Evidence of Coverage
(EOC) MEMBER HANDBOOK

CALUMET, KENOSHA, MILWAUKEE, OUTAGAMIE,
OZAUKEE, RACINE, WASHINGTON, WAUKESHA
AND WAUPACA COUNTIES

JANUARY 1, 2018 – DECEMBER 31, 2018

For help or information, please call Customer Service or visit our website at www.communitycareinc.org. Call toll free: 1-866-992-6600.
TTY users call the Wisconsin Relay System at 711.

Community Care Health Plan, Inc. • 205 Bishops Way • Brookfield, WI 53005
Evidence of Coverage:
Your Medicare and Medicaid Health Benefits and Services and Prescription Drug Coverage as a Member of Community Care Family Care Partnership Program (HMO SNP)(Community Care)

This booklet gives you the details about your Medicare and Medicaid health care, long-term care, and prescription drug coverage from January 1 – December 31, 2018. It explains how to get coverage for the health care services and prescription drugs you need. This is an important legal document. Please keep it in a safe place.

This plan, Community Care, is offered by Community Care Health Plan, Inc. (When this Evidence of Coverage says “we,” “us,” or “our,” it means Community Care Health Plan, Inc. When it says “plan” or “our plan,” it means Community Care.)

Community Care is a Coordinated Care Plan with a Medicare Advantage Contract and a contract with the Wisconsin Medicaid Program. Enrollment in Community Care depends on contact renewal. Community Care has a Medicaid contract with the state of Wisconsin Department of Health Services (DHS) for the Wisconsin Medicaid Program. Community Care is a Coordinated Care Plan with a Medicare Advantage Contract and a contract with the Wisconsin Department of Health Services (DHS) for the Medicaid Program. Enrollment in Community Care depends on contact renewal. Enrollment is available to anyone who has both Medical Assistance from the State and Medicare and is functionally eligible as determined by the Wisconsin Long-Term Care Functional Screen.

- For help to translate or understand this, please call 1-866-992-6600 (TTY Call the Wisconsin Relay System at 711.)
- Si necesita ayuda para traducir o entender este texto, por favor llame al teléfono 1-866-992-6600. (TTY Call the Wisconsin Relay System at 711.)
- Если вам не всё понятно в этом документе, позвоните по телефону 1-866-992-6600. (TTY Call the Wisconsin Relay System at 711.)
- Yog xav tau kev pab txhais cov ntaub ntawv no kom koj totaub, hu rau 1-866-992-6600. (TTY Call the Wisconsin Relay System at 711.)
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1-866-992-6600 (TTY Call the Wisconsin Relay System at 711)
Please contact our Customer Service number at 1-866-992-6600 for additional information. (TTY users should call 711.) You can call 24 hours a day, 7 days a week.

Please contact your team about the availability of alternate formats, such as Braille, large print, etc. Benefits, premium, deductible, and/or copayments/coinsurance may change on January 1, 2019.

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

H2034_EOC_2018 Accepted    DHS Approved: 08/25/2017
## 2018 Evidence of Coverage

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Getting started as a member
# Chapter 1. Getting started as a member

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SECTION 1  Introduction

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

You are covered by both Medicare and Medicaid:

- **Medicare** is the Federal health insurance program for people 65 years of age or older, some people under age 65 with certain disabilities, and people with end-stage renal disease (kidney failure).
- **Medicaid** is a joint Federal and state government program that helps with medical costs for certain people with limited incomes and resources. Medicaid coverage varies depending on the state and the type of Medicaid you have. Some people with Medicaid get help paying for their Medicare premiums and other costs. Other people also get coverage for additional services and drugs that are not covered by Medicare.

You have chosen to get your Medicare and Medicaid health care and your prescription drug coverage through our plan, Community Care.

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

**Coverage under this Plan qualifies as minimum essential coverage (MEC)** and satisfies the Patient Protection and Affordable Care Act’s (ACA) individual shared responsibility requirement. Please visit the Internal Revenue Service (IRS) website at: [https://www.irs.gov/Affordable-Care-Act/Individuals-and-Families](https://www.irs.gov/Affordable-Care-Act/Individuals-and-Families) for more information.

Because you get assistance from Medicaid with your Medicare Part A and B cost-sharing (deductibles, copayments, and coinsurance), you may pay nothing for your Medicare health care services. Medicaid also provides other benefits to you by covering health care services, prescription drugs long-term care and home and community based services that are not usually covered under Medicare. Per the State Medicaid Agency Contract, you will also receive “Extra Help” from Medicare to pay for the costs of your Medicare prescription drugs. Community Care will help manage all of these benefits for you, so that you get the health care services and payment assistance that you are entitled to.

Community Care is run by a non-profit organization. Like all Medicare Advantage Plans, this Medicare Special Needs Plan is approved by Medicare. The plan also has a contract with the Wisconsin Medicaid program to coordinate your Medicaid benefits. We are pleased to be providing your Medicare and Medicaid health care coverage, including your prescription drug coverage and long-term care services.
Section 1.2  What is the Evidence of Coverage booklet about?

This Evidence of Coverage booklet tells you how to get your Medicare and Medicaid medical care, long-term care, home and community based services, and prescription drugs covered through our plan. This booklet explains your rights and responsibilities, what is covered, and what you pay as a member of the plan.

The word “coverage” and “covered services” refers to the medical care, long-term care, home and community based services and prescription drugs available to you as a member of Community Care.

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

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

Section 1.3  Legal information about the Evidence of Coverage

It’s part of our contract with you

This Evidence of Coverage is part of our contract with you about how Community Care covers your care. Other parts of this contract include your enrollment form, the List of Covered Drugs (Formulary), and any notices you receive from us about changes to your coverage or conditions that affect your coverage. These notices are sometimes called “riders” or “amendments.”

The contract is in effect for months in which you are enrolled in Community Care between January 1, 2018 and December 31, 2018.

Each calendar year, Medicare allows us to make changes to the plans that we offer. This means we can change the costs and benefits of Community Care after December 31, 2018. We can also choose to stop offering the plan, or to offer it in a different service area, after December 31, 2018.

Medicare must approve our plan each year

Medicare (the Centers for Medicare & Medicaid Services) must approve Community Care each year. Medicaid also approves our plan each year. You can continue to get Medicare coverage as a member of our plan as long as we choose to continue to offer the plan and Medicare renews its approval of the plan.
SECTION 2 What makes you eligible to be a plan member?

Section 2.1 Your eligibility requirements

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

- You have both Medicare Part A and Medicare Part B (section 2.2 tells you about Medicare Part A and Medicare Part B)
- -- and -- You live in our geographic service area (section 2.3 below describes our service area)
- -- and -- you are a United States citizen or are lawfully present in the United States
- -- and -- You meet the special eligibility requirements described below.

Special eligibility requirements for our plan

Our plan is designed to meet the needs of people who receive certain Medicaid benefits. (Medicaid is a joint Federal and state government program that helps with medical costs for certain people with limited incomes and resources.) To be eligible for our plan you must be eligible for Medicare and Full Medicaid Benefits.

You are eligible for membership in our plan as long as you meet the special eligibility requirements described below.

- Be at least 18 years old;
- Be a frail elder or an adult with physical or developmental disabilities;
- Are a resident of Calumet, Kenosha, Milwaukee, Outagamie, Ozaukee, Racine, Washington, Waukesha or Waupaca County (section 2.4 below describes our service area);
- Are functionally eligible as determined via the Wisconsin Adult Long-term Care Functional Screen;
- You must be enrolled in Medicare Parts A, B, and D;

You may have a monthly “Cost Share” that you must pay to remain eligible for Wisconsin Medicaid and Community Care. Your county Income Maintenance agency determines your Cost Share amount. Call Customer Service for more information (see Chapter 2 for listing of phone numbers).

Please note: If you lose your Medicaid eligibility but can reasonably be expected to regain eligibility within 1 month(s), then you are still eligible for membership in our plan (Chapter 4, Section 2.1 tells you about coverage during a period of deemed continued eligibility).
Section 2.2 What are Medicare Part A and Medicare Part B?

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

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

Section 2.3 What is Medicaid?

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

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

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

Section 2.4 Here is the plan service area for Community Care

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

Our service area includes these counties in Wisconsin:

- Calumet, Kenosha, Milwaukee, Outagamie, Ozaukee, Racine, Washington, Waukesha and Waupaca
If you plan to move out of the service area, please contact Customer Service (phone numbers are printed on the back cover of this booklet). When you move, you will have a Special Enrollment Period that will allow you to switch to Original Medicare or enroll in a Medicare health or drug plan that is available in your new location.

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

### Section 2.5 U.S. Citizen or Lawful Presence

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

### SECTION 3 What other materials will you get from us?

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

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

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

**Here’s why this is so important:** If you get covered services using your red, white, and blue Medicare card instead of using your Community Care membership card while you are a plan member, you may have to pay the full cost yourself.
If your plan membership card is damaged, lost, or stolen, call Customer Service right away and we will send you a new card. (Phone numbers for Customer Service are printed on the back cover of this booklet.)

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

The Provider Directory lists our network providers and durable medical equipment suppliers. The directory also includes participating Medicaid providers.

What are “network providers”?

Network providers are the doctors and other health care professionals, medical groups, durable medical equipment suppliers, hospitals, other health care facilities, pharmacies and providers of long-term care services that have an agreement with us to accept our payment and any plan cost-sharing as payment in full. We have arranged for these providers to deliver covered services to members in our plan. The most recent list of providers and suppliers is available on our website at www.communitycareinc.org.

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

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

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

Section 3.3 The plan’s List of Covered Drugs (Formulary)

The plan has a List of Covered Drugs (Formulary). We call it the “Drug List” for short. It tells which prescription drugs are covered by Community Care. The drugs on this list are selected by the plan with the help of a team of doctors and pharmacists. The list must meet requirements set by Medicare and Medicaid. Medicare and Medicaid have approved the Community Care Drug List.

The Drug List also tells you if there are any rules that restrict coverage for your drugs.
We will send you a notice explaining how to find the Drug List on our website or request a copy of the Drug List. To get the most complete and current information about which drugs are covered, you can visit the plan’s website (www.communitycareinc.org) or call Customer Service (phone numbers are printed on the back cover of this booklet).

**Section 3.4 The Part D Explanation of Benefits (the “Part D EOB”): Reports with a summary of payments made for your Part D prescription drugs**

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

The *Part D Explanation of Benefits* tells you the total amount you, or others on your behalf, have spent on your Part D prescription drugs and the total amount we have paid for each of your Part D prescription drugs during the month. Chapter 5 (Using the plan’s coverage for your Part D prescription drugs) gives more information about the Explanation of Benefits and how it can help you keep track of your drug coverage.

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

**SECTION 4 Your monthly premium for Community Care**

**Section 4.1 How much is your plan premium?**

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

As explained in Section 2 above, in order to be eligible for our plan, you must maintain your eligibility for Medicaid as well as be entitled to Medicare Part A and enrolled in Medicare Part B. For most Community Care members, Medicaid pays for your Part A premium (if you don’t qualify for it automatically) and for your Part B premium. If Medicaid is not paying your Medicare premiums for you, you must continue to pay your Medicare premiums to remain a member of the plan.

Some people pay an extra amount for Part D because of their yearly income; this is known as Income Related Monthly Adjustment Amounts, also known as IRMAA. If your income is greater than $85,000 for an individual (or married individuals filing separately), or greater than $170,000 for married couples, you must pay an extra amount directly to the government (not the Medicare plan) for your Medicare Part D coverage.

- If you have to pay an extra amount, Social Security, not your Medicare plan, will send you a letter telling you what that extra amount will be. If you had a life-changing event
that caused your income to go down, you can ask Social Security to reconsider their decision.

- **If you are required to pay the extra amount and you do not pay it, you will be disenrolled from the plan.**

- You can also visit [http://www.medicare.gov](http://www.medicare.gov) on the Web or call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048. Or you may call Social Security at 1-800-772-1213. TTY users should call 1-800-325-0778.

Your copy of *Medicare & You 2018* gives information about these premiums in the section called “2018 Medicare Costs.” Everyone with Medicare receives a copy of *Medicare & You* each year in the fall. Those new to Medicare receive it within a month after first signing up. You can also download a copy of *Medicare & You 2018* from the Medicare website ([http://www.medicare.gov](http://www.medicare.gov)). Or, you can order a printed copy by phone at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users call 1-877-486-2048.

**Section 4.2 Can we change your monthly plan premium during the year?**

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

If you ever lose your low income subsidy (“Extra Help”), you would be subject to the monthly Part D late enrollment penalty if you have ever gone without creditable prescription drug coverage for 63 days or more.

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

**SECTION 5 Please keep your plan membership record up to date**

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

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

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

**Let us know about these changes:**

- Changes to your name, your address, or your phone number
• Changes in any other health insurance coverage you have (such as from your employer, your spouse’s employer, workers’ compensation, or Medicaid)
• If you have any liability claims, such as claims from an automobile accident
• If you have been admitted to a nursing home
• If you receive care in an out-of-area or out-of-network hospital or emergency room
• If your designated responsible party (such as a caregiver) changes
• If you are participating in a clinical research study

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

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

You should also call your county’s income maintenance agency directly to report changes to the State program. See Chapter 2, Section 9 for contact information.

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

Medicare requires that we collect information from you about any other medical or drug insurance coverage that you have. That’s because we must coordinate any other coverage you have with your benefits under our plan. (For more information about how our coverage works when you have other insurance, see Section 7 in this chapter.)

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

SECTION 6 We protect the privacy of your personal health information

Section 6.1 We make sure that your health information is protected

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

For more information about how we protect your personal health information, please go to Chapter 7, Section 1.4 of this booklet.
SECTION 7 How other insurance works with our plan

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

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

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

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

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

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

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

If you have other insurance, tell your doctor, hospital, and pharmacy. If you have questions about who pays first, or you need to update your other insurance information, call Customer Service (phone numbers are printed on the back cover of this booklet). You may need to give your plan member ID number to your other insurers (once you have confirmed their identity) so your bills are paid correctly and on time.
CHAPTER 2

Important phone numbers and resources
Chapter 2. Important phone numbers and resources

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How to contact our plan’s Customer Service

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

<table>
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<th>Customer Service – Contact Information</th>
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| CALL   | 1-866-992-6600  
   Calls to this number are free. You can call 24 hours a day, 7 days a week. Customer Service also has free language interpreter services available for non-English speakers. |
| TTY    | Call the Wisconsin Relay System at 711.  
   This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.  
   Calls to this number are free. You can call 24 hours a day, 7 days a week. |
| WRITE  | 205 Bishops Way  
   Brookfield, WI 53005 |
| WEBSITE | [www.communitycareinc.org](http://www.communitycareinc.org) |
How to contact us when you are asking for a coverage decision about your medical care and Part D prescription drugs

A coverage decision is a decision we make about your benefits and coverage or about the amount we will pay for your medical services and Part D prescription drugs. For more information on asking for coverage decisions about your medical care and Part D prescription drugs, see Chapter 8 (What to do if you have a problem or complaint (coverage decisions, appeals, complaints)).

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

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<tr>
<th>Method</th>
<th>Coverage Decisions for Medical Care and Part D Prescription Drugs – Contact Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>CALL</td>
<td>1-866-992-6600&lt;br&gt;Calls to this number are free. You can call 24 hours a day, 7 days a week.</td>
</tr>
<tr>
<td>TTY</td>
<td>Call the Wisconsin Relay System at 711.&lt;br&gt;This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.&lt;br&gt;Calls to this number are free. You can call 24 hours a day, 7 days a week.</td>
</tr>
<tr>
<td>WRITE</td>
<td>205 Bishops Way&lt;br&gt;Brookfield, WI 53005</td>
</tr>
<tr>
<td>WEBSITE</td>
<td><a href="http://www.communitycareinc.org">www.communitycareinc.org</a></td>
</tr>
</tbody>
</table>
**How to contact us when you are making an appeal about your medical care and Part D prescription drugs**

An appeal is a formal way of asking us to review and change a coverage decision we have made. For more information on making an appeal about your medical care, see Chapter 8 (*What to do if you have a problem or complaint (coverage decisions, appeals, complaints)*).

<table>
<thead>
<tr>
<th>Method</th>
<th>Appeals for Medical Care and Part D Prescription Drugs – Contact Information</th>
</tr>
</thead>
</table>
| **CALL** | 1-866-992-6600  
Calls to this number are free. You can call 24 hours a day, 7 days a week. |
| **TTY** | Call the Wisconsin Relay System at 711.  
This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.  
Calls to this number are free. You can call 24 hours a day, 7 days a week. |
| **WRITE** | 205 Bishops Way  
Brookfield, WI 53005 |
| **WEBSITE** | [www.communitycareinc.org](http://www.communitycareinc.org) |
How to contact us when you are making a complaint about your medical care or Part D prescription drugs

You can make a complaint about us or one of our network providers, including a complaint about the quality of your care. This type of complaint does not involve coverage or payment disputes. (If your problem is about the plan’s coverage or payment, you should look at the section above about making an appeal.) For more information on making a complaint about your medical care, see Chapter 8 (What to do if you have a problem or complaint (coverage decisions, appeals, complaints)).

<table>
<thead>
<tr>
<th>Method</th>
<th>Complaints about Medical Care and Part D Prescription Drugs–Contact Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>CALL</td>
<td>1-866-992-6600</td>
</tr>
<tr>
<td></td>
<td>Calls to this number are free. You can call 24 hours a day, 7 days a week.</td>
</tr>
<tr>
<td>TTY</td>
<td>Call the Wisconsin Relay System at 711.</td>
</tr>
<tr>
<td></td>
<td>This number requires special telephone equipment and is only for people</td>
</tr>
<tr>
<td></td>
<td>who have difficulties with hearing or speaking.</td>
</tr>
<tr>
<td></td>
<td>Calls to this number are free. You can call 24 hours a day, 7 days a week.</td>
</tr>
<tr>
<td>WRITE</td>
<td>205 Bishops Way</td>
</tr>
<tr>
<td></td>
<td>Brookfield, WI 53005</td>
</tr>
<tr>
<td>MEDICARE</td>
<td>You can submit a complaint about Community Care directly to Medicare.</td>
</tr>
<tr>
<td>WEBSITE</td>
<td>To submit an online complaint to Medicare, go to</td>
</tr>
</tbody>
</table>

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

For more information on situations in which you may need to ask us for reimbursement or to pay a bill you have received from a provider, see Chapter 6 (Asking us to pay a bill you have received for covered medical services or drugs).

Please note: If you send us a payment request and we deny any part of your request, you can appeal our decision. See Chapter 8 (What to do if you have a problem or complaint (coverage decisions, appeals, complaints)) for more information.
### SECTION 2 Medicare
(how to get help and information directly from the Federal Medicare program)

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

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

<table>
<thead>
<tr>
<th>Method</th>
<th>Medicare – Contact Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>CALL</td>
<td>1-800-MEDICARE, or 1-800-633-4227</td>
</tr>
<tr>
<td></td>
<td>Calls to this number are free.</td>
</tr>
<tr>
<td></td>
<td>24 hours a day, 7 days a week.</td>
</tr>
<tr>
<td>TTY</td>
<td>1-877-486-2048</td>
</tr>
<tr>
<td></td>
<td>This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.</td>
</tr>
<tr>
<td></td>
<td>Calls to this number are free.</td>
</tr>
</tbody>
</table>
### Method

#### Medicare – Contact Information

<table>
<thead>
<tr>
<th>Method</th>
<th>Medicare – Contact Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>WEBSITE</td>
<td><a href="https://www.medicare.gov">https://www.medicare.gov</a></td>
</tr>
</tbody>
</table>

This is the official government website for Medicare. It gives you up-to-date information about Medicare and current Medicare issues. It also has information about hospitals, nursing homes, physicians, home health agencies, and dialysis facilities. It includes booklets you can print directly from your computer. You can also find Medicare contacts in your state.

The Medicare website also has detailed information about your Medicare eligibility and enrollment options with the following tools:

- **Medicare Eligibility Tool**: Provides Medicare eligibility status information.
- **Medicare Plan Finder**: Provides personalized information about available Medicare prescription drug plans, Medicare health plans, and Medigap (Medicare Supplement Insurance) policies in your area. These tools provide an *estimate* of what your out-of-pocket costs might be in different Medicare plans.

<table>
<thead>
<tr>
<th>WEBSITE (continued)</th>
<th>You can also use the website to tell Medicare about any complaints you have about Community Care:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td><strong>Tell Medicare about your complaint</strong>: You can submit a complaint about Community Care directly to Medicare. To submit a complaint to Medicare, go to <a href="https://www.medicare.gov/MedicareComplaintForm/home.aspx">www.medicare.gov/MedicareComplaintForm/home.aspx</a>. Medicare takes your complaints seriously and will use this information to help improve the quality of the Medicare program.</td>
</tr>
<tr>
<td></td>
<td>If you don’t have a computer, your local library or senior center may be able to help you visit this website using its computer. Or, you can call Medicare and tell them what information you are looking for. They will find the information on the website, print it out, and send it to you. (You can call Medicare at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.)</td>
</tr>
</tbody>
</table>

### SECTION 3

#### State Health Insurance Assistance Program

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

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

Wisconsin State Health Insurance Assistance Program 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. Wisconsin State Health Insurance Assistance Program counselors can also help you understand your Medicare plan choices and answer questions about switching plans.

<table>
<thead>
<tr>
<th>Method</th>
<th>Wisconsin State Health Insurance Assistance Program—Contact Information</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>CALL</strong></td>
<td>Wisconsin Board on Aging &amp; Long-term Care</td>
</tr>
<tr>
<td></td>
<td>Medigap Part D Prescription Drug Helpline operated by the Coalition of Wisconsin Aging Groups primarily for persons age 60 and older</td>
</tr>
<tr>
<td></td>
<td>Disability Drug Benefit Helpline operated by Disability Rights Wisconsin, primarily for persons under age 60 eligible for Medicare because of a disability</td>
</tr>
<tr>
<td></td>
<td>Office for the Deaf and Hard of Hearing for persons who are deaf or hard of hearing and use sign language as their primary language.</td>
</tr>
</tbody>
</table>

| WEB SITE         | [https://www.dhs.wisconsin.gov/benefit-specialists/medicare-counseling.htm](https://www.dhs.wisconsin.gov/benefit-specialists/medicare-counseling.htm) |

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

There is a designated Quality Improvement Organization for serving Medicare beneficiaries in each state. For Wisconsin the Quality Improvement Organization is called KEPRO.

KEPRO has a group of doctors and other health care professionals who are paid by the Federal government. This organization is paid by Medicare to check on and help improve the quality of care for people with Medicare. KEPRO is an independent organization. It is not connected with our plan.
You should contact KEPRO in any of these situations:

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

<table>
<thead>
<tr>
<th>Method</th>
<th>KEPRO (Wisconsin's Quality Improvement Organization) – Contact Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>CALL</td>
<td>1-855-408-8557</td>
</tr>
<tr>
<td>TTY</td>
<td>1-855-843-4776</td>
</tr>
<tr>
<td></td>
<td>This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.</td>
</tr>
<tr>
<td>WRITE</td>
<td>5201 W. Kennedy Blvd., Suite 900</td>
</tr>
<tr>
<td></td>
<td>Tampa, FL 33609</td>
</tr>
<tr>
<td></td>
<td>Attention: Beneficiary Complaints</td>
</tr>
<tr>
<td>WEBSITE</td>
<td><a href="http://www.keproqio.com">http://www.keproqio.com</a></td>
</tr>
</tbody>
</table>

**SECTION 5  Social Security**

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

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

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

**CALL**
1-800-772-1213
Calls to this number are free.
Available 7:00 am to 7:00 pm, Monday through Friday.
You can use Social Security’s automated telephone services to get recorded information and conduct some business 24 hours a day.

**TTY**
1-800-325-0778
This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.
Calls to this number are free.
Available 7:00 am to 7:00 pm, Monday through Friday.

**WEBSITE**
[https://www.ssa.gov](https://www.ssa.gov)

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

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

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

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

If you have questions about the assistance you get from Medicaid, contact the Wisconsin Department of Health Services.
Wisconsin Department of Health Services (DHS) – Contact Information

<table>
<thead>
<tr>
<th>Method</th>
<th>Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>CALL</td>
<td>1-800-362-3002</td>
</tr>
<tr>
<td>TTY</td>
<td>Wisconsin Relay System 711</td>
</tr>
<tr>
<td>WRITE</td>
<td>1 W. Wilson Street</td>
</tr>
<tr>
<td></td>
<td>P.O. Box 309</td>
</tr>
<tr>
<td></td>
<td>Madison, WI 53703</td>
</tr>
<tr>
<td>WEBSITE</td>
<td><a href="http://www.dhs.wisconsin.gov/Medicaid">www.dhs.wisconsin.gov/Medicaid</a></td>
</tr>
</tbody>
</table>

All Medicaid applicants and members can also use ACCESS. ACCESS is an online tool at www.access.wi.gov that can be used for:

- Finding out what if you are eligible for a program
- Applying for benefits
- Checking your benefits
- Reporting changes
- Getting a new ForwardHealth Card

You can call the ForwardHealth Customer Service at 1-800-362-3002 for:

- To get general information about Medicaid
- To get a new ForwardHealth Card

You can contact Your Local County or Tribal Agency for:

- Answers about enrollment rules
- Reporting changes by phone, fax or email
- Sending proof/verification of eligibility

To get the address or phone number of your local agency, see page 1 of your latest notice, go to www.dhs.wisconsin.gov/em/CustomerHelp, or call ForwardHealth Customer Service at 1-800-362-3002.

The Wisconsin Board on Aging and Long-term Care and Disability Rights Wisconsin helps people enrolled in Medicaid with service or billing problems. They can help you file a grievance or appeal with our plan.
### Wisconsin Board on Aging and Long-term Care - Ombudsmen

**Method**

Wisconsin Board on Aging and Long-term Care - Ombudsmen from this agency provide assistance to individuals age 60 and older -

<table>
<thead>
<tr>
<th>Contact Information</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>CALL</strong> 1-800-815-0015</td>
</tr>
<tr>
<td><strong>WRITE</strong> 1402 Pankratz Street, Suite 111 Madison WI 53704-4001</td>
</tr>
<tr>
<td><strong>WEBSITE</strong> <a href="http://www.boaltc@ltc.state.wi.us">www.boaltc@ltc.state.wi.us</a></td>
</tr>
</tbody>
</table>

Disability Rights Wisconsin - Ombudsmen from this agency provide assistance to individuals under age 60 -

<table>
<thead>
<tr>
<th>Contact Information</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>CALL</strong> General: (608) 267-0214 Fax: (608) 267-0368 Milwaukee Toll Free: 1-800-708-3034</td>
</tr>
<tr>
<td><strong>TTY</strong> 1-888-758-6049</td>
</tr>
<tr>
<td><strong>WRITE</strong> 131 W. Wilson Street, Suite 700 Madison, WI 53703</td>
</tr>
<tr>
<td><strong>WEBSITE</strong> <a href="http://www.disabilityrightswi.org/programs/fcop">www.disabilityrightswi.org/programs/fcop</a></td>
</tr>
</tbody>
</table>

The Wisconsin Board on Aging and Long-term Care helps people get information about nursing homes and resolve problems between nursing homes and residents or their families.

### Medicare’s “Extra Help” Program

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

Medicare’s “Extra Help” Program
Per the State Medicaid Agency Contract, because you are eligible for Medicaid, you qualify for and are getting “Extra Help” from Medicare to pay for your prescription drug plan costs. You do not need to do anything further to get this “Extra Help.”

If you have questions about “Extra Help,” call:

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

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

What is the AIDS Drug Assistance Program (ADAP)?

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

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

For additional information about the AIDS Drug Assistance Program (ADAP), contact the Wisconsin AIDS/HIV Program at 608-267-6875 or 800-991-5532 or at https://www.dhs.wisconsin.gov/aids-hiv/adap.htm.

For information on eligibility criteria, covered drugs, or how to enroll in the program, please call the Wisconsin AIDS/HIV Program at 608-267-6875 or 800-991-5532.

What if you get “Extra Help” from Medicare to help pay your prescription drug costs?

Can you get the discounts?

Most of our members get “Extra Help” from Medicare to pay for their prescription drug plan costs. If you get “Extra Help,” the Medicare Coverage Gap Discount Program does not apply to you. If you get “Extra Help,” you already have coverage for your prescription drug costs during the coverage gap.
What if you don’t get a discount, and you think you should have?

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

SECTION 8 How to contact the Railroad Retirement Board

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

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

<table>
<thead>
<tr>
<th>Method</th>
<th>Railroad Retirement Board – Contact Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>CALL</td>
<td>1-877-772-5772</td>
</tr>
<tr>
<td></td>
<td>Calls to this number are free.</td>
</tr>
<tr>
<td></td>
<td>Available 9:00 am to 3:30 pm, Monday through Friday</td>
</tr>
<tr>
<td></td>
<td>If you have a touch-tone telephone, recorded information and automated services are available 24 hours a day, including weekends and holidays.</td>
</tr>
<tr>
<td>TTY</td>
<td>1-312-751-4701</td>
</tr>
<tr>
<td></td>
<td>This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.</td>
</tr>
<tr>
<td></td>
<td>Calls to this number are not free.</td>
</tr>
<tr>
<td>WEBSITE</td>
<td><a href="https://secure.rrb.gov/">https://secure.rrb.gov/</a></td>
</tr>
</tbody>
</table>

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

If you (or your spouse) get benefits from your (or your spouse’s) employer or retiree group as part of this plan, you may call the employer/union benefits administrator or Customer Service if you have any questions. You can ask about your (or your spouse’s) employer or retiree health benefits, premiums, or the enrollment period. (Phone numbers for Customer Service are printed...
on the back cover of this booklet.) You may also call 1-800-MEDICARE (1-800-633-4227; TTY: 1-877-486-2048) with questions related to your Medicare coverage under this plan.

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

SECTION 10 You can get assistance from Aging and Disability Resource Centers (ADRC)

ADRCs provide a place to get information and assistance on all aspects of life related to aging or living with a disability, including all available programs and services. ADRC services can be provided at the Center, via telephone or through a home visit, whichever is more convenient to you. The ADRC is responsible for enrollment counseling and enrollment and disenrollment in the Family Care and Family Care Partnership Programs and the Program of All-Inclusive Care for the Elderly (PACE) in Wisconsin. Visit www.dhs.wisconsin.gov for more information about ADRCs.

You can contact the ADRC for your county of residence as listed below.

<table>
<thead>
<tr>
<th>County</th>
<th>Phone Number</th>
<th>TTY</th>
</tr>
</thead>
<tbody>
<tr>
<td>Calumet County ADRC</td>
<td>920-849-1451</td>
<td>Call the Wisconsin Relay System at 711</td>
</tr>
<tr>
<td>Kenosha County ADRC</td>
<td>262-605-6646</td>
<td>Call the Wisconsin Relay System at 711</td>
</tr>
<tr>
<td>Milwaukee County ARC</td>
<td>414-286-6874</td>
<td>414-289-8591</td>
</tr>
<tr>
<td>Milwaukee County DRC</td>
<td>414-289-6660</td>
<td>414-289-8559</td>
</tr>
<tr>
<td>Racine County ADRC</td>
<td>262-638-6800</td>
<td>Call the Wisconsin Relay System at 711</td>
</tr>
<tr>
<td>Outagamie County ADRC</td>
<td>920-832-5178</td>
<td>Call the Wisconsin Relay System at 711</td>
</tr>
<tr>
<td>Ozaukee County ADRC</td>
<td>262-284-8120</td>
<td>Call the Wisconsin Relay System at 711</td>
</tr>
<tr>
<td>Washington County ADRC</td>
<td>262-335-4497</td>
<td>Call the Wisconsin Relay System at 711</td>
</tr>
<tr>
<td>Waukesha County ADRC</td>
<td>262-548-7848</td>
<td>Call the Wisconsin Relay System at 711</td>
</tr>
<tr>
<td>Waupaca County ADRC</td>
<td>715-258-6400</td>
<td>Call the Wisconsin Relay System at 711</td>
</tr>
</tbody>
</table>

1 For individuals age 60 and older

2 For individuals under age 60
You can contact the Income Maintenance Consortium for your county of residence as listed below. You must report changes in your living situation or finances within 10 days. If you move, you must report your new address. These changes can affect whether you are eligible for Medicaid and Community Care Partnership.

