1 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"

Complaint	Example
Quality of your medical care	• Are you unhappy with the quality of the care you have received (including care in the hospital)?

Complaint	Example
Respecting your privacy	• Do you believe that someone did not respect your right to privacy or shared information about you that you feel should be confidential?
Disrespect, poor customer service, or other negative behaviors	• Has someone been rude or disrespectful to you? • Are you unhappy with how our Customer Care Center has treated you? • Do you feel you are being encouraged to leave the 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 our Customer Care Center or other staff at the plan? o Examples include waiting too long on the phone, in the waiting room, when getting a prescription, or in the exam room.
Cleanliness	• Are you unhappy with the cleanliness or condition of a clinic, hospital, or doctor's office?
Information you get from us	• Do you believe we have not given you a notice that we are required to give? • Do you think written information we have given you is hard to understand?

Complaint	Example
Timeliness (These types of complaints are all related to the *timeliness* of our actions related to coverage decisions and appeals)	The process of asking for a coverage decision and making appeals is explained in sections 4-10 of this chapter. If you are asking for a decision or making an appeal, you use that process, not the complaint process. However, if you have already asked us for a coverage decision or made an appeal, and you think that we are not responding quickly enough, you can also make a complaint about our slowness. Here are examples: • If you have asked us to give you a "fast coverage decision" or a "fast appeal," and we have said we will not, you can make a complaint. • If you believe we are not meeting the deadlines for giving you a coverage decision or an answer to an appeal you have made, you can make a complaint. • When a coverage decision we made is reviewed and we are told that we must cover or reimburse you for certain medical services or drugs, there are deadlines that apply. If you think we are not meeting these deadlines, you can make a complaint. • When we do not give you a decision on time, we are required to forward your case to the Independent Review Organization. If we do not do that within the required deadline, you can make a complaint.

Section 11.2 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 11.3 Step-by-step: Making a complaint

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

- **Usually, calling our Customer Care Center is the first step.** If there is anything else you need to do, our Customer Care Center will let you know. Call (877) 874-3930, 8 a.m. to 8 p.m., 7 days a week. TTY users should call 711, 8 a.m. to 8 p.m., 7 days a week.
- **If you do not wish to call (or you called and were not satisfied), you can put your complaint in writing and send it to us.** If you put your complaint in writing, we will respond to your complaint in writing.
- You have the right to file a complaint if you have a problem or concern other than one which involves an unfavorable determination about payment or authorization of services or supplies (other than a coverage determination, organization determination or a Low Income Subsidy or Late Enrollment Penalty determination). If you have questions regarding this process or would like to file a complaint, please contact us. You may file in person, by phone or in writing. Our contact information is:

Banner – University Care Advantage
2701 E. Elvira Road
Tucson, AZ 85756

Customer Care Center: (877) 874-3930, TTY users should call 711
(866) 465-8340 (Fax)
BUHPGrievances&Appeals@bannerhealth.com

Hours of operation are 8 a.m. to 8 p.m., 7 days a week.

Your complaint must be made within 60 days after you experience the problem. Banner – University Care Advantage strives to answer every complaint quickly. If you call us and we cannot resolve your complaint over the phone, we will respond to you within 30 calendar days from the date you file the complaint. The longest time Banner – University Care Advantage can take to answer a complaint is 30 days. If Banner – University Care Advantage needs more information or the delay will benefit you, we can take up to 14 days more to respond to your complaint. We will notify you of the need for the 14- day extension, the reason for the extension and how it is in your best interest, and instructions on how to file a "fast" or expedited complaint if you do not agree with our decision to take the extension.

If you file a written grievance, have a complaint related to quality of care or ask for a written response, then Banner – University Care Advantage will respond to you in writing. You have two options for filing a quality of care complaint. You may file your quality of care complaint with Banner – University Care Advantage and/or directly with the Quality Improvement Organization (QIO). In Arizona, the QIO is Livanta and their contact information is:

Livanta BFCC-QIO Program
10820 Guilford Road, Suite 202
Annapolis Junction, MD 20701

1-877-588-1123
TTY: 1-855-887-6668
Fax: 1-833-868-4063

If you have asked Banner – University Care Advantage to give you a "fast" or expedited response for a coverage decision or appeal and we have said no, you can file a "fast" or expedited complaint. If you disagree with Banner – University Care Advantage's decision to extend the time frame for us to make a coverage determination, we must treat this disagreement as a "fast" or expedited complaint. Banner – University Care Advantage will provide a response to you for "fast" or expedited complaints within 24 hours.

