Evidence of Coverage

Minnesota Senior Care Plus

January 1, 2012

Health care that starts with you.

MSC+_121911 DHS Approved (12212011) MDH Approved (12212011)

Attention. If you want free help translating this information, call UCare at 612-676-3200 or toll free at 1-800-203-7225.

ملاحظة: إذا أردت مساعدة مجانية في ترجمة هذه المعلومات، فاتصل على الرقم الموجود أعلاه.

កំណត់សំគាល់ បើអ្នកចង់បានជំនួយបកប្រែពត៌មាននេះដោយមិនគិតថ្លៃ សូមទូរស័ព្ទ ទៅលេខនៅខាងលើ។

Pažnja. Ako vam je potrebna besplatna pomoć za prevod ove informacije, nazovite gornji broj.

Ceeb toom. Yog koj xav tau kev pab txhais cov xov no dawb, thov hu rau tus xov tooj saud.

ໂປດຊາບ. ຖ້າຫາກທ່ານຕ້ອງການການຊ່ວຍເຫຼືອໃນການແປຂໍ້ຄວາມດັ່ງກ່າວນີ້ຟຣີ, ຈົ່ງໂທຣຕາມເລກໂທຣທີ່ຢູ່ຂ້າງເທີງນີ້.

Hubaddhu. Yoo akka odeeffannoon kun sii hiikamu gargaarsa tolaa feeta ta’e, lakkoofsa armaa olii bilbili.

Внимание. Если вам нужна бесплатная помощь в переводе этой информации, позвоните по указанному выше телефону.

Ogow. Haddii aad dooneyso in lagaa kaalmeeyo tarjama dda macluumaadkani oo lacag la’aan ah, wac lambarka kore.

Atención. Si desea recibir asistencia gratuita para traducir esta información, llame al número que aparece más arriba.

Chú Ý. Nếu quý vị cần dịch thông tin này miễn phí, xin gọi số nêu trên.

LB5-0009 (1-08)

This information is available in other forms to people with disabilities by calling: 612-676-3200 (voice) or toll free at 1-800-203-7225 (voice), 612-676-6810 (TTY) or toll free at 1-800-688-2534 (TTY); or through the Minnesota Relay at 711 or toll free direct access at 1-800-627-3529 (TTY, Voice, ASCII, Hearing Carry Over), or 1-877-627-3848 (speech to speech relay service).

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

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

UCare Minnesota
P.O. Box 52
Minneapolis, MN 55440-0052
www.ucare.org

Customer Services: 7:45 a.m. to 5 p.m., Monday through Friday
612-676-3200 or 1-800-203-7225 (toll free)
TDD/TTY if you are hearing impaired (requires special equipment) at
612-676-6810 or 1-800-688-2534 (toll free)

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Welcome to UCare

We are pleased to welcome you as a member of UCare's Minnesota Senior Care Plus plan (referred to as "Plan").

UCare Minnesota (referred to as "we," "us," or "our") is part of the Minnesota Senior Care Plus program (MSC+). We coordinate and cover your medical services. You will get most of your health services through the Plan network of providers. When you need health care or have questions about your health services, you can call us. We will help you decide what to do next and which doctor to see.

This *Evidence of Coverage* or EOC (formerly called *Certificate of Coverage* or COC), together with any amendments that we may send to you, is our contract with you. It is an important legal document. Please keep it in a safe place.

This EOC includes:

- Contact information.
- Information on how to get the care you need.
- Your rights and responsibilities as a member of the Plan.
- Information about copays.
- A listing of covered and non-covered services.
- Information on what to do if you have a complaint or want to appeal an action.
- Definitions.

The counties in the Plan service area are as follows: Aitkin, Anoka, Benton, Blue Earth, Carlton, Carver, Cass, Chippewa, Chisago, Cook, Cottonwood, Crow Wing, Dakota, Dodge, Faribault, Fillmore, Hennepin, Houston, Isanti, Jackson, Kandiyohi, Kittson, Koochiching, Lac Qui Parle, Lake, Le Sueur, Lincoln, Lyon, Marshall, Martin, Mille Lacs, Mower, Murray, Nicollet, Nobles, Norman, Olmsted, Otter Tail, Pennington, Pine, Polk, Ramsey, Red Lake, Redwood, Rice, Rock, Roseau, , Sherburne, St. Louis, Stearns, Swift, Wabasha, Washington, Watonwan, Winona, Wright, and Yellow Medicine in Minnesota.

Please tell us how we're doing. You can call or write to us at any time. (Section 1 of this EOC tells how to contact us.) Your comments are always welcome, whether they are positive or negative. From time to time, we do surveys that ask our members to tell about their experiences with us. If you are contacted, we hope you will participate in a member satisfaction survey. Your answers to the survey questions will help us know what we are doing well and where we need to improve.

Section 1. Telephone numbers and contact information

How to contact our Customer Services

If you have any questions or concerns, please call or write to Customer Services. We will be happy to help you. Customer Services' hours of service are 7:45 a.m. to 5 p.m., Monday through Friday.

CALL: 612-676-3200 or 1-800-203-7225 (toll free)

TDD/TTY: 612-676-6810 or 1-800-688-2534 (toll free)
If you are hearing impaired; requires special equipment.

FAX: 612-676-6501 or 1-866-457-7145 (toll free)

WRITE: UCare
Attn: Customer Services
P.O. Box 52
Minneapolis, MN 55440-0052

VISIT: UCare
500 Stinson Boulevard NE
Minneapolis, MN 55413

WEB SITE: www.ucare.org

Our Plan contact information for certain services

Appeals and Grievances

CALL: 612-676-6841 or 1-877-523-1517 (toll free)
8 a.m. to 4:30 p.m., Monday through Friday

TDD/TTY: 612-676-6810 or 1-800-688-2534 (toll free)
If you are hearing impaired; requires special equipment.

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

See Section 13 for more information.

Chemical Dependency Services
UCare uses a network of chemical dependency providers in your community. We work with Behavioral Healthcare Providers (BHP) or Mayo Management Service, Inc. (MMSI) to provide these services.

If you choose a Primary Care Clinic in the MMSI network, you will also receive any chemical dependency services you need through MMSI. The MMSI network consists of certain clinics in the following counties: Brown, Blue Earth, Dodge, Faribault, Fillmore, Freeborn, Goodhue, Houston, Le Sueur, Mower, Nicollet, Olmsted, Rice, Steele, Waseca, and Winona.

If you use an MMSI Primary Care Clinic in one of the counties listed above, to access chemical dependency services, call UCare Customer Services at 612-676-3200 or 1-800-203-7225 (toll free), 7:45 a.m. to 5 p.m., Monday through Friday. TTY: 612-676-6810 or 1-800-688-2534 (toll free). You can also call UCare's 24-hour nurse line, Health Connection, at 1-800-942-7858 (toll free) or TTY at 1-877-728-3311 (toll free).

Otherwise, please call Behavioral Healthcare Providers (BHP) at 763-525-9919 or 1-800-361-0491 (toll free), Monday through Friday, 8 a.m. to 5 p.m. TTY: 1-800-627-3529 (toll free). After-hours calls are answered by Fairview University Mental Health Intake.

If you are unsure about what number to call, please call UCare Customer Services at 612-676-3200 or 1-800-203-7225 (toll free), 7:45 a.m. to 5 p.m., Monday through Friday. TTY: 612-676-6810 or 1-800-688-2534 (toll free).

Chiropractic Services
We contract with Chiropractic Care of Minnesota, Inc. (CCMI) to provide chiropractic services. You need to see a CCMI provider to have coverage for this benefit. For help finding a chiropractor, or for general chiropractic benefit information, call UCare Customer Services at 612-676-3200 or 1-800-203-7225 (toll free). TTY number for hearing impaired (requires special equipment) is 612-676-6810 or 1-800-688-2534 (toll free).

Dental Services
We contract with DentaQuest to provide dental services. Call DentaQuest at 1-800-896-2372 (toll free) or TTY for hearing impaired (requires special equipment) at 1-800-466-7566 (toll free) with any questions. Make sure you mention that you are a Plan member. You can call UCare's See-A-Dentist Appointment Hotline at 1-800-235-0564 (toll free) from 8 a.m. to 5 p.m., Monday through Friday, to schedule a routine dental appointment within 30 days. If you are hearing impaired, please call the TTY line (requires special equipment) at 1-800-466-7566 (toll free).

Durable Medical Equipment Coverage Criteria
Call UCare Customer Services at 612-676-3200 or 1-800-203-7225 (toll free) with any questions. TTY number for hearing impaired (requires special equipment) is 612-676-6810 or 1-800-688-2534 (toll free).

Home and Community-Based Services (Elderly Waiver)
If you have questions about Home and Community-Based Services, call Customer Services at 612-676-3200 or 1-800-203-7225, or TTY if you are hearing impaired (requires special equipment) at 612-676-6810 or 1-800-688-2534 (toll free).

Interpreter Services
If you need either a hearing or spoken language interpreter, call the patient representative at your Primary Care Clinic. You may also call UCare Customer Services at 612-676-3200 or 1-800-203-7225 (toll free). TTY number for hearing impaired (requires special equipment) is 612-676-6810 or 1-800-688-2534 (toll free).

Health Promotion Programs
UCare offers programs to improve your health and wellness. We offer to eligible members:

- Community Education discounts (through local school districts).
- Help to stop using tobacco with Mayo Clinic Tobacco Quitline.
- Mammogram reward program for members ages 65-69.
- Strong & Stable Kit to improve fitness, increase balance, and prevent falls.

For more information on these programs, call UCare Customer Services at 612-676-3200 or 1-800-203-7225 (toll free). TTY: 612-676-6810 or 1-800-688-2534 (toll free).