Report these changes to your county’s income maintenance consortium and Community Care. Consortiums in our service regions are:

<table>
<thead>
<tr>
<th>Counties</th>
<th>Consortium</th>
<th>Phone/Fax</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ozaukee, Washington and Waukesha</td>
<td>Moraine Lakes Consortium</td>
<td>Phone: 1-888-446-1239 Fax: 1-855-293-1822</td>
</tr>
<tr>
<td>Calumet, Outagamie, Waupaca,</td>
<td>East Central Consortia</td>
<td>Phone: 1-888-256-4563 Fax: 1-855-293-1822</td>
</tr>
<tr>
<td>Racine and Kenosha</td>
<td>Wisconsin Kenosha Racine Partnership (WKRP)</td>
<td>Phone: 1-888-794-5820 Fax: 1-855-293-1822</td>
</tr>
<tr>
<td>Milwaukee</td>
<td>Not in a consortium. Milwaukee County has a stand-alone Income Maintenance Agency run by the State.</td>
<td>Phone: 1-888-947-6583 Fax: 1-888-409-1979</td>
</tr>
</tbody>
</table>
CHAPTER 3

Using the plan’s coverage for your medical, long-term care and other covered services
Chapter 3. Using the plan’s coverage for your medical, long-term care and other covered services

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

Section 1.1 What are “network providers” and “covered services”? While the plan

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

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

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

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

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

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

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

Section 3.1 Getting care if you have a medical emergency

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

Section 3.3 Getting care during a disaster

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

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

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

For the details on what medical care, long-term care and home and community based services are covered by our plan, use the benefits chart in the next chapter, Chapter 4 (Benefits Chart, what is covered).

Section 1.1  What are “network providers” and “covered services”?

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

- **Providers** are doctors and other health care professionals licensed by the state to provide medical services and care. The term “providers” also includes hospitals and other health care facilities.

- **Network providers** are the doctors and other health care professionals, medical groups, hospitals, and other health care facilities that have an agreement with us to accept our payment as payment in full. We have arranged for these providers to deliver covered services to members in our plan. The providers in our network bill us directly for care they give you. When you see a network provider, you pay nothing for covered services.

- **Covered services** include all the medical care, health care services, supplies, and equipment that are covered by our plan. Your covered services for medical care are listed in the benefits chart in Chapter 4.

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

As a Medicare and Medicaid health plan, Community Care must cover all services covered by Original Medicare and other services.

Community Care will generally cover your medical care as long as:

- **The care you receive is included in the plan’s Benefits Chart** (this chart is in Chapter 4 of this booklet).

- **The care you receive is considered medically necessary**. “Medically necessary” means that the services, supplies, or drugs are needed for the prevention, diagnosis, or treatment of your medical condition and meet accepted standards of medical practice.
• You have a network primary care provider (a PCP) who is providing and overseeing your care. As a member of our plan, you must choose a network PCP (for more information about this, see Section 2.1 in this chapter).
  o In most situations, our plan must give you approval in advance before you can use other providers in the plan’s network, such as specialists, hospitals, skilled nursing facilities, or home health care agencies. This is called giving you a “referral.” For more information about this, see Section 2.3 of this chapter.
  o Referrals from your PCP are not required for emergency care or urgently needed services. There are also some other kinds of care you can get without having approval in advance from your PCP (for more information about this, see Section 2.2 of this chapter).

• You must receive your care from a network provider (for more information about this, see Section 2 in this chapter). In most cases, care you receive from an out-of-network provider (a provider who is not part of our plan’s network) will not be covered. Here are three exceptions:
  o The plan covers emergency care or urgently needed services that you get from an out-of-network provider. For more information about this, and to see what emergency or urgently needed services means, see Section 3 in this chapter.
  o If you need medical care that Medicare or Medicaid requires our plan to cover and the providers in our network cannot provide this care, you can get this care from an out-of-network provider. Authorization must be obtained from the plan prior to receiving care. In this situation, we will cover these services at no cost to you. For information about getting approval to see an out-of-network doctor, see Section 2.4 in this chapter.
  o The plan covers kidney dialysis services that you get at a Medicare-certified dialysis facility when you are temporarily outside the plan’s service area.

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

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

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

• What is a PCP?

Your PCP is the physician who collaborates with your Team and our Plan to oversee your health care. When you become a member of Partnership, you are encouraged to choose a network physician to be your PCP. Your PCP is a physician who meets state licensing requirements and is trained to give you basic medical care. As we explain below, you will get your routine or basic care from your PCP. Your PCP, in collaboration with the rest of your Team, will also coordinate the rest of the covered services you get as a Plan member.
There are several types of physicians who may be your PCP. Please talk to your team about your options.

- **How does your Team work with** your PCP?

  Talk with your Team about getting care from your PCP. You will usually see your PCP for most of your routine health care needs. Except in an emergency or for urgently needed care, you can get only a few types of covered services on your own without first contacting your Team.

  Your Team will arrange or coordinate the covered health care services you get as a Plan member. This includes such things as x-rays, laboratory tests, therapies, care from doctors who are specialists, hospital admissions, and follow-up care. “Coordinating” your services includes checking or consulting with other network providers about your care and how it is going.

  If you need certain types of covered services or supplies, your Team must give approval in advance. Since your PCP and your Team will provide and coordinate your medical care, you should have all of your past medical records sent to your new PCP’s office (if your PCP changes).

Community Care is a provider of the Family Care Partnership Program (Partnership). Partnership is a different kind of health Plan. An **Interdisciplinary Team** works with you to identify your goals (outcomes), and develops a Plan to support you with achieving these outcomes. The Team consists of:

- You, the Partnership Member
- Your family and significant others (at your option)
- Your Primary Care Physician
- Your Partnership Nurse Practitioner
- Your Partnership Registered Nurse
- Your Partnership Care Manager
- Other people you choose to include on your Team

The primary goal of Partnership is to support you with achieving your outcomes. The following statements demonstrate the areas that people have identified as being important. These statements provide a framework for you and the Team to talk about and understand your outcomes, preferences, and identified needs.

- You decide where and with whom you live;
- You make decisions regarding your supports and services and who provides them;
- You decide how you spend your day;
- You have relationships with family and friends you care about;
- You do things that are important to you;
- You are involved in your community;
- Your life is stable;
• You are respected and treated fairly;
• You have privacy;
• You have the best possible health;
• You feel safe;
• You are free from abuse and neglect.

You and the Team develop your plan of care based on your outcomes. Community Care has a responsibility to support your outcomes in the most cost-effective manner possible. To accomplish this, your Team uses a process called **Resource Allocation Decision-Making (RAD)**. This process is approved by the State of Wisconsin to help guide decision-making regarding your Plan of care. As stated above, you and others are part of the Team who take an active role in decision-making regarding the health, long-term care and home and community based services you need to support your outcomes.

You have the option to choose **Self-Directed Supports (SDS)** as your way of receiving long-term care services. Choosing SDS means making your own decisions about how and from whom you receive your long-term care services. You take the lead in managing your care, having control over resources, including finances; and taking responsibility for personal decisions and actions. If you are interested in learning more about SDS, contact your Team.

**How do you choose your PCP?**

You may choose a PCP by using the Provider Directory or by getting help from Customer Service. PCP’s do not automatically accept new patients. Our provider directory identifies PCPs that are not accepting new patients. You may keep your current PCP if he/she is part of our Plan network. You can tell us your choice of PCP by calling your Team or Customer Service. You can change PCPs (as explained later in this section). If there is a particular specialist or hospital that you want to use, check first to be sure your PCP makes referrals to that specialist, or uses that hospital.

**Changing your PCP**

You may change your PCP for any reason, at any time. Also, it’s possible that your PCP might leave our plan’s network of providers and you would have to find a new PCP. To change your PCP, call your Team. When you call, be sure to tell your Team if you are seeing specialists or getting other covered services that needed your PCP’s approval (such as home health services and durable medical equipment). Your Team will help make sure that you can continue with the specialty care and other services you have been getting when you change your PCP. They will check to be sure the PCP that you want to switch to is accepting new patients. Your Team will tell you when the change to your new PCP will take effect.
Section 2.2  What kinds of medical care and other services can you get without getting approval in advance from your PCP?

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

- Routine women’s health care, which includes breast exams, screening mammograms (x-rays of the breast), Pap tests, and pelvic exams as long as you get them from a network provider.

- Flu shots, Hepatitis B vaccinations, and pneumonia vaccinations as long as you get them from a network provider.

- Emergency services from network providers or from out-of-network providers.

- Urgently needed services from network providers or from out-of-network providers when network providers are temporarily unavailable or inaccessible, e.g., when you are temporarily outside of the plan’s service area.

- Kidney dialysis services that you get at a Medicare-certified dialysis facility when you are temporarily outside the plan’s service area. (If possible, please call Customer Service before you leave the service area so we can help arrange for you to have maintenance dialysis while you are away. Phone numbers for Customer Service are printed on the back cover of this booklet.)

- Family planning services.

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

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

- Oncologists care for patients with cancer.

- Cardiologists care for patients with heart conditions.

- Orthopedists care for patients with certain bone, joint, or muscle conditions.

- Contact your Team if you need health care from a specialist. For most services, you need to get prior authorization from your team. Refer members to Chapter 4, Section 2.1 for information about which services require prior authorization.

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

We may make changes to the hospitals, doctors, and specialists (providers) that are part of your plan during the year. There are a number of reasons why your provider might leave your plan but if your doctor or specialist does leave your plan you have certain rights and protections that are summarized below:
• Even though our network of providers may change during the year, Medicare requires that we furnish you with uninterrupted access to qualified doctors and specialists.

• We will make a good faith effort to provide you with at least 30 days’ notice that your provider is leaving our plan so that you have time to select a new provider.

• We will assist you in selecting a new qualified provider to continue managing your health care needs.

• If you are undergoing medical treatment you have the right to request, and we will work with you to ensure, that the medically necessary treatment you are receiving is not interrupted.

• If you believe we have not furnished you with a qualified provider to replace your previous provider or that your care is not being appropriately managed you have the right to file an appeal of our decision.

• If you find out your doctor or specialist is leaving your plan please contact us at 1-866-992-6600 so we can assist you in finding a new provider and managing your care.

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

If you need medical care that Medicare or Medicaid requires our plan to cover and the providers in our network cannot provide this care, you can get this care from an out-of-network provider. Authorization must be obtained from the plan prior to receiving care. In this situation, we will cover these services at no cost to you. For information about getting approval to see an out-of-network doctor, contact your Team (see Chapter 2 for contact information).

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

#### Section 3.1 Getting care if you have a medical emergency

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

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

If you have a medical emergency:

• **Get help as quickly as possible.** Call 911 for help or go to the nearest emergency room or hospital. Call for an ambulance if you need it. You do *not* need to get approval or a referral first from your PCP.
• **As soon as possible, make sure that our plan has been told about your emergency.**
  We need to follow up on your emergency care. You or someone else should call to tell us about your emergency care, usually within 48 hours. Call the phone number on the back of your membership card.

**What is covered if you have a medical emergency?**

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

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

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

**What if it wasn’t a medical emergency?**

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

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

• You go to a network provider to get the additional care.

• *– or –* The additional care you get is considered “urgently needed services” and you follow the rules for getting this urgent care (for more information about this, see Section 3.2 below).

---

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

**What are “urgently needed services”?**

“Urgently needed services” are non-emergency, unforeseen medical illness, injury, or condition that requires immediate medical care. Urgently needed services may be furnished by network providers or by out-of-network providers when network providers are temporarily unavailable or inaccessible. The unforeseen condition could, for example, be an unforeseen flare-up of a known condition that you have.
What if you are in the plan’s service area when you have an urgent need for care?

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

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

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

Our plan does not cover urgently needed services or any other care if you receive the care outside of the United States.

Section 3.3 Getting care during a disaster

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

Please visit the following website: www.communitycareinc.org for information on how to obtain needed care during a disaster.

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

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

Section 4.1 You can ask us to pay for covered services

If you have paid for your covered services or if you have received a bill for covered medical services, go to Chapter 6 (Asking us to pay a bill you have received for covered medical services or drugs) for information about what to do.

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

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

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

Chapter 8 (What to do if you have a problem or complaint (coverage decisions, appeals, complaints)) has more information about what to do if you want a coverage decision from us or want to appeal a decision we have already made. You may also call Customer Service to get more information (phone numbers are printed on the back cover of this booklet).

For covered services that have a benefit limitation, you pay the full cost of any services you get after you have used up your benefit for that type of covered service. You can call Customer Service when you want to know how much of your benefit limit you have already used.

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

Section 5.1 What is a “clinical research study”?

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

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

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

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

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

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

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

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

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

Original Medicare pays most of the cost of the covered services you receive as part of the study. After Medicare has paid its share of the cost for these services, our plan will pay the rest. Like for all covered services, you will pay nothing for the covered services you get in the clinical research study.

In order for us to pay for our share of the costs, you will need to submit a request for payment. With your request, you will need to send us a copy of your Medicare Summary Notices or other documentation that shows what services you received as part of the study. Please see Chapter 6 for more information about submitting requests for payment.

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

- Generally, Medicare will not pay for the new item or service that the study is testing unless Medicare would cover the item or service even if you were not in a study.
- Items and services the study gives you or any participant for free.
- Items or services provided only to collect data, and not used in your direct health care. For example, Medicare would not pay for monthly CT scans done as part of the study if your medical condition would normally require only one CT scan.
SECTION 6 Rules for getting care covered in a “religious non-medical health care institution”

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

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

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

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

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

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

- The facility providing the care must be certified by Medicare.
- Our plan’s coverage of services you receive is limited to non-religious aspects of care.
- If you get services from this institution that are provided to you in a facility, the following conditions apply:
  - You must have a medical condition that would allow you to receive covered services for inpatient hospital care or skilled nursing facility care.
  - You must get approval in advance from our plan before you are admitted to the facility or your stay will not be covered.
There is unlimited coverage for this benefit.

SECTION 7  Rules for ownership of durable medical equipment

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

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

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

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

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

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

If you made fewer than 13 payments for the DME item under Original Medicare before you joined our plan, your previous payments also do not count toward the 13 consecutive payments. You will have to make 13 new consecutive payments after you return to Original Medicare in order to own the item. There are no exceptions to this case when you return to Original Medicare.
CHAPTER 4

Benefits Chart (what is covered)
### Chapter 4. Benefits Chart (what is covered)

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SECTION 1  Understanding covered services

This chapter focuses on what services are covered. It includes a Benefits Chart that lists your covered services as a member of Community Care. Later in this chapter, you can find information about medical services that are not covered.

Section 1.1  You pay nothing for your covered services

Because you get assistance from Medicaid, you pay nothing for your covered services as long as you follow the plan’s rules for getting your care. (See Chapter 3 for more information about the plan’s rules for getting your care.)

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

Section 2.1  Your medical and long-term care benefits as a member of the plan

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

- Your Medicare and Medicaid covered services must be provided according to the coverage guidelines established by Medicare and Medicaid.
- Your services (including medical care, services, supplies, and equipment) must be medically necessary. “Medically necessary” means that the services, supplies, or drugs are needed for the prevention, diagnosis, or treatment of your medical condition and meet accepted standards of medical practice.
- You receive your care from a network provider. In most cases, care you receive from an out-of-network provider will not be covered. Chapter 3 provides more information about requirements for using network providers and the situations when we will cover services from an out-of-network provider.
- You have a primary care provider (a PCP) who is providing and overseeing your care. In most situations, your PCP must give you approval in advance before you can see other providers in the plan’s network. This is called giving you a “referral.” Chapter 3 provides more information about getting a referral and the situations when you do not need a referral.
- Some of the services listed in the Benefits Chart are covered only if your doctor or other network provider gets approval in advance (sometimes called “prior authorization”) from us. Covered services that need approval in advance are marked in the Benefits Chart.
Other important things to know about our coverage:

- You are covered by both Medicare and Medicaid. Medicare covers health care and prescription drugs. Medicaid covers your cost-sharing for Medicare services. Medicaid also covers services Medicare does not cover, like long-term care, over-the-counter drugs, home and community-based services, or other Medicaid-only services.

- Like all Medicare health plans, we cover everything that Original Medicare covers. (If you want to know more about the coverage and costs of Original Medicare, look in your Medicare & You 2018 Handbook. View it online at http://www.medicare.gov or ask for a copy by calling 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.)

- For all preventive services that are covered at no cost under Original Medicare, we also cover the service at no cost to you.

- Sometimes, Medicare adds coverage under Original Medicare for new services during the year. If Medicare adds coverage for any services during 2018, either Medicare or our plan will cover those services.

- Community Care fully integrates both Medicare and Medicaid benefits. The benefits charts reflect the covered benefits. You pay nothing for covered Medicare and Medicaid benefits.

- If you are within our plan’s 1-month period of deemed continued eligibility, we will continue to provide all Medicare Advantage plan-covered Medicare benefits. Contact your Team at 1-866-992-6600 to discuss your Medicaid benefits. Medicare cost sharing amounts for Medicare basic and supplemental benefits do not change during this period.

You do not pay anything for the services listed in the Benefits Chart, as long as you meet the coverage requirements described above.

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

You are covered by both Medicare and Medicaid. Health care and prescription drugs are usually covered by Medicare. Long-term care services and supports and covered over-the-counter drugs that are listed in the Plan Formulary are usually covered by Medicaid.

Community Care Family Care Partnership Program is a fully-integrated health plan which means that all of your health and long-term care needs and prescription drugs are provided through one plan and coordinated by your Team. We contract with both Medicare, the Centers for Medicare & Medicaid Services (CMS), and Medicaid, the Wisconsin Department of Health Services (DHS) in order to offer this plan. We don’t separate which of the services you receive are covered by Medicare and which are covered by Medicaid. However, we would like you to better understand your benefits and whether Medicare or Medicaid covers them.
As you review the Benefits Chart below, please keep the following in mind:

- Medicaid covers some care and services that Medicare does not cover at all and covers other services that Medicare does not fully cover, such as nursing home and home health care.

- Original Medicare limits certain benefits and the frequency of some screenings and tests. Because you have Medicaid, we cover authorized medically necessary care obtained from network providers without these limitations.

- Original Medicare includes deductibles, coinsurance and cost-sharing. Because you have Medicaid, we cover these costs on your behalf.

- Original Medicare pays physicians part of the Medicare-approved amount and you would have to pay the physician 20% of the Medicare-approved amount. Because you have Medicaid, we pay this amount on your behalf.

- Original Medicare does not cover long-term care benefits. Because you have Medicaid, we cover the health related and long-term care benefits listed at the end of the benefits chart.

- Our plan covers all Medicare and Medicaid covered services, including preventive services, at no cost to you.

- For a complete list of Medicaid services covered by this plan, please see the Summary of Medicaid-Covered Benefits in the Summary of Benefits.
## Benefits Chart

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<tbody>
<tr>
<td><strong>Abdominal aortic aneurysm screening</strong>&lt;br&gt;A one-time screening ultrasound for people at risk. The plan only covers this screening if you have certain risk factors and if you get a referral for it from your physician, physician assistant, nurse practitioner, or clinical nurse specialist.</td>
<td></td>
</tr>
<tr>
<td>You pay nothing when you receive these covered services from network providers.</td>
<td></td>
</tr>
<tr>
<td>Prior authorization may be required.</td>
<td></td>
</tr>
<tr>
<td>There is no coinsurance, copayment, or deductible for members eligible for this preventive screening.</td>
<td></td>
</tr>
</tbody>
</table>

**Ambulance services**

- Covered ambulance services include fixed wing, rotary wing, and ground ambulance services, to the nearest appropriate facility that can provide care only if they are furnished to a member whose medical condition is such that other means of transportation could endanger the person’s health or if authorized by the plan.
- Non-emergency transportation by ambulance is appropriate if it is documented that the member’s condition is such that other means of transportation could endanger the person’s health and that transportation by ambulance is medically required.

You pay nothing when you receive these covered services from network providers.

Prior authorization is required for all non-emergency transportation.

**Annual wellness visit**

If you’ve had Part B for longer than 12 months, you can get an annual wellness visit to develop or update a personalized prevention plan based on your current health and risk factors. This is covered once every 12 months.

**Note:** Your first annual wellness visit can’t take place within 12 months of your “Welcome to Medicare” preventive visit. However, you don’t need to have had a “Welcome to Medicare” visit to be covered for annual wellness visits after you’ve had Part B for 12 months.

There is no coinsurance, copayment, or deductible for the annual wellness visit.

Contact your Team to arrange your annual wellness visit.
<table>
<thead>
<tr>
<th>Services that are covered for you</th>
<th>What you must pay when you get these services</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Bone mass measurement</strong></td>
<td>You pay nothing when you receive these covered services from network providers.</td>
</tr>
<tr>
<td>For qualified individuals (generally, this means people at risk of losing bone mass or at risk of osteoporosis), the following services are covered every 24 months or more frequently if medically necessary: procedures to identify bone mass, detect bone loss, or determine bone quality, including a physician’s interpretation of the results.</td>
<td>Prior authorization may be required.</td>
</tr>
<tr>
<td></td>
<td>There is no coinsurance, copayment, or deductible for Medicare-covered bone mass measurement.</td>
</tr>
<tr>
<td><strong>Breast cancer screening (mammograms)</strong></td>
<td>You pay nothing when you receive these covered services from network providers.</td>
</tr>
<tr>
<td>Covered services include:</td>
<td>Prior authorization may be required.</td>
</tr>
<tr>
<td>• One baseline mammogram between the ages of 35 and 39</td>
<td>There is no coinsurance, copayment, or deductible for covered screening mammograms.</td>
</tr>
<tr>
<td>• One screening mammogram every 12 months for women age 40 and older</td>
<td></td>
</tr>
<tr>
<td>• Clinical breast exams once every 24 months</td>
<td></td>
</tr>
<tr>
<td><strong>Cardiac rehabilitation services</strong></td>
<td>You pay nothing when you receive these covered services from network providers.</td>
</tr>
<tr>
<td>Comprehensive programs of cardiac rehabilitation services that include exercise, education, and counseling are covered for members who meet certain conditions with a doctor’s referral. The plan also covers intensive cardiac rehabilitation programs that are typically more rigorous or more intense than cardiac rehabilitation programs.</td>
<td>Prior authorization may be required.</td>
</tr>
<tr>
<td>Services that are covered for you</td>
<td>What you must pay when you get these services</td>
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<td>----------------------------------</td>
<td>-----------------------------------------------</td>
</tr>
<tr>
<td><strong>Cardiovascular disease risk reduction visit (therapy for cardiovascular disease)</strong>&lt;br&gt; We cover one visit per year with your primary care doctor to help lower your risk for cardiovascular disease. During this visit, your doctor may discuss aspirin use (if appropriate), check your blood pressure, and give you tips to make sure you’re eating well.</td>
<td>You pay nothing when you receive these covered services from network providers. &lt;br&gt; Prior authorization may be required. &lt;br&gt; There is no coinsurance, copayment, or deductible for the intensive behavioral therapy cardiovascular disease preventive benefit.</td>
</tr>
<tr>
<td><strong>Cardiovascular disease testing</strong>&lt;br&gt; Blood tests for the detection of cardiovascular disease (or abnormalities associated with an elevated risk of cardiovascular disease) once every 5 years (60 months).</td>
<td>You pay nothing when you receive these covered services from network providers. &lt;br&gt; Prior authorization may be required. &lt;br&gt; There is no coinsurance, copayment, or deductible for cardiovascular disease testing that is covered once every 5 years.</td>
</tr>
<tr>
<td><strong>Cervical and vaginal cancer screening</strong>&lt;br&gt; Covered services include: &lt;br&gt; • For all women: Pap tests and pelvic exams are covered once every 24 months &lt;br&gt; • If you are at high risk of cervical or vaginal cancer or you are of childbearing age and have had an abnormal Pap test within the past 3 years: one Pap test every 12 months</td>
<td>You pay nothing when you receive these covered services from network providers. &lt;br&gt; Prior authorization may be required. &lt;br&gt; There is no coinsurance, copayment, or deductible for Medicare-covered preventive Pap and pelvic exams.</td>
</tr>
<tr>
<td>Services that are covered for you</td>
<td>What you must pay when you get these services</td>
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<td>----------------------------------</td>
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</tr>
<tr>
<td><strong>Chiropractic services</strong></td>
<td>You pay nothing when you receive these covered services from network providers.</td>
</tr>
<tr>
<td>Covered services include:</td>
<td>Prior authorization may be required.</td>
</tr>
<tr>
<td>• We cover only manual manipulation of the spine to correct subluxation</td>
<td></td>
</tr>
<tr>
<td><strong>Colorectal cancer screening</strong></td>
<td>You pay nothing when you receive these covered services from network providers.</td>
</tr>
<tr>
<td>For people 50 and older, the following are covered:</td>
<td>Prior authorization may be required.</td>
</tr>
<tr>
<td>• Flexible sigmoidoscopy (or screening barium enema as an alternative) every 48 months</td>
<td>There is no coinsurance, copayment, or deductible for a Medicare-covered colorectal cancer screening exam.</td>
</tr>
<tr>
<td>One of the following every 12 months:</td>
<td></td>
</tr>
<tr>
<td>• Guaiac-based fecal occult blood test (gFOBT)</td>
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<tr>
<td>• Fecal immunochemical test (FIT)</td>
<td></td>
</tr>
<tr>
<td>DNA based colorectal screening every 3 years</td>
<td></td>
</tr>
<tr>
<td>For people at high risk of colorectal cancer, we cover:</td>
<td></td>
</tr>
<tr>
<td>• Screening colonoscopy (or screening barium enema as an alternative) every 24 months</td>
<td></td>
</tr>
<tr>
<td>For people not at high risk of colorectal cancer, we cover:</td>
<td></td>
</tr>
<tr>
<td>• Screening colonoscopy every 10 years (120 months), but not within 48 months of a screening sigmoidoscopy</td>
<td></td>
</tr>
<tr>
<td><strong>Dental services</strong></td>
<td>You pay nothing when you receive these covered services from network providers.</td>
</tr>
<tr>
<td>In general, preventive dental services (such as cleaning, routine dental exams, and dental x-rays) are not covered by Original Medicare.</td>
<td>Prior authorization may be required.</td>
</tr>
<tr>
<td>Because you have Medicaid, we cover:</td>
<td></td>
</tr>
<tr>
<td>• Dental services covered by Wisconsin Medicaid</td>
<td></td>
</tr>
<tr>
<td>• Routine dental care, including exams, cleanings and x-rays</td>
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<tr>
<td>• Fillings</td>
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<tr>
<td>• Surgery of the jaw or related structures</td>
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<tr>
<td>• Setting fractures of the jaw or facial bones</td>
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</tr>
<tr>
<td>• Extraction of teeth</td>
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</tr>
<tr>
<td>• Services that would be covered when provided by a doctor.</td>
<td></td>
</tr>
<tr>
<td>Services that are covered for you</td>
<td>What you must pay when you get these services</td>
</tr>
<tr>
<td>--------------------------------------------------------------------------------------------------</td>
<td>---------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td><strong>Depression screening</strong></td>
<td>You pay nothing when you receive these covered services from network providers.</td>
</tr>
<tr>
<td>We cover one screening for depression per year. The screening must be done in a primary care setting that can provide follow-up treatment and referrals.</td>
<td>Prior authorization may be required.</td>
</tr>
<tr>
<td></td>
<td>There is no coinsurance, copayment, or deductible for an annual depression screening visit.</td>
</tr>
<tr>
<td><strong>Diabetes screening</strong></td>
<td>You pay nothing when you receive these covered services from network providers.</td>
</tr>
<tr>
<td>We cover this screening (includes fasting glucose tests) if you have any of the following risk factors: high blood pressure (hypertension), history of abnormal cholesterol and triglyceride levels (dyslipidemia), obesity, or a history of high blood sugar (glucose). Tests may also be covered if you meet other requirements, like being overweight and having a family history of diabetes. Based on the results of these tests, you may be eligible for up to two diabetes screenings every 12 months.</td>
<td>Prior authorization may be required.</td>
</tr>
<tr>
<td></td>
<td>There is no coinsurance, copayment, or deductible for the Medicare covered diabetes screening tests.</td>
</tr>
<tr>
<td><strong>Diabetes self-management training, diabetic services and supplies</strong></td>
<td>You pay nothing when you receive these covered services from network providers.</td>
</tr>
<tr>
<td>For all people who have diabetes (insulin and non-insulin users). Covered services include:</td>
<td>Prior authorization may be required.</td>
</tr>
<tr>
<td>• Supplies to monitor your blood glucose: Blood glucose monitor, blood glucose test strips, lancet devices and lancets, and glucose-control solutions for checking the accuracy of test strips and monitors.</td>
<td></td>
</tr>
<tr>
<td>• For people with diabetes who have severe diabetic foot disease: One pair per calendar year of therapeutic custom-molded shoes (including inserts provided with such shoes) and two additional pairs of inserts, or one pair of depth shoes and three pairs of inserts (not including the non-customized removable inserts provided with such shoes). Coverage includes fitting.</td>
<td></td>
</tr>
<tr>
<td>• Diabetes self-management training is covered under certain conditions.</td>
<td></td>
</tr>
<tr>
<td>Services that are covered for you</td>
<td>What you must pay when you get these services</td>
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<td>----------------------------------</td>
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</tr>
</tbody>
</table>
| **Durable medical equipment (DME) and related supplies**  
(For a definition of “durable medical equipment,” see Chapter 11 of this booklet.)  
Covered items include, but are not limited to: wheelchairs, crutches, powered mattress systems, diabetic supplies, hospital beds ordered by a provider for use in the home, IV infusion pumps, speech generating devices, oxygen equipment, nebulizers, and walkers.  
We cover all medically necessary DME covered by Original Medicare. If our supplier in your area does not carry a particular brand or manufacturer, you may ask your Team if they can special order it for you.  
If you (or your provider) don’t agree with the plan’s coverage decision, you or your provider may file an appeal. You can also file an appeal if you don’t agree with your provider’s decision about what product or brand is appropriate for your medical condition. (For more information about appeals, see Chapter 8, *What to do if you have a problem or complaint (coverage decisions, appeals, complaints)*.) | You pay nothing when you receive these covered services from network providers.  
Prior authorization may be required. |
## Emergency care

Emergency care refers to services that are:

- Furnished by a provider qualified to furnish emergency services, and
- Needed to evaluate or stabilize an emergency medical condition.

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

Cost sharing for necessary emergency services furnished out-of-network is the same as for such services furnished in-network.

Coverage is for care provided within the U.S. and its territories.

<table>
<thead>
<tr>
<th>Services that are covered for you</th>
<th>What you must pay when you get these services</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Emergency care</strong></td>
<td>If you receive emergency care at an out-of-network hospital and need inpatient care after your emergency condition is stabilized, <strong>contact your Team</strong>.</td>
</tr>
<tr>
<td></td>
<td>You must return to a network hospital in order for your care to continue to be covered <strong>OR</strong> you must have your inpatient care at the out-of-network hospital authorized by the plan.</td>
</tr>
</tbody>
</table>

## Health and wellness education programs

These are programs focused on health conditions such as high blood pressure, cholesterol, asthma, and special diets. Programs designed to enrich the health and lifestyles of members include weight management, fitness, and stress management.

<table>
<thead>
<tr>
<th>Services that are covered for you</th>
<th>What you must pay when you get these services</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Health and wellness education programs</strong></td>
<td>You pay nothing when you receive these covered services from network providers.</td>
</tr>
<tr>
<td></td>
<td>Prior authorization may be required.</td>
</tr>
<tr>
<td>Services that are covered for you</td>
<td>What you must pay when you get these services</td>
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<td>----------------------------------</td>
<td>-----------------------------------------------</td>
</tr>
<tr>
<td><strong>Hearing services</strong></td>
<td></td>
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</tbody>
</table>
| Diagnostic hearing and balance evaluations performed by your PCP OR network provider to determine if you need medical treatment are covered as outpatient care when furnished by a physician, audiologist, or other qualified provider. Because you have Medicaid, we cover:  
  - Routine hearing exams  
  - Diagnostic hearing exams  
  - Hearing aids, batteries and repairs as needed  
  - Evaluations for fitting hearing aids. | You pay nothing when you receive these covered services from network providers.  
Prior authorization may be required. |
| **HIV screening**                |                                               |
| For people who ask for an HIV screening test or who are at increased risk for HIV infection, we cover:  
  - One screening exam every 12 months  
For women who are pregnant, we cover:  
  - Up to three screening exams during a pregnancy | You pay nothing when you receive these covered services from network providers.  
Prior authorization may be required.  
There is no coinsurance, copayment, or deductible for members eligible for Medicare-covered preventive HIV screening. |
| **Home health agency care**      |                                               |
| Prior to receiving home health services, a doctor must certify that you need home health services and will order home health services to be provided by a home health agency. Covered services include, but are not limited to:  
  - Personal Care services are covered by Medicaid  
  - Part-time or intermittent skilled nursing and home health aide services (To be covered under the home health care benefit, your skilled nursing and home health aide services combined must total fewer than 8 hours per day and 35 hours per week)  
  - Physical therapy, occupational therapy, and speech therapy  
  - Medical and social services  
  - Medical equipment and supplies | You pay nothing when you receive these covered services from network providers.  
Prior authorization may be required. |
<table>
<thead>
<tr>
<th>Services that are covered for you</th>
<th>What you must pay when you get these services</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Hospice care</strong></td>
<td></td>
</tr>
<tr>
<td>You may receive care from any Medicare-certified hospice program. You are eligible for the hospice benefit when your doctor and the hospice medical director have given you a terminal prognosis certifying that you’re terminally ill and have 6 months or less to live if your illness runs its normal course. Your hospice doctor can be a network provider or an out-of-network provider. Covered services include:</td>
<td></td>
</tr>
<tr>
<td>• Drugs for symptom control and pain relief</td>
<td></td>
</tr>
<tr>
<td>• Short-term respite care</td>
<td></td>
</tr>
<tr>
<td>• Home care</td>
<td></td>
</tr>
<tr>
<td>For hospice services and for services that are covered by Medicare Part A or B and are related to your terminal prognosis: Original Medicare (rather than our plan) will pay for your Hospice services related to your terminal prognosis. While you are in the hospice program, your hospice provider will bill Original Medicare for the services that Original Medicare pays for.</td>
<td></td>
</tr>
<tr>
<td>For services that are covered by Medicare Part A or B and are not related to your terminal prognosis: If you need non-emergency, non-urgently needed services that are covered under Medicare Part A or B and that are not related to your terminal prognosis, your cost for these services depends on whether you use a provider in our plan’s network:</td>
<td></td>
</tr>
<tr>
<td>• If you obtain the covered services from a network provider, you only pay the plan cost-sharing amount for in-network services.</td>
<td></td>
</tr>
<tr>
<td>• If you obtain the covered services from an out-of-network provider, you pay the cost-sharing under Fee-for-Service Medicare (Original Medicare)</td>
<td></td>
</tr>
<tr>
<td>For services that are covered by Community Care but are not covered by Medicare Part A or B: Community Care will continue to cover plan-covered services that are not covered under Part A or B whether or not they are related to your terminal prognosis.</td>
<td></td>
</tr>
<tr>
<td>For drugs that may be covered by the plan’s Part D benefit: Drugs are never covered by both hospice and our plan at the same time. For more information, please see Chapter 5,</td>
<td></td>
</tr>
<tr>
<td>When you enroll in a Medicare-certified hospice program, your hospice services and your Part A and Part B services related to your terminal prognosis are paid for by Original Medicare, not Community Care.</td>
<td></td>
</tr>
<tr>
<td>Prior authorization may be required</td>
<td></td>
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</tbody>
</table>
### Services that are covered for you

<table>
<thead>
<tr>
<th>What you must pay when you get these services</th>
</tr>
</thead>
</table>

#### Section 9.4 (*What if you’re in Medicare-certified hospice*)

**Note:** If you need non-hospice care (care that is not related to your terminal prognosis), you should contact us to arrange the services.