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

Legal Terms
What this section calls a **"fast complaint"** is also called an **"expedited 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 calendar days (44 calendar days total) to answer your complaint. If we decide to take extra days, we will tell you in writing.
- **If we do not agree** with some or all of your complaint or don't take responsibility for the problem you are complaining about, we will let you know. Our response will include our reasons for this answer. We must respond whether we agree with the complaint or not.

Section 11.4 You can also make complaints about quality of care to the Quality Improvement Organization

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

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

- **You can make your complaint to the Quality Improvement Organization**. If you prefer, you can make your complaint about the quality of care you received directly to this organization (*without* making the complaint to us).
    - The Quality Improvement Organization is a group of practicing doctors and other health care experts paid by the Federal government to check and improve the care given to Medicare patients.
    - To find the name, address, and phone number of the Quality Improvement Organization for your state, look in Chapter 2, Section 4 of this booklet. If you make a complaint to this organization, we will work with them to resolve your complaint.
- **Or you can make your complaint to both at the same time**. If you wish, you can make your complaint about quality of care to us and also to the Quality Improvement Organization.

Section 11.5 You can also tell Medicare about your complaint

You can submit a complaint about Banner – University Care Advantage directly to Medicare. To submit a complaint to Medicare, go to https://www.medicare.gov/MedicareComplaintForm/home.aspx. Medicare takes your complaints seriously and will use this information to help improve the quality of the Medicare program.

If you have any other feedback or concerns, or if you feel the plan is not addressing your issue, please call 1-800-MEDICARE (1-800-633-4227). TTY/TDD users can call 1-877-486-2048.

PROBLEMS ABOUT YOUR AHCCCS (MEDICAID) BENEFITS

SECTION 12 Handling problems about your AHCCCS (Medicaid) benefits

You should contact your AHCCCS (Medicaid) plan directly. If you have Banner – University Family Care, the information below will tell you how to handle problems about your AHCCCS (Medicaid) benefits.

Concerns or Grievances about Banner – University Family Care (AHCCCS Complete Care)

For inquiries, questions, or to file a complaint, please contact our Grievance & Appeals Department.

Banner – University Family Care
Attn: Grievance & Appeals Department
2701 E. Elvira Road Tucson, AZ 85756
Phone: (800) 582-8686, ask for Grievance & Appeals
Fax: (866) 465-8340
BUHPGrievances&Appeals@bannerhealth.com

What if you have questions, problems or complaints about Banner -– University Family Care?

Call our Customer Care Center if you want to report grievance (complaint) or if you are dissatisfied with any aspect of your care or a provider. Examples of grievances are: service issues, transportation issues, quality of care issues and provider office issues.

Interpretation services are available in any language at no cost to you.

You may call our Customer Care Center to file a grievance (complaint). You may also file your grievance in writing by mailing it to the address listed above. Your grievance will be reviewed and a response will be provided no later than ninety (90) days from the date that you contact us.

Appeal and Request for Fair Hearing

What if you disagree with a denied service?

If you are dissatisfied with an "action" such as a reduction, suspension or termination of previously approved services, or denial of services, or denial of payment of services by Banner – University Family Care, you may file an "appeal." An appeal must be filed within 60 days from receipt of Banner – University Family Care's Notice of Adverse Benefit Determination.

Who may file an appeal?

You, as the enrollee, your representative, or a legal representative of a deceased enrollee's estate, may file an appeal. A provider, acting on behalf of an enrollee and with the enrollee's written consent, may file an appeal.

What can you file an appeal for?

The reasons you may file an appeal are:

- Denial or limited authorization of a requested service, including the type or level of service.
- Reduction, suspension, or termination of a previously authorized service.
- Denial, in whole or in part, of payment for a service.
- Failure to provide services in a timely manner.
- Failure to act within the timeframe required for standard and expedited resolution of appeals and standard disposition of grievances.

- The denial of a rural enrollee's request to obtain services outside the contractor's network under 42CFR 438.52(b)(2)(ii), when the contractor is the only contractor in the rural area.

How do you file an appeal?

You can mail, email or fax the appeal to the Grievance & Appeals Department or you may call and ask to speak to an Appeals representative using the information listed above. Banner – University Family Care will provide you with a written decision within 30 days of filing the appeal.

How do you request a State Fair Hearing?