Health Questions Phone Line
Call Health Connection at 1-800-942-7858 (toll free) or TTY number for hearing impaired (requires special equipment) at 1-877-728-3311 (toll free). Health Connection is a 24-hour health resource line for members. You can call 24 hours a day, 365 days a year to speak directly to a registered nurse. Health Connection nurses are available to answer your health questions. Also, call Health Connection if your Primary Care Clinic is closed or you do not know what to do. In an emergency, call 911.

Mental Health Services
UCare uses a network of mental health providers in your community. We work with Behavioral Healthcare Providers (BHP) or Mayo Management Service, Inc. (MMSI) to provide these services.

If you choose a Primary Care Clinic in the MMSI network, you will also receive any mental health services you need through MMSI. The MMSI network consists of certain clinics in the following counties: Brown, Blue Earth, Dodge, Faribault, Fillmore, Freeborn, Goodhue, Houston, Le Sueur, Mower, Nicollet, Olmsted, Rice, Steele, Waseca, and Winona.

If you use an MMSI Primary Care Clinic in one of the counties listed above, to access mental health services, call UCare Customer Services at 612-676-3200 or 1-800-203-7225 (toll free), 7:45 a.m. to 5 p.m., Monday through Friday. TTY: 612-676-6810 or 1-800-688-2534 (toll free). You can also call UCare's 24-hour nurse line, Health Connection, at 1-800-942-7858 (toll free) or TTY at 877-728-3311 (toll free).

Otherwise, please call Behavioral Healthcare Providers (BHP) at 763-525-9919 or 1-800-361-0491 (toll free), Monday through Friday, 8 a.m. to 5 p.m. TTY: 1-800-627-3529 (toll free). After-hours calls are answered by Fairview University Mental Health Intake.

If you are unsure about what number to call, please call UCare Customer Services at 612-676-3200 or 1-800-203-7225 (toll free), 7:45 a.m. to 5 p.m., Monday through Friday. TTY: 612-676-6810 or 1-800-688-2534 (toll free).

Prescriptions
If you have questions about drug benefits, call UCare Customer Services at 612-676-3200 or 1-800-203-7225 (toll free), or TTY if you are hearing impaired (requires special equipment) at 612-676-6810 or 1-800-688-2534 (toll free).

Transportation
If you need transportation to and from medical appointments, call Health Ride at 612-676-6830 or 1-800-864-2157 (toll free) for a ride. TTY (if you are hearing impaired; requires special equipment) at 612-676-6810 or 1-800-688-2534 (toll free).

Other important contact information

People with hearing loss or a speech disability may call the following numbers to access the resources listed in this *Evidence of Coverage:* 711, Minnesota Relay Service at 1-800-627-3529 (TTY, Voice, ASCII, Hearing Carry Over), or 1-877-627-3848 (speech-to-speech relay service). These calls are toll free.

Minnesota Department of Human Services
The Minnesota Department of Human Services (DHS) is a State agency that helps people meet their basic needs. It provides or administers health care, financial help, and other services. DHS administers the Medical Assistance program through counties. If you have questions about your eligibility for Medical Assistance, contact your county worker.

Ombudsman for State Managed Health Care Programs
The Ombudsman for State Managed Health Care Programs, at the Minnesota Department of Human Services, helps people enrolled in a health plan in resolving service and billing problems. They can help you file a grievance or appeal with us. The Ombudsman can also help you request a State Fair Hearing. Call 651-431-2660 or 1-800-657-3729 (toll free).

Office of Ombudsman for Long-Term Care
Contact the Office of Ombudsman for Older Minnesotans for assistance with concerns about nursing homes, boarding care homes, adult care homes (i.e., housing with services, assisted living, customized living, or foster care), home care services, and hospital access or discharge for people with Medicare. Call 651-431-2555 or 1-800-657-3591 (toll free).

How to contact the 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.

Call 1-800-MEDICARE (1-800-633-4227) to ask questions or get free information booklets about Medicare. TTY users should call 1-877-486-2048. Customer service representatives are available 24 hours a day, including weekends.

Visit www.medicare.gov. This is the official government web site for Medicare. It gives you up-to-date information about Medicare and current Medicare issues. It also has information about hospitals, nursing homes, physicians, home health agencies, and dialysis facilities. It includes booklets you can print directly from your computer. It has tools to help you compare Medicare Advantage Plans and Medicare drug plans in your area. You can also find Medicare contacts in your state by selecting "Useful Phone Numbers and Websites," located under "Help & Support."

If you don't have a computer, your local library or senior center may be able to help you visit this web site using its computer. Or, you can call Medicare at the number above and tell them what information you are looking for. They will find the information on the web site, print it out, and send it to you.

Senior LinkAge Line® – a State program that gives free help, information, and answers to your questions about Medicare.

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

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

You may contact the Senior LinkAge Line® at 1-800-333-2433, or write to them at Minnesota Board on Aging, P.O. Box 64976, St. Paul, MN 55164-0976. You may also find the web site for the Senior LinkAge Line® at www.minnesotahelp.info.

Section 2. Important information on getting the care you need

Each time you get health services, check to be sure the provider is a Plan network provider. Members receive a *Provider Directory*. It lists Plan network providers. It is current as of the date it is printed. To verify current information, you can call Customer Services at the phone number in Section 1, or visit our web site listed in Section 1.

You chose or have been assigned to a Plan network doctor or clinic. The name of the doctor or clinic you must go to is on your member card. This is your Primary Care Clinic.

Your Primary Care Clinic or doctor will arrange most of your medical care. It is important that one doctor knows about all your medical needs. The doctor can make sure you get the care you need.

You do not need a referral to see a Plan network specialist.

Contact your Primary Care Clinic for information about the clinic's hours and service authorizations, and to make an appointment. If you cannot go to your appointment, call your clinic right away.

You may change your Primary Care Provider or Clinic. To find out how to do this, call Customer Services at the phone number in Section 1.

Transition of care:

If you are a newly enrolled member who is currently receiving care from a provider who is not a Plan network provider, we will help you transition to a participating provider.

Service authorizations:

Our approval is needed for some services to be covered. This is called service authorization. The approval must be obtained before you get the services or before we pay for them. Many of these services are noted in Section 7. For more information, call Customer Services at the phone number in Section 1.

If you need a covered service that you cannot get from a Plan network provider, you must get a service authorization from us to see a non-network provider. Exceptions to this rule are:

- Open access services: family planning, diagnosis of infertility, testing and treatment of sexually transmitted diseases (STDs), and testing for AIDS or other HIV-related conditions are open access services. You can go to any doctor, clinic, pharmacy, or family planning agency, even if it is not in our network, to get these services.
- Emergency and post-stabilization services.

For more information, call Customer Services at the phone number listed in Section 1.

If we are unable to find you a qualified Plan network provider, we must give you a standing service authorization for you to see a qualified specialist for any of these conditions:

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

If you do not get a service authorization from us when needed, the bill may not be paid. For more information, call Customer Services at the phone number in Section 1.

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

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

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

For more information, call Customer Services at the phone number in Section 1.

Covered and non-covered services:

Enrollment in the Plan does not guarantee that certain items are covered. Some prescription drugs or medical equipment may not be covered. This is true even if they were covered before.

Some services and supplies are not covered. All health services must be medically necessary for them to be covered services. Read this EOC carefully. It lists many services and supplies that are not covered. See Sections 7 and 8.

Some services are not covered under the Plan, but may be covered through another source. See Section 9 for more information. If you are not sure whether a service is covered, call our Customer Services at the phone number in Section 1.

We may cover additional or substitute services under some conditions.

Cost sharing:

You may be required to contribute an amount toward some medical services. This is called cost sharing. Cost sharing consists of a copay or a deductible on certain services. You are responsible to pay your cost sharing amount to your provider. See Section 6 for more information.

Payments to providers:

We cannot pay you back for most medical bills that you pay. State and federal laws prevent us from paying you directly. If you paid for a service that you think we should have covered, call Customer Services.

You may get health services or supplies not covered by the Plan if you agree to pay for them. Providers must have you sign a form acknowledging that you will be responsible for the bill. Providers must have a signed form before providing services or supplies that are not covered by the Plan.

Interpreter services:

We will provide interpreter services to help you access services. This includes spoken language interpreters and hearing interpreters. Face-to-face oral language interpreter services are only covered if the interpreter is listed in the Minnesota Department of Health's Spoken Language Health Care Interpreter Roster. Please call Customer Services at the phone number in Section 1 to find out which interpreters you can use.

Home and Community-Based Services:

If you need certain services to help you live in the community, see Home and Community-Based Services in Section 7 for information on Elderly Waiver services.

Other health insurance:

If you have other health or dental insurance, tell us **before** you get care. We will let you know if you should use the Plan network providers or the health care providers used by your other insurance. We will coordinate with your other insurance plan. If your other health or dental insurance changes, tell your county worker.

If you have Medicare, you need to get most of your prescription drugs through the Medicare Prescription Drug Program (Medicare Part D). You must be enrolled in a Medicare prescription drug plan to get these services. The Plan does not pay for prescriptions that are covered under the Medicare Prescription Drug Program.

Private information:

We, and the health providers who take care of you, have the right to see information about your health care. When you enrolled in this Minnesota Health Care Program, you gave your consent for us to do this. We will keep this information private according to law.

Restricted Recipient Program:

The Restricted Recipient Program is a program for members who have received medical care and have not followed the rules or have misused services. Restricted Recipients may not pay out of pocket for services from provider types to whom they are currently restricted. If you are placed in this program, we may replace your regular member card with a Restricted Recipient Program card.

You must get health services from one designated doctor, one pharmacy, one hospital, or other health service provider. You must do this for at least 24 months of eligibility for Minnesota Health Care Programs (MHCP). You may also be assigned to a home health agency or other providers. You may not be allowed to use the personal care assistance choice or flexible use options or consumer-directed services. Placement in the program will stay with you if you change health plans. Placement in the program will also stay with you if you change to MHCP fee-for-service. You will not lose eligibility for MHCP because of placement in the program.