Our plan covers hospice consultation services (one time only) for a terminally ill person who hasn’t elected the hospice benefit.

#### Immunizations

Covered Medicare Part B services include:

- Pneumonia vaccine
- Flu shots, once a year in the fall or winter
- Hepatitis B vaccine if you are at high or intermediate risk of getting Hepatitis B
- Other vaccines if you are at risk and they meet Medicare Part B coverage rules

We also cover some vaccines under our Part D prescription drug benefit.

- You pay nothing when you receive these covered services from network providers.
- Prior authorization may be required
- There is no coinsurance, copayment, or deductible for the pneumonia, influenza, and Hepatitis B vaccines.
<table>
<thead>
<tr>
<th>Services that are covered for you</th>
<th>What you must pay when you get these services</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Inpatient hospital care</strong></td>
<td>You pay nothing when you receive these covered services from network providers.</td>
</tr>
<tr>
<td>Includes inpatient acute, inpatient rehabilitation, long-term care hospitals and other types of inpatient hospital services.</td>
<td>If you get authorized inpatient care at an out-of-network hospital after your emergency condition is stabilized, your cost is the cost-sharing you would pay at a network hospital.</td>
</tr>
<tr>
<td>Inpatient hospital care starts the day you are formally admitted to the hospital with a doctor’s order. The day before you are discharged is your last inpatient day.</td>
<td>Prior authorization is required for non-emergent inpatient hospital care.</td>
</tr>
<tr>
<td>Covered services include but are not limited to:</td>
<td></td>
</tr>
<tr>
<td>- Semi-private room (or a private room if medically necessary)</td>
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<tr>
<td>- Meals including special diets</td>
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<tr>
<td>- Regular nursing services</td>
<td></td>
</tr>
<tr>
<td>- Costs of special care units (such as intensive care or coronary care units)</td>
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<tr>
<td>- Drugs and medications</td>
<td></td>
</tr>
<tr>
<td>- Lab tests</td>
<td></td>
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<tr>
<td>- X-rays and other radiology services</td>
<td></td>
</tr>
<tr>
<td>- Necessary surgical and medical supplies</td>
<td></td>
</tr>
<tr>
<td>- Use of appliances, such as wheelchairs</td>
<td></td>
</tr>
<tr>
<td>- Operating and recovery room costs</td>
<td></td>
</tr>
<tr>
<td>- Physical, occupational, and speech language therapy</td>
<td></td>
</tr>
<tr>
<td>- Inpatient substance abuse services</td>
<td></td>
</tr>
</tbody>
</table>
## Inpatient hospital care (continued)

- Under certain conditions, the following types of transplants are covered: corneal, kidney, kidney-pancreatic, heart, liver, lung, heart/lung, bone marrow, stem cell, and intestinal/multivisceral. If you need a transplant, we will arrange to have your case reviewed by a Medicare-approved transplant center that will decide whether you are a candidate for a transplant. Transplant providers may be local or outside of the service area. If our in-network transplant services are outside of the community pattern of care, you may choose to go locally as long as the local transplant providers are willing to accept the Original Medicare rate. If Community Care provides transplant services at a location outside the pattern of care for transplants in your community and you choose to obtain transplants at this distant location, we will arrange or pay for appropriate lodging and transportation costs for you and a companion.

- Blood - including storage and administration.

- Physician services

**Note:** To be an inpatient, your provider must write an order to admit you formally as an inpatient of the hospital. Even if you stay in the hospital overnight, you might still be considered an “outpatient.” If you are not sure if you are an inpatient or an outpatient, you should ask the hospital staff.

You can also find more information in a Medicare fact sheet called “Are You a Hospital Inpatient or Outpatient? If You Have Medicare – Ask!” This fact sheet is available on the Web at [https://www.medicare.gov/Pubs/pdf/11435.pdf](https://www.medicare.gov/Pubs/pdf/11435.pdf) or by calling 1-800-MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048. You can call these numbers for free, 24 hours a day, 7 days a week.

### Inpatient mental health care

Covered services include mental health care services that require a hospital stay.

You pay nothing when you receive these covered services from network providers.

Prior authorization may be required.
<table>
<thead>
<tr>
<th>Services that are covered for you</th>
<th>What you must pay when you get these services</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Medical nutrition therapy</strong></td>
<td>You pay nothing when you receive these covered services from network providers.</td>
</tr>
<tr>
<td>This benefit is for people with diabetes, renal (kidney) disease (but not on dialysis), or after a kidney transplant when referred by your doctor.</td>
<td></td>
</tr>
<tr>
<td>We cover 3 hours of one-on-one counseling services during your first year that you receive medical nutrition therapy services under Medicare (this includes our plan, any other Medicare Advantage plan, or Original Medicare), and 2 hours each year after that. If your condition, treatment, or diagnosis changes, you may be able to receive more hours of treatment with a physician’s referral. A physician must prescribe these services and renew their referral yearly if your treatment is needed into the next calendar year.</td>
<td></td>
</tr>
<tr>
<td>Prior authorization may be required.</td>
<td></td>
</tr>
<tr>
<td>There is no coinsurance, copayment, or deductible for members eligible for Medicare-covered medical nutrition therapy services.</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Medicare Diabetes Prevention Program (MDPP)</th>
<th>There is no coinsurance, copayment, or deductible for the MDPP benefit.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Beginning April 1, 2018, MDPP services will be covered for eligible Medicare beneficiaries under all Medicare health plans.</td>
<td></td>
</tr>
<tr>
<td>MDPP is a structured health behavior change intervention that provides practical training in long-term dietary change, increased physical activity, and problem-solving strategies for overcoming challenges to sustaining weight loss and a healthy lifestyle.</td>
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</tr>
<tr>
<td>Services that are covered for you</td>
<td>What you must pay when you get these services</td>
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</tbody>
</table>
| **Medicare Part B prescription drugs**<br>These drugs are covered under Part B of Original Medicare. Members of our plan receive coverage for these drugs through our plan. Covered drugs include: | You pay nothing when you receive these covered services from network providers.  
Prior authorization may be required. |
| - Drugs that usually aren’t self-administered by the patient and are injected or infused while you are getting physician, hospital outpatient, or ambulatory surgical center services  
- Drugs you take using durable medical equipment (such as nebulizers) that were authorized by the plan  
- Clotting factors you give yourself by injection if you have hemophilia  
- Immunosuppressive drugs, if you were enrolled in Medicare Part A at the time of the organ transplant  
- Injectable osteoporosis drugs, if you are homebound, have a bone fracture that a doctor certifies was related to post-menopausal osteoporosis, and cannot self-administer the drug  
- Antigens  
- Certain oral anti-cancer drugs and anti-nausea drugs  
- Certain drugs for home dialysis, including heparin, the antidote for heparin when medically necessary, topical anesthetics, and erythropoiesis-stimulating agents (such as Epogen®, Procrit®, Epoetin Alfa, Aranesp®, or Darbepoetin Alfa)  
- Intravenous Immune Globulin for the home treatment of primary immune deficiency diseases | There is no coinsurance, copayment, or deductible for Medicare Part B prescription drugs. |

Chapter 5 explains the Part D prescription drug benefit, including rules you must follow to have prescriptions covered.

---

**Obesity screening and therapy to promote sustained weight loss**

If you have a body mass index of 30 or more, we cover intensive counseling to help you lose weight. This counseling is covered if you get it in a primary care setting, where it can be coordinated with your comprehensive prevention plan. Talk to your primary care doctor, practitioner or your team to find out more.

You pay nothing when you receive these covered services from network providers.

There is no coinsurance, copayment, or deductible for preventive obesity screening and therapy.
### Services that are covered for you

<table>
<thead>
<tr>
<th><strong>Outpatient diagnostic tests and therapeutic services and supplies</strong></th>
<th><strong>What you must pay when you get these services</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Covered services include, but are not limited to:</td>
<td>You pay nothing when you receive these covered services from network providers.</td>
</tr>
<tr>
<td>• X-rays</td>
<td></td>
</tr>
<tr>
<td>• Radiation (radium and isotope) therapy including technician materials and supplies</td>
<td>Prior authorization may be required.</td>
</tr>
<tr>
<td>• Surgical supplies, such as dressings</td>
<td></td>
</tr>
<tr>
<td>• Splints, casts and other devices used to reduce fractures and dislocations</td>
<td></td>
</tr>
<tr>
<td>• Laboratory tests</td>
<td></td>
</tr>
<tr>
<td>• Blood, including storage and administration.</td>
<td></td>
</tr>
<tr>
<td>• Other outpatient diagnostic tests</td>
<td></td>
</tr>
</tbody>
</table>
### Services that are covered for you

<table>
<thead>
<tr>
<th>What you must pay when you get these services</th>
</tr>
</thead>
<tbody>
<tr>
<td>You pay nothing when you receive these covered services from network providers.</td>
</tr>
<tr>
<td>Prior authorization may be required.</td>
</tr>
</tbody>
</table>

### Outpatient hospital services

We cover medically-necessary services you get in the outpatient department of a hospital for diagnosis or treatment of an illness or injury.

Covered services include, but are not limited to:

- Services in an emergency department or outpatient clinic, such as observation services or outpatient surgery
- Laboratory and diagnostic tests billed by the hospital
- Mental health care, including care in a partial-hospitalization program, if a doctor certifies that inpatient treatment would be required without it
- X-rays and other radiology services billed by the hospital
- Medical supplies such as splints and casts
- Certain drugs and biologicals that you can’t give yourself

**Note:** Unless the provider has written an order to admit you as an inpatient to the hospital, you are an outpatient and pay the cost-sharing amounts for outpatient hospital services. Even if you stay in the hospital overnight, you might still be considered an “outpatient.” If you are not sure if you are an outpatient, you should ask the hospital staff.

You can also find more information in a Medicare fact sheet called “Are You a Hospital Inpatient or Outpatient? If You Have Medicare – Ask!” This fact sheet is available on the Web at [https://www.medicare.gov/Pubs/pdf/11435.pdf](https://www.medicare.gov/Pubs/pdf/11435.pdf) or by calling 1-800-MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048. You can call these numbers for free, 24 hours a day, 7 days a week.

### Outpatient mental health care

Covered services include:

Mental health services provided by a state-licensed psychiatrist or doctor, clinical psychologist, clinical social worker, clinical nurse specialist, nurse practitioner, physician assistant, or other Medicare-qualified mental health care professional as allowed under applicable state laws.

You pay nothing when you receive these covered services from network providers.

Prior authorization may be required.
<table>
<thead>
<tr>
<th>Services that are covered for you</th>
<th>What you must pay when you get these services</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Outpatient rehabilitation services</strong>&lt;br&gt;Covered services include: physical therapy, occupational therapy, and speech language therapy.&lt;br&gt;Outpatient rehabilitation services are provided in various outpatient settings, such as hospital outpatient departments, independent therapist offices, and Comprehensive Outpatient Rehabilitation Facilities (CORFs).</td>
<td>You pay nothing when you receive these covered services from network providers.&lt;br&gt;Prior authorization may be required.</td>
</tr>
<tr>
<td><strong>Outpatient substance abuse services</strong>&lt;br&gt;Covered services include: Outpatient substance abuse services provided by a state-licensed psychiatrist or doctor, clinical psychologist, clinical social worker, clinical nurse specialist, nurse practitioner, physician assistant, or other Medicare-qualified mental health care professional as allowed under applicable state laws.</td>
<td>You pay nothing when you receive these covered services from network providers.&lt;br&gt;Prior authorization may be required.</td>
</tr>
<tr>
<td><strong>Outpatient surgery, including services provided at hospital outpatient facilities and ambulatory surgical centers</strong>&lt;br&gt;Note: If you are having surgery in a hospital facility, you should check with your provider about whether you will be an inpatient or outpatient. Unless the provider writes an order to admit you as an inpatient to the hospital, you are an outpatient and pay the cost-sharing amounts for outpatient surgery. Even if you stay in the hospital overnight, you might still be considered an “outpatient.”</td>
<td>You pay nothing when you receive these covered services from network providers.&lt;br&gt;Prior authorization may be required.</td>
</tr>
<tr>
<td><strong>Partial hospitalization services</strong>&lt;br&gt;“Partial hospitalization” is a structured program of active psychiatric treatment provided as a hospital outpatient service or by a community mental health center, that is more intense than the care received in your doctor’s or therapist’s office and is an alternative to inpatient hospitalization.</td>
<td>You pay nothing when you receive these covered services from network providers.&lt;br&gt;Prior authorization may be required.</td>
</tr>
</tbody>
</table>
### Services that are covered for you

<table>
<thead>
<tr>
<th>Covered services</th>
<th>What you must pay when you get these services</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Physician/Practitioner services, including doctor’s office visits</strong></td>
<td></td>
</tr>
<tr>
<td>Covered services include:</td>
<td>You pay nothing when you receive these covered services from network providers.</td>
</tr>
<tr>
<td>• Medically-necessary medical care or surgery services furnished in a physician’s office, certified ambulatory surgical center, hospital outpatient department, or any other location</td>
<td>Prior authorization may be required.</td>
</tr>
<tr>
<td>• Consultation, diagnosis, and treatment by a specialist</td>
<td></td>
</tr>
<tr>
<td>• Basic hearing and balance exams performed by your PCP OR specialist, if your doctor orders it to see if you need medical treatment</td>
<td></td>
</tr>
<tr>
<td>• Second opinion by another network provider prior to surgery</td>
<td></td>
</tr>
<tr>
<td>• Non-routine dental care (covered services are limited to surgery of the jaw or related structures, setting fractures of the jaw or facial bones, extraction of teeth to prepare the jaw for radiation treatments of neoplastic cancer disease, or services that would be covered when provided by a physician)</td>
<td></td>
</tr>
<tr>
<td><strong>Podiatry services</strong></td>
<td>You pay nothing when you receive these covered services from network providers.</td>
</tr>
<tr>
<td>Covered services include:</td>
<td>Prior authorization may be required.</td>
</tr>
<tr>
<td>• Diagnosis and the medical or surgical treatment of injuries and diseases of the feet (such as hammer toe or heel spurs).</td>
<td></td>
</tr>
<tr>
<td>• Routine foot care for members with certain medical conditions affecting the lower limbs</td>
<td></td>
</tr>
<tr>
<td><strong>Prostate cancer screening exams</strong></td>
<td>You pay nothing when you receive these covered services from network providers.</td>
</tr>
<tr>
<td>For men age 50 and older, covered services include the following - once every 12 months:</td>
<td>There is no coinsurance, copayment, or deductible for an annual PSA test.</td>
</tr>
<tr>
<td>• Digital rectal exam</td>
<td></td>
</tr>
<tr>
<td>• Prostate Specific Antigen (PSA) test</td>
<td></td>
</tr>
<tr>
<td>Contact your Team to arrange a screening.</td>
<td></td>
</tr>
<tr>
<td>Services that are covered for you</td>
<td>What you must pay when you get these services</td>
</tr>
<tr>
<td>----------------------------------</td>
<td>-----------------------------------------------</td>
</tr>
<tr>
<td><strong>Prosthetic devices and related supplies</strong></td>
<td>You pay nothing when you receive these covered services from network providers.</td>
</tr>
<tr>
<td>Devices (other than dental) that replace all or part of a body part or function. These include, but are not limited to: colostomy bags and supplies directly related to colostomy care, pacemakers, braces, prosthetic shoes, artificial limbs, and breast prostheses (including a surgical brassiere after a mastectomy). Includes certain supplies related to prosthetic devices, and repair and/or replacement of prosthetic devices. Also includes some coverage following cataract removal or cataract surgery – see “Vision Care” later in this section for more detail.</td>
<td>Prior authorization may be required.</td>
</tr>
<tr>
<td><strong>Pulmonary rehabilitation services</strong></td>
<td>You pay nothing when you receive these covered services from network providers.</td>
</tr>
<tr>
<td>Comprehensive programs of pulmonary rehabilitation are covered for members who have moderate to very severe chronic obstructive pulmonary disease (COPD) and a referral for pulmonary rehabilitation from the doctor treating the chronic respiratory disease.</td>
<td>Prior authorization may be required.</td>
</tr>
<tr>
<td><strong>Screening and counseling to reduce alcohol misuse</strong></td>
<td>You pay nothing when you receive these covered services from network providers.</td>
</tr>
<tr>
<td>We cover one alcohol misuse screening for adults with Medicare (including pregnant women) who misuse alcohol, but aren’t alcohol dependent. If you screen positive for alcohol misuse, you can get up to 4 brief face-to-face counseling sessions per year (if you’re competent and alert during counseling) provided by a qualified primary care doctor or practitioner in a primary care setting.</td>
<td>Prior authorization may be required.</td>
</tr>
<tr>
<td></td>
<td>There is no coinsurance, copayment, or deductible for the Medicare-covered screening and counseling to reduce alcohol misuse preventive benefit.</td>
</tr>
<tr>
<td>Services that are covered for you</td>
<td>What you must pay when you get these services</td>
</tr>
<tr>
<td>----------------------------------</td>
<td>-----------------------------------------------</td>
</tr>
</tbody>
</table>
| **Screening for lung cancer with low dose computed tomography (LDCT)**  
For qualified individuals, a LDCT is covered every 12 months.  
**Eligible members are:** people aged 55 – 77 years who have no signs or symptoms of lung cancer, but who have a history of tobacco smoking of at least 30 pack-years and who currently smoke or have quit smoking within the last 15 years, who receive a written order for LDCT during a lung cancer screening counseling and shared decision making visit that meets the Medicare criteria for such visits and be furnished by a physician or qualified non-physician practitioner.  
*For LDCT lung cancer screenings after the initial LDCT screening:* the member must receive a written order for LDCT lung cancer screening, which may be furnished during any appropriate visit with a physician or qualified non-physician practitioner. If a physician or qualified non-physician practitioner elects to provide a lung cancer screening counseling and shared decision making visit for subsequent lung cancer screenings with LDCT, the visit must meet the Medicare criteria for such visits. | You pay nothing when you receive these covered services from network providers.  
Prior authorization may be required.  
There is no coinsurance, copayment, or deductible for the Medicare covered counseling and shared decision making visit or for the LDCT. |

| **Screening for sexually transmitted infections (STIs) and counseling to prevent STIs**  
We cover sexually transmitted infection (STI) screenings for chlamydia, gonorrhea, syphilis, and Hepatitis B. These screenings are covered for pregnant women and for certain people who are at increased risk for an STI when the tests are ordered by a primary care provider. We cover these tests once every 12 months or at certain times during pregnancy.  
We also cover up to 2 individual 20 to 30 minute, face-to-face high-intensity behavioral counseling sessions each year for sexually active adults at increased risk for STIs. We will only cover these counseling sessions as a preventive service if they are provided by a primary care provider and take place in a primary care setting, such as a doctor’s office.  
Contact your Team to arrange a screening. | You pay nothing when you receive these covered services from network providers.  
Prior authorization may be required.  
There is no coinsurance, copayment, or deductible for the Medicare-covered screening for STIs and counseling for STIs preventive benefit. |
<table>
<thead>
<tr>
<th>Services that are covered for you</th>
<th>What you must pay when you get these services</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Services to treat kidney disease and conditions</strong></td>
<td>You pay nothing when you receive these covered services from network providers.</td>
</tr>
</tbody>
</table>

Covered services include:

- Kidney disease education services to teach kidney care and help members make informed decisions about their care. For members with stage IV chronic kidney disease when referred by their doctor, we cover up to six sessions of kidney disease education services per lifetime.
- Outpatient dialysis treatments (including dialysis treatments when temporarily out of the service area, as explained in Chapter 3)
- Inpatient dialysis treatments (if you are admitted as an inpatient to a hospital for special care)
- Self-dialysis training (includes training for you and anyone helping you with your home dialysis treatments)
- Home dialysis equipment and supplies
- Certain home support services (such as, when necessary, visits by trained dialysis workers to check on your home dialysis, to help in emergencies, and check your dialysis equipment and water supply)

Certain drugs for dialysis are covered under your Medicare Part B drug benefit. For information about coverage for Part B Drugs, please go to the section, “Medicare Part B prescription drugs.”
## Skilled nursing facility (SNF) care

(For a definition of “skilled nursing facility care,” see Chapter 11 of this booklet. Skilled nursing facilities are sometimes called “SNFs.”)

Covered services include but are not limited to:

- Semiprivate room (or a private room if medically necessary)
- Meals, including special diets
- Skilled nursing services
- Physical therapy, occupational therapy, and speech therapy
- Drugs administered to you as part of your plan of care (This includes substances that are naturally present in the body, such as blood clotting factors.)
- Blood - including storage and administration.
- Medical and surgical supplies ordinarily provided by SNFs
- Laboratory tests ordinarily provided by SNFs
- X-rays and other radiology services ordinarily provided by SNFs
- Use of appliances such as wheelchairs ordinarily provided by SNFs
- Physician/Practitioner services

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

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

### What you must pay when you get these services

You pay nothing when you receive these covered services from network providers.

Prior authorization may be required.
## Smoking and tobacco use cessation (counseling to stop smoking or tobacco use)

<table>
<thead>
<tr>
<th>Services that are covered for you</th>
<th>What you must pay when you get these services</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Smoking and tobacco use cessation (counseling to stop smoking or tobacco use)</strong></td>
<td><strong>You pay nothing when you receive these covered services from network providers.</strong></td>
</tr>
<tr>
<td>If you use tobacco, but do not have signs or symptoms of tobacco-related disease: We cover two counseling quit attempts within a 12-month period as a preventive service with no cost to you. Each counseling attempt includes up to four face-to-face visits.</td>
<td><strong>Prior authorization may be required.</strong></td>
</tr>
<tr>
<td>If you use tobacco and have been diagnosed with a tobacco-related disease or are taking medicine that may be affected by tobacco: We cover cessation counseling services. We cover two counseling quit attempts within a 12-month period; however, you will pay the applicable cost-sharing. Each counseling attempt includes up to four face-to-face visits.</td>
<td><strong>There is no coinsurance, copayment, or deductible for the Medicare-covered smoking and tobacco use cessation preventive benefits.</strong></td>
</tr>
</tbody>
</table>

## Urgently needed services

Urgently needed services are provided to treat a non-emergency, unforeseen medical illness, injury, or condition that requires immediate medical care. Urgently needed services may be furnished by network providers or by out-of-network providers when network providers are temporarily unavailable or inaccessible.

Cost sharing for necessary urgently needed services furnished out-of-network is the same as for such services furnished in-network.

Coverage is for care provided in the United States and its territories.

You pay nothing when you receive these covered services from network providers.

Prior authorization may be required.
<table>
<thead>
<tr>
<th>Services that are covered for you</th>
<th>What you must pay when you get these services</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Vision care</strong></td>
<td></td>
</tr>
<tr>
<td>Covered services include:</td>
<td></td>
</tr>
<tr>
<td>• Outpatient physician services</td>
<td>You pay nothing when you receive these</td>
</tr>
<tr>
<td>for the diagnosis and</td>
<td>covered services from network providers.</td>
</tr>
<tr>
<td>treatment of diseases and</td>
<td></td>
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<tr>
<td>injuries of the eye,</td>
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<tr>
<td>including treatment for</td>
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<tr>
<td>age-related macular</td>
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<tr>
<td>degeneration. Original</td>
<td></td>
</tr>
<tr>
<td>Medicare doesn’t cover</td>
<td></td>
</tr>
<tr>
<td>routine eye exams (eye</td>
<td></td>
</tr>
<tr>
<td>refractions) for</td>
<td></td>
</tr>
<tr>
<td>eyeglasses/contacts.</td>
<td></td>
</tr>
<tr>
<td>• For people who are at high</td>
<td>Prior authorization may be required.</td>
</tr>
<tr>
<td>risk of glaucoma, we will</td>
<td></td>
</tr>
<tr>
<td>cover one glaucoma</td>
<td></td>
</tr>
<tr>
<td>screening each year.</td>
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<tr>
<td>People at high risk of</td>
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<tr>
<td>glaucoma include: people</td>
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<tr>
<td>with a family history of</td>
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</tr>
<tr>
<td>glaucoma, people with</td>
<td></td>
</tr>
<tr>
<td>diabetes, African-Americans</td>
<td></td>
</tr>
<tr>
<td>who are age 50 and older</td>
<td></td>
</tr>
<tr>
<td>and Hispanic Americans</td>
<td></td>
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<tr>
<td>who are 65 or older.</td>
<td></td>
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<tr>
<td>• For people with diabetes,</td>
<td></td>
</tr>
<tr>
<td>screening for diabetic</td>
<td></td>
</tr>
<tr>
<td>retinopathy is covered</td>
<td></td>
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<tr>
<td>once per year.</td>
<td></td>
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<tr>
<td>• One pair of eyeglasses or</td>
<td></td>
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<tr>
<td>contact lenses after each</td>
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</tr>
<tr>
<td>cataract surgery that</td>
<td></td>
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<tr>
<td>includes insertion of an</td>
<td></td>
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<tr>
<td>intraocular lens. (If you</td>
<td></td>
</tr>
<tr>
<td>have two separate cataract</td>
<td></td>
</tr>
<tr>
<td>operations, you cannot</td>
<td></td>
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<tr>
<td>reserve the benefit after</td>
<td></td>
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<tr>
<td>the first surgery and</td>
<td></td>
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<tr>
<td>purchase two eyeglasses</td>
<td></td>
</tr>
<tr>
<td>after the second surgery.)</td>
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</tr>
</tbody>
</table>

Because you have Medicaid, we cover:

- Outpatient services for eye care provided by an optometrist, optician or physician, including routine eye exams (eye refractions) for eyeglasses.
- Eyeglasses as needed.

---

**“Welcome to Medicare” Preventive Visit**

The plan covers the one-time “Welcome to Medicare” preventive visit. The visit includes a review of your health, as well as education and counseling about the preventive services you need (including certain screenings and shots), and referrals for other care if needed.

**Important:** We cover the “Welcome to Medicare” preventive visit only within the first 12 months you have Medicare Part B. When you make your appointment, let your doctor’s office know you would like to schedule your “Welcome to Medicare” preventive visit.

There is no coinsurance, copayment, or deductible for the “Welcome to Medicare” preventive visit.
Listed below are the Wisconsin Medicaid benefits covered by Community Care. Because you are a member of this Partnership program, your Medicare deductible and coinsurance amounts are paid on your behalf.

When people are eligible for both Medicare and Medicaid, health care and prescription drugs are usually covered by Medicare while long-term care benefits and over-the-counter drugs are usually covered by Medicaid.

All members of Community Care receive coverage for health care and drugs. These benefits include but are not limited to:

1. Alcohol and other drug abuse (AODA) services
2. Audiology
3. Case management
4. Chiropractic
5. Dental services
6. Diagnostic testing services
7. Dialysis services
8. Drugs
9. Durable medical equipment and medical supplies
10. Home care services (Home health, nursing and personal care)
11. Hospice care services
12. Hospital services
13. Medicare deductible and coinsurance
14. Mental health services
15. Nursing home services.
16. Physician services
17. Podiatry services
18. Respiratory care for ventilator-assisted recipients
19. Therapy – physical therapy, occupational therapy and

Members are required to use network providers for all types of service, except emergency care.

There are no deductibles or copays for covered, authorized services.

In 2018 Partnership members will not have to pay a copay for Part D prescription drugs.

Prior authorization is required for most types of services. Contact your Team for details.

Services are NOT covered outside of the United States and its territories, except under limited circumstances.

As a member of Community Care, you may be responsible for a monthly cost share. This amount is determined by your county and must be paid to keep your eligibility for Medicaid. Community Care will bill you for the cost share each month. (The federal government refers to this as the “post-eligibility treatment of income.”).
<table>
<thead>
<tr>
<th>Services that are covered for you</th>
<th>What you must pay when you get these services</th>
</tr>
</thead>
<tbody>
<tr>
<td>speech and language pathology services</td>
<td>If you reside in substitute care, you must also pay for room and board. Community Care will also bill you for room and board each month.</td>
</tr>
<tr>
<td>20. Transportation</td>
<td></td>
</tr>
<tr>
<td>21. Vision care services</td>
<td>Providers may not bill you for covered benefits that were authorized by Community Care and received while you were enrolled in our plan. Providers may bill you for non-covered services that you have agreed to pay.</td>
</tr>
<tr>
<td>All members of Community Care are also eligible to receive the following long-term care benefits which are covered by Medicaid:</td>
<td></td>
</tr>
<tr>
<td>• Adaptive aids</td>
<td></td>
</tr>
<tr>
<td>• Adult day care services</td>
<td></td>
</tr>
<tr>
<td>• Assistive Technology / Communication aids</td>
<td></td>
</tr>
<tr>
<td>• Care/case management</td>
<td></td>
</tr>
<tr>
<td>• Consultative clinical and therapeutic services for caregivers</td>
<td></td>
</tr>
<tr>
<td>• Consumer education and training services</td>
<td></td>
</tr>
<tr>
<td>• Counseling and therapeutic services</td>
<td></td>
</tr>
<tr>
<td>• Environmental accessibility adaptations / Home modifications</td>
<td></td>
</tr>
<tr>
<td>• Financial management services</td>
<td></td>
</tr>
<tr>
<td>• Habilitation:</td>
<td></td>
</tr>
<tr>
<td>▪ Daily living skills training</td>
<td></td>
</tr>
<tr>
<td>▪ Day habilitation services</td>
<td></td>
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<tr>
<td>▪ Prevocational services</td>
<td></td>
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<tr>
<td>▪ Supported employment</td>
<td></td>
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<tr>
<td>□ Individual employment support</td>
<td></td>
</tr>
<tr>
<td>□ Small group employment support</td>
<td></td>
</tr>
<tr>
<td>▪ Vocational futures planning and support</td>
<td></td>
</tr>
<tr>
<td>• Home delivered meals</td>
<td></td>
</tr>
<tr>
<td>• Housing counseling</td>
<td></td>
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<tr>
<td>• Personal Emergency Response Systems</td>
<td></td>
</tr>
<tr>
<td>• Relocation services</td>
<td></td>
</tr>
<tr>
<td>• Residential Care</td>
<td></td>
</tr>
<tr>
<td>▪ Adult family homes of 1-2 beds</td>
<td></td>
</tr>
<tr>
<td>▪ Adult family homes of 3-4 beds</td>
<td></td>
</tr>
<tr>
<td>▪ Community-based residential facilities (CBRF)</td>
<td></td>
</tr>
<tr>
<td>▪ Residential care apartment complexes (RCAC)</td>
<td></td>
</tr>
<tr>
<td>• Respite care</td>
<td></td>
</tr>
</tbody>
</table>
SECTION 3  What services are not covered by the plan?