If you are not satisfied with the appeal decision, you may file a request for State Fair Hearing with Banner – University Family Care. This request must be made in writing to Banner - University Family Care within 120 days of the date of receipt of the appeal decision. You can mail, email or fax your request to the Grievance & Appeals Department. Banner – University Family Care will send your appeal file to AHCCCS (Medicaid) and a hearing date will be scheduled for you to attend. Additionally, there are Legal Services Programs in your area that may be able to help you with the hearing process. General legal information about your rights can also be found on the internet at the following website: www.azlawhelp.org.

What is an expedited appeal?

You may file an expedited appeal, or it may be filed on your behalf by your provider with your written authorization. Expedited appeals will only be approved if Banner – University Family Care determines that the time to process a standard appeal would seriously jeopardize your health, life or ability to attain, maintain or regain maximum function. If an expedited appeal request is not approved, Banner - University Family Care will notify you within twenty-four (24) hours.

Can you continue to receive services during the appeal process?

Yes, but the request must be made in writing and be received by Banner – University Family Care within 10 days of the receipt of the Notice of Adverse Benefit Determination. However, you may be responsible for payment of those services if Banner – University Family Care upholds the denial.

CHAPTER 10

Ending your membership in the plan

Chapter 10. Ending your membership in the plan

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SECTION 1 Introduction

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

Ending your membership in Banner – University Care Advantage may be **voluntary** (your own choice) or **involuntary** (not your own choice):

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

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

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

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

Section 2.1 You may be able to end your membership because you have Medicare and Medicaid

Most people with Medicare can end their membership only during certain times of the year. Because you have Medicaid, you may be able to end your membership in our plan or switch to a different plan one time during each of the following Special Enrollment Periods:

- January to March
- April to June
- July to September

If you joined our plan during one of these periods, you'll have to wait for the next period to end your membership or switch to a different plan. You can't use this Special Enrollment Period to

end your membership in our plan between October and December. However, all people with Medicare can make changes from October 15 – December 7 during the Annual Enrollment Period. Section 2.2 tells you more about the Annual Enrollment Period.

- **What type of plan can you switch to?** If you decide to change to a new plan, you can choose any of the following types of Medicare plans:
    - Another Medicare health plan. (You can choose a plan that covers prescription drugs or one that does not cover prescription drugs.)
    - Original Medicare *with* a separate Medicare prescription drug plan
        - If you switch to Original Medicare and do not enroll in a separate Medicare prescription drug plan, Medicare may enroll you in a drug plan, unless you have opted out of automatic enrollment.

    Note: If you disenroll from Medicare prescription drug coverage and go without "creditable" prescription drug coverage for a continuous period of 63 days or more, you may have to pay a Part D late enrollment penalty if you join a Medicare drug plan later. ("Creditable" coverage means the coverage is expected to pay, on average, at least as much as Medicare's standard prescription drug coverage.)

    Contact your State Medicaid Office to learn about your Medicaid plan options (telephone numbers are in Chapter 2, Section 6 of this booklet).
- **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 plans. Your enrollment in your new plan will also begin on this day.

Section 2.2 You can end your membership during the Annual Enrollment Period

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

- **When is the Annual Enrollment Period?** This happens from October 15 to December 7.
- **What type of plan can you switch to during the Annual Enrollment Period?** You can choose to keep your current coverage or make changes to your coverage for the upcoming year. If you decide to change to a new plan, you can choose any of the following types of plans:
    - Another Medicare health plan. (You can choose a plan that covers prescription drugs or one that does not cover prescription drugs.)
    - Original Medicare *with* a separate Medicare prescription drug plan
    - *or* – Original Medicare *without* a separate Medicare prescription drug plan.

        If you receive "Extra Help" from Medicare to pay for your prescription drugs: If you switch to Original Medicare and do not enroll in a separate

Medicare prescription drug plan, Medicare may enroll you in a drug plan, unless you have opted out of automatic enrollment.

Note: If you disenroll from Medicare prescription drug coverage and go without creditable prescription drug coverage, you may have to pay a Part D late enrollment penalty if you join a Medicare drug plan later. ("Creditable" coverage means the coverage is expected to pay, on average, at least as much as Medicare's standard prescription drug coverage.) See Chapter 1, Section 5 for more information about the late enrollment penalty.

- **When will your membership end?** Your membership will end when your new plan's coverage begins on January 1.

