

2026

# Evidence of Coverage

## **iCare Family Care Partnership (HMO D-SNP)**

This is a Fully Integrated Dual Eligible (FIDE) Special Needs Plan.

Wisconsin

Eastern and South Central Wisconsin



INDEPENDENT CARE HEALTH PLAN  
iCare is a wholly-owned subsidiary of Humana

January 1, 2026–December 31, 2026

## Your Medicare and Medicaid Health and Drug Coverage under iCare Family Care Partnership (HMO D-SNP)

### ***Evidence of Coverage* Introduction**

This *Evidence of Coverage* tells you about your coverage under our plan through December 31, 2026. It explains health care services, drug coverage, and long-term services and supports. Key terms and their definitions appear in alphabetical order in **Chapter 12** of this *Evidence of Coverage*.

**This is an important legal document. Keep it in a safe place.**

This plan is offered by Independent Care Health Plan (iCare), a wholly-owned subsidiary of Humana. When this *Evidence of Coverage* says “we”, “us”, “our”, or “our plan”, it means iCare Family Care Partnership.

This document is available for free translation into your written language.

You can get this document for free in other formats, such as large print, braille, and/or audio by calling Customer Care at the number at the bottom of this page. The call is free.

Once we receive your alternative format request, all future state mandated communications will be provided in your chosen format. If we are unable to provide printed materials within your requested format, then the member will receive those communications over the phone with an interpreter.

If you want to change your standing request, call Customer Care at 1-800-777-4376 (TTY: 711) to have your request updated. Please note: we can only accommodate standing requests for alternate formats.

OMB Approval 0938-1444 (Expires: June 30, 2026)



**If you have questions**, please call iCare Family Care Partnership at 1-800-777-4376 (TTY: 711), 24 hours a day, 7 days a week. The call is free. **For more information**, visit [www.icarehealthplan.org](http://www.icarehealthplan.org).

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## Disclaimers

- iCare Family Care Partnership is a Dual Eligible Special Needs HMO SNP plan with a Medicare contract and a contract with the state Medicaid program. Enrollment in iCare Family Care Partnership depends on iCare's contract renewal.
- Benefits and/or copayments may change on January 1, 2027.
- Our covered drugs, pharmacy network, and/or provider network may change at any time. You'll get a notice about any changes that may affect you at least 30 days in advance.



**If you have questions**, please call iCare Family Care Partnership at 1-800-777-4376 (TTY: 711), 24 hours a day, 7 days a week. The call is free. **For more information**, visit [www.icarehealthplan.org](http://www.icarehealthplan.org).

# Chapter 1: Getting started as a member

## Introduction

This chapter includes information about iCare Family Care Partnership, a health plan that coordinates all of your Medicare and Family Care Partnership services, and your membership in it. It also tells you what to expect and what other information you'll get from us. Key terms and their definitions appear in alphabetical order in the last chapter of this *Evidence of Coverage*.

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**If you have questions**, please call iCare Family Care Partnership at 1-800-777-4376 (TTY: 711), 24 hours a day, 7 days a week. The call is free. **For more information**, visit [www.icarehealthplan.org](http://www.icarehealthplan.org).

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## A. Welcome to our plan

Our plan provides Medicare and Family Care Partnership services to individuals who are eligible for both programs. Our plan includes doctors, hospitals, pharmacies, providers of long-term services and supports, behavioral health providers, and other providers. We also have care managers and care teams to help you manage your providers and services. They all work together to provide the care you need.

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## B. Information about Medicare and Family Care Partnership

### B1. Medicare

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).

### B2. Family Care Partnership

Family Care Partnership is the name of Wisconsin Medicaid program. Family Care Partnership is run by the state and is paid for by the state and the federal government. Family Care Partnership helps people with limited incomes and resources pay for Long-Term Services and Supports (LTSS) and medical costs. It covers extra services and drugs not covered by Medicare.

Each state decides:

- what counts as income and resources,
- who is eligible,
- what services are covered, **and**
- the cost for services.

States can decide how to run their programs, as long as they follow the federal rules.

Medicare and the state of Wisconsin approved our plan. You can get Medicare and Family Care Partnership services through our plan as long as:

- we choose to offer the plan, **and**
- Medicare and the state of Wisconsin allow us to continue to offer this plan.

Even if our plan stops operating in the future, your eligibility for Medicare and Family Care Partnership services isn't affected.

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## C. Advantages of our plan

You'll now get all your covered Medicare and Family Care Partnership services from our plan, including drugs.

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**If you have questions**, please call iCare Family Care Partnership at 1-800-777-4376 (TTY: 711), 24 hours a day, 7 days a week. The call is free. **For more information**, visit [www.icarehealthplan.org](http://www.icarehealthplan.org).