Section 3.1  Services not covered by the plan

This section tells you what services are “excluded.” Excluded means that the plan doesn’t cover these services. In some cases, we cover items or services that are excluded by Medicare under our plan’s Medicaid benefits. For more information about Medicaid benefits, call your Team (phone numbers are printed on the back cover of this booklet).

The chart below describes some services and items that aren’t covered by the plan under any conditions or are covered by the plan only under specific conditions. The chart also tells you if the service or item is covered under Medicaid.

We won’t pay for the excluded medical services listed in the chart below except under the specific conditions listed. The only exception: we will pay if a service in the chart below is found upon appeal to be a medical service that we should have paid for or covered because of your specific situation. (For information about appealing a decision we have made to not cover a medical service, go to Chapter 8, Section 6.3 in this booklet.)

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

<table>
<thead>
<tr>
<th>Services not covered by Medicare</th>
<th>Not covered under any condition</th>
<th>Covered only under specific conditions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Services considered not reasonable and necessary, according to the standards of Original Medicare</td>
<td></td>
<td>Unless these services are listed by our plan as covered services</td>
</tr>
<tr>
<td>Services not covered by Medicare</td>
<td>Not covered under any condition</td>
<td>Covered only under specific conditions</td>
</tr>
<tr>
<td>----------------------------------</td>
<td>---------------------------------</td>
<td>----------------------------------------</td>
</tr>
<tr>
<td>Experimental medical and surgical procedures, equipment and medications.</td>
<td></td>
<td>May be covered by Original Medicare under a Medicare-approved clinical research study or by our plan. (See Chapter 3, Section 5 for more information on clinical research studies.)</td>
</tr>
<tr>
<td>Experimental procedures and items are those items and procedures determined by our plan and Original Medicare to not be generally accepted by the medical community.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Private room in a hospital.</td>
<td></td>
<td>Covered only when medically necessary.</td>
</tr>
<tr>
<td>Personal items in your room at a hospital or a skilled nursing facility, such as a telephone or a television.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Full-time nursing care in your home.</td>
<td></td>
<td>May be covered by our plan under Medicaid in limited circumstances</td>
</tr>
<tr>
<td>*Custodial care is care provided in a nursing home, hospice, or other facility setting when you do not require skilled medical care or skilled nursing care.</td>
<td></td>
<td>May be covered by our plan under Medicaid</td>
</tr>
<tr>
<td>Homemaker services include basic household assistance, including light housekeeping or light meal preparation.</td>
<td></td>
<td>May be covered by our plan under Medicaid</td>
</tr>
<tr>
<td>Fees charged for care by your immediate relatives or members of your household.</td>
<td></td>
<td>May be covered by our plan under Medicaid</td>
</tr>
</tbody>
</table>
| Cosmetic surgery or procedures | | • Covered in cases of an accidental injury or for improvement of the functioning of a malformed body member.  
• Covered for all stages of reconstruction for a breast |
<table>
<thead>
<tr>
<th>Services not covered by Medicare</th>
<th>Not covered under any condition</th>
<th>Covered only under specific conditions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Routine dental care, such as cleanings, fillings or dentures.</td>
<td>√</td>
<td>after a mastectomy, as well as for the unaffected breast to produce a symmetrical appearance.</td>
</tr>
<tr>
<td>Non-routine dental care.</td>
<td></td>
<td>May be covered by our plan under Medicaid</td>
</tr>
<tr>
<td>Routine chiropractic care</td>
<td>√</td>
<td>Dental care required to treat illness or injury may be covered as inpatient or outpatient care.</td>
</tr>
<tr>
<td>Routine foot care</td>
<td>√</td>
<td>Manual manipulation of the spine to correct a subluxation is covered. May be covered by our plan under Medicaid</td>
</tr>
<tr>
<td>Home-delivered meals</td>
<td></td>
<td>Some limited coverage provided according to Medicare guidelines, e.g., if you have diabetes. May be covered by our plan under Medicaid</td>
</tr>
<tr>
<td>Orthopedic shoes</td>
<td>√</td>
<td>If shoes are part of a leg brace and are included in the cost of the brace, or the shoes are for a person with diabetic foot disease. May be covered by our plan under Medicaid</td>
</tr>
<tr>
<td>Supportive devices for the feet</td>
<td></td>
<td>Orthopedic or therapeutic shoes for people with diabetic foot disease.</td>
</tr>
<tr>
<td>Service</td>
<td>Covered by Plan</td>
<td></td>
</tr>
<tr>
<td>------------------------------------------------------------------------</td>
<td>-----------------</td>
<td></td>
</tr>
<tr>
<td>Routine hearing exams, hearing aids, or exams to fit hearing aids.</td>
<td>May be covered by Medicaid</td>
<td></td>
</tr>
<tr>
<td>Routine eye examinations, eyeglasses, radial keratotomy, LASIK surgery, vision therapy and other low vision aids.</td>
<td>May be covered by Medicaid</td>
<td></td>
</tr>
<tr>
<td>Reversal of sterilization procedures and or non-prescription contraceptive supplies.</td>
<td>√</td>
<td></td>
</tr>
<tr>
<td>Acupuncture</td>
<td>√</td>
<td></td>
</tr>
<tr>
<td>Naturopath services (uses natural or alternative treatments).</td>
<td>√</td>
<td></td>
</tr>
</tbody>
</table>

*Custodial care is personal care that does not require the continuing attention of trained medical or paramedical personnel, such as care that helps you with activities of daily living, such as bathing or dressing.
CHAPTER 5

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

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- Section 2.1 To have your prescription covered, use a network pharmacy
- Section 2.2 Finding network pharmacies
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How can you get information about your drug costs?

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

SECTION 1 Introduction

This chapter describes your coverage for Part D drugs.

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

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

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

In addition to the drugs covered by Medicare, some prescription drugs are covered for you under your Medicaid benefits. The Drug List tells you how to find out about your Medicaid drug coverage. You can also contact your Team to learn about Medicaid drug coverage.
Section 1.2 Basic rules for the plan’s Part D drug coverage

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

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

SECTION 2 Fill your prescription at a network pharmacy

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

In most cases, your prescriptions are covered *only* if they are filled at the plan’s network pharmacies. (See Section 2.3 for information about when we would cover prescriptions filled at out-of-network pharmacies.)

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

Section 2.2 Finding network pharmacies

How do you find a network pharmacy in your area?

To find a network pharmacy, you can look in your *Provider Directory*, visit our website (*www.communitycareinc.org*), or call Customer Service (phone numbers are printed on the back cover of this booklet).

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

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

If the pharmacy you have been using leaves the plan’s network, you will have to find a new pharmacy that is in the network. To find another network pharmacy in your area, you can get help from Customer Service (phone numbers are printed on the back cover of this booklet) or use the *Provider Directory*. You can also find information on our website at www.communitycareinc.org.

**What if you need a specialized pharmacy?**

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

- Pharmacies that supply drugs for home infusion therapy.
- Pharmacies that supply drugs for residents of a long-term care (LTC) facility. Usually, a long-term care facility (such as a nursing home) has its own pharmacy. If you are in an LTC facility, we must ensure that you are able to routinely receive your Part D benefits through our network of LTC pharmacies, which is typically the pharmacy that the LTC facility uses. If you have any difficulty accessing your Part D benefits in an LTC facility, please contact Customer Service.
- Pharmacies that serve the Indian Health Service / Tribal / Urban Indian Health Program (not available in Puerto Rico). Except in emergencies, only Native Americans or Alaska Natives have access to these pharmacies in our network.
- Pharmacies that dispense drugs that are restricted by the FDA to certain locations or that require special handling, provider coordination, or education on their use. (Note: This scenario should happen rarely.)

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

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**Section 2.3 When can you use a pharmacy that is not in the plan's network?**

**Your prescription may be covered in certain situations**

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

If you take a prescription drug on a regular basis and you are going on a trip, be sure to check your supply of the drug before you leave. When possible, take along all the medication you will need.

If you are traveling within the United States and territories and become ill, lose or run out of your prescription drugs we will cover prescriptions that are filled at an out-of-network pharmacy. In this situation, you will have to pay the full cost when you fill your prescription. You can ask us to reimburse you for our share of the cost by submitting a claim form. To learn how to submit a paper claim, please refer to “How to ask us to pay you back or to pay a bill you have received” in Chapter 6, Section 2 of this EOC/Member Handbook.

We have network pharmacies outside of the service area where you can get your drugs covered as a member of our Plan. You can call Customer Service at 1-866-992-6600 to find out if there is a network pharmacy in the area where you are traveling. If there are no network pharmacies in that area, Customer Service may be able to make arrangements for you to get your prescriptions from an out-of-network pharmacy.

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

**Getting a prescription because of a medical emergency or urgent care.**

We will cover prescriptions that are filled at an out-of-network pharmacy if the prescriptions are related to care for a medical emergency or urgent care. In this situation, you will have to pay the full cost when you fill your prescription. You can ask us to reimburse you for our share of the cost by submitting a paper claim form. To learn how to submit a paper claim, please refer to “How to ask us to pay you back or to pay a bill you have received” in Chapter 6, Section 2 of this EOC/Member Handbook.

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

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

- If you are unable to obtain a covered drug in a timely manner within our service area because there is no network pharmacy within a reasonable driving distance that provides 24 hour service.
- If you are trying to fill a prescription drug that is not regularly stocked at an accessible network retail pharmacy (including high cost and unique drugs).

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

**How do you ask for reimbursement from the plan?**

If you must use an out-of-network pharmacy, you will generally have to pay the full cost at the time you fill your prescription. You can ask us to reimburse you (Chapter 6, Section 2.1 explains how to ask the plan to pay you back.)

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## SECTION 3 Your drugs need to be on the plan’s “Drug List”

### Section 3.1 The “Drug List” tells which Part D drugs are covered

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

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

The Drug List includes the drugs covered under Medicare Part D (earlier in this chapter, Section 1.1 explains about Part D drugs). In addition to the drugs covered by Medicare, some prescription drugs are covered for you under your Medicaid benefits. The Drug List tells you how to find out about your Medicaid drug coverage. You can also contact your Team to learn about Medicaid drug coverage.

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

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

### The Drug List includes both brand name and generic drugs

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

Our plan also covers certain over-the-counter drugs. Some over-the-counter drugs are less expensive than prescription drugs and work just as well. For more information, call Customer Service (phone numbers are printed on the back cover of this booklet).

What is not on the Drug List?

The plan does not cover all prescription drugs.

- In some cases, the law does not allow any Medicare plan to cover certain types of drugs (for more information about this, see Section 7.1 in this chapter).
- In other cases, we have decided not to include a particular drug on our Drug List.

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

You have 4 ways to find out:

1. Check the notice about the Drug List we sent you in the mail. The notice tells you how to find the formulary on our website and how to request a hard copy.
2. Visit the plan’s website (www.communitycareinc.org). The Drug List on the website is always the most current.
3. Call Customer Service to find out if a particular drug is on the plan’s Drug List or to ask for a copy of the list. (Phone numbers for Customer Service are printed on the back cover of this booklet.)
4. Call your team to find out if a particular drug is on the plan’s Drug List or to ask for a copy of the list.

SECTION 4  There are restrictions on coverage for some drugs

Section 4.1  Why do some drugs have restrictions?

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

In general, our rules encourage you to get a drug that works for your medical condition and is safe and effective. Whenever a safe, lower-cost drug will work just as well medically as a higher-cost drug, the plan’s rules are designed to encourage you and your provider to use that lower-cost option. We also need to comply with Medicare’s rules and regulations for drug coverage and cost-sharing.
If there is a restriction for your drug, it usually means that you or your provider will have to take extra steps in order for us to cover the drug. If you want us to waive the restriction for you, you will need to use the coverage decision process and ask us to make an exception. We may or may not agree to waive the restriction for you. (See Chapter 8, Section 7.2 for information about asking for exceptions.)

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

### Section 4.2 What kinds of restrictions?

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

**Restricting brand name drugs when a generic version is available**

Generally, a “generic” drug works the same as a brand name drug and usually costs less. **When a generic version of a brand name drug is available, our network pharmacies will provide you the generic version.** We usually will not cover the brand name drug when a generic version is available. However, if your provider has told us the medical reason that the generic drug will not work for you OR has written “No substitutions” on your prescription for a brand name drug OR has told us the medical reason that neither the generic drug nor other covered drugs that treat the same condition will work for you, then we will cover the brand name drug.

**Getting plan approval in advance**

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

**Trying a different drug first**

This requirement encourages you to try less costly but just as effective drugs before the plan covers another drug. For example, if Drug A and Drug B treat the same medical condition, the plan may require you to try Drug A first. If Drug A does not work for you, the plan will then cover Drug B. This requirement to try a different drug first is called **step therapy.**

**Quantity limits**

For certain drugs, we limit the amount of the drug that you can have by limiting how much of a drug you can get each time you fill your prescription. For example, if it is normally considered safe to take only one pill per day for a certain drug, we may limit coverage for your prescription to no more than one pill per day.
Section 4.3  Do any of these restrictions apply to your drugs?

The plan’s Drug List includes information about the restrictions described above. To find out if any of these restrictions apply to a drug you take or want to take, check the Drug List. For the most up-to-date information, call Customer Service (phone numbers are printed on the back cover of this booklet) or check our website (www.communitycareinc.org).

If there is a restriction for your drug, it usually means that you or your provider will have to take extra steps in order for us to cover the drug. If there is a restriction on the drug you want to take, you should contact Customer Service to learn what you or your provider would need to do to get coverage for the drug. If you want us to waive the restriction for you, you will need to use the coverage decision process and ask us to make an exception. We may or may not agree to waive the restriction for you. (See Chapter 8, Section 7.2 for information about asking for exceptions.)

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

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

We hope that your drug coverage will work well for you. But it’s possible that there could be a prescription drug you are currently taking, or one that you and your provider think you should be taking that is not on our formulary or is on our formulary with restrictions. For example:

- The drug might not be covered at all. Or maybe a generic version of the drug is covered but the brand name version you want to take is not covered.

- The drug is covered, but there are extra rules or restrictions on coverage for that drug. As explained in Section 4, some of the drugs covered by the plan have extra rules to restrict their use. For example, you might be required to try a different drug first, to see if it will work, before the drug you want to take will be covered for you. Or there might be limits on what amount of the drug (number of pills, etc.) is covered during a particular time period. In some cases, you may want us to waive the restriction for you.

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

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

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

You may be able to get a temporary supply

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

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

1. The change to your drug coverage must be one of the following types of changes:
   - The drug you have been taking is no longer on the plan’s Drug List.
   - -- or -- the drug you have been taking is now restricted in some way (Section 4 in this chapter tells about restrictions).

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

   - For those members who are new or who were in the plan last year and aren’t in a long-term care (LTC) facility:
     We will cover a temporary supply of your drug during the first 90 days of your membership in the plan if you were new and during the first 90 days of the calendar year if you were in the plan last year. This temporary supply will be for a maximum of a 30-day supply. If your prescription is written for fewer days, we will allow multiple fills to provide up to a maximum of a 30-day supply of medication. The prescription must be filled at a network pharmacy.

   - For those members who are new or who were in the plan last year and reside in a long-term care (LTC) facility:
     We will cover a temporary supply of your drug during the first 90 days of your membership in the plan if you are new and during the first 90 days of the calendar year if you were in the plan last year. The total supply will be for a maximum of a 31-day supply. If your prescription is written for fewer days, we will allow multiple fills to
provide up to a maximum of a 91-day supply of medication. (Please note that the long-
term care pharmacy may provide the drug in smaller amounts at a time to prevent waste.)

- **For those members who have been in the plan for more than 90 days and reside in a long-term care (LTC) facility and need a supply right away:**
  We will cover one 31-day supply of a particular drug, or less if your prescription is written for fewer days. This is in addition to the above long-term care transition supply.

- **Current members with a change where they receive care.** Community Care has a transition process that addresses unplanned transitions as members change treatment settings due to changes in the type of care that they require. Changes in the location where you live or receive care may warrant a temporary one-time fill exception regardless of whether or not you are in the first 90 days of program enrollment. Examples of situations include:
  - You were discharged from the hospital and were provided a discharge list of medications based upon the formulary of the hospital.
  - You are in a skilled nursing facility and Medicare coverage (where payments include all pharmacy charges) comes to an end. In this circumstance your coverage will revert to our Plan formulary.
  - Beneficiaries who give up Hospice Status to revert back to standard Medicare or Medicaid benefits
  - Beneficiaries who are discharged from Chronic Psychiatric Hospitals with combinations of medications that are highly individualized.

Please note that our transition policy applies only to those drugs that are on our formulary and are supplied by a network pharmacy.

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

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

**You can change to another drug**

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

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

If you and your provider want to ask for an exception, Chapter 8, Section 7.4 tells what to do. It explains the procedures and deadlines that have been set by Medicare to make sure your request is handled promptly and fairly.

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

Section 6.1 The Drug List can change during the year

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

- Add or remove drugs from the Drug List. New drugs become available, including new generic drugs. Perhaps the government has given approval to a new use for an existing drug. Sometimes, a drug gets recalled and we decide not to cover it. Or we might remove a drug from the list because it has been found to be ineffective.

- Add or remove a restriction on coverage for a drug (for more information about restrictions to coverage, see Section 4 in this chapter).

- Replace a brand name drug with a generic drug.

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

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

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

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

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

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

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

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

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

- If a brand name drug you are taking is replaced by a new generic drug, the plan must give you at least 60 days’ notice or give you a 60-day refill of your brand name drug at a network pharmacy.
  - During this 60-day period, you should be working with your provider to switch to the generic or to a different drug that we cover.
  - Or you and your provider can ask the plan to make an exception and continue to cover the brand name drug for you. For information on how to ask for an exception, see Chapter 8 (What to do if you have a problem or complaint (coverage decisions, appeals, complaints).
- Again, if a drug is suddenly recalled because it’s been found to be unsafe or for other reasons, the plan will immediately remove the drug from the Drug List. We will let you know of this change right away.
  - Your provider will also know about this change, and can work with you to find another drug for your condition.

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

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This section tells you what kinds of prescription drugs are “excluded.” This means neither Medicare nor Medicaid pays for these drugs.

We won’t pay for the drugs that are listed in this section. The only exception: If the requested drug is found upon appeal to be a drug that is not excluded under Part D and we should have paid for or covered it because of your specific situation. (For information about appealing a decision...
Here are three general rules about drugs that Medicare drug plans will not cover under Part D:

- Our plan’s Part D drug coverage cannot cover a drug that would be covered under Medicare Part A or Part B.
- Our plan cannot cover a drug purchased outside the United States and its territories.
- Our plan usually cannot cover off-label use. “Off-label use” is any use of the drug other than those indicated on a drug’s label as approved by the Food and Drug Administration.
  - Generally, coverage for “off-label use” is allowed only when the use is supported by certain reference books. These reference books are the American Hospital Formulary Service Drug Information, the DRUGDEX Information System, and for cancer, the National Comprehensive Cancer Network and Clinical Pharmacology, or their successors. If the use is not supported by any of these reference books, then our plan cannot cover its “off-label use.”

Also, by law, the categories of drugs listed below are not covered by Medicare. However, some of these drugs may be covered for you under your Medicaid drug coverage, as indicated below.

- Non-prescription drugs (also called over-the-counter drugs) – may be covered by our plan under your Medicaid benefit
- Drugs when used to promote fertility
- Drugs when used for the relief of cough or cold symptoms – may be covered by our plan under your Medicaid benefit
- Drugs when used for cosmetic purposes or to promote hair growth
- Prescription vitamins and mineral products, except prenatal vitamins and fluoride preparations – may be covered by our plan under your Medicaid benefit
- Drugs when used for the treatment of sexual or erectile dysfunction, such as Viagra, Cialis, Levitra, and Caverject
- Drugs when used for treatment of anorexia, weight loss, or weight gain
- Outpatient drugs for which the manufacturer seeks to require that associated tests or monitoring services be purchased exclusively from the manufacturer as a condition of sale

Because you have Wisconsin Medicaid, we offer additional coverage of some drugs not normally covered in a Medicare Prescription Drug Plan. Please see Community Care’s Drug List to determine what drug coverage may be available to you.
SECTION 8  Show your plan membership card when you fill a prescription

Section 8.1  Show your membership card

To fill your prescription, show your plan membership card at the network pharmacy you choose. When you show your plan membership card, the network pharmacy will automatically bill the plan for your covered prescription drug.

Section 8.2  What if you don’t have your membership card with you?

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

If the pharmacy is not able to get the necessary information, you may have to pay the full cost of the prescription when you pick it up. (You can then ask us to reimburse you. See Chapter 6, Section 2.1 for information about how to ask the plan for reimbursement.)

SECTION 9  Part D drug coverage in special situations

Section 9.1  What if you’re in a hospital or a skilled nursing facility for a stay that is covered by the plan?

If you are admitted to a hospital or to a skilled nursing facility for a stay covered by the plan, we will generally cover the cost of your prescription drugs during your stay. Once you leave the hospital or skilled nursing facility, the plan will cover your drugs as long as the drugs meet all of our rules for coverage. See the previous parts of this section that tell about the rules for getting drug coverage.

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

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

Check your Provider Directory to find out if your long-term care facility’s pharmacy is part of our network. If it isn’t, or if you need more information, please contact Customer Service (phone numbers are printed on the back cover of this booklet).
What if you’re a resident in a long-term care (LTC) facility and become a new member of the plan?

If you need a drug that is not on our Drug List or is restricted in some way, the plan will cover a temporary supply of your drug during the first 90 days of your membership. The total supply will be for a maximum of a 98-day supply depending on the dispensing increment, or less if your prescription is written for fewer days. If needed, we will cover additional refills during your first 90 days (Please note that the long-term care pharmacy may provide the drug in smaller amounts at a time to prevent waste.) If you have been a member of the plan for more than 90 days and need a drug that is not on our Drug List or if the plan has any restriction on the drug’s coverage, we will cover one 31-day supply, or less if your prescription is written for fewer days.

During the time when you are getting a temporary supply of a drug, you should talk with your provider to decide what to do when your temporary supply runs out. Perhaps there is a different drug covered by the plan that might work just as well for you. Or you and your provider can ask the plan to make an exception for you and cover the drug in the way you would like it to be covered. If you and your provider want to ask for an exception, Chapter 8, Section 7.4 tells what to do.

Section 9.3 What if you’re also getting drug coverage from an employer or retiree group plan?

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

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

Special note about ‘creditable coverage’:

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

If the coverage from the group plan is “creditable,” it means that the plan has drug coverage that is expected to pay, on average, at least as much as Medicare’s standard prescription drug coverage.

Keep these notices about creditable coverage, because you may need them later. If you enroll in a Medicare plan that includes Part D drug coverage, you may need these notices to show that you have maintained creditable coverage. If you didn’t get a notice about creditable coverage from your employer or retiree group plan, you can get a copy from your employer or retiree plan’s benefits administrator or the employer or union.
**Section 9.4 What if you’re in Medicare-certified hospice?**

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

In the event you either revoke your hospice election or are discharged from hospice our plan should cover all your drugs. To prevent any delays at a pharmacy when your Medicare hospice benefit ends, you should bring documentation to the pharmacy to verify your revocation or discharge.

**SECTION 10 Programs on drug safety and managing medications**

**Section 10.1 Programs to help members use drugs safely**

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

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

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

If we see a possible problem in your use of medications, we will work with your provider to correct the problem.
We have a program that can help our members with complex health needs. For example, some members have several medical conditions, take different drugs at the same time, and have high drug costs.

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

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

If we have a program that fits your needs, we will automatically enroll you in the program and send you information. If you decide not to participate, please notify us and we will withdraw you from the program. If you have any questions about these programs, please contact Customer Service (phone numbers are printed on the back cover of this booklet).

Our plan keeps track of the costs of your prescription drugs when you get your prescriptions filled or refilled at the pharmacy. This way, we can tell you when you have moved from one drug payment stage to the next. We keep track of your “total drug costs.” This is the amount others pay on your behalf plus the amount paid by the plan.

Our plan will prepare a written report called the Part D Explanation of Benefits (it is sometimes called the “Part D EOB”) when you have had one or more prescriptions filled through the plan during the previous month. It includes:
• **Information for that month.** This report gives the payment details about the prescriptions you have filled during the previous month. It shows the total drug costs, what the plan paid, and what you and others on your behalf paid.

• **Totals for the year since January 1.** This is called “year-to-date” information. It shows you the total drug costs and total payments for your drugs since the year began.

### Section 11.2 Help us keep our information about your drug payments up to date

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

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

• **Make sure we have the information we need.** There are times you may pay for prescription drugs when we will not automatically get the information we need to keep track of your out-of-pocket costs. To help us keep track of your out-of-pocket costs, you may give us copies of receipts for drugs that you have purchased. (If you are billed for a covered drug, you can ask our plan to pay for the drug. For instructions on how to do this, go to Chapter 6, Section 2 of this booklet.) Here is an example of when you may want to give us copies of your drug receipts to be sure we have a complete record of what you have spent for your drugs:
  o Any time you have purchased covered drugs at out-of-network pharmacies or other times you have paid the full price for a covered drug under special circumstances.

• **Send us information about the payments others have made for you.** Payments made by certain other individuals and organizations also count toward your out-of-pocket costs and help qualify you for catastrophic coverage. For example, payments made by an AIDS drug assistance program (ADAP), the Indian Health Service, and most charities count toward your out-of-pocket costs. You should keep a record of these payments and send them to us so we can track your costs.

• **Check the written report we send you.** When you receive a *Part D Explanation of Benefits* (a Part D EOB) in the mail, please look it over to be sure the information is complete and correct. If you think something is missing from the report, or you have any questions, please call us at Customer Service (phone numbers are printed on the back cover of this booklet). Be sure to keep these reports. They are an important record of your drug expenses.
Asking us to pay a bill you have received for covered medical services or drugs
Chapter 6. Asking us to pay a bill you have received for covered medical services or drugs

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

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

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

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

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

Section 3.1 We check to see whether we should cover the service or drug.

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

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

Section 4.1 In some cases, you should send copies of your receipts to us to help us track your out-of-pocket drug costs.
SECTION 1  Situations in which you should ask us to pay for your covered services or drugs

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

Our network providers bill the plan directly for your covered services and drugs – you should not receive a bill for covered services or drugs. If you get a bill for medical care or drugs you have received, you should send this bill to us so that we can pay it. When you send us the bill, we will look at the bill and decide whether the services should be covered. If we decide they should be covered, we will pay the provider directly.

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

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

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

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

   • If you pay the entire amount yourself at the time you receive the care, you need to ask us to pay you back. Send us the bill, along with documentation of any payments you have made.

   • At times you may get a bill from the provider asking for payment that you think you do not owe. Send us this bill, along with documentation of any payments you have already made.

     ○ If the provider is owed anything, we will pay the provider directly.

     ○ If you have already paid for the service, we will pay you back.

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

   Network providers should always bill the plan directly. But sometimes they make mistakes, and ask you to pay for your services.

   • Whenever you get a bill from a network provider send us the bill. We will contact the provider directly and resolve the billing problem.
• If you have already paid a bill to a network provider, send us the bill along with documentation of any payment you have made. You should ask us to pay you back for your covered services.

3. If you are retroactively enrolled in our plan.

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

If you were retroactively enrolled in our plan and you paid out-of-pocket for any of your covered services or drugs after your enrollment date, you can ask us to pay you back. You will need to submit paperwork for us to handle the reimbursement.

Please contact Customer Service for additional information about how to ask us to pay you back and deadlines for making your request. (Phone numbers for Customer Service are printed on the back cover of this booklet.)

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

If you go to an out-of-network pharmacy and try to use your membership card to fill a prescription, the pharmacy may not be able to submit the claim directly to us. When that happens, you will have to pay the full cost of your prescription. (We cover prescriptions filled at out-of-network pharmacies only in a few special situations. Please go to Chapter 5, Section 2.3 to learn more.)

• Save your receipt and send a copy to us when you ask us to pay you back

5. When you pay the full cost for a prescription because you don’t have your plan membership card with you

• If you do not have your plan membership card with you, you can ask the pharmacy to call the plan or to look up your plan enrollment information. However, if the pharmacy cannot get the enrollment information they need right away, you may need to pay the full cost of the prescription yourself. Save your receipt and send a copy to us when you ask us to pay you back.

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

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

• For example, the drug may not be on the plan’s List of Covered Drugs (Formulary); or it could have a requirement or restriction that you didn’t know about or don’t think should apply to you. If you decide to get the drug immediately, you may need to pay the full cost for it.

• Save your receipt and send a copy to us when you ask us to pay you back. In some situations, we may need to get more information from your doctor in order to pay you back for the drug.
When you send us a request for payment, we will review your request and decide whether the service or drug should be covered. This is called making a “coverage decision.” If we decide it should be covered, we will pay for the service or drug. If we deny your request for payment, you can appeal our decision. Chapter 8 of this booklet (What to do if you have a problem or complaint (coverage decisions, appeals, complaints)) has information about how to make an appeal.

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

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

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

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

Community Care Claims Department
1801 Dolphin Drive
Waukesha WI 53186

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

Community Care Pharmacy
1555 S. Layton Blvd.
Milwaukee, WI 53215

You may also call our plan to request payment. For details, go to Chapter 2, Section 1 and look for the section called, “Where to send a request that asks us to pay for medical care or a drug you have received.”

You must submit your claim to us no later than March 31, 2019.

Contact Customer Service if you have any questions (phone numbers are printed on the back cover of this booklet). If you receive bills and you don’t know what to do about those bills, we can help. You can also call if you want to give us more information about a request for payment you have already sent to us.
SECTION 3  We will consider your request for payment and say yes or no

Section 3.1  We check to see whether we should cover the service or drug

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

- If we decide that the medical care or drug is covered and you followed all the rules for getting the care or drug, we will pay for the service. If you have already paid for the service or drug, we will mail your reimbursement to you. If you have not paid for the service or drug yet, we will mail the payment directly to the provider. (Chapter 3 explains the rules you need to follow for getting your medical services covered. Chapter 5 explains the rules you need to follow for getting your Part D prescription drugs covered.)

- If we decide that the medical care or drug is not covered, or you did not follow all the rules, we will not pay for the care or drug. Instead, we will send you a letter that explains the reasons why we are not sending the payment you have requested and your rights to appeal that decision.

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

If you think we have made a mistake in turning down your request for payment or you don’t agree with the amount we are paying, you can make an appeal. If you make an appeal, it means you are asking us to change the decision we made when we turned down your request for payment.

For the details on how to make this appeal, go to Chapter 8 of this booklet (What to do if you have a problem or complaint (coverage decisions, appeals, complaints)). The appeals process is a formal process with detailed procedures and important deadlines. If making an appeal is new to you, you will find it helpful to start by reading Section 5 of Chapter 8. Section 5 is an introductory section that explains the process for coverage decisions and appeals and gives definitions of terms such as “appeal.” Then after you have read Section 5, you can go to the section in Chapter 8 that tells what to do for your situation:

- If you want to make an appeal about getting paid back for a medical service, go to Section 6.3 in Chapter 8.
- If you want to make an appeal about getting paid back for a drug, go to Section 7.5 of Chapter 8.
SECTION 4  Other situations in which you should save your receipts and send copies to us

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

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

Below is an example of a situation when you should send us copies of receipts to let us know about payments you have made for your drugs:

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

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

- Save your receipt and send a copy to us so that we can have your out-of-pocket expenses count toward qualifying you for the Catastrophic Coverage Stage.

- Please note: Because you are getting your drug through the patient assistance program and not through the plan’s benefits, we will not pay for these drug costs. But sending a copy of the receipt allows us to calculate your out-of-pocket costs correctly and may help you qualify for the Catastrophic Coverage Stage more quickly.

Since you are not asking for payment in the case described above, this situation is not considered a coverage decision. Therefore, you cannot make an appeal if you disagree with our decision.
CHAPTER 7

Your rights and responsibilities
Chapter 7. Your rights and responsibilities

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

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

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

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

If you have any trouble getting information from our plan in a format that is accessible and appropriate for you, please call to file a grievance with the member rights specialist at 1-866-992-6600. You may also file a complaint with Medicare by calling 1-800-MEDICARE (1-800-633-4227) or directly with the Office for Civil Rights. Contact information is included in this Evidence of Coverage or with this mailing, or you may contact Customer Service for additional information (phone numbers are printed on the back cover of this booklet).

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

Our plan must obey laws that protect you from discrimination or unfair treatment. We do not discriminate based on a person’s race, ethnicity, national origin, religion, gender, age, mental or physical disability, health status, claims experience, medical history, genetic information, evidence of insurability, or geographic location within the service area.