Section 2.3 You can end your membership during the Medicare Advantage Open Enrollment Period

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

- **When is the annual Medicare Advantage Open Enrollment Period?** This happens every year from January 1 to March 31.
- **What type of plan can you switch to during the annual Medicare Advantage Open Enrollment Period?** During this time, you can:
  - Switch to another Medicare Advantage Plan. (You can choose a plan that covers prescription drugs or one that does not cover prescription drugs.)
  - Disenroll from our plan and obtain coverage through Original Medicare. If you choose to switch to Original Medicare during this period, you have until March 31 to join a separate Medicare prescription drug plan to add drug coverage.
- **When will your membership end?** Your membership will end on the first day of the month after you enroll in a different Medicare Advantage plan or we get your request to switch to Original Medicare. If you also choose to enroll in a Medicare prescription drug plan, your membership in the drug plan will begin the first day of the month after the drug plan gets your enrollment request.

Section 2.4 In certain situations, you can end your membership during a Special Enrollment Period

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

- **Who is eligible for a Special Enrollment Period?** If any of the following situations apply to you, you may be eligible to end your membership during a Special Enrollment Period. These are just examples, for the full list you can contact the plan, call Medicare, or visit the Medicare website (https://www.medicare.gov):
  - Usually, when you have moved

- If you have AHCCCS (Medicaid)
- If you are eligible for "Extra Help" with paying for your Medicare prescriptions
- If we violate our contract with you
- If you are getting care in an institution, such as a nursing home or long-term care (LTC) hospital

Note: Section 2.1 tells you more about the special enrollment period for people with AHCCCS (Medicaid).

- **When are Special Enrollment Periods?** The enrollment periods vary depending on your situation.
- **What can you do?** To find out if you are eligible for a Special Enrollment Period, please call Medicare at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users call 1-877-486-2048. If you are eligible to end your membership because of a special situation, you can choose to change both your Medicare health coverage and prescription drug coverage. This means you can choose any of the following types of plans:
  - Another Medicare health plan. (You can choose a plan that covers prescription drugs or one that does not cover prescription drugs.)
  - Original Medicare *with* a separate Medicare prescription drug plan
  - – *or* – Original Medicare *without* a separate Medicare prescription drug plan.

  If you receive "Extra Help" from Medicare to pay for your prescription drugs: If you switch to Original Medicare and do not enroll in a separate Medicare prescription drug plan, Medicare may enroll you in a drug plan, unless you have opted out of automatic enrollment.

  Note: If you disenroll from Medicare prescription drug coverage and go without creditable prescription drug coverage for a continuous period of 63 days or more, you may have to pay a Part D late enrollment penalty if you join a Medicare drug plan later. ("Creditable" coverage means the coverage is expected to pay, on average, at least as much as Medicare's standard prescription drug coverage.) See Chapter 1, Section 5 for more information about the late enrollment penalty.
- **When will your membership end?** Your membership will usually end on the first day of the month after your request to change your plan is received.

Note: Sections 2.1 and 2.2 tell you more about the special enrollment period for people with Medicaid and Extra Help.

Section 2.5 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 our Customer Care Center** (phone numbers are printed on the back cover of this booklet).

- You can find the information in the ***Medicare & You 2020*** Handbook.
  - Everyone with Medicare receives a copy of *Medicare & You* each fall. Those new to Medicare receive it within a month after first signing up.
  - You can also download a copy from the Medicare website (https://www.medicare.gov). Or, you can order a printed copy by calling Medicare at the number below.
- You can contact **Medicare** at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

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

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

Usually, to end your membership in our plan, you simply enroll in another Medicare plan. However, if you want to switch from our plan to Original Medicare but you have not selected a separate Medicare prescription drug plan, you must ask to be disenrolled from our plan. There are two ways you can ask to be disenrolled:

- You can make a request in writing to us. Contact our Customer Care Center if you need more information on how to do this (phone numbers are printed on the back cover of this booklet).
- --*or*--You can contact Medicare at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

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

If you would like to switch from our plan to:	This is what you should do:
• Another Medicare health plan	• Enroll in the new Medicare health plan. Your new coverage will begin on the first day of the following month. You will automatically be disenrolled from Banner – University Care Advantage when your new plan's coverage begins.