At the end of the 24 months, your use of health care services will be reviewed. If you still did not follow the rules, you will be placed in the program for an additional 36 months of eligibility. You have the right to appeal placement in the Restricted Recipient Program. See Section 13.

Cancellation:

Your coverage with us will be canceled if you are not eligible for Medical Assistance. It will also be canceled if you change health plans.

Section 3. Enrollee Bill of Rights

You have the right to:

Be treated with respect, dignity, and consideration for privacy.

Get the services you need 24 hours a day, seven days a week. This includes emergencies.

Be told about your health problems.

Get information about treatments, your treatment choices, and how they will help or harm you.

Participate with providers in making decisions about your health care.

Refuse treatment and get information about what might happen if you refuse treatment.

Refuse care from specific providers.

Know that we will keep your records private according to law.

Request and receive a copy of your medical records. You also have the right to ask to correct the records.

Get notice of our decisions if we deny, reduce or stop a service, or deny payment for a service.

File a grievance or appeal with us. You can also file a complaint with the Minnesota Department of Health.

Request a State Fair Hearing with the Minnesota Department of Human Services (also referred to as "the State"). You may request a State Fair Hearing before or at any time during our appeal process. You do not have to file an appeal with us before you request a State Fair Hearing.

Receive a clear explanation of covered nursing home and home care services.

Give written instructions that inform others of your wishes about your health care. This is called a "health care directive." It allows you to name a person (agent) to decide for you if you are unable to decide, or if you want someone else to decide for you.

Choose where you will get family planning services.

Get a second opinion for medical, mental health, and chemical dependency services.

Be free of restraints or seclusion used as a means of coercion; discipline; convenience; or retaliation.

Request a copy of this *Evidence of Coverage* at least once a year.

Get the following information from us, if you ask for it:

- Whether we use a physician incentive plan that affects the use of referral services.
- The type(s) of incentive arrangement used.
- Whether stop-loss protection is provided.

- Results of a member survey, if one is required because of our physician incentive plan.
- Results of an external quality review study from the State.

Make recommendations about our rights and responsibilities policy.

Exercise the rights listed here.

Section 4. Enrollee responsibilities

You have the responsibility to:

Read this *Evidence of Coverage* and know which services are covered under the Plan and how to get them.

Show your health plan member card and your Minnesota Health Care Program (ID) card every time you get health care. Also show the cards of any other health coverage you have, such as Medicare or private insurance.

Establish a relationship with a plan network primary care doctor before you become ill. This helps you and your primary care doctor understand your total health condition.

Give information asked for by your doctor. Share information about your health history.

Follow all of your doctor's instructions. If you have questions about your care, ask your doctor.

Work with your doctor to understand your total health condition. It is important to know what to do when a health problem occurs, when and where to seek help, and how to prevent health problems.

Practice preventive health care. Have tests, exams and shots recommended for you based on your age and gender.

Contact us if you have any questions, concerns, problems or suggestions. If you do, please call Customer Services at the phone number in Section 1.

Section 5. Your health plan member card

Each member will receive a member card.

Always carry your member card with you.

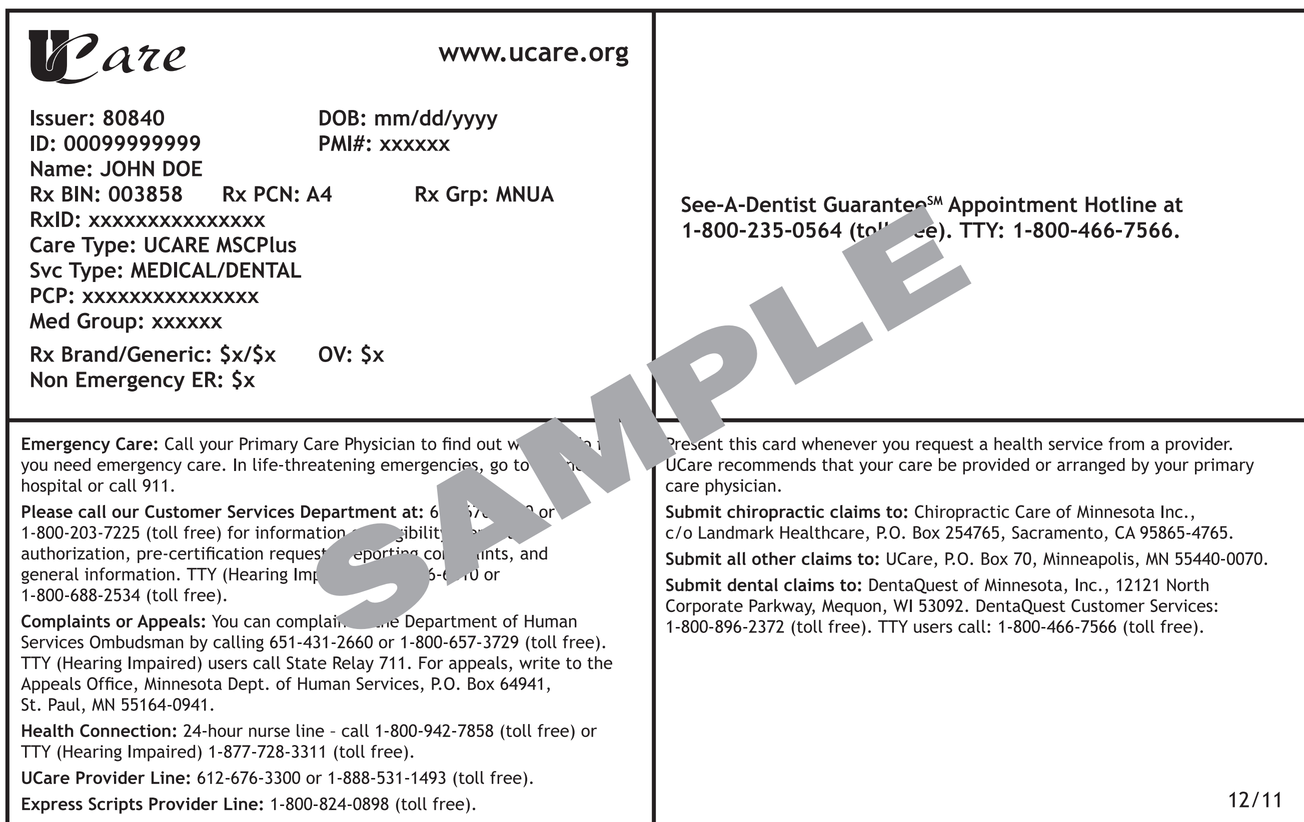
You must show your member card whenever you get health care.

You must use your health plan member card along with your Minnesota Health Care Program (ID) card. Also show the cards of any other health coverage you have, such as Medicare or private insurance.

Call Customer Services at the phone number in Section 1 right away if your member card is lost or stolen. We will send you a new card.

Call your county worker if your Minnesota Health Care Program (ID) card is lost or stolen.

Here is a sample member card to show what it looks like:



UCare www.ucare.org

Issuer: 80840 DOB: mm/dd/yyyy
ID: 00099999999 PMI#: xxxxxx
Name: JOHN DOE
Rx BIN: 003858 Rx PCN: A4 Rx Grp: MNUA
RxID: xxxxxxxxxxxxxxx
Care Type: UCARE MSCPlus
Svc Type: MEDICAL/DENTAL
PCP: xxxxxxxxxxxxxxx
Med Group: xxxxxx
Rx Brand/Generic: $x/$x OV: $x
Non Emergency ER: $x

See-A-Dentist Guarantee(SM) Appointment Hotline at 1-800-235-0564 (toll [illegible]). TTY: 1-800-466-7566.

SAMPLE

Emergency Care: Call your Primary Care Physician to find out w[illegible] you need emergency care. In life-threatening emergencies, go to [illegible] hospital or call 911.

Please call our Customer Services Department at: 6[illegible] or 1-800-203-7225 (toll free) for information [illegible] authorization, pre-certification request[illegible] reporting co[illegible]ints, and general information. TTY (Hearing Imp[illegible] or 1-800-688-2534 (toll free).

Complaints or Appeals: You can complain [illegible] Department of Human Services Ombudsman by calling 651-431-2660 or 1-800-657-3729 (toll free). TTY (Hearing Impaired) users call State Relay 711. For appeals, write to the Appeals Office, Minnesota Dept. of Human Services, P.O. Box 64941, St. Paul, MN 55164-0941.

Health Connection: 24-hour nurse line - call 1-800-942-7858 (toll free) or TTY (Hearing Impaired) 1-877-728-3311 (toll free).

UCare Provider Line: 612-676-3300 or 1-888-531-1493 (toll free).

Express Scripts Provider Line: 1-800-824-0898 (toll free).

Present this card whenever you request a health service from a provider. UCare recommends that your care be provided or arranged by your primary care physician.

Submit chiropractic claims to: Chiropractic Care of Minnesota Inc., c/o Landmark Healthcare, P.O. Box 254765, Sacramento, CA 95865-4765.

Submit all other claims to: UCare, P.O. Box 70, Minneapolis, MN 55440-0070.

Submit dental claims to: DentaQuest of Minnesota, Inc., 12121 North Corporate Parkway, Mequon, WI 53092. DentaQuest Customer Services: 1-800-896-2372 (toll free). TTY users call: 1-800-466-7566 (toll free).

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Section 6. Cost sharing

Cost sharing refers to your responsibility to pay an amount towards your medical costs. Cost sharing consists of copays and a monthly deductible.