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

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

You have the right to be treated with dignity, respect, and fairness at all times, to have your care kept private and to get compassionate, considerate care from Community Care staff and providers.
You have the right:

- To get your health care in a safe, clean environment.
- To be free from harm. This includes physical or mental abuse, neglect, physical punishment, being placed by yourself against your will, excessive medication, and any physical or chemical restraint or seclusion that is used on you for discipline or convenience of staff and that you do not need to treat your medical symptoms.
- To information about what constitutes abuse, neglect or financial exploitation and what resources exist for reporting and assistance, including an emergency 24 hour phone number.
- To be encouraged to exercise your rights as a member of Community Care.
- To get help, if you need it, to use the Medicare and Wisconsin Medicaid grievance and appeal processes, and your civil and other legal rights.
- To be encouraged and helped in talking to Community Care staff about changes in policy and services you think should be made. You may be asked to participate in member interviews about the Plan.
- You may be asked to participate in the quality review process for Community Care.
- To use a telephone while at the Community Care facility.
- To not have to do work or services for Community Care.

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

As a member of our plan, you work with a Team that will coordinate or arrange for your covered services. Call your Team for assistance in choosing your providers and to arrange for covered services. You have the right to choose a primary care provider (PCP) in the plan’s network to provide and arrange for your covered services (Chapter 3 explains more about this). Call Customer Service to learn which doctors are accepting new patients (phone numbers are printed on the back cover of this booklet). You also have the right to go to a women’s health specialist (such as a gynecologist) without a referral.

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

If you think that you are not getting your medical care or Part D drugs within a reasonable amount of time, Chapter 8, Section 11 of this booklet tells what you can do. (If we have denied coverage for your medical care or drugs and you don’t agree with our decision, Chapter 8, Section 5 tells what you can do.)

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

Federal and state laws protect the privacy of your medical records and personal health information. We protect your personal health information as required by these laws.
• Your “personal health information” includes the personal information you gave us when you enrolled in this plan as well as your medical records and other medical and health information.

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

How do we protect the privacy of your health information?

• We make sure that unauthorized people don’t see or change your records.

• In most situations, if we give your health information to anyone who isn’t providing your care or paying for your care, we are required to get written permission from you first. Written permission can be given by you or by someone you have given legal power to make decisions for you.

• There are certain exceptions that do not require us to get your written permission first. These exceptions are allowed or required by law.
  o For example, we are required to release health information to government agencies that are checking on quality of care.
  o Because you are a member of our plan through Medicare, we are required to give Medicare your health information including information about your Part D prescription drugs. If Medicare releases your information for research or other uses, this will be done according to Federal statutes and regulations.

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

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

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

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

Please see Chapter 10 for Community Care Notice of Privacy Practices.

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

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

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

- **Information about our plan.** This includes, for example, information about the plan’s financial condition. It also includes information about the number of appeals made by members and the plan’s performance ratings, including how it has been rated by plan members and how it compares to other Medicare health plans.

- **Information about our network providers including our network pharmacies.**
  
  - For example, you have the right to get information from us about the qualifications of the providers and pharmacies in our network and how we pay the providers in our network.
  
  - For a list of the providers and pharmacies in the plan’s network, see the Provider Directory.
  
  - For more detailed information about our providers or pharmacies, you can call Customer Service (phone numbers are printed on the back cover of this booklet) or visit our website at www.communitycareinc.org.

- **Information about your coverage and the rules you must follow when using your coverage.**
  
  - In Chapters 3 and 4 of this booklet, we explain what medical services are covered for you, any restrictions to your coverage, and what rules you must follow to get your covered medical services.
  
  - To get the details on your Part D prescription drug coverage, see Chapter 5 of this booklet plus the plan’s *List of Covered Drugs (Formulary).* This chapter, together with the *List of Covered Drugs (Formulary),* tell you what drugs are covered and explain the rules you must follow and the restrictions to your coverage for certain drugs.
  
  - If you have questions about the rules or restrictions, please call Customer Service (phone numbers are printed on the back cover of this booklet).

- **Information about why something is not covered and what you can do about it.**
  
  - If a medical service, long-term care service or a drug is not covered for you, or if your coverage is restricted in some way, you can ask us for a written explanation. You have the right to this explanation even if you received the medical or long-term care service or a drug from an out-of-network provider or pharmacy.
  
  - If you are not happy or if you disagree with a decision we make about what medical care, long-term care services or drugs are covered for you, you have the right to ask us to change the decision. You can ask us to change the decision by making an appeal. For details on what to do if something is not covered for you in the way you think it should be covered, see Chapter 8 of this booklet. It gives you the details about how to make an appeal if you want us to change our decision.
Section 1.6 We must support your right to make decisions about your care

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

- You are a member of your Interdisciplinary Team (Team). You have the right to participate in the resource allocation decision-making (RAD) process to determine your Care Plan and treatment options based on the outcomes your Team has identified.
- You have the right to be informed of your available choices regarding the services and supports you receive and from whom you receive them.
- You have the right to be fully informed of your health status and how well you are doing.
- You have the right to get full information from your providers when you go for medical care.
- You have the right to our policies on obtaining a second medical opinion.
- You have the right to request a reassessment from your Team.
- You have the right to utilize a health care professional in advising or advocating on your behalf.
- You have the right to be given reasonable advance written notice of any transfer to another setting for treatment and of the reason for the transfer.
- You have the right to contact the Wisconsin Department of Justice (DOJ) to perform a criminal history record search on a caregiver who comes to your home to provide personal care services. You are responsible for payment of the fee that the DOJ will charge for completing the search. If you want to request this type of criminal history record search from the WI DOJ, contact your Care Team.

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

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

- **To know about all of your choices.** This means that you have the right to be told about all of the treatment options that are recommended for your condition, no matter what they cost or whether they are covered by our plan. It also includes being told about programs our plan offers to help members manage their medications and use drugs safely.

- **To know about the risks.** You have the right to be told about any risks involved in your care. You must be told in advance if any proposed medical care or treatment is part of a research experiment. You always have the choice to refuse any experimental treatments.
• **The right to say “no.”** You have the right to refuse any recommended treatment. This includes the right to leave a hospital or other medical facility, even if your doctor advises you not to leave. You also have the right to stop taking your medication. Of course, if you refuse treatment or stop taking medication, you accept full responsibility for what happens to your body as a result.

• **To receive an explanation if you are denied coverage for care.** You have the right to receive an explanation from us if a provider has denied care that you believe you should receive. To receive this explanation, you will need to ask us for a coverage decision. Chapter 8 of this booklet tells how to ask the plan for a coverage decision.

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

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

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

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

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

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

• **Get the form.** If you want to have an advance directive, you can get a form from your lawyer, from a social worker, or from some office supply stores. You can sometimes get advance directive forms from organizations that give people information about Medicare. You can also contact Customer Service to ask for the forms (phone numbers are printed on the back cover of this booklet).

• **Fill it out and sign it.** Regardless of where you get this form, keep in mind that it is a legal document. You should consider having a lawyer help you prepare it.

• **Give copies to appropriate people.** You should give a copy of the form to your doctor and to the person you name on the form as the one to make decisions for you if you can’t. You may want to give copies to close friends or family members as well. Be sure to keep a copy at home.

If you know ahead of time that you are going to be hospitalized, and you have signed an advance directive, **take a copy with you to the hospital.**
• If you are admitted to the hospital, they will ask you whether you have signed an advance directive form and whether you have it with you.

• If you have not signed an advance directive form, the hospital has forms available and will ask if you want to sign one.

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

What if your instructions are not followed?

If you have signed an advance directive, and you believe that a doctor or hospital did not follow the instructions in it, you may file a complaint with the:

Wisconsin Department of Health Services
Division of Quality Assurance
P. O. Box 2969
Madison, WI 53701

Phone (608) 266-8481

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

If you have any problems or concerns about your covered services or care, Chapter 8 of this booklet tells what you can do. It gives the details about how to deal with all types of problems and complaints. What you need to do to follow up on a problem or concern depends on the situation. You might need to ask our plan to make a coverage decision for you, make an appeal to us to change a coverage decision, or make a complaint. Whatever you do – ask for a coverage decision, make an appeal, or make a complaint – we are required to treat you fairly and not retaliate, discriminate, interfere, or take action against you.

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

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

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

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

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

- You can call Customer Service (phone numbers are printed on the back cover of this booklet).
- You can call the State Health Insurance Assistance Program. For details about this organization and how to contact it, go to Chapter 2, Section 3.
- Or, you can call Medicare at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.
- You can call your Team or the plan’s Member Rights Specialist.
- You can call your Ombudsman Program. The Wisconsin Department of Health Services has arrangements with Disability Rights Wisconsin and the Wisconsin Board on Aging and Long-term Care to offer ombudsman assistance free of charge.

Regional ombudsmen will assist current or potential Family Care Partnership members with ensuring quantity and quality of services; complaint investigation; mediation and resolution of conflicts; provision of information and education on current and potential enrollees’ rights and benefits; and preparation for and representation at appeals, grievances and fair hearings.

You can contact:

- Disability Rights Wisconsin—Ombudsmen from this agency provide assistance to individuals under age 60.
  
  131 W. Wilson Street, Suite 700
  Madison, WI 53703

  General: (608) 267-0214
  TTY: 1-888-758-6049
  Fax: (608) 267-0368
  Madison Toll-Free: 1-800-928-8778
  Milwaukee Toll-Free: 1-800-708-3034
  Rice Lake Toll-Free: 1-877-338-3724

  www.disabilityrightswi.org
  (See Web site for contact information for other locations.)

- Wisconsin Board on Aging and Long-term Care—Ombudsmen from this agency provide assistance to individuals age 60 and older.
  
  1402 Pankratz Street, Suite 111
  Madison, WI 53704-4001
  Toll-Free: 1-800-815-0015
  Fax: (608) 246-7001
  http://longtermcare.state.wi.us/home/
What is abuse, neglect, and financial exploitation?

Community Care members have the right to be free from abuse, neglect, and financial exploitation. It is important to be clear about the definitions of abuse, neglect, and financial exploitation. It is also important that you know what to do if you are experiencing or witnessing abuse, neglect, or financial exploitation of a vulnerable adult.

Abuse can be:

- Physical and it does not matter whether the abuse is intentional or reckless but that the action of one person results in physical pain or injury, illness, or any impairment of physical condition to another person.
- Emotional abuse which includes language or behavior that serves no legitimate purpose and is intended to be intimidating, humiliating, threatening, frightening, or otherwise harassing, and that does or reasonably could intimidate, humiliate, threaten, frighten, or otherwise harass the person to whom the behavior or language is directed.
- Sexual abuse is defined as a violation of criminal assault law. It usually involves a sexual activity that is not agreed to by both people involved and/or causes physical or emotional injury.
- Any treatment that is not agreed to and forced upon a person, such as: the administration of medication to an individual who has not provided informed consent, or the performance of psychosurgery, electroconvulsive therapy, or experimental research on an individual who has not provided informed consent, or with the knowledge that no lawful authority exists for the administration or performance.
- Unreasonable confinement or restraint, such as: the intentional and unreasonable confinement of a person in a locked room, involuntarily removing a person from his or her living area, putting a restraining device on a person, or making a person take unnecessary or excessive medication. There are very rare exceptions when the use of these methods is allowed because all other methods have failed, but any use of these methods or devices must be applied according to state and federal standards governing confinement and restraint.

Neglect can be:

- Intentional or unintentional but it is the failure of a caregiver to secure or maintain adequate care, services, or supervision for a person in their care. This includes food, clothing, shelter, or physical or mental health care, and the result of the neglect creates significant risk or danger to the person’s physical or mental health.

Neglect does not include a decision that is made to not seek medical care for an individual, if that decision is consistent with the individual’s previously executed declaration such as a do-not-resuscitate order, a power of attorney for health care, or as otherwise authorized by law.
Self-neglect means that a person who is responsible for his or her own care does not obtain adequate care, including food, shelter, clothing, or medical or dental care. The inability to obtain care results in a significant danger to the person’s physical or mental health.

Financial exploitation can be:

- Fraud, enticement or coercion,
- Theft,
- Misconduct by a fiscal agent,
- Identity theft,
- Unauthorized use of the identity of a company or agency,
- Forgery, or
- Unauthorized use of financial transaction cards including credit, debit, ATM and similar cards.

How do I discuss or report abuse, neglect, and/or financial exploitation?

Your Community Care Team is available to consult with you regarding issues that you feel may constitute abuse, neglect, or financial exploitation. They will assist you with coordination of reporting or securing services for safety.

- You should always call 911 in an emergency for immediate assistance. The County Health and Human Services Department offers Adult Protective Services which are provided to people with developmental disabilities, degenerative brain disorder, serious and persistent mental illness, or other similar incapacity to keep the individual safe from abuse, neglect, financial exploitation, or misappropriation of property or prevent the individual from experiencing deterioration or from inflicting harm on himself or herself or another person.

Section 1.10 How to get more information about your rights

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

- You can call Customer Service (phone numbers are printed on the back cover of this booklet).
- You can call the State Health Insurance Assistance Program. For details about this organization and how to contact it, go to Chapter 2, Section 3.
- You can contact Medicare.
  - You can visit the Medicare website to read or download the publication “Your Medicare Rights & Protections.” (The publication is available at: [http://www.medicare.gov/Pubs/pdf/11534.pdf](http://www.medicare.gov/Pubs/pdf/11534.pdf))
SECTION 2  You have some responsibilities as a member of the plan

Section 2.1  What are your responsibilities?

Things you need to do as a member of the plan are listed below. If you have any questions, please call your Team or Customer Service (phone numbers are printed on the back cover of this booklet). We’re here to help.

- **Participate in your Interdisciplinary Team (Team) as a team member.**
- **Participate as a Team member in the Resource Allocation Decision-making (RAD) process to determine your care plan and treatment options based on your outcomes.**
- **Get familiar with your covered services and the rules you must follow to get these covered services.** Use this Evidence of Coverage booklet to learn what is covered for you and the rules you need to follow to get your covered services.
  - Chapters 3 and 4 give the details about your medical services, including what is covered, what is not covered, rules to follow, and what you pay.
  - Chapter 5 gives the details about your coverage for Part D prescription drugs.
- **If you have any other health insurance coverage or prescription drug coverage in addition to our plan, you are required to tell us.** Please call Customer Service to let us know (phone numbers are printed on the back cover of this booklet).
  - We are required to follow rules set by Medicare and Medicaid to make sure that you are using all of your coverage in combination when you get your covered services from our plan. This is called “coordination of benefits” because it involves coordinating the health and drug benefits you get from our plan with any other health and drug benefits available to you. We’ll help you coordinate your benefits. (For more information about coordination of benefits, go to Chapter 1, Section 7.)
- **Tell your doctor and other health care providers that you are enrolled in our plan.** Show your plan membership card whenever you get your medical care or Part D prescription drugs.
- **Help your doctors and other providers help you by giving them information, asking questions, and following through on your care.**
  - To help your doctors and other health providers give you the best care, learn as much as you are able about your health problems and give them the information they need about you and your health. Follow the treatment plans and instructions that you and your doctors agree upon.
- Make sure your doctors know all of the drugs you are taking, including over-the-counter drugs, vitamins, and supplements.
- If you have any questions, be sure to ask. Your doctors and other health care providers are supposed to explain things in a way you can understand. If you ask a question and you don’t understand the answer you are given, ask again.

**Be considerate.** We expect all our members to respect the rights of other patients. We also expect you to act in a way that helps the smooth running of your doctor’s office, hospitals, and other offices.

**Take good care of the durable medical equipment we provide.** Respect the equipment we supply, and use it as directed. We replace equipment at the end of its useful lifetime or if it has been lost, stolen or damaged beyond repair. We do not repair or replace equipment that has been abused, neglected or misused.

**Pay what you owe.** As a plan member, you are responsible for these payments:
- In order to be eligible for our plan, you must have Medicare Part A, Medicare Part B, Medicare Part D and have Full Medicaid benefits. For most Community Care members, Medicaid pays for your Part A premium (if you don’t qualify for it automatically) and for your Part B premium. If Medicaid is not paying your Medicare premiums for you, you must continue to pay your Medicare premiums to remain a member of the plan.
- If you get any medical services or drugs that are not covered by our plan or by other insurance you may have, you must pay the full cost.
  - If you disagree with our decision to deny coverage for a service or drug, you can make an appeal. Please see Chapter 8 of this booklet for information about how to make an appeal.
- If you are required to pay the extra amount for Part D because of your higher income (as reported on your last tax return), you must pay the extra amount directly to the government to remain a member of the plan.

**Tell us if you move.** If you are going to move, it’s important to tell us right away. Call Customer Service (phone numbers are printed on the back cover of this booklet).
- **If you move outside of our plan service area, you cannot remain a member of our plan.** (Chapter 1 tells about our service area.) We can help you figure out whether you are moving outside our service area. If you are leaving our service area, you will have a Special Enrollment Period when you can join any Medicare plan available in your new area. We can let you know if we have a plan in your new area.
- **If you move within our service area, we still need to know** so we can keep your membership record up to date and know how to contact you.
- If you move, it is also important to tell Social Security (or the Railroad Retirement Board). You can find phone numbers and contact information for these organizations in Chapter 2.
Call your Team or Customer Service for help if you have questions or concerns. We also welcome any suggestions you may have for improving our plan.

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

### Section 2.2 Will I be subject to Estate Recovery?

- Through estate recovery, the State of Wisconsin seeks to be paid back for the cost of certain Medicaid long-term care services. Recovery is made from your estate, or your spouse’s estate after both of you have died. The money recovered goes back to the State of Wisconsin to be used for care to others in need.

- Recovery is made by filing claims on estates. Remember the State of Wisconsin will not try to be paid back from your estate when your spouse or child with a disability is still alive. Recovery will happen after their death.

For more information about estate recovery and the services that are subject to recovery contact your Team or see: [https://www.dhs.wisconsin.gov/medicaid/erp.htm](https://www.dhs.wisconsin.gov/medicaid/erp.htm)
CHAPTER 8

What to do if you have a problem or complaint (coverage decisions, appeals, complaints)
Chapter 8. What to do if you have a problem or complaint (coverage decisions, appeals, complaints)

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BACKGROUND

SECTION 1 Introduction

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

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

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

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

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

Which one do you use? The guide in Section 3 will help you identify the right process to use.

Section 1.2 What about the legal terms?

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

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

However, it can be helpful – and sometimes quite important – for you to know the correct legal terms for the situation you are in. Knowing which terms to use will help you communicate more clearly and accurately when you are dealing with your problem and get the right help or information for your situation. To help you know which terms to use, we include legal terms when we give the details for handling specific types of situations.
SECTION 2  You can get help from government organizations that are not connected with us

Section 2.1  Where to get more information and personalized assistance

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

Get help from an independent government organization

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

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

You can also get help and information from Medicare

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

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

You can get help and information from Medicaid

Your Team and the Member Rights Specialist are always available to help you. But in some situations you may also want help or guidance from someone who is not connected with us. You can always contact MetaStar, the state’s Quality Improvement Organization. They can answer your questions, give you more information, and offer guidance on what to do. Their services are free.

MetaStar
2909 Landmark Place
Madison, WI 53713
Toll-Free: 1-888-203-8338
Fax: (608) 274-8340
E-mail: dhspacepartnershipga@wisconsin.gov
You can also call your Ombudsman Program: The Wisconsin Department of Health Services has arrangements with Disability Rights Wisconsin (for members age 18 to 59) and the Wisconsin Board on Aging and Long-term Care (for members age 60 and over) to offer ombudsman assistance free of charge. Regional ombudsmen will assist current or potential Family Care Partnership members with ensuring quantity and quality of services; complaint investigation; mediation and resolution of conflicts; provision of information and education on current and potential enrollees’ rights and benefits; and preparation for and representation at appeals, grievances and fair hearings. See Chapter 7, Section 1.8 for information on how to contact your Ombudsman Program.

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

<table>
<thead>
<tr>
<th>Section 3.1</th>
<th>Should you use the process for Medicare benefits or Medicaid benefits?</th>
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</table>

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

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

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

Is your problem about Medicare benefits or Medicaid benefits?

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

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

My problem is about Medicaid coverage.

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

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**PROBLEMS ABOUT YOUR MEDICARE BENEFITS**

**SECTION 4** Handling problems about your Medicare benefits

<table>
<thead>
<tr>
<th>Section 4.1</th>
<th>Should you use the process for coverage decisions and appeals? Or should you use the process for making complaints?</th>
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</table>

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

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

**Is your problem or concern about your benefits or coverage?**

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

Yes. My problem is about benefits or coverage.

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

No. My problem is not about benefits or coverage.

Skip ahead to Section 11 at the end of this chapter: “How to make a complaint about quality of care, waiting times, customer service or other concerns.”
SECTION 5  A guide to the basics of coverage decisions and appeals

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

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

**Asking for coverage decisions**

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

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

**Making an appeal**

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

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

If we say no to all or part of your Level 1 Appeal, you can go on to a Level 2 Appeal. The Level 2 Appeal is conducted by an independent organization that is not connected to us. (In some situations, your case will be automatically sent to the independent organization for a Level 2 Appeal. If this happens, we will let you know. In other situations, you will need to ask for a Level 2 Appeal.) If you are not satisfied with the decision at the Level 2 Appeal, you may be able to continue through additional levels of appeal.
Would you like some help? Here are resources you may wish to use if you decide to ask for any kind of coverage decision or appeal a decision:

- **You can call us at Customer Service** (phone numbers are printed on the back cover of this booklet).

- **To get free help from an independent organization** that is not connected with our plan, contact your State Health Insurance Assistance Program (see Section 2 of this chapter).

- **Your doctor can make a request for you.**
  - For medical care, your doctor can request a coverage decision or a Level 1 Appeal on your behalf. If your appeal is denied at Level 1, it will be automatically forwarded to Level 2. To request any appeal after Level 2, your doctor must be appointed as your representative.
  
  - For Part D prescription drugs, your doctor or other prescriber can request a coverage decision or a Level 1 or Level 2 Appeal on your behalf. To request any appeal after Level 2, your doctor or other prescriber must be appointed as your representative.

- **You can ask someone to act on your behalf.** If you want to, you can name another person to act for you as your “representative” to ask for a coverage decision or make an appeal.
  
  - There may be someone who is already legally authorized to act as your representative under State law.
  
  - If you want a friend, relative, your doctor or other provider, or other person to be your representative, call Customer Service (phone numbers are printed on the back cover of this booklet) and ask for the “Appointment of Representative” form. (The form is also available on Medicare’s website at [https://www.cms.hhs.gov/cmsforms/downloads/cms1696.pdf](https://www.cms.hhs.gov/cmsforms/downloads/cms1696.pdf) or on our website at www.communitycareinc.org.) The form gives that person permission to act on your behalf. It must be signed by you and by the person who you would like to act on your behalf. You must give us a copy of the signed form.

- **You also have the right to hire a lawyer to act for you.** You may contact your own lawyer, or get the name of a lawyer from your local bar association or other referral service. There are also groups that will give you free legal services if you qualify. However, you are not required to hire a lawyer to ask for any kind of coverage decision or appeal a decision.
There are four different types of situations that involve coverage decisions and appeals. Since each situation has different rules and deadlines, we give the details for each one in a separate section:

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

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

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

Have you read Section 5 of this chapter (*A guide to “the basics” of coverage decisions and appeals*)? If not, you may want to read it before you start this section.

**Section 6.1**  This section tells what to do if you have problems getting coverage for medical care or if you want us to pay you back for your care

This section is about your benefits for medical care and services. These benefits are described in Chapter 4 of this booklet: *Benefits Chart (what is covered)*. To keep things simple, we generally refer to “medical care coverage” or “medical care” in the rest of this section, instead of repeating “medical care or treatment or services” every time.
This section tells what you can do if you are in any of the five following situations:

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

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

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

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

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

• NOTE: If the coverage that will be stopped is for hospital care, home health care, skilled nursing facility care, or Comprehensive Outpatient Rehabilitation Facility (CORF) services, you need to read a separate section of this chapter because special rules apply to these types of care. Here’s what to read in those situations:
  
  o Chapter 8, Section 8: How to ask us to cover a longer inpatient hospital stay if you think the doctor is discharging you too soon.
  
  o Chapter 8, Section 9: How to ask us to keep covering certain medical services if you think your coverage is ending too soon. This section is about three services only: home health care, skilled nursing facility care, and Comprehensive Outpatient Rehabilitation Facility (CORF) services.

• For all other situations that involve being told that medical care you have been getting will be stopped, use this section (Section 6) as your guide for what to do.
Which of these situations are you in?

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

Section 6.2 Step-by-step: How to ask for a coverage decision (how to ask our plan to authorize or provide the medical care coverage you want)

Legal Terms

When a coverage decision involves your medical care, it is called an “organization determination.”

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

Legal Terms

A “fast coverage decision” is called an “expedited determination.”

How to request coverage for the medical care you want

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

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

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

- **However, we can take up to 14 more calendar days** if you ask for more time, or if we need information (such as medical records from out-of-network providers) that may benefit you. If we decide to take extra days to make the decision, we will tell you in writing.

- If you believe we should **not** take extra days, you can file a “fast complaint” about our decision to take extra days. When you file a fast complaint, we will give you an answer to your complaint within 24 hours. (The process for making a complaint is different from the process for coverage decisions and appeals. For more information about the process for making complaints, including fast complaints, see Section 11 of this chapter.)

**If your health requires it, ask us to give you a “fast coverage decision”**

- **A fast coverage decision means we will answer within 72 hours.**
  - **However, we can take up to 14 more calendar days** if we find that some information that may benefit you is missing (such as medical records from out-of-network providers), or if you need time to get information to us for the review. If we decide to take extra days, we will tell you in writing.
  
  - **However, we can take up to 14 more calendar days** if we need information (such as medical records from out-of-network providers), or if you need time to get information to us for the review. If we decide to take extra days, we will tell you in writing.

- **If you believe we should **not** take extra days, you can file a “fast complaint” about our decision to take extra days. (For more information about the process for making complaints, including fast complaints, see Section 11 of this chapter.) We will call you as soon as we make the decision.

- **To get a fast coverage decision, you must meet two requirements:**
  - **You can get a fast coverage decision only** if you are asking for coverage for medical care you have not yet received. (You cannot get a fast coverage decision if your request is about payment for medical care you have already received.)
  
  - **You can get a fast coverage decision only** if using the standard deadlines could cause serious harm to your health or hurt your ability to function.

- **If your doctor tells us that your health requires a “fast coverage decision,” we will automatically agree to give you a fast coverage decision.**

- **If you ask for a fast coverage decision on your own, without your doctor’s support, we will decide whether your health requires that we give you a fast coverage decision.**
If we decide that your medical condition does not meet the requirements for a fast coverage decision, we will send you a letter that says so (and we will use the standard deadlines instead).

This letter will tell you that if your doctor asks for the fast coverage decision, we will automatically give a fast coverage decision.

The letter will also tell how you can file a “fast complaint” about our decision to give you a standard coverage decision instead of the fast coverage decision you requested. (For more information about the process for making complaints, including fast complaints, see Section 11 of this chapter.)

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

**Deadlines for a “fast” coverage decision**

- Generally, for a fast coverage decision, we will give you our answer **within 72 hours**.
  - As explained above, we can take up to 14 more calendar days under certain circumstances. If we decide to take extra days to make the coverage decision, we will tell you in writing.
  - If you believe we should *not* take extra days, you can file a “fast complaint” about our decision to take extra days. When you file a fast complaint, we will give you an answer to your complaint within 24 hours. (For more information about the process for making complaints, including fast complaints, see Section 11 of this chapter.)
  - If we do not give you our answer within 72 hours (or if there is an extended time period, by the end of that period), you have the right to appeal. Section 6.3 below tells how to make an appeal.
- **If our answer is yes to part or all of what you requested**, we must authorize or provide the medical care coverage we have agreed to provide within 72 hours after we received your request. If we extended the time needed to make our coverage decision, we will authorize or provide the coverage by the end of that extended period.
- **If our answer is no to part or all of what you requested**, we will send you a detailed written explanation as to why we said no.

**Deadlines for a “standard” coverage decision**

- Generally, for a standard coverage decision, we will give you our answer **within 14 calendar days of receiving your request**.
  - We can take up to 14 more calendar days (“an extended time period”) under certain circumstances. If we decide to take extra days to make the coverage decision, we will tell you in writing.
  - If you believe we should *not* take extra days, you can file a “fast complaint” about our decision to take extra days. When you file a fast complaint, we will
give you an answer to your complaint within 24 hours. (For more information about the process for making complaints, including fast complaints, see Section 11 of this chapter.)

- If we do not give you our answer within 14 calendar days (or if there is an extended time period, by the end of that period), you have the right to appeal. Section 6.3 below tells how to make an appeal.

- **If our answer is yes to part or all of what you requested,** we must authorize or provide the coverage we have agreed to provide within 14 calendar days after we received your request. If we extended the time needed to make our coverage decision, we will authorize or provide the coverage by the end of that extended period.

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

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

- If we say no, you have the right to ask us to reconsider – and perhaps change – this decision by making an appeal. Making an appeal means making another try to get the medical care coverage you want.

- If you decide to make an appeal, it means you are going on to Level 1 of the appeals process (see Section 6.3 below).

### Section 6.3 Step-by-step: How to make a Level 1 Appeal

(How to ask for a review of a medical care coverage decision made by our plan)

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<tr>
<th>Legal Terms</th>
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<tr>
<td>An appeal to the plan about a medical care coverage decision is called a plan “reconsideration.”</td>
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</table>

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

**What to do**

- **To start an appeal you, your doctor, or your representative, must contact us.** For details on how to reach us for any purpose related to your appeal, go to Chapter 2, Section 1 and look for the section called, *How to contact us when you are making an appeal about your medical care.*

- **If you are asking for a standard appeal, make your standard appeal in writing by submitting a request.** You may also ask for an appeal by calling us at the
If you have someone appealing our decision for you other than your doctor, your appeal must include an Appointment of Representative form authorizing this person to represent you. (To get the form, call Customer Service (phone numbers are printed on the back cover of this booklet) and ask for the “Appointment of Representative” form. It is also available on Medicare’s website at http://www.cms.hhs.gov/cmsforms/downloads/cms1696.pdf or on our website at www.communitycareinc.org.) While we can accept an appeal request without the form, we cannot begin or complete our review until we receive it. If we do not receive the form within 44 calendar days after receiving your appeal request (our deadline for making a decision on your appeal), your appeal request will be dismissed. If this happens, we will send you a written notice explaining your right to ask the Independent Review Organization to review our decision to dismiss your appeal.

- **If you are asking for a fast appeal, make your appeal in writing or call us** at the phone number shown in Chapter 2, Section 1 (*How to contact us when you are making an appeal about your medical care*).

- **You must make your appeal request within 60 calendar days** from the date on the written notice we sent to tell you our answer to your request for a coverage decision. If you miss this deadline and have a good reason for missing it, we may give you more time to make your appeal. Examples of good cause for missing the deadline may include if you had a serious illness that prevented you from contacting us or if we provided you with incorrect or incomplete information about the deadline for requesting an appeal.

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

*If your health requires it, ask for a “fast appeal” (you can make a request by calling us)*

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<th>Legal Terms</th>
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<tr>
<td>A “fast appeal” is also called an “expedited reconsideration.”</td>
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</table>

- If you are appealing a decision we made about coverage for care you have not yet received, you and/or your doctor will need to decide if you need a “fast appeal.”

- The requirements and procedures for getting a “fast appeal” are the same as those for getting a “fast coverage decision.” To ask for a fast appeal, follow the instructions for
asking for a fast coverage decision. (These instructions are given earlier in this section.)

- If your doctor tells us that your health requires a “fast appeal,” we will give you a fast appeal.

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

- When we are reviewing your appeal, we take another careful look at all of the information about your request for coverage of medical care. We check to see if we were following all the rules when we said no to your request.

- We will gather more information if we need it. We may contact you or your doctor to get more information.

**Deadlines for a “fast” appeal**

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

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

- **If our answer is yes to part or all of what you requested**, we must authorize or provide the coverage we have agreed to provide within 72 hours after we receive your appeal.

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

**Deadlines for a “standard” appeal**

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

  o However, if you ask for more time, or if we need to gather more information that may benefit you, we **can take up to 14 more calendar days**. If we decide to take extra days to make the decision, we will tell you in writing.

  o If you believe we should not take extra days, you can file a “fast complaint” about our decision to take extra days. When you file a fast complaint, we will
give you an answer to your complaint within 24 hours. (For more information about the process for making complaints, including fast complaints, see Section 11 of this chapter.)

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

- If our answer is yes to part or all of what you requested, we must authorize or provide the coverage we have agreed to provide within 30 calendar days after we receive your appeal.

- If our answer is no to part or all of what you requested, we will send you a written denial notice informing you that we have automatically sent your appeal to the Independent Review Organization for a Level 2 Appeal.

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

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

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

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

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<th>Legal Terms</th>
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<td>The formal name for the “Independent Review Organization” is the “Independent Review Entity.” It is sometimes called the “IRE.”</td>
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</table>

**Step 1: The Independent Review Organization reviews your appeal.**

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

- We will send the information about your appeal to this organization. This information is called your “case file.” You have the right to ask us for a copy of your case file.
• You have a right to give the Independent Review Organization additional information to support your appeal.

• Reviewers at the Independent Review Organization will take a careful look at all of the information related to your appeal.