If you would like to switch from our plan to:	This is what you should do:
• Original Medicare *with* a separate Medicare prescription drug plan	• Enroll in the new Medicare prescription drug plan. Your new coverage will begin on the first day of the following month. You will automatically be disenrolled from Banner – University Care Advantage when your new plan's coverage begins.
• Original Medicare *without* a separate Medicare prescription drug plan o If you switch to Original Medicare and do not enroll in a separate Medicare prescription drug plan, Medicare may enroll you in a drug plan, unless you have opted out of automatic enrollment. o If you disenroll from Medicare prescription drug coverage and go without creditable prescription drug coverage, you may have to pay a late enrollment penalty if you join a Medicare drug plan later.	• **Send us a written request to disenroll.** Contact our Customer Care Center if you need more information on how to do this (phone numbers are printed on the back cover of this booklet). • You can also contact **Medicare**, at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week, and ask to be disenrolled. TTY users should call 1-877-486-2048. • You will be disenrolled from Banner – University Care Advantage when your coverage in Original Medicare begins.

For questions about your AHCCCS (Medicaid) benefits, contact AHCCCS (Medicaid) at_1-855-432-7587, AZ Relay Service for the hearing impaired – 1-800-367-8939. Hours are Monday through Friday 8 a.m. – 5 p.m. Ask how joining another plan or returning to Original Medicare affects how you get your AHCCCS (Medicaid) coverage.

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

- **You should continue to use our network pharmacies to get your prescriptions filled until your membership in our plan ends.** Usually, your prescription drugs are only

covered if they are filled at a network pharmacy including through our mail-order pharmacy services.

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

SECTION 5 Banner – University Care Advantage must end your membership in the plan in certain situations

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

Banner – University Care Advantage must end your membership in the plan if any of the following happen:

- If you no longer have Medicare Part A and Part B
- If you are no longer eligible for AHCCCS (Medicaid). As stated in Chapter 1, Section 2.1, our plan is for people who are eligible for both Medicare and AHCCCS (Medicaid). We will continue to provide Medicare coverage for 6 months. During this time you must regain eligibility for AHCCCS (Medicaid) to remain on our plan.
- If you move out of our service area
- If you are away from our service area for more than six months
    - If you move or take a long trip, you need to call our Customer Care Center to find out if the place you are moving or traveling to is in our plan's area. (Phone numbers for our Customer Care Center are printed on the back cover of this booklet.)
- If you become incarcerated (go to prison)
- If you are not a United States citizen or lawfully present in the United States
- If you lie about or withhold information about other insurance you have that provides prescription drug coverage
- If you intentionally give us incorrect information when you are enrolling in our plan and that information affects your eligibility for our plan. (We cannot make you leave our plan for this reason unless we get permission from Medicare first.)
- If you continuously behave in a way that is disruptive and makes it difficult for us to provide medical care for you and other members of our plan. (We cannot make you leave our plan for this reason unless we get permission from Medicare first.)
- If you let someone else use your membership card to get medical care. (We cannot make you leave our plan for this reason unless we get permission from Medicare first.)
    - If we end your membership because of this reason, Medicare may have your case investigated by the Inspector General.

- If you are required to pay the extra Part D amount because of your income and you do not pay it, Medicare will disenroll you from our plan

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 **our Customer Care Center** for more information (phone numbers are printed on the back cover of this booklet).

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

Banner – University Care Advantage is not allowed to 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 file a grievance or make a complaint about our decision to end your membership. You can also look in Chapter 9, Section 11 for information about how to make a complaint.

CHAPTER 11

Legal notices

Chapter 11. Legal notices

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SECTION 1 Notice about governing law

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

SECTION 2 Notice about nondiscrimination

Our plan must obey laws that protect you from discrimination or unfair treatment. **We don't discriminate** based on race, ethnicity, national origin, color, religion, sex, gender, age, mental or physical disability, health status, claims experience, medical history, genetic information, evidence of insurability, or geographic location within the service area. All organizations that provide Medicare Advantage plans, like our plan, must obey Federal laws against discrimination, including Title VI of the Civil Rights Act of 1964, the Rehabilitation Act of 1973, the Age Discrimination Act of 1975, the Americans with Disabilities Act, Section 1557 of the Affordable Care Act, all other laws that apply to organizations that get Federal funding, and any other laws and rules that apply for any other reason.

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

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

SECTION 3 Notice about Medicare Secondary Payer subrogation rights

We have the right and responsibility to collect for covered Medicare services for which Medicare is not the primary payer. According to CMS regulations at 42 CFR sections 422.108 and 423.462, Banner – University Care Advantage as a Medicare Advantage Organization, will exercise the same rights of recovery that the Secretary exercises under CMS regulations in subparts B through D of part 411 of 42 CFR and the rules established in this section supersede any State laws.