If your income is at or below 100 percent of federal poverty guidelines, you will pay no more than 5 percent of your monthly family income for cost sharing. This may reduce the copay and deductible amount to less than the amounts listed here. DHS will tell us each month if you have a reduced cost sharing amount.

Copays

The members listed here **do not** have to pay copays for medical services that are covered by Medical Assistance (MA) under the Plan:

- Members receiving hospice care.
- Members residing in a nursing home, hospital, or other long-term care facility for more than 30 days.

Some services require copays. A copay is an amount that you will be responsible to pay to your provider.

Copays are listed in the following chart:

Service	Copay Amount
Non-preventive visits *(such as visits for a sore throat, diabetes check-up, high fever, sore back, etc.)* – provided by a physician, physician assistant, advanced practice nurse, certified professional midwife, chiropractor, acupuncturist, podiatrist, audiologist, or eye doctor. There are no copays for mental health services.	$3.00
Diagnostic procedures *(for example: colonoscopy, endoscopy, arthroscopy).*	$3.00
Emergency room visit when it is not an emergency.	$3.50
Brand-name prescriptions. *The most you will have to pay in copays for prescriptions is $12.00 per month.*	$3.00
Generic prescriptions. *The most you will have to pay in copays for prescriptions is $12.00 per month.*	$1.00

The most you will have to pay in copays for prescriptions is $12.00 per month. Copays will not be charged for some mental health drugs and most family planning drugs.

If you have Medicare, you must get most of your prescription drugs through a Medicare prescription drug (Medicare Part D) plan. You may have different copays with no monthly limit for some of these services.

You must pay your copay directly to your provider. Some providers require that you pay the copay when you arrive for the medical service. The hospital may bill you after your non-emergency visit to the emergency room.

If you are unable to pay the copay, the provider must still provide services. This is true even if you have not paid your copay to that provider in the past or if you have other debts to that provider. The provider may still bill you for the unpaid copays.

We get information from the State about which members do not have copays. You may need to pay a copay until you are listed in our system as a person who is exempt from copays.

Examples of services that do not have copays:

- Chemical dependency treatment.
- Dental services.
- Emergency services.
- Eyeglasses.
- Family planning services.
- Home care.
- Immunizations.
- Inpatient hospital stays.
- Interpreter services.
- Medical equipment and supplies.
- Mental health services.
- Rehabilitation therapies.
- Preventive care visits, like physicals.
- Repair of eyeglasses.
- Services covered by Medicare, except for Medicare Part D drugs.
- Some mental health drugs (anti-psychotics).
- Tests such as blood work and X-rays.
- Medical transportation.
- 100% federally funded services at Indian Health Services clinics.

This is not a complete list. Call Customer Services at the phone number in Section 1 if you have questions.

Family Deductible

A family deductible is an amount adult family members must pay each month toward health care costs. A deductible is separate from copays. The family deductible amount is $2.55 per month.

The members listed here **do not** have to pay a deductible for medical services that are covered by Medical Assistance (MA) under the Plan:

- Members receiving hospice care.
- Members residing in a nursing home, hospital, or other long-term care facility for more than 30 days.

The deductible will not apply to the following services:

- Pharmacy charges.
- Emergency services provided in a hospital, clinic, office or other facility.
- Family planning services.
- Any service that has a copay applied to it.
- Chemical dependency treatment services.

- Services paid by Medicare.
- Services received by an American Indian from an Indian Health Care Provider or through contracted health services (IHS-CHS) referral from an IHS facility.

Call Customer Services at the phone number in Section 1 if you have questions.

Section 7. Covered services

This section describes the major services that are covered under the Plan for Medical Assistance enrollees. It is not a complete list. Some services have limitations or require a service authorization. These services are marked with an asterisk (*). Make sure there is a service authorization in place before you get the service. All health care services must be medically necessary for them to be covered. Call Customer Services at the phone number in Section 1 for more information.

Some services require cost sharing. Cost sharing refers to your responsibility to pay an amount toward your medical costs. See Section 6 for information about cost sharing and exceptions to cost sharing.

Chemical Dependency Services

Covered Services:

- Assessment/diagnosis.*
- Outpatient treatment.*
- Inpatient hospital.*
- Residential non-hospital treatment.*
- Outpatient methadone treatment.*
- Detoxification *(only if required for medical treatment).*
- Room and board determined necessary by chemical dependency assessment.*

Notes:

See Section 1 for Chemical Dependency Services contact information.

A qualified Plan network assessor will decide what type of chemical dependency care you need. You may get a second assessment if you do not agree with the first one. To get a second assessment you must send us a request. We must get your request within five working days of when you get the results of your first assessment, or before you begin treatment (whichever is first). We will cover a second assessment by a different qualified assessor not in the Plan network. We will do this within five working days of when we get your request. If you agree with the second assessment, we will authorize services according to chemical dependency standards and the second assessment. You have the right to appeal. See Section 13 of this *Evidence of Coverage.*

Chiropractic Care*

Covered Services:

- One evaluation or exam per year.
- Manual manipulation (adjustment) of the spine to treat subluxation of the spine.
- Acupuncture for chronic pain management within the scope of practice by chiropractors with acupuncture training or credentialing.
- X-rays when needed to support a diagnosis of subluxation of the spine.

Not Covered Services:

- Other adjustments, vitamins, medical supplies, therapies, and equipment from a chiropractor.

Dental Services

Covered Services:

- Diagnostic services, including:
  - Comprehensive exam *(every five years for).*
  - Periodic exam *(once per calendar year for. UCare also covers one additional periodic exam per calendar year).*
  - Limited problem-focused exams *(once per day per facility).*
  - X-rays are limited to:
    - Bitewing *(once per calendar year).*
    - Single x-rays for diagnosis of problems.
    - Panoramic *(once every five years; as medically necessary for diagnosis and follow-up of oral and maxillofacial conditions and trauma; once every two years in limited situations).*
    - Full mouth x-rays *(once every five years only when provided in an outpatient hospital or freestanding Ambulatory Surgery Center (ASC)).*
- Preventive services, including:
  - Cleaning *(once per calendar year. UCare also covers one additional cleaning per calendar year).*
  - Fluoride varnish *(once per calendar year).*
- Restorative services, including:
  - Fillings.
  - Sedative fillings for relief of pain.
- Endodontics (root canals) *(on anterior teeth and premolars only and once per lifetime; retreatment is not covered).*
- Periodontics, including:*
  - Gross removal of plaque and tartar *(once every five years).*
  - Scaling and root planing *(once every two years only when provided in an outpatient hospital or freestanding Ambulatory Surgery Center (ASC)).*
- Prosthodontics, including:*
  - Removable prostheses (dentures and partials) once every six years per dental arch.
- Oral surgery *(limited to extractions, biopsies, and incision and drainage of abscesses).**
- Additional general services, including:
  - Treatment for pain *(once per day).*
  - General anesthesia *(only when provided in an outpatient hospital or freestanding Ambulatory Surgery Center (ASC)).*

Not Covered Services:

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

UCare See-A-Dentist Guarantee℠ feature. Through this unique guarantee, you get a dental appointment with one phone call. We will:

- Offer you a dental appointment within 30 days for cleaning and routine check-ups.
- Help you schedule appointments for more complex dental needs.
- Assist in scheduling appointments for you on our Mobile Dental Clinic (when in the service area).
- Provide personal scheduling assistance through our See-A-Dentist Hotline (see Section 1 for the phone number).

If we are unable to offer an appointment within 30 days, we will continue to work with you to access a dentist. We will also give you a free dental care kit, including an electric toothbrush and a complete guide to oral health. Certain limitations apply.

Notes:

See Section 1 for Dental Services contact information.

Diagnostic Services

Covered Services:

- Lab tests and X-rays.
- Other medical diagnostic tests ordered by your doctor.

Doctor and Other Health Services

Covered Services:

- Doctor visits, including:
  - Family planning – **open access service.**
  - Lab tests and x-rays.
  - Physical exams.
  - Preventive exams.
  - Preventive office visits.
  - Specialists.
  - Telemedicine consultation.
  - Vaccines and drugs administered in a doctor's office.
  - Visits for illness or injury.
  - Visits in the hospital or nursing home.
- Immunizations.
- Clinical trial coverage: Routine care that: 1) is provided as part of the Protocol Treatment of a cancer Clinical Trial; 2) is usual, customary and appropriate to your condition; and 3) would be typically provided outside of a Clinical Trial. This includes services and items needed for the treatment of effects and complications of the Protocol Treatment.
- Podiatry services *(debridement of toenails, infected corns and calluses, and other non-routine foot care).*
- Services of a certified public health nurse or a registered nurse practicing in a public health nursing clinic under a governmental unit.

- Advanced practice nurse services: services provided by a nurse practitioner, nurse anesthetist, nurse midwife, or clinical nurse specialist.
- Community health worker care coordination and patient education services.
- Health education and counseling *(e.g., smoking cessation, nutrition counseling, diabetes education).*
- Blood and blood products.
- Cancer screenings *(including mammography, Pap test, prostate cancer screening, colorectal cancer screening).*
- Tuberculosis care management and direct observation of drug intake.
- Counseling and testing for sexually transmitted diseases (STDs), AIDS, and other HIV-related conditions **– open access service.**
- Treatment for AIDS and other HIV-related conditions **– NOT** an open access service. You must see a provider in the Plan network.
- Treatment for sexually transmitted diseases (STDs) **– open access service.**
- Acupuncture for chronic pain management by licensed acupuncturist, or within the scope of practice by a licensed provider with acupuncture training or credentialing.
- Respiratory therapy.

Not Covered Services:

- Artificial ways to become pregnant *(artificial insemination, including in-vitro fertilization and related services; fertility drugs and related services).*

Emergency Medical Services and Post-Stabilization Care

Covered Services:

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

Not Covered Services:

- Emergency care, urgent care, or other health care services received from providers located outside of the United States.