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

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

• However, if the Independent Review Organization needs to gather more information that may benefit you, it **can take up to 14 more calendar days**.

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

• If you had a standard appeal to our plan at Level 1, you will automatically receive a standard appeal at Level 2. The review organization must give you an answer to your Level 2 Appeal **within 30 calendar days** of when it receives your appeal.

• However, if the Independent Review Organization needs to gather more information that may benefit you, it **can take up to 14 more calendar days**.

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

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

• **If the review organization says yes to part or all of what you requested,** we must authorize the medical care coverage within 72 hours or provide the service within 14 calendar days after we receive the decision from the review organization for standard requests or within 72 hours from the date the plan receives the decision from the review organization for expedited requests.

• **If this organization says no to part or all of your appeal,** it means they agree with our plan that your request (or part of your request) for coverage for medical care should not be approved. (This is called “upholding the decision.” It is also called “turning down your appeal.”)
  
  o If the Independent Review Organization “upholds the decision” you have the right to a Level 3 Appeal. However, to make another appeal at Level 3, the dollar value of the medical care coverage you are requesting must meet a certain minimum. If the dollar value of the coverage you are requesting is too low, you cannot make another appeal, which means that the decision at Level 2 is final. The written notice you get from the Independent Review Organization will tell you how to find out the dollar amount to continue the appeals process.
Step 3: If your case meets the requirements, you choose whether you want to take your appeal further.

- There are three additional levels in the appeals process after Level 2 (for a total of five levels of appeal).

- If your Level 2 Appeal is turned down and you meet the requirements to continue with the appeals process, you must decide whether you want to go on to Level 3 and make a third appeal. The details on how to do this are in the written notice you got after your Level 2 Appeal.

- The Level 3 Appeal is handled by an administrative law judge. Section 10 in this chapter tells more about Levels 3, 4, and 5 of the appeals process.

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

If you want to ask us for payment for medical care, start by reading Chapter 6 of this booklet: Asking us to pay a bill you have received for covered medical services or drugs. Chapter 6 describes the situations in which you may need to ask for reimbursement or to pay a bill you have received from a provider. It also tells how to send us the paperwork that asks us for payment.

Asking for reimbursement is asking for a coverage decision from us

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

We will say yes or no to your request

- If the medical care you paid for is covered and you followed all the rules, we will send you the payment for your medical care within 60 calendar days after we receive your request. Or, if you haven’t paid for the services, we will send the payment directly to the provider. When we send the payment, it’s the same as saying yes to your request for a coverage decision.

- If the medical care is not covered, or you did not follow all the rules, we will not send payment. Instead, we will send you a letter that says we will not pay for the services and the reasons why in detail. (When we turn down your request for payment, it’s the same as saying no to your request for a coverage decision.)
What if you ask for payment and we say that we will not pay?

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

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

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

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

Have you read Section 5 of this chapter (A guide to “the basics” of coverage decisions and appeals)? If not, you may want to read it before you start this section.

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

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

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

As discussed in Section 5 of this chapter, a coverage decision is a decision we make about your benefits and coverage or about the amount we will pay for your drugs.

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

- You ask us to make an exception, including:
  - Asking us to cover a Part D drug that is not on the plan’s *List of Covered Drugs (Formulary)*
  - Asking us to waive a restriction on the plan’s coverage for a drug (such as limits on the amount of the drug you can get)

- You ask us whether a drug is covered for you and whether you meet the requirements for coverage. (For example, when your drug is on the plan’s *List of Covered Drugs (Formulary)* but we require you to get approval from us before we will cover it for you.)
  - *Please note*: If your pharmacy tells you that your prescription cannot be filled as written, you will get a written notice explaining how to contact us to ask for a coverage decision.

- You ask us to pay for a prescription drug you already bought. This is a request for a coverage decision about payment.

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

This section tells you both how to ask for coverage decisions and how to request an appeal. Use the chart below to help you determine which part has information for your situation:
### Which of these situations are you in?

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

### Section 7.2 What is an exception?

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

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

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

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

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

- The extra rules and restrictions on coverage for certain drugs include:
  - Being required to use the generic version of a drug instead of the brand name drug.
  - Getting plan approval in advance before we will agree to cover the drug for you. (This is sometimes called “prior authorization.”)
  - Being required to try a different drug first before we will agree to cover the drug you are asking for. (This is sometimes called “step therapy.”)
  - Quantity limits. For some drugs, there are restrictions on the amount of the drug you can have.

### Section 7.3 Important things to know about asking for exceptions

**Your doctor must tell us the medical reasons**

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

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

**We can say yes or no to your request**

- If we approve your request for an exception, our approval usually is valid until the end of the plan year. This is true as long as your doctor continues to prescribe the drug for you and that drug continues to be safe and effective for treating your condition.

- If we say no to your request for an exception, you can ask for a review of our decision by making an appeal. Section 7.5 tells how to make an appeal if we say no.

The next section tells you how to ask for a coverage decision, including an exception.
Step-by-step: How to ask for a coverage decision, including an exception

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

*What to do*

- **Request the type of coverage decision you want.** Start by calling, writing, or faxing us to make your request. You, your representative, or your doctor (or other prescriber) can do this. You can also access the coverage decision process through our website. For the details, go to Chapter 2, Section 1 and look for the section called, *How to contact us when you are asking for a coverage decision about your Part D prescription drugs*. Or if you are asking us to pay you back for a drug, go to the section called, *Where to send a request that asks us to pay for medical care or a drug you have received*.

- **You or your doctor or someone else who is acting on your behalf** can ask for a coverage decision. Section 5 of this chapter tells how you can give written permission to someone else to act as your representative. You can also have a lawyer act on your behalf.

- **If you want to ask us to pay you back for a drug,** start by reading Chapter 6 of this booklet: *Asking us to pay a bill you have received for covered medical services or drugs*. Chapter 6 describes the situations in which you may need to ask for reimbursement. It also tells how to send us the paperwork that asks us to pay you back for a drug you have paid for.

- **If you are requesting an exception, provide the “supporting statement.”** Your doctor or other prescriber must give us the medical reasons for the drug exception you are requesting. (We call this the “supporting statement.”) Your doctor or other prescriber can fax or mail the statement to us. Or your doctor or other prescriber can tell us on the phone and follow up by faxing or mailing a written statement if necessary. See Sections 6.2 and 6.3 for more information about exception requests.

- **We must accept any written request,** including a request submitted on the CMS Model Coverage Determination Request Form available on our website.

*If your health requires it, ask us to give you a “fast coverage decision”*

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<tr>
<td>A “fast coverage decision” is called an “expedited coverage determination.”</td>
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- When we give you our decision, we will use the “standard” deadlines unless we have agreed to use the “fast” deadlines. A standard coverage decision means we
will give you an answer within 72 hours after we receive your doctor’s statement. A fast coverage decision means we will answer within 24 hours after we receive your doctor’s statement.

- **To get a fast coverage decision, you must meet two requirements:**
  - You can get a fast coverage decision *only* if you are asking for a *drug you have not yet received*. (You cannot get a fast coverage decision if you are asking us to pay you back for a drug you have already bought.)
  - You can get a fast coverage decision *only* if using the standard deadlines could *cause serious harm to your health or hurt your ability to function*.

- **If your doctor or other prescriber tells us that your health requires a “fast coverage decision,” we will automatically agree to give you a fast coverage decision.**

- If you ask for a fast coverage decision on your own (without your doctor’s or other prescriber’s support), we will decide whether your health requires that we give you a fast coverage decision.
  - If we decide that your medical condition does not meet the requirements for a fast coverage decision, we will send you a letter that says so (and we will use the standard deadlines instead).
  - This letter will tell you that if your doctor or other prescriber asks for the fast coverage decision, we will automatically give a fast coverage decision.
  - The letter will also tell how you can file a complaint about our decision to give you a standard coverage decision instead of the fast coverage decision you requested. It tells how to file a “fast” complaint, which means you would get our answer to your complaint within 24 hours of receiving the complaint. (The process for making a complaint is different from the process for coverage decisions and appeals. For more information about the process for making complaints, see Section 11 of this chapter.)

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

**Deadlines for a “fast” coverage decision**

- If we are using the fast deadlines, we must give you our answer *within 24 hours*.
  - Generally, this means within 24 hours after we receive your request. If you are requesting an exception, we will give you our answer within 24 hours after we receive your doctor’s statement supporting your request. We will give you our answer sooner if your health requires us to.
  - If we do not meet this deadline, we are required to send your request on to Level 2 of the appeals process, where it will be reviewed by an independent outside organization. Later in this section, we talk about this review organization and explain what happens at Appeal Level 2.
• If our answer is yes to part or all of what you requested, we must provide the coverage we have agreed to provide within 24 hours after we receive your request or doctor’s statement supporting your request.

• If our answer is no to part or all of what you requested, we will send you a written statement that explains why we said no. We will also tell you how to appeal.

**Deadlines for a “standard” coverage decision about a drug you have not yet received**

• If we are using the standard deadlines, we must give you our answer within 72 hours.
  
  o Generally, this means within 72 hours after we receive your request. If you are requesting an exception, we will give you our answer within 72 hours after we receive your doctor’s statement supporting your request. We will give you our answer sooner if your health requires us to.
  
  o If we do not meet this deadline, we are required to send your request on to Level 2 of the appeals process, where it will be reviewed by an independent organization. Later in this section, we talk about this review organization and explain what happens at Appeal Level 2.

• If our answer is yes to part or all of what you requested –
  
  o If we approve your request for coverage, we must provide the coverage we have agreed to provide within 72 hours after we receive your request or doctor’s statement supporting your request.

• If our answer is no to part or all of what you requested, we will send you a written statement that explains why we said no. We will also tell you how to appeal.

**Deadlines for a “standard” coverage decision about payment for a drug you have already bought**

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

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

• If our answer is no to part or all of what you requested, we will send you a written statement that explains why we said no. We will also tell you how to appeal.

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

• If we say no, you have the right to request an appeal. Requesting an appeal means asking us to reconsider – and possibly change – the decision we made.
Step 1: You contact us and make your Level 1 Appeal. If your health requires a quick response, you must ask for a “fast appeal.”

What to do

- To start your appeal, you (or your representative or your doctor or other prescriber) must contact us.
  - For details on how to reach us by phone, fax, or mail, or on our website, for any purpose related to your appeal, go to Chapter 2, Section 1, and look for the section called, How to contact us when you are making an appeal about your Part D prescription drugs.

- If you are asking for a standard appeal, make your appeal by submitting a written request. You may also ask for an appeal by calling us at the phone number shown in Chapter 2, Section 1 (How to contact our plan when you are making an appeal about your Part D prescription drugs).

- If you are asking for a fast appeal, you may make your appeal in writing or you may call us at the phone number shown in Chapter 2, Section 1 (How to contact our plan when you are making an appeal about your Part D prescription drugs).

- We must accept any written request, including a request submitted on the CMS Model Coverage Determination Request Form, which is available on our website.

- You must make your appeal request within 60 calendar days from the date on the written notice we sent to tell you our answer to your request for a coverage decision. If you miss this deadline and have a good reason for missing it, we may give you more time to make your appeal. Examples of good cause for missing the deadline may include if you had a serious illness that prevented you from contacting us or if we provided you with incorrect or incomplete information about the deadline for requesting an appeal.

- You can ask for a copy of the information in your appeal and add more information.
  - You have the right to ask us for a copy of the information regarding your appeal.
If you wish, you and your doctor or other prescriber may give us additional information to support your appeal.

**If your health requires it, ask for a “fast appeal”**

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<td>A “fast appeal” is also called an “expedited redetermination.”</td>
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- If you are appealing a decision we made about a drug you have not yet received, you and your doctor or other prescriber will need to decide if you need a “fast appeal.”
- The requirements for getting a “fast appeal” are the same as those for getting a “fast coverage decision” in Section 7.4 of this chapter.

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

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

**Deadlines for a “fast” appeal**

- If we are using the fast deadlines, we must give you our answer **within 72 hours after we receive your appeal**. We will give you our answer sooner if your health requires it.
  - If we do not give you an answer within 72 hours, we are required to send your request on to Level 2 of the appeals process, where it will be reviewed by an Independent Review Organization. Later in this section, we talk about this review organization and explain what happens at Level 2 of the appeals process.
- **If our answer is yes to part or all of what you requested,** we must provide the coverage we have agreed to provide within 72 hours after we receive your appeal.
- **If our answer is no to part or all of what you requested,** we will send you a written statement that explains why we said no and how to appeal our decision.

**Deadlines for a “standard” appeal**

- If we are using the standard deadlines, we must give you our answer **within 7 calendar days after we receive your appeal**. We will give you our decision sooner if you have not received the drug yet and your health condition requires us to do so. If you believe your health requires it, you should ask for “fast” appeal.
  - If we do not give you a decision within 7 calendar days, we are required to send your request on to Level 2 of the appeals process, where it will be reviewed by an Independent Review Organization. Later in this section, we tell about this review organization and explain what happens at Level 2 of the appeals process.
If our answer is yes to part or all of what you requested –

- If we approve a request for coverage, we must provide the coverage we have agreed to provide as quickly as your health requires, but no later than 7 calendar days after we receive your appeal.

- If we approve a request to pay you back for a drug you already bought, we are required to send payment to you within 30 calendar days after we receive your appeal request.

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

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

- If we say no to your appeal, you then choose whether to accept this decision or continue by making another appeal.

  - If you decide to make another appeal, it means your appeal is going on to Level 2 of the appeals process (see below).

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

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

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<td>The formal name for the “Independent Review Organization” is the “Independent Review Entity.” It is sometimes called the “IRE.”</td>
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**Step 1: To make a Level 2 Appeal, you (or your representative or your doctor or other prescriber) must contact the Independent Review Organization and ask for a review of your case.**

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

- When you make an appeal to the Independent Review Organization, we will send the information we have about your appeal to this organization. This information is called your “case file.” You have the right to ask us for a copy of your case file.
You have a right to give the Independent Review Organization additional information to support your appeal.

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

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

**Deadlines for “fast” appeal at Level 2**

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

**Deadlines for “standard” appeal at Level 2**

- If you have a standard appeal at Level 2, the review organization must give you an answer to your Level 2 Appeal within 7 calendar days after it receives your appeal.
- If the Independent Review Organization says yes to part or all of what you requested –
  - If the Independent Review Organization approves a request for coverage, we must provide the drug coverage that was approved by the review organization within 72 hours after we receive the decision from the review organization.
  - If the Independent Review Organization approves a request to pay you back for a drug you already bought, we are required to send payment to you within 30 calendar days after we receive the decision from the review organization.

**What if the review organization says no to your appeal?**

If this organization says no to your appeal, it means the organization agrees with our decision not to approve your request. (This is called “upholding the decision.” It is also called “turning down your appeal.”)
If the Independent Review Organization “upholds the decision” you have the right to a Level 3 appeal. However, to make another appeal at Level 3, the dollar value of the drug coverage you are requesting must meet a minimum amount. If the dollar value of the drug coverage you are requesting is too low, you cannot make another appeal and the decision at Level 2 is final. The notice you get from the Independent Review Organization will tell you the dollar value that must be in dispute to continue with the appeals process.

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

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

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

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

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

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

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

During your covered hospital stay, you will be given a written notice called *An Important Message from Medicare about Your Rights*. Everyone with Medicare gets a copy of this notice.
whenever they are admitted to a hospital. Someone at the hospital (for example, a caseworker or nurse) must give it to you within two days after you are admitted. If you do not get the notice, ask any hospital employee for it. If you need help, please call Customer Service (phone numbers are printed on the back cover of this booklet). You can also call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

1. **Read this notice carefully and ask questions if you don’t understand it.** It tells you about your rights as a hospital patient, including:
   
   - Your right to receive Medicare-covered services during and after your hospital stay, as ordered by your doctor. This includes the right to know what these services are, who will pay for them, and where you can get them.
   
   - Your right to be involved in any decisions about your hospital stay, and know who will pay for it.
   
   - Where to report any concerns you have about quality of your hospital care.
   
   - Your right to appeal your discharge decision if you think you are being discharged from the hospital too soon.

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

2. **You must sign the written notice to show that you received it and understand your rights.**
   
   - You or someone who is acting on your behalf must sign the notice. (Section 5 of this chapter tells how you can give written permission to someone else to act as your representative.)
   
   - Signing the notice shows only that you have received the information about your rights. The notice does not give your discharge date (your doctor or hospital staff will tell you your discharge date). Signing the notice does not mean you are agreeing on a discharge date.

3. **Keep your copy** of the signed notice so you will have the information about making an appeal (or reporting a concern about quality of care) handy if you need it.
   
   - If you sign the notice more than two days before the day you leave the hospital, you will get another copy before you are scheduled to be discharged.
Section 8.2 Step-by-step: How to make a Level 1 Appeal to change your hospital discharge date

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

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

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

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

A “fast review” is also called an “immediate review.”

**What is the Quality Improvement Organization?**

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

**How can you contact this organization?**

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

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

**Ask for a “fast review”:**

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

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<td>A “fast review” is also called an “immediate review” or an “expedited review.”</td>
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**Step 2: The Quality Improvement Organization conducts an independent review of your case.**

**What happens during this review?**

- Health professionals at the Quality Improvement Organization (we will call them “the reviewers” for short) will ask you (or your representative) why you believe coverage for the services should continue. You don’t have to prepare anything in writing, but you may do so if you wish.
- The reviewers will also look at your medical information, talk with your doctor, and review information that the hospital and we have given to them.
- By noon of the day after the reviewers informed our plan of your appeal, you will also get a written notice that gives your planned discharge date and explains in detail the reasons why your doctor, the hospital, and we think it is right (medically appropriate) for you to be discharged on that date.
Step 3: Within one full day after it has all the needed information, the Quality Improvement Organization will give you its answer to your appeal.

What happens if the answer is yes?

- If the review organization says yes to your appeal, we must keep providing your covered inpatient hospital services for as long as these services are medically necessary.

- You will have to keep paying your share of the costs (such as deductibles or copayments, if these apply). In addition, there may be limitations on your covered hospital services. (See Chapter 4 of this booklet.)

What happens if the answer is no?

- If the review organization says no to your appeal, they are saying that your planned discharge date is medically appropriate. If this happens, our coverage for your inpatient hospital services will end at noon on the day after the Quality Improvement Organization gives you its answer to your appeal.

- If the review organization says no to your appeal and you decide to stay in the hospital, then you may have to pay the full cost of hospital care you receive after noon on the day after the Quality Improvement Organization gives you its answer to your appeal.

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

- If the Quality Improvement Organization has turned down your appeal, and you stay in the hospital after your planned discharge date, then you can make another appeal. Making another appeal means you are going on to “Level 2” of the appeals process.
### Section 8.3 Step-by-step: How to make a Level 2 Appeal to change your hospital discharge date

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

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

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

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

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

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

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

**If the review organization says yes:**

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

- You must continue to pay your share of the costs and coverage limitations may apply.

**If the review organization says no:**

- It means they agree with the decision they made on your Level 1 Appeal and will not change it.

- The notice you get will tell you in writing what you can do if you wish to continue with the review process. It will give you the details about how to go on to the next level of appeal, which is handled by a judge.
Step 4: If the answer is no, you will need to decide whether you want to take your appeal further by going on to Level 3.

- There are three additional levels in the appeals process after Level 2 (for a total of five levels of appeal). If the review organization turns down your Level 2 Appeal, you can choose whether to accept that decision or whether to go on to Level 3 and make another appeal. At Level 3, your appeal is reviewed by a judge.
- Section 10 in this chapter tells more about Levels 3, 4, and 5 of the appeals process.

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

You can appeal to us instead

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

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

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

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

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<tr>
<td>A “fast” review (or “fast appeal”) is also called an “expedited appeal”.</td>
</tr>
</tbody>
</table>

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

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

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

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

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

- **If we say yes to your fast appeal,** it means we have agreed with you that you still need to be in the hospital after the discharge date, and will keep providing your covered inpatient hospital services for as long as it is medically necessary. It also means that we have agreed to reimburse you for our share of the costs of care you have received since the date when we said your coverage would end. (You must pay your share of the costs and there may be coverage limitations that apply.)

- **If we say no to your fast appeal,** we are saying that your planned discharge date was medically appropriate. Our coverage for your inpatient hospital services ends as of the day we said coverage would end.
  
  - If you stayed in the hospital after your planned discharge date, then **you may have to pay the full cost** of hospital care you received after the planned discharge date.

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

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

**Step-by-Step: Level 2 Alternate Appeal Process**

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

<table>
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<tr>
<th>Legal Terms</th>
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<tbody>
<tr>
<td>The formal name for the “Independent Review Organization” is the <strong>Independent Review Entity.”</strong> It is sometimes called the “IRE.”</td>
</tr>
</tbody>
</table>

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

- We are required to send the information for your Level 2 Appeal to the Independent Review Organization within 24 hours of when we tell you that we are saying no to
your first appeal. (If you think we are not meeting this deadline or other deadlines, you can make a complaint. The complaint process is different from the appeal process. Section 11 of this chapter tells how to make a complaint.)

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

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

- Reviewers at the Independent Review Organization will take a careful look at all of the information related to your appeal of your hospital discharge.

- If this organization says yes to your appeal, then we must reimburse you (pay you back) for our share of the costs of hospital care you have received since the date of your planned discharge. We must also continue the plan’s coverage of your inpatient hospital services for as long as it is medically necessary. You must continue to pay your share of the costs. If there are coverage limitations, these could limit how much we would reimburse or how long we would continue to cover your services.

- If this organization says no to your appeal, it means they agree with us that your planned hospital discharge date was medically appropriate.
  - The notice you get from the Independent Review Organization will tell you in writing what you can do if you wish to continue with the review process. It will give you the details about how to go on to a Level 3 Appeal, which is handled by a judge.

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

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

- Section 10 in this chapter tells more about Levels 3, 4, and 5 of the appeals process.
SECTION 9 How to ask us to keep covering certain medical services if you think your coverage is ending too soon

Section 9.1 This section is about three services only:
Home health care, skilled nursing facility care, and Comprehensive Outpatient Rehabilitation Facility (CORF) services

This section is about the following types of care only:

- **Home health care services** you are getting.
- **Skilled nursing care** you are getting as a patient in a skilled nursing facility. (To learn about requirements for being considered a “skilled nursing facility,” see Chapter 11, Definitions of important words.)
- **Rehabilitation care** you are getting as an outpatient at a Medicare-approved Comprehensive Outpatient Rehabilitation Facility (CORF). Usually, this means you are getting treatment for an illness or accident, or you are recovering from a major operation. (For more information about this type of facility, see Chapter 11, Definitions of important words.)

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

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

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

Section 9.2 We will tell you in advance when your coverage will be ending

1. **You receive a notice in writing.** At least two days before our plan is going to stop covering your care, you will receive a notice.
   - The written notice tells you the date when we will stop covering the care for you.
   - The written notice also tells what you can do if you want to ask our plan to change this decision about when to end your care, and keep covering it for a longer period of time.
In telling you what you can do, the written notice is telling how you can request a “fast-track appeal.” Requesting a fast-track appeal is a formal, legal way to request a change to our coverage decision about when to stop your care. (Section 9.3 below tells how you can request a fast-track appeal.)

The written notice is called the “Notice of Medicare Non-Coverage.” To get a sample copy, call Customer Service (phone numbers are printed on the back cover of this booklet) or 1-800-MEDICARE (1-800-633-4227, 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.). Or see a copy online at https://www.cms.gov/Medicare/Medicare-General-Information/BNI/MAEDNotices.html

2. **You must sign the written notice to show that you received it.**
   - You or someone who is acting on your behalf must sign the notice. (Section 5 tells how you can give written permission to someone else to act as your representative.)
   - Signing the notice shows only that you have received the information about when your coverage will stop. **Signing it does not mean you agree** with the plan that it’s time to stop getting the care.

### Section 9.3 Step-by-step: How to make a Level 1 Appeal to have our plan cover your care for a longer time

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

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

- **Meet the deadlines.** The deadlines are important. Be sure that you understand and follow the deadlines that apply to things you must do. There are also deadlines our plan must follow. (If you think we are not meeting our deadlines, you can file a complaint. Section 11 of this chapter tells you how to file a complaint.)

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

**During a Level 1 Appeal, the Quality Improvement Organization reviews your appeal and decides whether to change the decision made by our plan.**
Step 1: Make your Level 1 Appeal: contact the Quality Improvement Organization for your state and ask for a review. You must act quickly.

What is the Quality Improvement Organization?

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

How can you contact this organization?

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

What should you ask for?

- Ask this organization for a “fast-track appeal” (to do an independent review) of whether it is medically appropriate for us to end coverage for your medical services.

Your deadline for contacting this organization.

- You must contact the Quality Improvement Organization to start your appeal no later than noon of the day after you receive the written notice telling you when we will stop covering your care.

- If you miss the deadline for contacting the Quality Improvement Organization about your appeal, you can make your appeal directly to us instead. For details about this other way to make your appeal, see Section 9.5.

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

What happens during this review?

- Health professionals at the Quality Improvement Organization (we will call them “the reviewers” for short) will ask you (or your representative) why you believe coverage for the services should continue. You don’t have to prepare anything in writing, but you may do so if you wish.

- The review organization will also look at your medical information, talk with your doctor, and review information that our plan has given to them.

- By the end of the day the reviewers informed us of your appeal, and you will also get a written notice from us that explains in detail our reasons for ending our coverage for your services.
Step 3: Within one full day after they have all the information they need, the reviewers will tell you their decision.

What happens if the reviewers say yes to your appeal?

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

What happens if the reviewers say no to your appeal?

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

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

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

Section 9.4 Step-by-step: How to make a Level 2 Appeal to have our plan cover your care for a longer time

If the Quality Improvement Organization has turned down your appeal and you choose to continue getting care after your coverage for the care has ended, then you can make a Level 2 Appeal. During a Level 2 Appeal, you ask the Quality Improvement Organization to take another look at the decision they made on your first appeal. If the Quality Improvement Organization turns down your Level 2 Appeal, you may have to pay the full cost for your home health care, or skilled nursing facility care, or Comprehensive Outpatient Rehabilitation Facility (CORF) services after the date when we said your coverage would end.
Here are the steps for Level 2 of the appeal process:

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

**Step 2: The Quality Improvement Organization does a second review of your situation.**
- Reviewers at the Quality Improvement Organization will take another careful look at all of the information related to your appeal.

**Step 3: Within 14 days of receipt of your appeal request, reviewers will decide on your appeal and tell you their decision.**

*What happens if the review organization says yes to your appeal?*
- We must reimburse you for our share of the costs of care you have received since the date when we said your coverage would end. **We must continue providing coverage** for the care for as long as it is medically necessary.
- You must continue to pay your share of the costs and there may be coverage limitations that apply.

*What happens if the review organization says no?*
- It means they agree with the decision we made to your Level 1 Appeal and will not change it.
- The notice you get will tell you in writing what you can do if you wish to continue with the review process. It will give you the details about how to go on to the next level of appeal, which is handled by a judge.

**Step 4: If the answer is no, you will need to decide whether you want to take your appeal further.**
- There are three additional levels of appeal after Level 2, for a total of five levels of appeal. If reviewers turn down your Level 2 Appeal, you can choose whether to accept that decision or to go on to Level 3 and make another appeal. At Level 3, your appeal is reviewed by a judge.
- Section 10 in this chapter tells more about Levels 3, 4, and 5 of the appeals process.
You can appeal to us instead

As explained above in Section 9.3, you must act quickly to contact the Quality Improvement Organization to start your first appeal (within a day or two, at the most). If you miss the deadline for contacting this organization, there is another way to make your appeal. If you use this other way of making your appeal, the first two levels of appeal are different.

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

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

Here are the steps for a Level 1 Alternate Appeal:

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| A “fast” review (or “fast appeal”) is also called an “expedited appeal”.

**Step 1: Contact us and ask for a “fast review.”**

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

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

- During this review, we take another look at all of the information about your case. We check to see if we were following all the rules when we set the date for ending the plan’s coverage for services you were receiving.
- We will use the “fast” deadlines rather than the standard deadlines for giving you the answer to this review.

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

- **If we say yes to your fast appeal,** it means we have agreed with you that you need services longer, and will keep providing your covered services for as long as it is medically necessary. It also means that we have agreed to reimburse you for our share of the costs of care you have received since the date when we said your coverage
would end. (You must pay your share of the costs and there may be coverage limitations that apply.)

- **If we say no to your fast appeal**, then your coverage will end on the date we told you and we will not pay any share of the costs after this date.

- If you continued to get home health care, or skilled nursing facility care, or Comprehensive Outpatient Rehabilitation Facility (CORF) services **after** the date when we said your coverage would end, then you **will have to pay the full cost** of this care yourself.

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

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

**Step-by-Step: Level 2 Alternate Appeal Process**

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

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

- We are required to send the information for your Level 2 Appeal to the Independent Review Organization within 24 hours of when we tell you that we are saying no to your first appeal. (If you think we are not meeting this deadline or other deadlines, you can make a complaint. The complaint process is different from the appeal process. Section 11 of this chapter tells how to make a complaint.)

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

- The **Independent Review Organization is an independent organization that is hired by Medicare.** This organization is not connected with our plan and it is not a government agency. This organization is a company chosen by Medicare to handle the job of being the Independent Review Organization. Medicare oversees its work.
• Reviewers at the Independent Review Organization will take a careful look at all of the information related to your appeal.

• **If this organization says yes to your appeal,** then we must reimburse you (pay you back) for our share of the costs of care you have received since the date when we said your coverage would end. We must also continue to cover the care for as long as it is medically necessary. You must continue to pay your share of the costs. If there are coverage limitations, these could limit how much we would reimburse or how long we would continue to cover your services.

• **If this organization says no to your appeal,** it means they agree with the decision our plan made to your first appeal and will not change it.
  - The notice you get from the Independent Review Organization will tell you in writing what you can do if you wish to continue with the review process. It will give you the details about how to go on to a Level 3 Appeal.

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

• There are three additional levels of appeal after Level 2, for a total of five levels of appeal. If reviewers say no to your Level 2 Appeal, you can choose whether to accept that decision or whether to go on to Level 3 and make another appeal. At Level 3, your appeal is reviewed by a judge.

• Section 10 in this chapter tells more about Levels 3, 4, and 5 of the appeals process.

**SECTION 10  Taking your appeal to Level 3 and beyond**

**Section 10.1  Levels of Appeal 3, 4, and 5 for Medical Service Appeals**

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

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

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

| Level 3 Appeal | A judge who works for the Federal government will review your appeal and give you an answer. This judge is called an “Administrative Law Judge.” |
If the Administrative Law Judge says yes to your appeal, the appeals process may or may not be over - We will decide whether to appeal this decision to Level 4. Unlike a decision at Level 2 (Independent Review Organization), we have the right to appeal a Level 3 decision that is favorable to you.

- If we decide not to appeal the decision, we must authorize or provide you with the service within 60 calendar days after receiving the judge’s decision.
- If we decide to appeal the decision, we will send you a copy of the Level 4 Appeal request with any accompanying documents. We may wait for the Level 4 Appeal decision before authorizing or providing the service in dispute.

If the Administrative Law Judge says no to your appeal, the appeals process may or may not be over.

- If we decide not to appeal the decision, we must authorize or provide you with the service within 60 calendar days after receiving the judge’s decision.
- If we decide to appeal the decision, we will send you a copy of the Level 4 Appeal request with any accompanying documents. We may wait for the Level 4 Appeal decision before authorizing or providing the service in dispute.

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

If the answer is yes, or if the Appeals Council denies our request to review a favorable Level 3 Appeal decision, the appeals process may or may not be over - We will decide whether to appeal this decision to Level 5. Unlike a decision at Level 2 (Independent Review Organization), we have the right to appeal a Level 4 decision that is favorable to you.

- If we decide not to appeal the decision, we must authorize or provide you with the service within 60 calendar days after receiving the Appeals Council’s decision.
- If we decide to appeal the decision, we will let you know in writing.

If the answer is no or if the Appeals Council denies the review request, the appeals process may or may not be over.

- If we decide not to appeal the decision, we must authorize or provide you with the service within 60 calendar days after receiving the Appeals Council’s decision.
- If we decide to appeal the decision, we will let you know in writing.

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

- This is the last step of the administrative appeals process.
Section 10.2  Levels of Appeal 3, 4, and 5 for Part D Drug Appeals

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

If the value of the drug you have appealed meets a certain dollar amount, you may be able to go on to additional levels of appeal. If the dollar amount is less, you cannot appeal any further. The written response you receive to your Level 2 Appeal will explain who to contact and what to do to ask for a Level 3 Appeal.

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

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

- **If the answer is yes, the appeals process is over.** What you asked for in the appeal has been approved. We must authorize or provide the drug coverage that was approved by the Administrative Law Judge within 72 hours (24 hours for expedited appeals) or make payment no later than 30 calendar days after we receive the decision.

- **If the answer is no, the appeals process may or may not be over.**
  - If you decide to accept this decision that turns down your appeal, the appeals process is over.
  - If you do not want to accept the decision, you can continue to the next level of the review process. If the administrative law judge says no to your appeal, the notice you get will tell you what to do next if you choose to continue with your appeal.