CHAPTER 12

Definitions of important words

Chapter 12. Definitions of important words

Ambulatory Surgical Center – An Ambulatory Surgical Center is an entity that operates exclusively for the purpose of furnishing outpatient surgical services to patients not requiring hospitalization and whose expected stay in the center does not exceed 24 hours.

Appeal – An appeal is something you do if you disagree with our decision to deny a request for coverage of 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 our decision to stop services that you are receiving. For example, you may ask for an appeal if we don'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.

Balance Billing – When a provider (such as a doctor or hospital) bills a patient more than the plan's allowed cost-sharing amount. As a member of Banner – University Care Advantage, you only have to pay our plan's cost-sharing amounts when you get services covered by our plan. We do not allow providers to "balance bill" or otherwise charge you more than the amount of cost-sharing your plan says you must pay.

Benefit Period – The way that both our plan and Original Medicare measures your use of hospital and skilled nursing facility (SNF) services. A benefit period begins the day you go into a hospital or skilled nursing facility. The benefit period ends when you haven't received any inpatient hospital care (or skilled care in a SNF) for 60 days in a row. If you go into a hospital or a skilled nursing facility after one benefit period has ended, a new benefit period begins. There is no limit to the number of benefit periods.

Brand Name Drug – A 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.

Catastrophic Coverage Stage – The stage in the Part D Drug Benefit where you pay a low copayment or coinsurance for your drugs after you or other qualified parties on your behalf have spent $6,350 in covered drugs during the covered year.

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

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

Complaint — The formal name for "making a complaint" is "filing a grievance." The complaint process is used for certain types of problems *only.* This includes problems related to quality of

care, waiting times, and the customer service you receive. See also "Grievance," in this list of definitions.

Comprehensive Outpatient Rehabilitation Facility (CORF) – A facility that mainly provides rehabilitation services after an illness or injury, and provides a variety of services including physical therapy, social or psychological services, respiratory therapy, occupational therapy and speech-language pathology services, and home environment evaluation services.

Copayment (or "copay") – An amount you may be required to pay as your share of the cost for a medical service or supply, like a doctor's visit, hospital outpatient visit, or a prescription drug. A copayment is a set amount, rather than a percentage. For example, you might pay $10 or $20 for a doctor's visit or prescription drug.

Cost-sharing – Cost-sharing refers to amounts that a member has to pay when services or drugs are received. Cost-sharing includes any combination of the following three types of payments: (1) any deductible amount a plan may impose before services or drugs are covered; (2) any fixed "copayment" amount that a plan requires when a specific service or drug is received; or (3) any "coinsurance" amount, a percentage of the total amount paid for a service or drug that a plan requires when a specific service or drug is received. A "daily cost-sharing rate" may apply when your doctor prescribes less than a full month's supply of certain drugs for you and you are required to pay a copayment.

Coverage Determination – A decision about whether a drug prescribed for you is covered by the plan and the amount, if any, you are required to pay for the 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. Coverage determinations are called "coverage decisions" in this booklet. Chapter 9 explains how to ask us for a coverage decision.

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 pay, on average, at least as much as Medicare's standard prescription drug coverage. People who have this kind of coverage when they become eligible for Medicare can generally keep that coverage without paying a penalty, if they decide to enroll in Medicare prescription drug coverage later.

Custodial Care – Custodial care is personal care provided in a nursing home, hospice, or other facility setting when you do not need skilled medical care or skilled nursing care. Custodial care is personal care that can be provided by people who don't have professional skills or training, such as help with activities of daily living like bathing, dressing, eating, getting in or out of a bed or chair, moving around, and using the bathroom. It may also include the kind of health-related

care that most people do themselves, like using eye drops. Medicare doesn't pay for custodial care.

Customer Care Center – 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 our Customer Care Center.

Daily cost-sharing rate – A "daily cost-sharing rate" may apply when your doctor prescribes less than a full month's supply of certain drugs for you and you are required to pay a copayment. A daily cost-sharing rate is the copayment divided by the number of days in a month's supply. Here is an example: If your copayment for a one-month supply of a drug is $30, and a one-month's supply in your plan is 30 days, then your "daily cost-sharing rate" is $1 per day. This means you pay $1 for each day's supply when you fill your prescription.