Notes:

In an emergency that needs treatment right away, either call 911 or go to the closest emergency room. Show them your member card and ask them to call your primary care doctor.

In all other cases, call your primary care doctor, if possible. The number is answered 24 hours a day, seven days a week. The doctor will tell you what to do.

If you are out of town, go to the closest emergency room. Show them your member card and ask them to call your primary care doctor.

You must call your Primary Care Clinic within 48 hours or as soon as you can after getting emergency care at a hospital that is not a part of the Plan network.

Eye Care Services

Covered Services:

- Eye exams.
- Eyeglasses, including identical replacement due to damage, loss, or theft.
- Repairs to frames and lenses for eyeglasses covered under the Plan.
- Tints or polarized lenses, when medically necessary.
- Contact lenses, when medically necessary under certain conditions.

Not Covered Services:

- Extra pair of glasses.
- Eyeglasses more often than every 24 months, unless medically necessary.
- Bifocal/Trifocal lenses without lines and progressive bifocals/trifocals.
- Protective coating for plastic lenses.
- Contact lenses supplies.

Family Planning Services

Covered Services:

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

Not Covered Services:

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

Notes:

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

Hearing Aids

Covered Services:

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

Home Care Services*

Covered Services:

- Skilled nursing.
- Rehabilitation therapies to restore function *(for example: speech, physical, occupational).*
- Home health aide.
- Private duty nursing.
- Personal Care Assistant (PCA) services.

Home and Community-Based Services (Elderly Waiver)

Covered Services:

- Adult Day Care: Health and social services given on a regular basis in a licensed setting.
- Adult Foster Care: A home that provides care in a family-like setting.
- Case Management: Management of your health and long-term care services among different health and social service workers.
- Chore Services: Services needed to keep your home clean and safe.
- Companion Services: Non-medical social support services for members who need supervision.
- Consumer Directed Community Support Services: Services that you manage yourself within a set budget.
- Customized Living/24-Hour Customized Living: A group of services given in an assisted living setting.
- Environmental Accessibility Adaptations: Physical changes to your home and vehicle needed to assure health and safety.
- Extended Home Health Care Services: This includes home health aide and nursing services that are over the Medical Assistance limit.
- Extended Private Duty Nursing: This includes private duty nursing services that are over the Medical Assistance limit.
- Extended Personal Care Assistance Services: Help with personal care and activities of daily living over the Medical Assistance limit.
- Family and Care Giver Training and Education: Training for unpaid caregivers.
- Home Delivered Meals: Meals delivered to your home.
- Homemaker Services: General household activities to keep up the home.

- Residential Care Services: A group of services offered in a licensed board and lodge setting.
- Respite Care: Short-term service when you cannot care for yourself, and your unpaid caregiver needs relief.
- Specialized Medical Supplies and Equipment: Supplies and equipment that are over the Medical Assistance limit or coverage.
- Transitional Supports Services: One-time costs related to setting up a household (such as when a person leaves a nursing home).
- Transportation: A ride to activities and services in the community.

Notes:

You must have a Long-Term Care Consultation (LTCC) done and found to be nursing home certifiable to get these Elderly Waiver (EW) services. You can request to have this assessment in your home, apartment, or facility where you live. Your MSC+ care coordinator will meet with you and your family to talk about your care needs within 10 days if you call to ask for a visit.

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

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

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

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

See Home and Community-Based Services in Section 1 for contact information.

Hospice

Covered Services:

- Doctor, nurse, and other professional services.
- Medical social services.
- Medical equipment and supplies.
- Physical, occupational, and speech therapies.
- Short-term inpatient care, including respite care.
- Counseling, including dietary counseling.

- Home health aide and homemaker services.
- Outpatient drugs for symptom management and pain relief.

Notes:

You must elect hospice benefits to receive hospice services.

Members under the age of 21 receiving hospice services have coverage for services related to treatment of the terminal condition.

If you are interested in using hospice services, please call Customer Services at the phone number in Section 1.

Hospital – Inpatient

Covered Services:

- Inpatient hospital stay.
- Your semi-private room and meals.
- Private room when medically necessary.
- Tests and x-rays.
- Surgery.
- Drugs.
- Medical supplies.
- Therapy services *(for example: physical, occupational, speech, respiratory).*

Not Covered Services:

- Personal comfort items, such as TV, phone, barber or beauty services, guest services.

Hospital – Outpatient

Covered Services:

- Urgent care for conditions that are not as serious as an emergency.
- Outpatient surgical center.
- Tests and x-rays.
- Dialysis.
- Emergency room services.
- Post-stabilization care.

Interpreter Services

Covered Services:

- Spoken language interpreter services.
- Hearing interpreter services.

Notes:

Interpreter services are available to help you get services.

Oral interpretation is available for any language.

Face-to-face oral language interpreter services are only covered if the interpreter is listed in the Minnesota Department of Health's Spoken Language Health Care Interpreter Roster. See Interpreter Services in Section 1 for contact information and to find out which interpreters you can use.

Medical Equipment and Supplies*

Covered Services:

- Prosthetics or orthotics.
- Durable medical equipment* *(e.g., wheelchair, hospital bed, walker, crutches, wigs for people with alopecia areata).* Contact Customer Services for more information on coverage for wigs.
- Repairs of medical equipment.*
- Batteries for medical equipment.
- Some shoes when part of a leg brace or when custom molded.
- Oxygen and oxygen equipment.
- Medical supplies you need to take care of your illness, injury or disability.
- Diabetic equipment and supplies.
- Nutritional/enteral products when specific criteria are met.
- Incontinence products.
- Family planning supplies – **open access service.** See Family Planning Services in this section.

Not Covered Services:

- Constructive modifications to home, vehicle, or workplace, including bathroom grab bars.
- Environmental products *(such as air filters, purifiers, conditioners, dehumidifiers).*
- Exercise equipment.

Notes:

You need a prescription/doctor's order in order for medical equipment and supplies to be covered.

Please call the Durable Medical Equipment Coverage Criteria phone number in Section 1 if you need more information on our durable medical equipment coverage criteria.

Mental Health Services

Covered Services:

- Crisis response services, including:
  - Assessment.
  - Intervention.

  - Stabilization.
  - Community intervention.
- Diagnostic assessments, including screening for the presence of co-occurring mental illness and substance use disorder.
- Mental Health Targeted Case Management (MH-TCM).*
- Dialectical Behavioral Therapy (DBT).*
- Inpatient psychiatric hospital stay.*
- Outpatient Mental Health Services, including:
  - Explanation of findings.
  - Mental health medication management.
  - Neuropsychological services.*
  - Psychotherapy.
  - Psychological testing.
- Rehabilitative Mental Health Services, including:
  - Assertive Community Treatment (ACT).*
  - Adult Day Treatment.
  - Adult Rehabilitative Mental Health Services (ARMHS).
  - Certified Peer Specialist Support Services in some situations.
  - Intensive Residential Treatment Services (IRTS).*
  - Partial Hospitalization Program.*
- Physician Mental Health Services, including:
  - Health and behavior assessment/intervention.
  - Inpatient visits.
  - Psychiatric consultations to primary care providers.
  - Physician consultation, evaluation, and management.

Not Covered Services:

The following services are not covered under the Plan, but may be available through your county. Call your county for information. Also see Section 9.

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

Notes:

See Mental Health Services in Section 1 for information on where you should call or write.

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

If we decide no structured mental health treatment is necessary, you may get a second opinion. For the second opinion, we must allow you to go to any qualified health professional that is not in the Plan network. We will pay for this. We must consider the second opinion, but we have the right to disagree with the second opinion.

You have the right to appeal our decision.

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

Nursing Home Services*

Covered Services:

- Nursing Home Daily Rate – We are responsible for paying a total of 180 days of nursing home room and board. If you need continued nursing home care beyond the 180 days, the Minnesota Department of Human Services (DHS) will pay directly for your care. If DHS is currently paying for your care in the nursing home, DHS, not us, will continue to pay for your care.
- Skilled nursing care.
- Therapy services.
- Drugs.
- Medical supplies and equipment.

Not Covered Services:

- A private room, unless your doctor orders it for a medical reason.
- Personal comfort items, such as TV, phone, barber or beauty services, guest services.

Out-of-Area Services

Covered Services:

- A service you need when temporarily out of the Plan service area.*
- A service you need after you move from our service area while you are still a Plan member.*
- Emergency services for an emergency that needs treatment right away.
- Post-stabilization care.
- Medically necessary urgent care when you are outside of the Plan service area. (Call Customer Services at the phone number in Section 1 as soon as possible.)
- Covered services that are not available in the Plan service area.*

Not Covered Services:
Emergency care, urgent care, or other health care services received from providers located outside of the United States.

Out-of-Network Services

Covered Services:

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

Prescription Drugs (for members who do NOT have Medicare)

Covered Services:

- Prescription drugs.
- Medication therapy management (MTM) services.
- Certain over-the-counter drugs *(when prescribed by a physician or pharmacist)*.

Not Covered Services:

- Drugs used to treat impotence or erectile dysfunction.
- Drugs used to enhance fertility.
- Drugs used for cosmetic purposes, including drugs to treat hair loss.
- Drugs or products to promote weight loss.
- Drugs not clinically proven to be effective.

Notes:

The drug must be on our covered drug list (formulary). We will cover a non-formulary drug if your doctor shows us that: 1) the drug that is normally covered has caused a harmful reaction to you; 2) there is a reason to believe the drug that is normally covered would cause a harmful reaction; or 3) the drug prescribed by your doctor is more effective for you than the drug that is normally covered. The drug must be in a class of drugs that is covered.