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

- **If the answer is yes, the appeals process is over.** What you asked for in the appeal has been approved. We must authorize or provide the drug coverage that was approved by the Appeals Council within 72 hours (24 hours for expedited appeals) or make payment no later than 30 calendar days after we receive the decision.

- **If the answer is no, the appeals process may or may not be over.**
  - If you decide to accept this decision that turns down your appeal, the appeals process is over.
  - If you do not want to accept the decision, you might be able to continue to the next level of the review process. If the Appeals Council says no to your appeal or denies your request to review the appeal, the notice you get will tell you whether the rules allow you to go on to a Level 5 Appeal. If the rules allow you to go on, the written notice will also tell you who to contact and what to do next if you choose to continue with your appeal.
Level 5 Appeal  A judge at the Federal District Court will review your appeal.

- This is the last step of the appeals process.

SECTION 11  How to make a complaint about quality of care, waiting times, customer service, or other concerns

? If your problem is about decisions related to benefits, coverage, or payment, then this section is not for you. Instead, you need to use the process for coverage decisions and appeals. Go to Section 5 of this chapter.

Section 11.1  What kinds of problems are handled by the complaint process?

This section explains how to use the process for making complaints. The complaint process is used for certain types of problems only. This includes problems related to quality of care, waiting times, and the customer service you receive. Here are examples of the kinds of problems handled by the complaint process.
If you have any of these kinds of problems, you can “make a complaint”

<table>
<thead>
<tr>
<th>Complaint</th>
<th>Example</th>
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<tbody>
<tr>
<td>Quality of your medical care</td>
<td>• Are you unhappy with the quality of the care you have received (including care in the hospital)?</td>
</tr>
<tr>
<td>Respecting your privacy</td>
<td>• Do you believe that someone did not respect your right to privacy or shared information about you that you feel should be confidential?</td>
</tr>
<tr>
<td>Disrespect, poor customer service, or other negative behaviors</td>
<td>• Has someone been rude or disrespectful to you?</td>
</tr>
<tr>
<td></td>
<td>• Are you unhappy with how our Customer Service has treated you?</td>
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<tr>
<td></td>
<td>• Do you feel you are being encouraged to leave the plan?</td>
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<tr>
<td>Waiting times</td>
<td>• Are you having trouble getting an appointment, or waiting too long to get it?</td>
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<tr>
<td></td>
<td>• Have you been kept waiting too long by doctors, pharmacists, or other health professionals? Or by our Customer Service or other staff at the plan?</td>
</tr>
<tr>
<td></td>
<td>o Examples include waiting too long on the phone, in the waiting room, when getting a prescription, or in the exam room.</td>
</tr>
<tr>
<td>Cleanliness</td>
<td>• Are you unhappy with the cleanliness or condition of a clinic, hospital, or doctor’s office?</td>
</tr>
<tr>
<td>Information you get from us</td>
<td>• Do you believe we have not given you a notice that we are required to give?</td>
</tr>
<tr>
<td></td>
<td>• Do you think written information we have given you is hard to understand?</td>
</tr>
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</table>
### Complaint Example

| Timeliness | The process of asking for a coverage decision and making appeals is explained in sections 4-10 of this chapter. If you are asking for a decision or making an appeal, you use that process, not the complaint process. However, if you have already asked us for a coverage decision or made an appeal, and you think that we are not responding quickly enough, you can also make a complaint about our slowness. Here are examples:
|             | • If you have asked us to give you a “fast coverage decision” or a “fast appeal”, and we have said we will not, you can make a complaint.
|             | • If you believe we are not meeting the deadlines for giving you a coverage decision or an answer to an appeal you have made, you can make a complaint.
|             | • When a coverage decision we made is reviewed and we are told that we must cover or reimburse you for certain medical services or drugs, there are deadlines that apply. If you think we are not meeting these deadlines, you can make a complaint.
|             | • When we do not give you a decision on time, we are required to forward your case to the Independent Review Organization. If we do not do that within the required deadline, you can make a complaint. |

### Section 11.2

The formal name for “making a complaint” is “filing a grievance”

<table>
<thead>
<tr>
<th>Legal Terms</th>
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<tr>
<td>• What this section calls a “complaint” is also called a “grievance.”</td>
</tr>
<tr>
<td>• Another term for “making a complaint” is “filing a grievance.”</td>
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<tr>
<td>• Another way to say “using the process for complaints” is “using the process for filing a grievance.”</td>
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Section 11.3 Step-by-step: Making a complaint

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

- Usually, calling your Team or Customer Service is the first step. If there is anything else you need to do, Customer Service will let you know. Call 1-866-992-6600. TTY call the Wisconsin Relay System at 711. You can call 24 hours a day, 7 days a week.

- If you do not wish to call (or you called and were not satisfied), you can put your complaint in writing and send it to us. If you put your complaint in writing, we will respond to your complaint in writing.

- Sometimes you may want to contact the Plan’s Member Rights Specialist. . Call 1-866-992-6600, TTY call the Wisconsin Relay System at 711. You can call 24 hours a day, 7 days a week. You can ask the Member Rights Specialist to put your verbal grievance in writing.

- Whether you call or write, you should contact Customer Service right away. The complaint must be made within 60 calendar days after you had the problem you want to complain about.

- If you are making a complaint because we denied your request for a “fast coverage decision” or a “fast appeal,” we will automatically give you a “fast” complaint. If you have a “fast” complaint, it means we will give you an answer within 24 hours.

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<th>Legal Terms</th>
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<tr>
<td>What this section calls a “fast complaint” is also called an “expedited grievance.”</td>
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**Step 2: We look into your complaint and give you our answer.**

- If possible, we will answer you right away. If you call us with a complaint, we may be able to give you an answer on the same phone call. If your health condition requires us to answer quickly, we will do that.

- Most complaints are answered in 30 calendar days. If we need more information and the delay is in your best interest or if you ask for more time, we can take up to 14 more calendar days (44 calendar days total) to answer your complaint. If we decide to take extra days, we will tell you in writing.

- If we do not agree with some or all of your complaint or don’t take responsibility for the problem you are complaining about, we will let you know. Our response will include our reasons for this answer. We must respond whether we agree with the complaint or not.
Section 11.4 You can also make complaints about quality of care to the Quality Improvement Organization

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

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

- **You can make your complaint to the Quality Improvement Organization.** If you prefer, you can make your complaint about the quality of care you received directly to this organization (without making the complaint to us).
  
  - The Quality Improvement Organization is a group of practicing doctors and other health care experts paid by the Federal government to check and improve the care given to Medicare patients.
  
  - To find the name, address, and phone number of the Quality Improvement Organization for your state, look in Chapter 2, Section 4, of this booklet. If you make a complaint to this organization, we will work with them to resolve your complaint.

- **Or you can make your complaint to both at the same time.** If you wish, you can make your complaint about quality of care to us and also to the Quality Improvement Organization.

Section 11.5 You can also tell Medicare about your complaint

You can submit a complaint about Community Care directly to Medicare. To submit a complaint to Medicare, go to [https://www.medicare.gov/MedicareComplaintForm/home.aspx](https://www.medicare.gov/MedicareComplaintForm/home.aspx). Medicare takes your complaints seriously and will use this information to help improve the quality of the Medicare program.

If you have any other feedback or concerns, or if you feel the plan is not addressing your issue, please call 1-800-MEDICARE (1-800-633-4227). TTY/TDD users can call 1-877-486-2048.

PROBLEMS ABOUT YOUR MEDICAID BENEFITS

SECTION 12 Handling problems about your Medicaid benefits

Section 12.1 Introduction

We are committed to providing quality service to our members. Our goal is to improve the care and services members receive, so we look to you for comments and suggestions. There may be a
time when you have a concern. As a member, you have the right to file a grievance or appeal a decision made by Community Care and to receive a prompt and fair review.

If you are unhappy with your care or services, you should talk with your Team first. Talking with your Team is usually the easiest and fastest way to address your concerns. If you do not want to talk with your Team, you can call our Member Rights Specialist. The Member Rights Specialist can tell you about your rights, attempt to informally resolve your concerns, and help you file a grievance or appeal. The Member Rights Specialist can help you determine if you should file a Medicaid or Medicare Appeal (See Chapter 8 Section 3.1) The Member Rights Specialist can work with you throughout the entire grievance and appeal process to try to find a workable solution.

For assistance with the grievance and appeal process contact
Community Care’s Member Rights Specialist, at:
 Community Care
 Member Rights Specialist
 205 Bishops Way
 Brookfield, WI 53005
 Toll-free: 1-866-992-6600
 TTY: Call the Wisconsin Relay System at 711

If you are unable to resolve your concerns by working directly with your Team or our Member Rights Specialist, Partnership gives you several ways to address your concerns. You can:

- File a grievance or appeal with Community Care.
- Ask for a review by the Wisconsin Department of Health Services (DHS).
- Ask for a State Fair Hearing with the Wisconsin Division of Hearings and Appeals (DHA).

Each way has different rules, procedures and deadlines.

Coordination with other insurance

If you have other insurance and want to file a grievance or appeal, you should file your grievance or appeal with the other insurance first.

When you have other insurance (like employer group health coverage), there are rules that decide whether our plan or your other insurance pays first. We are required to follow these rules to make sure that you are using all of your coverage in combination when you get your covered services from our plan. This is called “coordination of benefits” because it involves coordinating the benefits you get from our plan with any other benefits available to you.

The insurance that pays first is called the “primary payer” and pays up to the limits of its coverage. The one that pays second, called the “secondary payer,” only pays if there are costs
left uncovered by the primary coverage. The secondary payer may not pay all of the uncovered costs. They only pay after the other insurance plan has paid.

If you have other insurance, Medicaid never pays first for services covered by the other insurance. Medicaid always pays last.

**Section 12.2 Copies of your records**

You can get a free copy of your records related to your grievance or appeal including but not limited to medical records if you think you need them to help you with your grievance or appeal. To request copies contact a Member Rights Specialist at 1-866-992-6600. TTY call the Wisconsin Relay System at 711.

You will not get into trouble if you complain or disagree with your Team. If you file a grievance or appeal with Community Care, our providers, or the State of Wisconsin, we won’t treat you differently.

We want you to be satisfied with your care.

**Section 12.3 Medicaid Grievances**

(Please see Chapter 8 Section 11 for additional information on Grievances)

What is a grievance?

A grievance is when you are not satisfied with Community Care, one of our providers, or have concerns about the quality of your care or services. For example, you might want to file a grievance if:

- Your personal care worker often arrives late.
- You feel your Team doesn’t listen to you.
- You have trouble getting appointments with a provider.
- You aren’t satisfied with your provider’s incontinence products.

Who can file a grievance on my behalf?

Your authorized representative, such as a legal guardian or activated power of attorney for health care, can file a grievance for you. Your family, a friend, or a provider can file a grievance for you too if they have your written permission.

What is the deadline to file a grievance?

You can file a grievance at any time.
What are my options?

If you want to file a grievance, you have two options. You can:

1.) Start by filing a grievance with Community Care.
   ➔ See Option 1, listed below.

2.) Start by asking for a review by the Wisconsin Department of Health Services (DHS).
   ➔ See Option 2, listed below.

You can use either or both ways together or at different times.

MEDICAID GRIEVANCE OPTION 1: File your grievance with Community Care

Community Care wants you to be happy with your care and services. Our Member Rights Specialist can work with you and your Team to try to resolve your concerns informally. A lot of the time we can take care of your concerns without going further. However, if we are unable to solve your concern, you can file a grievance with Community Care by calling or writing to us at:

Community Care
Member Rights Specialist
205 Bishops Way
Brookfield, WI 53005
Toll-free: 1-866-992-6600
TTY: Call the Wisconsin Relay System at 711

What happens next?

If you file a grievance with Community Care, we will send you a letter within five business days to let you know we received your grievance. Then, Community Care staff who are not on your Team will try to help informally address your concerns or come up with a solution that satisfies both Community Care and you. If we are not able to come up with a solution, or if you do not want to work with Community Care staff to informally address your concerns, our Grievance and Appeals Committee will review your grievance and issue a decision.

- The Committee is made up of Community Care representatives and at least one consumer. The consumer is a person who also receives services from us (or represents someone who does). We train this person on how to protect the privacy of others while serving on the Committee. Sometimes other people who specialize in the area of your grievance might be part of the Committee.
- We will let you know when the Committee plans to meet to review your grievance.
- The meeting is confidential. You can ask that the consumer not be on the Committee if you are concerned about privacy or have other concerns.
• You have the right to appear in person. You can bring an advocate, friend, family member, or witnesses with you.
• The Committee will give you a chance to explain your concerns. You may provide information to the Committee.
• Your Team or other Community Care staff will likely be at the meeting.
• The Committee will make a decision within 20 business days from the date we first got your grievance. You will get a written notice of the decision.

What if I disagree with the Grievance and Appeal Committee’s decision?

If you disagree, you can ask for a review by the Department of Health Services, unless you have already done so. You could also talk to our Member Rights Specialist or an advocate for advice on other options.

MEDICAID GRIEVANCE OPTION 2: Ask for a DHS review

You can also ask the State of Wisconsin Department of Health Services (DHS) to review your grievance instead of or before filing a grievance with Community Care. DHS is the agency that is in charge of the Partnership program. The purpose of a DHS review is to see if you and Community Care can work out an informal solution.

Your concerns can often be resolved directly with Community Care before asking DHS to review the situation. Using Community Care’s grievance process first is not a requirement, but it is encouraged.

To ask for a DHS review, call or e-mail:

<table>
<thead>
<tr>
<th>DHS Partnership Grievances</th>
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<tr>
<td>Toll-free: 1-888-203-8338</td>
</tr>
<tr>
<td>E-mail: <a href="mailto:dhsfamcare@wisconsin.gov">dhsfamcare@wisconsin.gov</a></td>
</tr>
</tbody>
</table>

What happens next?

DHS works with an outside organization to review grievances. If you ask for a DHS review, that external review organization will contact you.

• The external review organization will reply in writing within five business days to let you know they received your grievance.
• They will ask you for information about your concerns. They will also contact your Team. The organization will try to resolve your concerns informally.
• **The external review organization will not issue a decision.** Instead, they will review your concerns and try to come up with an informal solution that is acceptable to you and Community Care.
• If the external review organization tells DHS that we failed to comply with certain requirements, DHS may order Community Care to take steps to fix the problem.
The external review organization will complete the review and send you a letter with their findings within 20 business days of your request.

What if I disagree with the DHS review?

If you are not happy with the result of the DHS review, you can file a grievance with Community Care, if you have not already done so. You could also talk to our Member Rights Specialist or an advocate for advice on other options.

Section 12.4 Medicaid Appeals

What is a Medicaid appeal?

A Medicaid appeal is a review of a decision made by Community Care related to your Medicaid benefits. For example, you can file an appeal if your Team denies a service or support you requested. Other examples are decisions to reduce or end a service, or to deny payment for a service.

Who can file an appeal on my behalf?

Your authorized representative, such as a legal guardian or activated power of attorney for health care, can file an appeal for you. Your family, a friend, or a provider can file an appeal for you too if they have your written permission.

What types of issues can I appeal?

You have the right to file an appeal in the following types of situations:

1.) You can file an appeal if Community Care:
   - Plans to stop, suspend or reduce a service you are receiving.
   - Decides to deny a service you asked for.
   - Decides not to pay for a service.

   If we take one of the actions listed above, we must send you a “Notice of Action.” The Notice of Action includes the date we plan to stop, suspend or reduce your services.

2.) You can file an appeal if:
   - You don’t like your care plan because it:
     - Doesn’t support you to live in the place where you want to live.
     - Doesn’t provide enough care, treatment, or support to meet your outcomes. (Refer to Chapter 3, Section 2.1, for information about outcomes.)
     - Requires you to accept care, treatment or support you don’t want.
• Community Care fails to:
  o Arrange or provide services in a timely manner.
  o Meet the required timeframes to resolve your appeal.

In these situations, Community Care will send you a notification of your appeal rights.

3.) You can file an appeal related to **decisions about your eligibility** for Partnership.

• If the Income Maintenance agency decides you are no longer financially eligible for Partnership, or says your cost share/spend down payment will change, the agency will send you a notice with information about your eligibility for Partnership. These notices have the words “About Your Benefits” on the first page. The last page has information about your right to request a State Fair Hearing with the Division of Hearings and Appeals.
• If your functional eligibility for Partnership changes, you will receive a written notice.
• Filing an appeal with the Division of Hearings and Appeals is the only way to challenge decisions related to eligibility for Partnership.
• **You cannot appeal a loss of financial or functional eligibility with Community Care.**

What is the deadline to file an appeal?

• You should file your appeal as soon as possible.
• Community Care will send you a **Notice of Action** if we:
  o Plan to stop, suspend or reduce a service you are getting.
  o Deny a new service you asked for.
  o Won’t pay for a service.

**You must file your appeal no later than 45 days after you receive the Notice of Action.** (For example, if you get a notice in the mail on August 1, you must file your appeal on or before September 15.)

If you receive a notification of your appeal rights, you should read this notice carefully. The notice may tell you the deadline for filing your appeal. You can always call our Member Rights Specialist for assistance.

What are my options?

If you want to file an appeal, you have three options. You can:

1.) Start by filing an appeal with Community Care.
  ➔ See Option 1 (Section 12.6, below).
2.) Start by asking the Wisconsin Department of Health Services (DHS) to review our decision.
   ➔ See Option 2 (Section 12.7, below) if you want to file with DHS.

3.) Start by filing an appeal with the State Division of Hearings and Appeals (DHA).
   ➔ See Option 3 (Section 12.8, below) if you want to file with DHA.

Each option has different rules, procedures and deadlines.

You cannot file an appeal with Community Care, or the Wisconsin Department of Health Services (DHS), **and** file an appeal with the Division of Hearings and Appeals (DHA) at the **same** time.

You can file a request for a fair hearing instead of, or after, receiving an appeal decision from Community Care.

If you want **both** Community Care and DHA to review you issue, then you have to file your appeal with Community Care **before** you file the appeal with DHA. Once you file an appeal with DHA, you cannot file the same appeal with Community Care.

**An appeal with DHA is the final level of appeal.**

If you want someone to help you file an appeal, you can talk with Community Care’s Member Rights Specialist. An advocate may also be able to help you. An advocate might be a family member, friend, attorney, ombudsman, or any other person willing to help. Ombudsman programs are available to help all Partnership members with appeals. See the beginning of this Chapter for information on how to contact an advocate.

**Section 12.5 Continuing Your Services During Your Medicaid Appeal**

If Community Care decides to stop, suspend or reduce a service you are currently receiving, you have the right to ask Community Care, DHS, or DHA to continue your services during your appeal.

If you want your services to continue, you must:

- Postmark or fax your appeal **on or before** the date Community Care plans to stop, suspend or reduce your services; **AND**
- Ask that your services continue throughout the course of your appeal.

If your services were continued during an appeal with Community Care and you lose the appeal, you can continue your services at the next level of appeal if you once again request that they be continued.
The final decision of the appeal may not be in your favor. If that happens, you might have to pay Community Care back for the service you got during the appeal process. If you can show that this would be a substantial financial burden, you may not have to pay us back.

**Section 12.6 Medicaid Appeal Option 1: Filing your appeal with Community Care**

To file an appeal with Community Care you can:

- **Call** Community Care. If you file your appeal by calling us, we will ask you to send in a written request. If you want, our Member Rights Specialist can help you put your appeal in writing.
- **Send in a request form.** The form is available at: www.dhs.wisconsin.gov/LTCare/Memberinfo/MCOrequest.htm.
- **Mail your request in a letter.**
- **Write down your request on a piece of paper.**

**To file an appeal with Community Care, call:**

Member Rights Specialist  
Toll-free: 1-866-992-6600  
TTY: Call the Wisconsin Relay System at 711

**Or, mail a completed request form, letter, or written note to:**

Community Care  
Member Rights Specialist  
205 Bishops Way  
Brookfield, WI53005

**What happens next?**

If you file an appeal with Community Care, we will send you a letter within five business days to let you know we received your appeal. Then, we will try to help informally address your concerns or come up with a solution that satisfies both Community Care and you. If we are not able to come up with a solution or if you do not want to work with Community Care staff to informally address your concerns, our Grievance and Appeals Committee will meet to review your appeal.

- We will let you know when the Committee plans to meet to review your appeal.
- The Committee is made up of Community Care representatives and at least one consumer. The consumer is a person who also receives services from us (or represents someone who does). We train this person on how to protect the privacy of others while serving on the Committee. Sometimes other people who specialize in the area of your appeal might be part of the Committee.
The meeting is confidential. You can ask that the consumer not be on the Committee if you are concerned about privacy or have other concerns.

- You have the right to appear in person. You can bring an advocate, friend, family member, or witnesses with you.
- Your Team or other Community Care staff will likely be at the meeting.
- The Committee will give you a chance to explain why you disagree with your Team’s decision. You or your representative can present information, bring witnesses, or describe your concerns to help the Committee understand your point of view.
- After the Committee hears your appeal, Community Care will send you a decision letter within 20 business days after we first got your appeal. Community Care may take up to 30 business days to issue a decision if:
  o You ask for more time to give the Committee information, or
  o We need more time to gather information. If we need additional time, we will send you a written notice informing you of the reason for delay.

Speeding up your appeal

Community Care has 20 business days to decide your appeal. If you think waiting that long could seriously harm your health or your ability to function, you can ask us to speed up your appeal. We call this an “expedited appeal.” You may ask for a fast appeal only if you believe that waiting for a decision could seriously harm your health or your ability to function. If you ask for a fast appeal, we will decide if your health requires a fast appeal. We will let you know as soon as possible if we will expedite your appeal.

In an expedited appeal, you will get a decision on your appeal within 72 hours of your request. However, Community Care may extend this to a total of 14 days if additional information is necessary and if the delay is in your best interest. If you have additional evidence you want us to consider, you will need to submit it quickly.

To request an expedited appeal, contact:

Community Care
Member Rights Specialist
Toll-free: 1-866-992-6600
TTY: Call the Wisconsin Relay System at 711

What if I disagree with the Grievance and Appeal Committee’s decision?

If you disagree, you can request a State Fair Hearing with the Division of Hearings and Appeals (DHA) or ask for a review by the Department of Health Services, and if you have not already done so. You must do so within 45 days from the date of the Grievance and Appeal Committee’s decision. You can file an appeal with DHA if Community Care does not issue an appeal decision in a timely manner.
MEDICAID APPEAL OPTION 2: Asking the Department of Health Services (DHS) to review Community Care’s decision

The Wisconsin Department of Health Services (DHS) is the agency that is in charge of the Partnership program. DHS works with an outside organization to review decisions made by Community Care. Staff from this external review organization will try to resolve your concerns informally.

The external review organization won’t issue a decision. Instead, they will review your concerns and try to come up with an informal solution that is acceptable to you and Community Care.

A DHS review will not typically result in DHS ordering Community Care to do what you want. Nor will DHS order you to accept what Community Care is planning to do. However, if the review organization tells DHS that we didn’t follow certain requirements, DHS may order Community Care to take steps to correct that.

How do I ask for a DHS review?

You may request a DHS review by calling or e-mailing:

DHS Partnership Appeals

Toll-free: 1-888-203-8338
E-mail: dhsfamcare@wisconsin.gov

What is the deadline to ask for a DHS review?

You can ask DHS to review Community Care’s decision before or instead of filing an appeal with Community Care or DHA.

You should ask DHS to review Community Care’s decision as soon as possible. You must ask for a DHS review within 45 days after you receive a Notice of Action or decision letter from Community Care. (For example, if you get a notice or decision letter in the mail on August 1, you must file your appeal on or before September 15.)

You can request to have your services continue during the review if you request the review on or before the date Community Care plans to stop or reduce your services.

What happens next?

- The external review organization will reply in writing within five business days to let you know they received your request.
They will contact you and ask why you disagree with Community Care’s decision. They will also contact your Team. The external review organization will try to resolve your concerns informally.

The external review organization will complete the review and send you a letter with their findings within 20 business days of your request.

What if I disagree with the results of the DHS review?

If you are not happy with the result of the DHS review, you can file an appeal with Community Care, and if you have not already done so, or the Division of Hearings and Appeals (or both if you haven’t already done so). After you receive the letter from the external review organization with their findings, you have up to 45 days to appeal with Community Care or DHA.

Section 12.8 State Fair Hearings

MEDICAID APPEAL OPTION 3: Filing your appeal with the Wisconsin Division of Hearings and Appeals (DHA)

If you file an appeal with the Wisconsin Division of Hearings and Appeals (DHA), you will have a State Fair Hearing with an independent judge. Judges at DHA do not have any connection to Community Care. You can find more information about State Fair Hearings online at http://dha.state.wi.us/home/HrgInfo.htm.

An appeal with DHA is the final level of appeal. If you go to DHA first, you can’t go back and file an appeal with Community Care or ask for a Department of Health Services review about the same issue. However, if you request a State Fair Hearing, the Department of Health Services will automatically review your appeal.

How do I request a State Fair Hearing?

To ask for a State Fair Hearing, you can either:

- Send a request form. You can get a copy from Community Care’s Member Rights Specialist or from one of the advocacy organizations listed in this handbook (see Chapter 2). Or, go to the Web to download the form at www.dhs.wisconsin.gov/forms/f0/f00236.doc.
- Mail a letter. Include your name and contact information and explain what you are appealing. If you received a Notice of Action or other notification of your appeal rights, it’s a good idea to include a copy of that notice with your request for a State Fair Hearing. Do not send your original copy.

The Member Rights Specialist or an advocate can help you put your appeal in writing. To contact an advocate, see Chapter 2, Section 6.
To request a State Fair Hearing

Send the completed request form or a letter asking for a hearing to:

  Partnership Request for Fair Hearing  
  c/o Wisconsin Division of Hearings and Appeals  
  5005 University Ave., #201  
  P.O. Box 7875  
  Madison, WI 53707-7875  
  (Or fax your request to 608-264-9885)

What is the deadline to file an appeal with DHA?

You should file your appeal as soon as possible. You must file your appeal within 45 days after you receive a Notice of Action or other notification of your appeal rights. (For example, if you get a notice in the mail on August 1, you must file your appeal on or before September 15.) If you began the appeal process by filing an appeal with Community Care and you received a decision you didn’t agree with, you have 45 days from the date you receive that decision to file a request for a State Fair Hearing.

You can request to have your services continue during the State Fair Hearing process if you file your appeal on or before the date Community Care plans to stop, suspend or reduce your services. See Section 12.5 for more information about continuing your services.

What happens next?

- After you send in your request for a State Fair Hearing, DHA will mail you a notice with the date, time and location of your hearing.
- The hearing will be at an office in your county or may be done by telephone.
- An Administrative Law Judge will run the hearing.
- You have the right to participate in the hearing. You can bring an advocate, friend, family member, or witnesses with you.
- Your Team or other Community Care staff will be present at the hearing to explain their decision.
- You will have a chance to explain why you disagree with your Team’s decision. You or your representative can present information, bring witnesses, or describe your concerns to help the Judge understand your point of view.
- The Administrative Law Judge must issue a decision within 90 days of the date you filed a request for the hearing.

What can I do if I disagree with the Judge’s decision?

If you disagree with Administrative Law Judge’s decision, you have two options.
1.) Ask for a re-hearing. If you want DHA to reconsider its decision, you must ask within 20 days from the date of the Judge’s decision. The Administrative Law Judge will only grant a re-hearing if:
   - You can show that a serious mistake in the facts or the law happened, or
   - You have new evidence that you were unable to obtain and present at the first hearing.

2.) Take your case to circuit court. If you want to take your case to court, you must file your petition within 30 days from the date of the Judge’s decision.

**Section 12.9 Who can help me with my Medicaid grievance or appeal?**

You can contact Community Care’s Member Rights Specialist any time you need help with a grievance or appeal, or have questions about your rights. Advocates are also available to answer questions about the grievance and appeal processes. An advocate can also tell you more about your rights and help make sure Community Care is supporting your needs and outcomes. You can ask anyone you want to act as an advocate for you, including family members, friends, an attorney, or any other person willing to help.

Below are some agencies you can contact for assistance. Community Care’s Member Rights Specialist may be able to give you information about other places that can help you too.

**Ombudsman Programs**

Regional Ombudsmen programs are available to help all Partnership members with grievances and appeals. They can respond to your concerns in a timely fashion. Both Ombudsmen programs will typically use informal negotiations to resolve your issues without a hearing.

**Wisconsin Board on Aging and Long-term Care** (age 60+)

Ombudsmen from this agency provide advocacy to Partnership members age 60 and older.

- Board on Aging and Long-term Care
  1402 Pankratz Street, Suite 111
  Madison, WI 53704-4001
  Toll-free: 1-800-815-0015
  Fax: 608-246-7001
  [http://longtermcare.state.wi.us](http://longtermcare.state.wi.us)

**Disability Rights Wisconsin (DRW)** (under age 60)

Ombudsmen from this agency provide advocacy to Partnership members under age 60.
Disability Rights Wisconsin
131 W. Wilson St., Suite 700
Madison, WI 53703
608-267-0214
TTY: 1-888-758-6049
Fax: 608-267-0368

Madison Toll-free: 1-800-928-8778
Milwaukee Toll-free: 1-800-708-3034
Rice Lake Toll-free: 1-877-338-3724
www.disabilityrightswi.org
Chapter 9

Ending your membership in the plan
Chapter 9. Ending your membership in the plan

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            our plan................................................................................................. 203
SECTION 1  Introduction

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

Ending your membership in Community Care may be voluntary (your own choice) or involuntary (not your own choice):

- You might leave our plan because you have decided that you want to leave.
  - You can end your membership in the plan at any time. Section 2 tells you about the types of plans you can enroll in and when your enrollment in your new coverage will begin.
  - The process for voluntarily ending your membership varies depending on what type of new coverage you are choosing. Section 3 tells you how to end your membership in each situation.

- There are also limited situations where you do not choose to leave, but we are required to end your membership. Section 5 tells you about situations when we must end your membership.

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

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

Section 2.1  You can end your membership at any time

You can end your membership in Community Care at any time.

- **When can you end your membership?** Most people with Medicare can end their membership only during certain times of the year. However, because you get assistance from Medicaid, you can end your membership in Community Care at any time.

- **What type of plan can you switch to?** If you decide to change to a new plan, you can choose any of the following types of Medicare plans:
  - Another Medicare health plan. (You can choose a plan that covers prescription drugs or one that does not cover prescription drugs.)
  - Original Medicare with a separate Medicare prescription drug plan.
    - If you switch to Original Medicare and do not enroll in a separate Medicare prescription drug plan, Medicare may enroll you in a drug plan, unless you have opted out of automatic enrollment.

  **Note:** If you disenroll from Medicare prescription drug coverage and go without “creditable” prescription drug coverage for a continuous period of 63 days or more,
you may need to pay a Part D late enrollment penalty if you join a Medicare drug
plan later. (“Creditable” coverage means the coverage is expected to pay, on average,
at least as much as Medicare’s standard prescription drug coverage.)

Contact your State Medicaid Office to learn about your Medicaid plan options
(telephone numbers are in Chapter 2, Section 6 of this booklet).

- **When will your membership end?** Your membership will usually end on the first day of
  the month after we receive your request to change your plans. Your enrollment in your
  new plan will also begin on this day.

<table>
<thead>
<tr>
<th>Section 2.2 Where can you get more information about when you can end your membership?</th>
</tr>
</thead>
<tbody>
<tr>
<td>If you have any questions or would like more information on when you can end your membership:</td>
</tr>
<tr>
<td>• You can call Customer Service (phone numbers are printed on the back cover of this booklet).</td>
</tr>
<tr>
<td>• You can contact the local Aging and Disability Resource Center to discuss Medicaid Partnership disenrollment. Here is the contact information for your county:</td>
</tr>
<tr>
<td>Calumet County ADRC 920-849-1451</td>
</tr>
<tr>
<td>Kenosha County ADRC 262-605-6646</td>
</tr>
<tr>
<td>Milwaukee County ARC 414-286-6874  For individuals age 60 and older</td>
</tr>
<tr>
<td>Milwaukee County DRC 414-289-6660  For individuals under age 60</td>
</tr>
<tr>
<td>Racine County ADRC 262-638-6800</td>
</tr>
<tr>
<td>Outagamie County ADRC 920-832-5178</td>
</tr>
<tr>
<td>Ozaukee County 262-284-8120</td>
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<tr>
<td>Washington County ADRC 262-335-4497</td>
</tr>
<tr>
<td>Waukesha County ADRC 262-548-7848</td>
</tr>
<tr>
<td>Waupaca County ADRC 715-258-6400</td>
</tr>
<tr>
<td>• You can find the information in the <em>Medicare &amp; You 2018</em> Handbook.</td>
</tr>
<tr>
<td>o Everyone with Medicare receives a copy of <em>Medicare &amp; You</em> each fall. Those new to Medicare receive it within a month after first signing up.</td>
</tr>
<tr>
<td>o You can also download a copy from the Medicare website (<a href="https://www.medicare.gov">https://www.medicare.gov</a>). Or, you can order a printed copy by calling Medicare at the number below.</td>
</tr>
<tr>
<td>• You can contact Medicare at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.</td>
</tr>
</tbody>
</table>
SECTION 3  How do you end your membership in our plan?