Deductible – The amount you must pay for health care or prescriptions before our plan begins to pay.

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).

Dispensing Fee – A fee charged each time a covered drug is dispensed to pay for the cost of filling a prescription. The dispensing fee covers costs such as the pharmacist's time to prepare and package the prescription.

Dual Eligible Individual – A person who qualifies for Medicare and AHCCCS (Medicaid) coverage.

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

Emergency – A medical emergency is when you, or any other prudent layperson with an average knowledge of health and medicine, believe that you have medical symptoms that require immediate medical attention to prevent loss of life, loss of a limb, or loss of function of a limb. The medical symptoms may be an illness, injury, severe pain, or a medical condition that is quickly getting worse.

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

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

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

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

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

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

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

Hospice – A member who has 6 months or less to live has the right to elect hospice. We, your plan, must provide you with a list of hospices in your geographic area. If you elect hospice and continue to pay premiums you are still a member of our plan. You can still obtain all medically necessary services as well as the supplemental benefits we offer. The hospice will provide special treatment for your state.

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

Income Related Monthly Adjustment Amount (IRMAA) – If your modified adjusted gross income as reported on your IRS tax return from 2 years ago is above a certain amount, you'll pay the standard premium amount and an Income Related Monthly Adjustment Amount, also known as IRMAA. IRMAA is an extra charge added to your premium. Less than 5% of people with Medicare are affected, so most people will not pay a higher premium.

Initial Coverage Limit – The maximum limit of coverage under the Initial Coverage Stage.

Initial Coverage Stage – This is the stage before your total drug costs including amounts you have paid and what your plan has paid on your behalf for the year have reached $6,350.

Initial Enrollment Period – When you are first eligible for Medicare, the period of time when you can sign up for Medicare Part A and Part B. For example, if you're eligible for Medicare when you turn 65, your Initial Enrollment Period is the 7-month period that begins 3 months

before the month you turn 65, includes the month you turn 65, and ends 3 months after the month you turn 65.

Institutional Special Needs Plan (SNP) – A Special Needs Plan that enrolls eligible individuals who continuously reside or are expected to continuously reside for 90 days or longer in a long-term care (LTC) facility. These LTC facilities may include a skilled nursing facility (SNF); nursing facility (NF); (SNF/NF); an intermediate care facility for the mentally retarded (ICF/MR); and/or an inpatient psychiatric facility. An institutional Special Needs Plan to serve Medicare residents of LTC facilities must have a contractual arrangement with (or own and operate) the specific LTC facility(ies).

Institutional Equivalent Special Needs Plan (SNP) – An institutional Special Needs Plan that enrolls eligible individuals living in the community but requiring an institutional level of care based on the State assessment. The assessment must be performed using the same respective State level of care assessment tool and administered by an entity other than the organization offering the plan. This type of Special Needs Plan may restrict enrollment to individuals that reside in a contracted assisted living facility (ALF) if necessary to ensure uniform delivery of specialized care.

List of Covered Drugs (Formulary or "Drug List") – A list of prescription drugs covered 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.

Low Income Subsidy (LIS) – See "Extra Help."

Maximum Out-of-Pocket Amount – The most that you pay out-of-pocket during the calendar year for covered Part A and Part B services. Amounts you pay for your late enrollment penalty, Medicare Part A and Part B premiums, and prescription drugs do not count toward the maximum out-of-pocket amount. If you are eligible for Medicare cost-sharing assistance under AHCCCS (Medicaid), you are not responsible for paying any out-of-pocket costs toward the maximum out-of-pocket amount for covered Part A and Part B services. (Note: Because our members also get assistance from AHCCCS (Medicaid), very few members ever reach this out-of-pocket maximum.) See Chapter 4, Section 1, for information about your maximum out-of-pocket amount.

AHCCCS (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 AHCCCS (Medicaid). See Chapter 2, Section 6 for information about how to contact AHCCCS (Medicaid) in your state.

Medically Accepted Indication – A use of a drug that is either approved by the Food and Drug Administration or supported by certain reference books. See Chapter 5, Section 3 for more information about a medically accepted indication.

Medically Necessary – Services, supplies, or drugs that are needed for the prevention, diagnosis, or treatment of your medical condition and meet accepted standards of medical practice.