We will cover an antipsychotic drug, even if it is not on our drug list, if your provider certifies this is best for you. There is no copay for anti-psychotic drugs. In certain cases, we will also cover other drugs used to treat a mental illness or emotional disturbance, even if the drug is not on our approved drug list. We will do this for up to one year if your provider certifies the drug is best for you and you have been treated with the drug for 90 days before: 1) we removed the drug from our drug list; or 2) you enrolled in the Plan. For most drugs, you can get only a 34-day supply at one time.

If your doctor prescribes a drug that is not on our formulary or a drug requires prior authorization, he or she should call Express Scripts to request a prior authorization. Non-formulary exception request forms and prior authorization forms can also be found on our web site at www.ucare.org (http://www.ucare.org/providers/formularies.html).

If a pharmacy staff tells you the drug is not covered and asks you to pay, ask them to call your doctor. We cannot pay you back if you pay for it. There may be another drug that will work that is covered by us under the Plan. If the pharmacy won't call your doctor, you can. You can also call Customer Services at the phone number in Section 1 for help.

CuraScript specialty pharmacy: CuraScript, Inc. (CuraScript) is the exclusive provider of specialty medications for UCare members. Specialty medications are costly injectable or oral drugs that often require special handling or have side effects that require monitoring by a trained pharmacist or nurse. If you are currently using a specialty medication, CuraScript will contact you and your physician to transfer the prescription to CuraScript. Your medication and any needed supplies will be shipped to your home, work, or doctor's office. CuraScript will also provide clinical support to you and your caregivers. A CuraScript pharmacist is available any time of day if you have an urgent need related to your medication.

Prescription Drugs (for members who have Medicare)

Covered Services:

- Benzodiazepines, barbiturates, some over-the-counter products, some prescription cough and cold products, and some vitamins that are not covered under the Medicare Prescription Drug Program (Medicare Part D).

Not Covered Services:

- Prescription drugs that are eligible to be covered under the Medicare Prescription Drug Program (Medicare Part D).
- Drugs used to treat impotence or erectile dysfunction.
- Drugs used to enhance fertility.
- Drugs used for cosmetic purposes, including drugs to treat hair loss.
- Drugs or products to promote weight loss.
- Drugs not clinically proven to be effective.

Notes:

Medicare pays for most of your prescription drugs through the Medicare Prescription Drug Program (Medicare Part D). **You must enroll in a Medicare prescription drug plan** to receive most of your prescription drug services. You will get your prescription drug services through your Medicare prescription drug plan – not through our Plan. You may have to pay a copay for prescriptions covered by your Medicare prescription drug plan.

Preventive Care and Screening Tests

Covered Services:

- Immunizations.
- Age and risk appropriate routine examinations *(e.g., physical, vision, and hearing).*
- Cancer screenings *(including mammography, Pap test, prostate cancer screening, colorectal cancer screening).*
- Health education and counseling *(e.g., smoking cessation, nutrition counseling, diabetes education).*
- Family planning visit **– open access service.**
- Bone mass measurement.

Rehabilitation*

Covered Services:

- Rehabilitation therapies to restore function: physical therapy, occupational therapy, speech therapy.
- Audiology services, including hearing tests.

Not Covered Services:

- Vocational rehabilitation.
- Health clubs and spas.

Surgery*

Covered Services:

- Office/clinic visits/surgery.
- Removal of port wine stain birthmarks.
- Reconstructive surgery *(e.g., following mastectomy, following surgery for injury, sickness or other diseases; for birth defects).*
- Anesthesia services.
- Circumcision when medically necessary.

Not Covered Services:

- Cosmetic surgery.
- Sex reassignment surgery.

Transplants*

Covered Services:

- Organ and tissue transplants, including: kidney, cornea, bone marrow, stem cell, heart, heart-lung, liver, lung, pancreas, pancreas-kidney, pancreatic islet cell, intestine, intestine-liver, and other transplants.

Notes:

The type of transplant must be: 1) listed in the Minnesota Department of Human Services Provider Manual; 2) a type covered by Medicare; or 3) be approved by the State's medical review agent.

Transplants must be done at transplant centers that meet the United Network for Organ Sharing (UNOS) standards, or at Medicare-approved transplant centers.

Stem cell or bone marrow transplants centers must meet the standards set by the Foundation for the Accreditation of Cellular Therapy (FACT).

Transportation to/from Medical Services

Covered Services:

- Emergency ambulance *(air or ground).*
- Non-emergency ambulance.
- Special transportation *(for members who, because of physical or mental impairment, cannot safely use a common carrier and do not need an ambulance).*
- Common carrier transportation *(e.g., bus, cab, or through volunteer driver programs).*

Not Covered Services:

- Mileage reimbursement (for example, when you use your own car), meals, lodging, and parking. These services are not covered under the Plan, but may be available through another source. Call your county for more information.

Notes:

If you need transportation to and from health services that we cover, call the Transportation phone number in Section 1.

The Plan is not required to provide transportation to your Primary Care Clinic if it is over 30 miles from your home, or if you choose a specialty provider who is more than 60 miles from your home. Call Health Ride at the Transportation phone number in Section 1 if you do not have a Primary Care Clinic that is available within 30 miles of your home, and/or if it is over 60 miles to your specialty provider.

Health Ride: We provide rides to medical appointments for eligible members who have no other means of transportation. You must be able to ride in a car, meet our guidelines, and follow the rules. You can have a ride or bus pass to eligible covered services. Bus passes are available in the seven-county Minneapolis/St. Paul metro area, St. Cloud, Duluth, and greater St. Louis County. Examples of eligible rides are to a Plan network doctor's office (primary care, chiropractor, eye care, doctor, dentist, podiatrist, psychiatrist), physical therapy, and mental health and chemical dependency treatment. Rides are also provided to a pharmacy to pick up prescriptions. You can have a ride during business appointment hours, Monday through Friday. Emergency rides are available 24 hours a day, seven days a week. Call the number shown in Section 1. In case of a medical emergency, call 911.

Guidelines and rules:

- Rides are free. You can have a one-way or round-trip ride, or a bus pass (if available).
- If you use a wheelchair that folds and you can get into a car independently, the Health Ride driver will store your wheelchair for you. If your wheelchair does not fold or you need help getting into a car and you are eligible for special transportation, you can arrange wheelchair van service yourself. Call Health Ride at the number shown under Transportation in Section 1 for names and phone numbers of van service providers.
- If you ride in a cab, you must ride to and from a single pick-up address and a clinic. You cannot pick up or drop off anyone during your trip.
- Call Health Ride to change your destination prior to calling your cab.
- You may bring an attendant.
- If you need special help with your cab ride or bus pass, call Health Ride to find out your options.
- **You must use Health Ride for authorized trips only.** Health Ride reserves the right to verify appointments prior to providing rides.
- We may place restrictions on your Health Ride services benefit if you:
  - Miss three or more scheduled rides within a calendar year.
  - Are physically or verbally abusive to any Health Ride staff or participating transportation vendor.
  - Use or attempt to use Health Ride for unauthorized and non-covered purposes.
- Unauthorized use of the Health Ride includes, but is not limited to;
  - Receiving a ride without Health Ride authorization.
  - Going to a different location or facility than what was requested.
  - Providing false information in order to obtain a ride.
  - Use of another member's ID card number or other information in order to secure a ride.

How to schedule or cancel a ride:

- You must schedule your ride with Health Ride at least two days before your appointment. See the phone number in Section 1. You can order a bus pass from Health Ride (if available in your area) ten days prior to your scheduled appointment.
- Please give the pick-up address, drop-off address, and clinic or hospital telephone number for each ride scheduled.
- To get home from your medical appointment, you may use your bus pass, or the driver will give you a return ride pass. Call the number on the return pass to schedule your ride home. If you need a ride home from the clinic but Health Ride did not take you there, call Health Ride at the number shown in Section 1.
- If you cancel your medical appointment, please give advance notice to Health Ride to cancel your scheduled ride.

While in the vehicle:

- Do not distract the driver.
- Do not eat, drink, or smoke.
- Please use your seat belt.
- Children under 4 years or who weigh less than 40 pounds should use a child restraint seat. We suggest you bring a restraint seat for the child. Please note the driver does not assist in putting the seat in the vehicle. If you do not have a car seat, please call Customer Services for information about our car seat program. The driver can refuse your ride if you refuse to use a child restraint seat. Children cannot be left unattended in the car.
- The driver can refuse to give you a ride if you are abusive in any way.

Urgent Care

Covered Services:

- Urgent care within the Plan service area.
- Urgent care outside of the Plan service area.

Not Covered Services:

- Urgent care, emergency care, or other health care services received from providers located outside of the United States.

Notes:

An urgent condition is not as serious as an emergency. This is care for a condition that needs prompt treatment to stop the condition from getting worse. Urgent care is available 24 hours a day.

Call Customer Services at the phone number in Section 1 as soon as possible when you get urgent care outside the Plan service area.

Section 8. Services we do not cover

If you get services or supplies that are not covered, you may have to pay for them yourself. Some "not covered" services and supplies are listed under each category in Section 7. Below is a list of other services and supplies that are not covered under the Plan. This is not a complete list. Call Customer Services for more information.

- Health care services or supplies that are not medically necessary.
- Supplies that are not used to treat a medical condition.
- Hospital inpatient and nursing home incidental services, such as TV, phone, barber and beauty services, guest services.
- Cosmetic procedures or treatment.
- Experimental or investigative services.
- Emergency care, urgent care, or other health care services received from providers located outside of the United States.
- Autopsies.

Section 9. Services that are not covered under the Plan but may be covered through another source

These services are not covered by us under the Plan, but may be covered through another source, such as the State, county, federal government, tribe, or a Medicare Prescription Drug plan. To find out more about these services, call the Minnesota Health Care Programs Member Helpdesk at 651-431-2670 or 1-800-657-3739 (toll free).