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

Usually, to end your membership in our plan, you simply enroll in another Medicare plan. However, if you want to switch from our plan to Original Medicare but you have not selected a separate Medicare prescription drug plan, you must ask to be disenrolled from our plan. There are two ways you can ask to be disenrolled:

- You can make a request in writing to us. Contact Customer Service if you need more information on how to do this (phone numbers are printed on the back cover of this booklet).
- --or-- You can contact Medicare at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

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

<table>
<thead>
<tr>
<th>If you would like to switch from our plan to:</th>
<th>This is what you should do:</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Another Medicare health plan.</td>
<td>• Enroll in the new Medicare health plan at any time. Your new coverage will begin on the first day of the following month. You will automatically be disenrolled from Community Care when your new plan’s coverage begins.</td>
</tr>
<tr>
<td>• Original Medicare with a separate Medicare prescription drug plan.</td>
<td>• Enroll in the new Medicare prescription drug plan at any time. Your new coverage will begin on the first day of the following month. You will automatically be disenrolled from Community Care when your new plan’s coverage begins.</td>
</tr>
</tbody>
</table>
If you would like to switch from our plan to: This is what you should do:

- Original Medicare without a separate Medicare prescription drug plan.
  - If you switch to Original Medicare and do not enroll in a separate Medicare prescription drug plan, Medicare may enroll you in a drug plan, unless you have opted out of automatic enrollment.
  - If you disenroll from Medicare prescription drug coverage and go without creditable prescription drug coverage, you may need to pay a late enrollment penalty if you join a Medicare drug plan later.
- Send us a written request to disenroll. Contact Customer Service if you need more information on how to do this (phone numbers are printed on the back cover of this booklet).
- You can also contact Medicare, at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week, and ask to be disenrolled. TTY users should call 1-877-486-2048.
- You will be disenrolled from Community Care when your coverage in Original Medicare begins.

You must contact the Aging and Disability Resource Center (ADRC) for your county no matter which way you choose to end your membership in our plan. A list of the ADRCs can be found in Chapter 2, Section 10 of this EOC. You can also use the following link to find an ADRC in your area: https://www.dhs.wisconsin.gov/adrc/consumer/index.htm.

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

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

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

- You should continue to use our network pharmacies to get your prescriptions filled until your membership in our plan ends. Usually, your prescription drugs are only covered if they are filled at a network pharmacy.
- If you are hospitalized on the day that your membership ends, your hospital stay will usually be covered by our plan until you are discharged (even if you are discharged after your new health coverage begins).
SECTION 5  Community Care must end your membership in the plan in certain situations

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

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

- If you no longer have Medicare Part A and Part B.
- If you are no longer eligible for Medicaid. As stated in Chapter 1, section 2.1, our plan is for people who are eligible for both Medicare and Medicaid.
  - If you lose your financial eligibility for Wisconsin Medicaid.
  - If you are no longer functionally eligible as determined by the State of Wisconsin Long-Term Care Functional Screen.
  - If you are 21 to 64 years of age, and are admitted to an Institution of Mental Disease (IMD).
- If you do not pay your Medicaid cost share. Medicaid cost share is any amount a member must pay to retain financial eligibility for Wisconsin Medicaid (The federal government refers to this as the “post-eligibility treatment of income.”).
- If you move out of our service area.
- If you are away from our service area for more than six months.
  - If you move or take a long trip, you need to call Customer Service to find out if the place you are moving or traveling to is in our plan’s area. (Phone numbers for Customer Service are printed on the back cover of this booklet.)
- If you become incarcerated (go to prison).
- If you are not a United States citizen or lawfully present in the United States.
- If you lie about or withhold information about other insurance you have that provides prescription drug coverage.
- If you intentionally give us incorrect information when you are enrolling in our plan and that information affects your eligibility for our plan. (We cannot make you leave our plan for this reason unless we get permission from Medicare and Medicaid first.)
- If you continuously behave in a way that is disruptive and makes it difficult for us to provide medical care for you and other members of our plan. (We cannot make you leave our plan for this reason unless we get permission from Medicare and Medicaid first.)
- If you let someone else use your membership card to get medical care. (We cannot make you leave our plan for this reason unless we get permission from Medicare and Medicaid first.)
  - If we end your membership because of this reason, Medicare may have your case investigated by the Inspector General.
If we end your membership because of this reason, Medicaid may have your case investigated by the Wisconsin Department of Health Services Office of the Inspector General (OIG).

- If you are required to pay the extra Part D amount because of your income and you do not pay it, Medicare will disenroll you from our plan.

**Where can you get more information?**

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

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

<table>
<thead>
<tr>
<th>Section 5.2</th>
<th>We cannot ask you to leave our plan for any reason related to your health</th>
</tr>
</thead>
</table>

Community Care is not allowed to ask you to leave our plan for any reason related to your health.

**What should you do if this happens?**

If you feel that you are being asked to leave our plan because of a health-related reason, you should call Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048. You may call 24 hours a day, 7 days a week.

<table>
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<tr>
<th>Section 5.3</th>
<th>You have the right to make a complaint if we end your membership in our plan</th>
</tr>
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</table>

If we end your membership in our plan, we must tell you our reasons in writing for ending your membership. We must also explain how you can file a grievance or make a complaint about our decision to end your membership. You can also look in Chapter 8, Section 11 for information about how to make a complaint.
CHAPTER 10

Legal notices
Chapter 10. Legal notices

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SECTION 2  Notice about nondiscrimination...................................................... 206
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SECTION 1  Notice about governing law

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

SECTION 2  Notice about nondiscrimination

We don’t discriminate based on race, ethnicity, national origin, creed (beliefs) color, religion, sex, gender, age, mental or physical disability, health status, claims experience, medical history, genetic information, evidence of insurability, or geographic location. All organizations that provide Medicare Advantage plans, like our plan, must obey Federal laws against discrimination, including Title VI of the Civil Rights Act of 1964, the Rehabilitation Act of 1973, the Age Discrimination Act of 1975, the Americans with Disabilities Act, Section 1557 of the Affordable Care Act, and all other laws that apply to organizations that get Federal funding, and any other laws and rules that apply for any other reason.

SECTION 3  Notice about Medicare Secondary Payer subrogation rights

We have the right and responsibility to collect for covered Medicare services for which Medicare is not the primary payer. According to CMS regulations at 42 CFR sections 422.108 and 423.462, Community Care, as a Medicare Advantage Organization, will exercise the same rights of recovery that the Secretary exercises under CMS regulations in subparts B through D of part 411 of 42 CFR and the rules established in this section supersede any State laws.

SECTION 4  Notice of Privacy Practices

Notice of Privacy Practices

Community Care, Inc. / Community Care Health Plan, Inc.  
(Community Care)  
205 Bishops Way  
Brookfield, WI 53005  
www.communitycareinc.org

The Health Insurance Portability & Accountability Act of 1996 (“HIPAA”) is a federal law that requires that all medical records and other individually identifiable health
information used or disclosed by Community Care in any form, are kept properly confidential. Recent changes to HIPAA give you significant new rights to understand and control how your health information is used.

As required by HIPAA, this notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

Your Rights

When it comes to your health information, you have certain rights. This section explains your rights and some of Community Care’s responsibilities to help you. You have the right to:

Get a copy of health and claims records

- You can ask to see or get a copy of the health and claims records and other health information we have about you.
- We will provide a copy or a summary of your health and claims records, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct health and claims records

- You can ask us to correct your health and claims records if you think they are incorrect or incomplete. Ask us how to do this.
- We are not required to agree to the change you have requested and may say “no” to your request, but we will tell you why in writing within 60 days.

Request confidential communications

- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will consider all reasonable requests, and must say “yes” if you tell us you would be in danger if we do not honor your request.

Ask us to limit what we use or share

- You can ask us not to use or share certain health information for treatment, payment, or our operations.
- We are not required to agree to your request, and we may say “no” if it would affect your care.
Get a list of those with whom we have shared information

- You can ask for a list (accounting) of the times we have shared your health information for six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We will provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice

You can ask for a copy of this notice at any time. We will provide you with a paper copy promptly.

Choose someone to act for you

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated

- You can complain if you feel we have violated your rights by contacting us. Our contact information can be found at the end of this notice.
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/.
- We will not retaliate against you for filing a complaint.

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.
In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in payment for your care
- Share information in a disaster relief situation

*If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.*

**Our Uses and Disclosures**

**How do we typically use or share your health information?**
We typically use or share your health information in the following ways:

**To help manage the health care treatment you receive**

- We can use your health information and share it with professionals who are treating you. Treatment means providing, coordinating, or managing your health care and related services.

  *Example: A doctor sends us information about your diagnosis and treatment plan so we can arrange additional services.*

**To run our organization**

- We can use and disclose your information to operate our organization and contact you when necessary. This includes the business aspects of running our health plan, such as conducting quality assessment and improvement activities, auditing, budgeting and customer service.

  *Example: We use health information about you to develop better services for you.*

**To pay for your health services**

- We can use and disclose your health information as we pay for your health services. Payment means such activities as reimbursing providers for services, confirming eligibility, billing or collection activities and utilization review.

  *Example: We process a claim and pay a provider for an office visit.*

**How else can we use or share your health information?**
We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes.
We may also create and distribute de-identified health information by removing all references to individually identifiable information.

Help with public health and safety issues

We can share health information about you for certain situations such as:

- Preventing disease
- Helping with product recalls
- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to anyone’s health or safety

Do research

We can use or share your information for health research if you give us written permission or if all references to your individually identifiable information have been removed.

Comply with the law

- We can share information about you if state or federal laws require it, including sharing your information with the Department of Health and Human Services if it wants to see that we’re complying with federal privacy law.

Respond to organ and tissue donation requests and work with a medical examiner or funeral director

- We can share health information about you with organ procurement organizations.
- We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers’ compensation, law enforcement, and other government requests

We can use or share health information about you:

- For workers’ compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
• For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions

We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities

• We are required by law to maintain the privacy and security of your protected health information.
• We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
• We must follow the duties and privacy practices described in this notice and give you a copy of it.
• We will not use or share your information other than as described here unless you give us written permission. You may change your mind at any time. Let us know in writing if you change your mind.
• We will not sell your health information.
• We will not share your psychiatric, substance abuse and HIV-related information without your written permission except when permitted by law.
• We will abide by all applicable state and federal laws. There may be state and federal laws that have more requirements than HIPAA on how we use and disclose your health information. If there are specific, more restrictive requirements, even for some of the purposes listed above, we may not disclose your health information without your written permission.

For more information see:

Changes to the Terms of this Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request and on our web site. We will provide you with a copy of the revised notice within 60 days of the change.

This notice is effective as of November 2013.
SECTION 5 Notice About Nondiscrimination and Accessibility Requirements

Notice Informing Individuals About Nondiscrimination and Accessibility Requirements

Community Care, Inc. complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Community Care, Inc. does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Community Care, Inc.:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact your Team.

If you believe that Community Care, Inc. has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with: Michael Garlie, Chief Compliance, Quality and Risk Officer, Community Care,
205 Bishops Way, Brookfield, WI 53005, 414-231-4000, (TTY 711), Fax 262-827-4044, compliancehotline@communitycareinc.org. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, Michael Garlie, Chief Compliance, Quality and Risk Officer, is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, 1-800-868-1019, 800-537-7697 (TDD).

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html

SECTION 6 Multi-Language Insert

Information is available for free in other languages.

ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call 1-866-992-6600 (TTY: 711).

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-866-992-6600 (TTY: 711). [SPANISH]


注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-866-992-6600 (TTY : 711)。[CHINESE]


ملحوظة: إذا كنت تتحدث اللغة، فإن خدمات المساعدة اللغوية تتوفر لك بالمجان. اتصل برقم 1-866-992-6600 (رقم هاتف الصم والبكم: 711). [ARABIC]

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-866-992-6600 (телетайп: 711). [RUSSIAN]

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-866-992-6600 (TTY: 711) 번으로 전화해 주십시오. [KOREAN]


ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। 1-866-992-6600 (TTY: 711) पर कॉल करें। [HINDI]


CHAPTER 11

Definitions of important words
Chapter 11. Definitions of important words

Aging and Disability Resource Center (ADRC) – Service Centers that provide a place to get information and assistance on all aspects of life related to aging or living with a disability, including all available programs and services. ADRC services can be provided at the Center, or via telephone or through a home visit, whichever is more convenient to the individual seeking help. The ADRC is responsible for enrollment counseling and enrollment and disenrollment in the Family Care and Family Care Partnership Programs and the Program of All-Inclusive Care for the Elderly (PACE) in Wisconsin. Visit www.dhs.wisconsin.gov for more information about ADRCs.

Ambulatory Surgical Center – An Ambulatory Surgical Center is an entity that operates exclusively for the purpose of furnishing outpatient surgical services to patients not requiring hospitalization and whose expected stay in the center does not exceed 24 hours.

Appeal – An appeal is something you do if you disagree with our decision to deny a request for coverage of health care services or prescription drugs or payment for services or drugs you already received. You may also make an appeal if you disagree with our decision to stop services that you are receiving. For example, you may ask for an appeal if we don’t pay for a drug, item, or service you think you should be able to receive. Chapter 8 explains appeals, including the process involved in making an appeal.

Benefit Period – The way that Original Medicare measures your use of hospital and skilled nursing facility (SNF) services. A benefit period begins the day you go into a hospital or skilled nursing facility. The benefit period ends when you haven’t received any inpatient hospital care (or skilled care in a SNF) for 60 days in a row. If you go into a hospital or a skilled nursing facility after one benefit period has ended, a new benefit period begins. There is no limit to the number of benefit periods.

Brand Name Drug – A prescription drug that is manufactured and sold by the pharmaceutical company that originally researched and developed the drug. Brand name drugs have the same active-ingredient formula as the generic version of the drug. However, generic drugs are manufactured and sold by other drug manufacturers and are generally not available until after the patent on the brand name drug has expired.

Business Day – Monday through Friday, except days which the office of Community Care is closed.

Care Management – Individualized assessment and care planning, authorizing, arranging and coordinating services in the Member’s care plan. Care management also includes assistance in filing grievances and appeals, maintaining eligibility, accessing community resources and obtaining advocacy services.

Centers for Medicare & Medicaid Services (CMS) – The Federal agency that administers Medicare. Chapter 2 explains how to contact CMS.
**Coinsurance** – An amount you may be required to pay as your share of the cost for services or prescription drugs. Coinsurance is usually a percentage (for example, 20%).

**Complaint** — The formal name for “making a complaint” is “filing a grievance.” The complaint process is used for certain types of problems only. This includes problems related to quality of care, waiting times, and the customer service you receive. See also “Grievance,” in this list of definitions.

**Comprehensive Outpatient Rehabilitation Facility (CORF)** – A facility that mainly provides rehabilitation services after an illness or injury, and provides a variety of services including physical therapy, social or psychological services, respiratory therapy, occupational therapy and speech-language pathology services, and home environment evaluation services.

**Copayment (or “copay”)** – An amount you may be required to pay as your share of the cost for a medical service or supply, like a doctor’s visit, hospital outpatient visit, or a prescription drug. A copayment is a set amount, rather than a percentage. For example, you might pay $10 or $20 for a doctor’s visit or prescription drug.

**Coverage Determination** – A decision about whether a drug prescribed for you is covered by the plan and the amount, if any, you are required to pay for the prescription. In general, if you bring your prescription to a pharmacy and the pharmacy tells you the prescription isn’t covered under your plan, that isn’t a coverage determination. You need to call or write to your plan to ask for a formal decision about the coverage. Coverage determinations are called “coverage decisions” in this booklet. Chapter 8 explains how to ask us for a coverage decision.

**Covered Drugs** – The term we use to mean all of the prescription drugs covered by our plan.

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

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

**Custodial Care** – Custodial care is personal care provided in a nursing home, hospice, or other facility setting when you do not need skilled medical care or skilled nursing care. Custodial care is personal care that can be provided by people who don’t have professional skills or training, such as help with activities of daily living like bathing, dressing, eating, getting in or out of a bed or chair, moving around, and using the bathroom. It may also include the kind of health-related care that most people do themselves, like using eye drops. Medicare doesn’t pay for custodial care.

**Customer Service** – A department within our plan responsible for answering your questions about your membership, benefits, grievances, and appeals. See Chapter 2 for information about how to contact Customer Service.
Department of Health Services (DHS) – The department in the State of Wisconsin that runs the Medicaid programs, including Family Care and Family Care Partnership.

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

Dual Eligible Individual – A person who qualifies for Medicare and Medicaid coverage.

Durable Medical Equipment (DME) – Certain medical equipment that is ordered by your doctor for medical reasons. Examples include walkers, wheelchairs, crutches, powered mattress systems, diabetic supplies, IV infusion pumps, speech generating devices, oxygen equipment, nebulizers, or hospital beds ordered by a provider for use in the home.

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

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

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

Exception – A type of coverage determination that, if approved, allows you to get a drug that is not on your plan sponsor’s formulary (a formulary exception), or get a non-preferred drug at a lower cost-sharing level (a tiering exception). You may also request an exception if your plan sponsor requires you to try another drug before receiving the drug you are requesting, or the plan limits the quantity or dosage of the drug you are requesting (a formulary exception).

Extra Help – A Medicare program to help people with limited income and resources pay Medicare prescription drug program costs, such as premiums, deductibles, and coinsurance.

Functional Eligibility – An eligibility criteria for Family Care and Family Care Partnership programs determined by use of the Long-Term Care Functional Screen approved by the Wisconsin Department of Health Services.

Generic Drug – A prescription drug that is approved by the Food and Drug Administration (FDA) as having the same active ingredient(s) as the brand name drug. Generally, a “generic” drug works the same as a brand name drug and usually costs less.
**Grievance** - A type of complaint you make about us or one of our network providers or pharmacies, including a complaint concerning the quality of your care. This type of complaint does not involve coverage or payment disputes.

**Health Maintenance Organization (HMO)** - A type of managed care organization that is licensed by the Wisconsin Office of the Commissioner of Insurance (OCI) to provide care for enrolled members through a network of hospitals, doctors, and other contracted providers. In order to obtain a license the HMO must demonstrate the capacity for financial solvency and stability to OCI.

**HMO SNP** – See the definition of Special Needs Plan in this chapter.

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

**Home Health Care** – Skilled nursing care and certain other health care services that you get in your home for the treatment of an illness or injury. Covered services are listed in the Benefits Chart in Chapter 4. The Home Health Care covered by Medicare includes services provided by:

- Home health skilled nursing services;
- Home health aide services;
- Home health therapy services;
- Durable medical equipment (DME); and
- Disposable medical supplies (DMS)

The Home Health Care covered by Medicaid includes all of the Medicare-covered services listed above and also includes:

- Personal care;
- Supportive home care; and
- Skilled nursing services including private duty nursing.

If you need home health care services, our Plan will cover these services for you provided you receive them from network providers and any necessary prior authorization has been obtained from your Team.

**Hospice** – A member who has 6 months or less to live has the right to elect hospice. We, your plan, must provide you with a list of hospices in your geographic area. If you elect hospice and continue to pay premiums you are still a member of our plan. You can still obtain all medically necessary services as well as the supplemental benefits we offer. The hospice will provide special treatment for your state.

**Hospital Inpatient Stay** – A hospital stay when you have been formally admitted to the hospital for skilled medical services. Even if you stay in the hospital overnight, you might still be considered an “outpatient.”
**Income Maintenance Agency** – A sub-unit of a county or tribal government responsible for administering Income Maintenance (IM) Programs including Wisconsin Medicaid; formerly known as the Economic Support Agency.

**Income Related Monthly Adjustment Amount (IRMAA)** – If your income is above a certain limit, you will pay an income-related monthly adjustment amount in addition to your plan premium. For example, individuals with income greater than $85,000 and married couples with income greater than $170,000 must pay a higher Medicare Part B (medical insurance) and Medicare prescription drug coverage premium amount. This additional amount is called the income-related monthly adjustment amount. Less than 5% of people with Medicare are affected, so most people will not pay a higher premium.

**Initial Enrollment Period** – When you are first eligible for Medicare, the period of time when you can sign up for Medicare Part A and Part B. For example, if you’re eligible for Medicare when you turn 65, your Initial Enrollment Period is the 7-month period that begins 3 months before the month you turn 65, includes the month you turn 65, and ends 3 months after the month you turn 65.

**Interdisciplinary Team (Team)** – The Member and the individuals identified by the plan to provide care management services to a Member. Individuals assigned to a Team have specialized knowledge of the conditions of the populations served by the plan. The Team may use other people with appropriate additional specialized expertise when needed to assist in assessment, consultation, ongoing coordination efforts and other areas as needed.

**List of Covered Drugs (Formulary or “Drug List”)** – A list of prescription drugs covered by the plan. The drugs on this list are selected by the plan with the help of doctors and pharmacists. The list includes both brand name and generic drugs.

**Long-Term Care** – A variety of services that help people with health or personal needs and activities of daily living over a period of time. Long-term care can be provided at home, in the community or in various types of facilities, including nursing homes and assisted living facilities.

**Long-Term Care Functional Screen** – A uniform screening tool approved by the Wisconsin Department of Health Services to determine Functional Eligibility for the Family Care and Family Care Partnership program.

**Low Income Subsidy (LIS)** – See “Extra Help.”

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

**Medically Accepted Indication** – A use of a drug that is either approved by the Food and Drug Administration or supported by certain reference books. See Chapter 5, Section 3 for more information about a medically accepted indication.
Medically Necessary – Services, supplies, or drugs that are needed for the prevention, diagnosis, or treatment of your medical condition and meet accepted standards of medical practice and meet the following standards:

- Are consistent with the member’s symptoms or with prevention, diagnoses or treatment of the member’s illness, injury or disability;
- Are provided consistent with standards of acceptable quality of care applicable to the type of service, the type of provider and the setting in which the service is provided;
- Are appropriate with regard to generally accepted standards of medical practice;
- Are not medically contraindicated with regard to the member’s diagnoses, symptom, or other medically necessary services being provided to the member;
- Are of proven medical value or usefulness and, consistent with ch. HSS 107.035 Wis. Adm. Code, are not experimental in nature;
- Are not duplicative with respect to other services being provided to the member;
- Are not solely for the convenience of the member, the member’s family or a provider;
- With respect to prior authorization of a service and other prospective coverage determinations made by DHS, are cost-effective compared to an alternative medically necessary service which is reasonably accessible to the member; and,
- Are the most appropriate supply or level of services that can safely and effectively be provided to the member.

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

Medicare Advantage (MA) Plan – Sometimes called Medicare Part C. A plan offered by a private company that contracts with Medicare to provide you with all your Medicare Part A and Part B benefits. A Medicare Advantage Plan can be an HMO, PPO, a Private Fee-for-Service (PFFS) plan, or a Medicare Medical Savings Account (MSA) plan. When you are enrolled in a Medicare Advantage Plan, Medicare services are covered through the plan, and are not paid for under Original Medicare. In most cases, Medicare Advantage Plans also offer Medicare Part D (prescription drug coverage). These plans are called Medicare Advantage Plans with Prescription Drug Coverage. Everyone who has Medicare Part A and Part B is eligible to join any Medicare health plan that is offered in their area, except people with End-Stage Renal Disease (unless certain exceptions apply).

Medicare-Covered Services – Services covered by Medicare Part A and Part B. All Medicare health plans, including our plan, must cover all of the services that are covered by Medicare Part A and B.

Medicare Health Plan – A Medicare health plan is offered by a private company that contracts with Medicare to provide Part A and Part B benefits to people with Medicare who enroll in the plan. This term includes all Medicare Advantage Plans, Medicare Cost Plans, Demonstration/Pilot Programs, and Programs of All-inclusive Care for the Elderly (PACE).
Medicare Prescription Drug Coverage (Medicare Part D) – Insurance to help pay for outpatient prescription drugs, vaccines, biologicals, and some supplies not covered by Medicare Part A or Part B.

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

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

Member Rights Specialist – A plan staff member who helps and supports members in understanding all of their rights and responsibilities. The Member Rights Specialist also helps Members understand the grievance and appeal processes and may assist members who wish to submit a grievance or appeal.

Necessary Long-Term Care Services and Supports – Any service or support that is provided to assist a member to complete daily living activities, learn new skills, maintain a general sense of safety and well-being, or otherwise pursue a normal daily life rhythm, and that meets the following standards:

- Is consistent with the member’s comprehensive assessment and Member Centered Plan;
- Is provided consistent with standards of acceptable quality of care applicable to the type of service, the type of provider and the setting in which the service is provided;
- Is appropriate with regard to Department’s and MCO’s generally accepted standards of long-term care and support;
- Is not duplicative with respect to other services being provided to the member;
- With respect to prior authorization of a service and other prospective coverage determinations made by the MCO, is cost-effective compared to an alternative necessary long-term care service which is reasonably accessible to the member; and,
- Is the most appropriate supply or level of service that can safely and effectively be provided to the member.

Network Pharmacy – A network pharmacy is a pharmacy where members of our plan can get their prescription drug benefits. We call them “network pharmacies” because they contract with our plan. In most cases, your prescriptions are covered only if they are filled at one of our network pharmacies.

Network Provider – “Provider” is the general term we use for doctors, other health care professionals, hospitals, and other health care facilities that are licensed or certified by Medicare and by the State to provide health care services. We call them “network providers” when they have an agreement with our plan to accept our payment as payment in full, and in some cases to coordinate as well as provide covered services to members of our plan. Our plan pays network providers based on the agreements it has with the providers or if the providers agree to provide you with plan-covered services. Network providers may also be referred to as “plan providers.”
**Organization Determination** – The Medicare Advantage plan has made an organization determination when it makes a decision about whether items or services are covered or how much you have to pay for covered items or services. Organization determinations are called “coverage decisions” in this booklet. Chapter 8 explains how to ask us for a coverage decision.

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

**Outcome** – A desirable situation, condition, or circumstance in a Member’s life that can be a result of the support provided by effective care management.

**Out-of-Network Pharmacy** – A pharmacy that doesn’t have a contract with our plan to coordinate or provide covered drugs to members of our plan. As explained in this Evidence of Coverage, most drugs you get from out-of-network pharmacies are not covered by our plan unless certain conditions apply.

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

**PACE plan** – A PACE (Program of All-Inclusive Care for the Elderly) plan combines medical, social, and long-term care (LTC) services for frail people to help people stay independent and living in their community (instead of moving to a nursing home) as long as possible, while getting the high-quality care they need. People enrolled in PACE plans receive both their Medicare and Medicaid benefits through the plan.

**Part A** – Medicare Part A generally covers services furnished by providers such as hospitals, skilled nursing facilities or home health agencies.

**Part B** – Medicare Part B is for most other medical services, such as physician’s services and other outpatient services.

**Part C** – see “Medicare Advantage (MA) Plan.”

**Part D** – The voluntary Medicare Prescription Drug Benefit Program. (For ease of reference, we will refer to the prescription drug benefit program as Part D.)
Part D Drugs – Drugs that can be covered under Part D. We may or may not offer all Part D drugs. (See your formulary for a specific list of covered drugs.) Certain categories of drugs were specifically excluded by Congress from being covered as Part D drugs.

Premium – The periodic payment to Medicare, an insurance company, or a health care plan for health or prescription drug coverage. Primary Care Provider (PCP) – Your primary care provider is the doctor or other provider you see first for most health problems. He or she makes sure you get the care you need to keep you healthy. He or she also may talk with other doctors and health care providers about your care and refer you to them. In many Medicare health plans, you must see your primary care provider before you see any other health care provider. See Chapter 3, Section 2.1 for information about Primary Care Providers.

Prior Authorization – Approval in advance to get services or certain drugs that may or may not be on our formulary. Some in-network medical services are covered only if your doctor or other network provider gets “prior authorization” from our plan. Covered services that need prior authorization are marked in the Benefits Chart in Chapter 4. Some drugs are covered only if your doctor or other network provider gets “prior authorization” from us. Covered drugs that need prior authorization are marked in the formulary.

Prosthetics and Orthotics – These are medical devices ordered by your doctor or other health care provider. Covered items include, but are not limited to, arm, back and neck braces; artificial limbs; artificial eyes; and devices needed to replace an internal body part or function, including ostomy supplies and enteral and parenteral nutrition therapy.

Quality Improvement Organization (QIO) – A group of practicing doctors and other health care experts paid by the Federal government to check and improve the care given to Medicare patients. See Chapter 2, Section 4 for information about how to contact the QIO for your state.

Quantity Limits – A management tool that is designed to limit the use of selected drugs for quality, safety, or utilization reasons. Limits may be on the amount of the drug that we cover per prescription or for a defined period of time.

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

Service Area – A geographic area where a health plan accepts members if it limits membership based on where people live. For plans that limit which doctors and hospitals you may use, it’s also generally the area where you can get routine (non-emergency) services. The plan may disenroll you if you permanently move out of the plan’s service area.

Skilled Nursing Facility (SNF) Care – Skilled nursing care and rehabilitation services provided on a continuous, daily basis, in a skilled nursing facility. Examples of skilled nursing facility care include physical therapy or intravenous injections that can only be given by a registered nurse or doctor.
Special Needs Plan – A special type of Medicare Advantage Plan that provides more focused health care for specific groups of people, such as those who have both Medicare and Medicaid, who reside in a nursing home, or who have certain chronic medical conditions.

Step Therapy – A utilization tool that requires you to first try another drug to treat your medical condition before we will cover the drug your physician may have initially prescribed.

Supplemental Security Income (SSI) – A monthly benefit paid by Social Security to people with limited income and resources who are disabled, blind, or age 65 and older. SSI benefits are not the same as Social Security benefits.

Urgently Needed Services – Urgently needed services are provided to treat a non-emergency, unforeseen medical illness, injury, or condition that requires immediate medical care. Urgently needed services may be furnished by network providers or by out-of-network providers when network providers are temporarily unavailable or inaccessible.
Community Care Customer Service

<table>
<thead>
<tr>
<th>Method</th>
<th>Customer Service – Contact Information</th>
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<tbody>
<tr>
<td>CALL</td>
<td>1-866-992-6600-</td>
</tr>
<tr>
<td></td>
<td>Calls to this number are free. You can call 24 hours a day, 7 days a week. Customer Service also has free language interpreter services available for non-English speakers.</td>
</tr>
<tr>
<td>TTY</td>
<td>Call the Wisconsin Relay System at 711</td>
</tr>
<tr>
<td></td>
<td>This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.</td>
</tr>
<tr>
<td></td>
<td>Calls to this number are free. You can call 24 hours a day, 7 days a week.</td>
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<tr>
<td>WRITE</td>
<td>205 Bishops Way</td>
</tr>
<tr>
<td></td>
<td>Brookfield, WI 53005</td>
</tr>
<tr>
<td>WEBSITE</td>
<td><a href="http://www.communitycareinc.org">www.communitycareinc.org</a></td>
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</table>

The Wisconsin State Health Insurance Assistance Program

The State Health Insurance Assistance Program is a state program that gets money from the Federal government to give free local health insurance counseling to people with Medicaid.

<table>
<thead>
<tr>
<th>CALL</th>
<th>Wisconsin Board on Aging &amp; Long-term Care</th>
<th>(800) 242-1060</th>
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<tbody>
<tr>
<td></td>
<td>Medigap Part D Prescription Drug Helpline operated by the Coalition of Wisconsin Aging Groups primarily for persons age 60 and older</td>
<td>(855) 677-2783</td>
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<tr>
<td></td>
<td>Disability Drug Benefit Helpline operated by Disability Rights Wisconsin, primarily for persons under age 60 eligible for Medicare because of a disability</td>
<td>(800) 926-4862</td>
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<tr>
<td></td>
<td>Office for the Deaf and Hard of Hearing for persons who are deaf or hard of hearing and use sign language as their primary language.</td>
<td>Wisconsin Relay System at 711</td>
</tr>
<tr>
<td>WEB SITE</td>
<td><a href="http://www.dhs.wisconsin.gov/aging/EBS/ship.htm">http://www.dhs.wisconsin.gov/aging/EBS/ship.htm</a></td>
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Community Care is a private, non-profit organization that integrates health care and well-being services to provide the wider range of help that seniors and adults with disabilities need. In business since 1977, our services allow people to continue living independently, in their own homes and communities.

The Community Care Family Care Partnership Program (HMO SNP) is a Coordinated Care Plan with a Medicare Advantage Contract and a contract with the Wisconsin Department of Health Services for the Medicaid Program. Enrollment in Community Care depends on contract renewal. Enrollment is available to anyone who has both Medical Assistance from the State and Medicare and is functionally eligible as determined by the Wisconsin Long-Term Care Functional Screen.