Medicare – The Federal health insurance program for people 65 years of age or older, some people under age 65 with certain disabilities, and people with End-Stage Renal Disease (generally those with permanent kidney failure who need dialysis or a kidney transplant). People with Medicare can get their Medicare health coverage through Original Medicare 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 and Part B benefits. A Medicare Advantage Plan can be an HMO, PPO, a Private Fee-for-Service (PFFS) plan, or a Medicare Medical Savings Account (MSA) plan. When you are enrolled in a Medicare Advantage Plan, Medicare services are covered through the plan, and are not paid for under Original Medicare. In most cases, Medicare Advantage Plans also offer Medicare Part D (prescription drug coverage). These plans are called **Medicare Advantage Plans with Prescription Drug Coverage**. Everyone who has Medicare Part A and Part B is eligible to join any Medicare health plan that is offered in their area, except people with End-Stage Renal Disease (unless certain exceptions apply).

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

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

Medicare Health Plan – A Medicare health plan is offered by a private company that contracts with Medicare to provide Part A and Part B benefits to people with Medicare who enroll in the plan. This term includes all Medicare Advantage Plans, Medicare Cost Plans, Demonstration/Pilot Programs, and Programs of All-inclusive Care for the Elderly (PACE).

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

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

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

Network 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."

Organization Determination – The Medicare Advantage plan has made an organization determination when it makes a decision about whether items or services are covered or how much you have to pay for covered items or services. Organization determinations are called "coverage decisions" in this booklet. Chapter 9 explains how to ask us for a coverage decision.

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

Out-of-Network 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 Evidence 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.

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

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

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

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

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

If you ever lose your low income subsidy ("Extra Help"), you would be subject to the monthly Part D late enrollment penalty if you have ever gone without creditable prescription drug coverage for 63 days or more.

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

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

Primary Care Provider (PCP) – Your primary care provider is the doctor or other provider you see first for most health problems. He or she makes sure you get the care you need to keep you healthy. He or she also may talk with other doctors and health care providers about your care and refer you to them. In many Medicare health plans, you must see your primary care provider before you see any other health care provider. See Chapter 3, Section 2.1 for information about Primary Care Providers.

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.

Prosthetics and Orthotics – These are medical devices ordered by your doctor or other health care provider. Covered items include, but are not limited to, arm, back, and neck braces; artificial limbs; artificial eyes; and devices needed to replace an internal body part or function, including ostomy supplies and enteral and parenteral nutrition therapy.

Quality Improvement Organization (QIO) – A group of practicing doctors and other health care experts paid by the Federal government to check and improve the care given to Medicare patients. See Chapter 2, Section 4 for information about how to contact the QIO for your state.

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

Service Area – A geographic area where a health plan accepts members if it limits membership based on where people live. For plans that limit which doctors and hospitals you may use, it's also generally the area where you can get routine (non-emergency) services. The plan may disenroll you if you permanently move out of the plan's service area.

Skilled Nursing Facility (SNF) Care – Skilled nursing care and rehabilitation services provided on a continuous, daily basis, in a skilled nursing facility. Examples of skilled nursing facility care include physical therapy or intravenous injections that can only be given by a registered nurse or doctor.

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.

Step Therapy – A utilization tool that requires you to first try another drug to treat your medical condition before we will cover the drug your physician may have initially prescribed.

Supplemental Security Income (SSI) – A monthly benefit paid by Social Security to people with limited income and resources who are disabled, blind, or age 65 and older. SSI benefits are not the same as Social Security benefits.

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

Banner – University Care Advantage Customer Care Center

Method	Customer Care Center – Contact Information
CALL	(877) 874-3930 Calls to this number are free. Hours are 8 a.m. to 8 p.m., 7 days a week. Our Customer Care Center also has free language interpreter services available for non-English speakers.
TTY	711 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 are 8 a.m. to 8 p.m., 7 days a week.
WRITE	Banner – University Care Advantage 2701 E. Elvira Road Tucson, AZ 85756
WEBSITE	www.BannerUCA.com

Arizona Department of Economic Security Aging & Adult Administration, Arizona's State Health Insurance Assistance Program (Arizona SHIP)

Arizona SHIP is a state program that gets money from the Federal government to give free local health insurance counseling to people with Medicare.

Method	Contact Information
CALL	Local phone (602) 542-4446 Statewide hotline (800) 432-4040 (leave message)
TTY	711 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.
WRITE	Arizona SHIP 1789 W. Jefferson St. Site Code 950A Phoenix, AZ 85007
WEBSITE	des.az.gov

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