- Case management for members with developmental disabilities.
- Intermediate care facility for members with developmental disabilities (ICF/DD).
- Nursing home stays.
- Prescriptions covered under the Medicare Prescription Drug Program (Medicare Part D). You must be enrolled in a Medicare prescription drug plan to get these services.
- Treatment at Rule 36 facilities that are not licensed as Intensive Residential Treatment Services (IRTS).
- Room and board associated with Intensive Residential Treatment Services (IRTS).
- Services provided by a state regional treatment center, a State-owned long-term care facility, or an institution for mental disease (IMD), unless approved by us or the service is ordered by a court under conditions specified in law.
- Services provided by federal institutions.
- Except Elderly Waiver services, other waiver services provided under Home and Community-Based Services waivers.
- Job training and educational services.
- Day training and habilitation services.
- Mileage reimbursement (for example, when you use your own car), meals, lodging, and parking. Contact your county for more information.

Section 10. When to call your county worker

Call your county worker to report these changes:

- Name or address changes.
- Admission to a nursing home.
- Addition or loss of a household member.
- Lost or stolen Minnesota Health Care Program (ID) card.
- New insurance or Medicare – begin/end dates.
- New job or change in income.

Section 11. Using the Plan coverage with other insurance

If you have other insurance, tell us before you get care. We will let you know if you should use the Plan network providers or the health care providers used by your other insurance. We will coordinate our payments with them. This is called "coordination of benefits." Examples of other insurance include:

- No-fault car insurance.
- Workers' compensation.
- Medicare.
- Other HMO coverage.
- Other commercial insurance.

When you become a member of the Plan, you agree to:

- Let us send bills to your other insurance.
- Let us get information from your other insurance.
- Let us get payments from your other insurance instead of payments going to you.
- Help us get payments from your other insurance.

If your other insurance changes, call your county worker.

Section 12. Subrogation or other claim

This first paragraph applies to certain non-citizens in the Minnesota Senior Care Plus Program (MSC+):

You may have other sources of payment for your medical care. They might be from another person, group, insurance company, or other organization. If you have a claim against another source for injuries, we will make a claim for medical care we covered for you. State law requires you to help us do this. The claim may be recovered from any settlement or judgment received by you from another source. This is true even if you did not get full payment of your claim. The amount of the claim will not be more than State law allows.

This second paragraph applies to members in the Minnesota Senior Care Plus Program (MSC+), except certain non-citizens:

You may have other sources of payment for your medical care. They might be from another person, group, insurance company or other organization. Federal and state laws provide that Medical Assistance benefits pay only if no other source of payment exists. If you have a claim against another source for injuries, we will make a separate claim for medical care we covered for you. The laws require you to help us do this. The claim may be recovered from any source that may be responsible for payment of the medical care we covered for you. The amount of the claim will not be more than Federal and State laws allow.

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Section 13. Grievance, appeal, and State Fair Hearing process

If you disagree with a decision or have a complaint, you can do any of the following:

You can call Customer Services at the phone number in Section 1 to file a grievance or appeal.

You can write to us to file a grievance or appeal. Write to the address listed in Section 1 listed under "Appeals and Grievances."

You can write to the Minnesota Department of Human Services to request a State Fair Hearing. You may request a State Fair Hearing at any time during the Plan appeal process. You do not have to file an appeal with us before you request a State Fair Hearing.

You can call or write to the Minnesota Department of Health.

Timelines for filing grievances, appeals, and State Fair Hearings:

You must request a State Fair Hearing **within 30 days** after the date on the notice from us. You have up to 90 days if you have a good reason for being late.

You must file a grievance or appeal with us **within 90 days** after the date on the Notice of Action or from the date of the incident about which you are complaining.

For the Restricted Recipient Program, an enrollee who receives a notice of restriction must file an appeal with us within 30 days of the date of the notice. You may also request a State Fair Hearing within 30 days of the date on the notice. You have up to 90 days if you have a good reason for being late.

Continuation of services:

If we are stopping or reducing a service, you can ask to keep getting the service if you file a health plan appeal or request a State Fair Hearing **within 10 days after we send you the notice, or before the service is stopped or reduced, whichever is later.** The participating treating provider must agree the service should continue. The service can continue until the appeal or State Fair Hearing is resolved. If you lose the appeal or State Fair Hearing, you may be billed for these services.

Personal Care Assistance (PCA) services during appeal:

If we are stopping or reducing your PCA services, you can ask to keep getting the same amount of services when you file a health plan appeal or a State Fair Hearing. You must file within 30 days from the date on the notice, or before the service is stopped or reduced, whichever is later. The services can continue until the appeal or State Fair Hearing is resolved. If you lose the appeal or State Fair Hearing, you may be billed for these services.

Your rights:

If you decide to file a grievance or appeal, or request a State Fair Hearing, it will not affect your eligibility for medical services. It will also not affect your enrollment in the health plan.

Your provider may file a grievance or appeal, or request a State Fair Hearing, on your behalf. The provider must have your written consent. The treating provider may appeal utilization review decisions with us without your written consent.

You can have a relative, friend, advocate, provider, or lawyer help with your grievance, appeal, or State Fair Hearing.

You may request a State Fair Hearing at any time during the Plan appeal process. You do not have to file an appeal with us before you request a State Fair Hearing.

There is no cost to you for filing an appeal with us or for a State Fair Hearing. We may pay for some expenses such as transportation, child care, photocopying, etc.

If you have seen a medical provider who is part of our Plan network and want another opinion, you can get a second opinion. You must see another Plan network medical provider.

If you have seen a mental health provider who is part of the Plan network and have been told that no structured mental health treatment is needed, you may get a second opinion. See "Mental Health Services" in Section 7 of this document for more information.

If you have seen a chemical dependency assessor who is part of our Plan network and you disagree with the assessment, you may get a second opinion. See "Chemical Dependency Services" in Section 7 of this document for more information.

If you ask to see your medical records, or want a copy, we or your provider must provide them to you at no cost. You may need to put your request in writing.

To file an oral grievance with us:

A grievance is an expression of discontent about any matter other than an action, as defined in Section 14. This includes, but is not limited to, discontent with:

- Quality of care or services provided.
- Failure to respect your rights.

Call Customer Services at the phone number in Section 1 and tell us about the problem.

We will give you a decision within 10 days. We may take up to 14 more days to make a decision if we need more information and it will be in your best interest. We will tell you within 10 days that we are taking extra time and the reasons why.

If your grievance is about our denial of an expedited appeal, or a grievance about urgent health care issues, we will give you a decision within 72 hours.

If you do not agree with our decision, you can file a complaint with the Minnesota Department of Health. You can also call the Ombudsman for State Managed Health Care Programs for help.

To file a written grievance with us:

Send a letter to us about your grievance. Write to the address listed in Section 1 listed under "Appeals and Grievances."

We can help you put your grievance in writing. Call Customer Services at the phone number in Section 1 if you need help.

We will notify you within 10 days that the grievance has been received.

We will give you a written decision within 30 days from the day we get your grievance. We may take up to 14 more days to make a decision if we need more information and it will be in your best interest. We will tell you within 30 days that we are taking extra time and the reasons why.

If your grievance is about our denial of an expedited appeal, or a grievance about urgent health care issues, we will give you a decision within 72 hours.

If you do not agree with our decision, you can file a complaint with the Minnesota Department of Health. You can also call the Ombudsman for State Managed Health Care Programs for help.

To file an oral or written appeal with us:

An appeal is your oral or written request for review of our action on a request for services or payment. This includes:

- Denial or limited authorization in the type or level of service.
- Reduction, suspension, or stopping of a service that was approved before.
- Denial of all or part of payment for a service.
- Not providing services in a reasonable amount of time.
- Not acting within required time frames for grievances and appeals.
- Denial of a member's request to get services out of network for members living in a rural area with only one health plan.

Call Customer Services at the phone number in Section 1 and request an oral appeal. Tell us why you disagree with the decision. Oral appeals must be followed by a written and signed appeal, unless you are requesting an expedited resolution. We will help you complete a written appeal. We will ask you to sign the written appeal.

You can also send a letter about your appeal. In the letter, explain why you disagree with the decision. Send the letter to the address in Section 1 listed under "Appeals and Grievances."

We can help you write your appeal. Call Customer Services at the phone number in Section 1 if you need help.

If your appeal is about an urgently needed service, we will give you a decision within 72 hours. We will try to call you with the decision before we send the written decision.

We may take up to 14 more days to make a decision, if we need more information and it will be in your best interest. We will tell you within 72 hours that we are taking extra time and the reasons why. If we do not grant your request for an expedited review, you may file a grievance.

We will notify you within 10 days that your appeal has been received.

For standard appeals, we will give you a written decision within 30 days from the day we get your appeal.
We may take up to 14 more days to make a decision, if we need more information and it will be in your best interest. We will tell you within 30 days that we are taking extra time and the reasons why.

The person making the decision will not be the same person who was involved in any prior level of review or decision-making.

If we are deciding an appeal regarding denial of a service for lack of medical necessity or one that involves clinical issues, the person making the decision will be a health care professional with appropriate clinical expertise in treating the condition or disease.

You, or your representative, may present your evidence in person, by telephone, or in writing.

You, or your representative, may examine the case file, including medical records and any other documents and records considered by us during the appeal process.

If you do not agree with our decision, you can request a State Fair Hearing with the Minnesota Department of Human Services**.** You can also call the Ombudsman for State Managed Health Care Programs for help.

To file a State Fair Hearing with the Minnesota Department of Human Services:

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

- A denial, termination, or reduction of services.
- Enrollment in the Plan.
- Denial in full or part of a claim for a service.
- Our failure to act within required timelines for service authorizations and appeals.
- Any other action.

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

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

Or fax to: 651-431-7523

A Human Services Judge from the State Appeals Office will hold a hearing. You may attend the hearing in person or by telephone.

Tell the State why you disagree with the decision made by us.

You can ask a friend, relative, advocate, provider, or lawyer to help you.

The process can take between 30-90 days. If your hearing is about an urgently needed service, tell the Judge or the Ombudsman when you call or write to them.

If your hearing is about a medical necessity denial, you may ask for an expert medical opinion. This will be from an outside reviewer. There is no cost to you.

If you do not agree with the Judge's decision, you may ask the Appeals Office to reconsider their decision. To ask for a reconsideration, send a written request to the Appeals Office within 30 days of the date on the decision.

You may also appeal to the district court in your county.

Ombudsman for State Managed Health Care Programs:

An Ombudsman for State Managed Health Care Programs may be able to help with your problem. They can help you file a grievance or appeal to us. They can also help you request a State Fair Hearing.

Write to: Minnesota Department of Human Services
Ombudsman Office for State Managed Health Care Programs
P.O. Box 64249
St. Paul, MN 55164-0249

Or call: 651-431-2660 or 1-800-657-3729 (toll free) or 1-800-627-3529 (TDD)

To file a complaint with the Minnesota Department of Health:

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

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

Section 14. Definitions

These are the meanings of some words in this *Evidence of Coverage*.

Action: This includes:

- Denial or limited authorization of the type or level of service.
- Reduction, suspension, or stopping of a service that was approved before.
- Denial of all or part of payment for a service.
- Not providing services in a reasonable amount of time.
- Not acting within required time frames for grievances and appeals.
- Denial of a member's request to get services out of network for members living in a rural area with only one health plan.

Anesthesia: Drugs that make you fall asleep for an operation.

Appeal: Your oral or written request to us for review of an action. This request may also be from your provider acting on your behalf with your written consent. Oral appeals must be followed by a written and signed appeal, unless you are requesting an expedited resolution. We will help you complete a written and signed appeal.

Autopsy: An exam that is done on the body of someone who dies. It is done to find out what caused a person's death.

Care Coordinator: A person who develops, coordinates, and provides (in some cases) supports and services stated in the care plan. This person works with us.

Chemical Dependency: Using alcohol or drugs in a way that harms you.

Clinical Trial: A qualified medical study test that is: subject to a defined peer review; sponsored by a clinical research program that meets federal and state rules and approved standards; and whose true results are reported.

Copay: An amount that you may be responsible to pay to the provider on specific medical services. Copays are usually paid at the time service is provided. See Section 6 for required copay amounts.

Cost Sharing: Amounts you may be responsible to pay toward your medical services. Cost sharing amounts include deductibles and copays. See Section 6 for information on cost sharing.

Covered Services: The health care services that are eligible for payment.

Deductible: An amount that you may be responsible to pay each month toward your medical services. See Section 6 for more information on the deductible.

Direct Access Services: You can go to any provider in the Plan network to get these services. You do not need a referral or service authorization before getting services.

Durable Medical Equipment: Equipment that can withstand repeated use. It is used for a medical purpose. The equipment must be medically necessary and ordered by a doctor.

Emergency: A condition that needs treatment right away. It is a condition that a prudent person believes needs prompt care, and without prompt care, it could cause: serious physical or mental harm; continuing severe pain; serious damage to body functions, organs, or parts; or death. Labor and childbirth can sometimes be an emergency.

Enrollee: A person who is receiving services through a certain program, such as a Minnesota Health Care Program or Medicare.

Evidence of Coverage (formerly called the *Certificate of Coverage*): What the document you are reading is called. This document tells you what services are covered under the Plan. It tells what you must do to get covered services. It tells your rights and responsibilities. It also tells our rights and responsibilities.

Experimental Service: A service that has not been proven to be safe and effective.

External Quality Review Study: A study about how quality, timeliness and access of care are provided by us. This study is external and independent.

Family Planning: Information, services, and supplies that help a person decide about having children. These decisions include choosing to have a child, when to have a child, or not to have a child.

Fee-For-Service: A method of payment for health services. The medical provider bills the Minnesota Department of Human Services (DHS) directly. DHS pays the provider for the medical services. This method is used when you are eligible for Minnesota Health Care Programs but are not enrolled in a health plan.

Formulary: The list of drugs covered under the Plan.

Grievance: Expression of discontent about any matter other than an action. This includes, but is not limited to, discontent with:

- Quality of care or services provided.
- Failure to respect your rights.

Home and Community-Based Services: Additional home healthcare services that are provided to help you remain in your home.

Hospice: A special program for members who are terminally ill and not expected to live more than six months. It offers special services for the member and his or her family.

Inpatient Hospital Stay: A stay in a hospital or treatment center that usually lasts 24 hours or more.

Investigative Service: A service that has not been proven to be safe and effective.

Medically Necessary: Care that is appropriate for the condition. This includes care related to physical conditions and mental health. It includes the kind and level of service. It includes the number of treatments. It also includes where you get the service and how long it continues. Medically necessary care must:

- Be the service that most other providers would usually order.
- Help you get better, or stay as well as you are.
- Help stop the condition from getting worse.
- Help prevent and find health problems.

Medicare: The federal health insurance program for people 65 years of age or older. It is also for some people under age 65 with disabilities, and people with End Stage Renal Disease.

Medicare Prescription Drug Plan: An insurance plan that offers the Medicare Prescription Drug Program (Medicare Part D) drug benefits.

Medicare Prescription Drug Program: The prescription drug benefit for Medicare enrollees. It is sometimes called Medicare Part D. Drug coverage is provided through a Medicare prescription drug plan.

Minnesota Senior Care Plus (MSC+): A program in which the State contracts with health plans to cover and manage health care and Elderly Waiver services for Medical Assistance enrollees age 65 and older.

Network: Our contracted health care providers for the Plan.

Notice of Action: A form or letter we send you telling you about a decision on a claim, a service, or any other action taken by us.

Nursing Home Certifiable: A decision that you need a nursing home level of care. A screener uses a process called a Long Term Care Consultation to decide.

Ombudsman for State Managed Care Health Programs: A person at the Minnesota Department of Human Services who can help you with access, service, or billing problems. The Ombudsman can also help you file a grievance or appeal to us or request a State Fair Hearing.

Open Access Services: Federal and state law allow you to choose any physician, clinic, hospital, pharmacy, or family planning agency – even if not in our network – to get these services.

Outpatient Hospital Services: Services provided at a hospital or outpatient facility which are not at an inpatient level of care. These services may also be available at your clinic or other health facility.

Out-of-Area Services: Health care provided to an enrollee by a non-network provider outside of the Plan service area.

Out-of-Network Services: Health care provided to an enrollee by a non-network provider.

Physician Incentive Plan: Special payment arrangements between us and the doctor that may affect the use of referrals. It may also affect other services that you might need.

Post-Stabilization Care: A hospital service needed to help a person's conditions stay stable after having emergency care. It starts when the hospital asks for our approval of coverage. It continues until: the person is discharged; our Plan network doctor begins care; or we, the hospital, and doctor agree to a different arrangement.

Prescriptions: Medicines and drugs ordered by a medical provider.

Preventive Services: Services that help you stay healthy, such as routine physicals, immunizations, and well-person care. These services help find and prevent health problems. Follow-up on conditions that have been diagnosed (like a diabetes check-up) are ***not*** preventive.

Primary Care Clinic: The clinic you choose for your routine care. This clinic will provide or approve most of your care. The name of your clinic appears on your member card.

Primary Care Provider: The doctor or other health professional you see at your Primary Care Clinic. This person will manage your health care.

Provider: A health care professional or facility approved under State law to provide health care.

Restricted Recipient Program: A program for members who have received medical care and have not followed the rules or have misused services. If you are in this program, you must get health services from one designated doctor, one pharmacy, one hospital, or other health services provider. You must do this for at least 24 months of eligibility for Minnesota Health Care Programs. Members in this program who fail to follow program rules will be required to continue in the program for an additional 36 months.

Second Opinion: If you do not agree with an opinion you get from a Plan network provider, you have the right to get an opinion from another provider. We will pay for this. For medical conditions, the second opinion will be from another Plan network provider. For mental health services, the second opinion will be from an out-of- network provider. For chemical dependency services, the second opinion will be from a different qualified assessor who is not in the Plan network.

Service Area: The area where a person must live to be able to become or remain a member of the Plan. Contact Customer Services at the phone number in Section 1 for details about the service area.

Service Authorization: Our approval that is needed for some services before you get them.

Skilled Nursing Care: Services that can only be done by, or under the supervision of, licensed nursing personnel.

Skilled Nursing Facility: A facility which provides inpatient skilled nursing care, rehabilitation services, or other related health services. Medicare must certify this facility if you are receiving Medicare benefits.

Standing Authorization: Written consent from us to see a non-network specialist more than one time (for ongoing care).

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

- A denial, termination, or reduction of services.
- Enrollment in the Plan.
- Denial in full or part of a claim for a service.
- Our failure to act within required timelines for service authorizations and appeals.
- Any other action.

Subrogation: Our right to collect money in your name from another person, group, or insurance company. We have this right when you get medical coverage under this Plan for a service that is covered by another source or third-party payer.

United States: For the purpose of this *Evidence of Coverage,* the United States includes the fifty states, the District of Columbia, the Commonwealth of Puerto Rico, The Virgin Islands, Guam, American Samoa, and the Northern Mariana Islands.

Urgent Care: Care for a condition that needs prompt treatment to stop the condition from getting worse. An urgent condition is not as serious as an emergency. Urgent care is available 24 hours a day.

P.O. Box 52
Minneapolis, MN 55440-0052

612-676-3200
1-800-203-7225 (toll free)

TTY/Hearing impaired
612-676-6810
1-800-688-2534 (toll free)

www.ucare.org

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U2544 (12/11)