### **You don't pay extra to join this health plan.**

We help make your Medicare and Medicaid benefits work better together and work better for you. Some of the advantages include:

- You can work with us for **most** of your health care needs.
- You will have a care team that you help put together. Your care team may include yourself, your caregiver, doctors, nurses, counselors, or other health professionals.
- You have access to a care manager. This is a person who works with you, with our plan, and with your care team to help make a care plan.
- You're able to direct your own care with help from your care team and care coordinator.
- Your care team and care manager work with you to make a care plan designed to meet **your** health needs. The care team helps coordinate the services you need. For example, this means that your care team makes sure:
  - Your doctors know about all the medicines you take so they can make sure you're taking the right medicines and can reduce any side effects that you may have from the medicines.
  - Your test results are shared with all of your doctors and other providers, as appropriate.

**New members to iCare Family Care Partnership (HMO D-SNP):** In most instances you'll be enrolled in iCare Family Care Partnership (HMO D-SNP) for your Medicare benefits the 1st day of the month after you request to be enrolled in iCare Family Care Partnership (HMO D-SNP). You may still receive your Wisconsin Medicaid from your previous Wisconsin Medicaid health plan for one additional month. After that, you'll receive your Wisconsin Medicaid services through iCare Family Care Partnership (HMO D-SNP). There will be no gap in your Wisconsin Medicaid coverage. Please call us at the number at the bottom of the page if you have any questions.

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## **D. Our plan's service area**

Our service area includes these counties in Wisconsin: Adams, Columbia, Dane, Dodge, Green Lake, Jefferson, Kenosha, Marquette, Milwaukee, Racine, Rock, Sauk, and Waushara.

Only people who live in our service area can join our plan.

You can't stay in our plan if you move outside of our service area. Refer to **Chapter 8** of this *Evidence of Coverage* for more information about the effects of moving out of our service area.

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## **E. What makes you eligible to be a plan member**

You are eligible for our plan as long as you:

- live in our service area (incarcerated individuals aren't considered living in the service area even if they're physically located in it), **and**
- have both Medicare Part A and Medicare Part B, **and**
- are a United States citizen or are lawfully present in the United States, **and**



**If you have questions**, please call iCare Family Care Partnership at 1-800-777-4376 (TTY: 711), 24 hours a day, 7 days a week. The call is free. **For more information**, visit [www.icarehealthplan.org](http://www.icarehealthplan.org).

- are currently eligible for Family Care Partnership.

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're eligible for membership in our plan as long as you meet the special eligibility requirements for the Family Care Partnership program described below:

- You must be enrolled in the Family Care Partnership program with Independent Care Health Plan (iCare) as your Managed Care Organization (MCO), **and**
- Are at least 18 years old, **and**
- Are a frail elder or an adult with physical or developmental disabilities, **and**
- Are a resident of Adams, Columbia, Dane, Dodge, Green Lake, Jefferson, Kenosha, Marquette, Milwaukee, Racine, Rock, Sauk, and Waushara counties, Wisconsin (**Section 2.3** below describes our service area), **and**
- Are functionally eligible as determined via the Wisconsin Adult Long-term Care Functional Screen, **and**
- Are enrolled in Medicare Parts A, B, and D, **and**
- You may have a monthly "Cost Share" that you must pay to remain eligible for Wisconsin Medicaid and iCare Family Care Partnership. Your county Income Maintenance agency determines your Cost Share amount. Call Customer Care for more information (see **Chapter 2** for listing of phone numbers).

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## F. What to expect when you first join our health plan

When you first join our plan, you get a health risk assessment (HRA), referred to as the comprehensive assessment, within 90 days before or after your enrollment effective date.

We must complete a comprehensive assessment with you. This comprehensive assessment is the basis for developing your care plan. The comprehensive assessment includes questions to identify your medical, behavioral health, and functional needs.

We reach out to you to complete the comprehensive assessment. We complete the comprehensive assessment during an in-person visit.

We'll send you more information about this comprehensive assessment.

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## G. Your care team and care plan

### G1. Care team

A care team can help you keep getting the care you need. A care team may include your doctor, a care manager, or other health person that you choose.

A care manager is a person trained to help you manage the care you need. You get a care manager when



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you enroll in our plan. This person also refers you to other community resources that our plan may not provide and will work with your care team to help coordinate your care.

Call us at the numbers at the bottom of the page for more information about your care manager and care team.

## G2. Care plan

Your care team works with you to make a care plan following the completion of a comprehensive assessment. A care plan tells you and your doctors what services you need and how to get them. It includes your medical, behavioral health, and LTSS or other services.

Your care plan includes:

- your physical health needs and your ability to do certain tasks and activities (such as eating and dressing),
- your strengths and preferences,
- identified risks through the comprehensive assessment process, conversations you and/or caregiver and/or risk identified via review of the member record
- your personal experience and long-term care outcomes,
- the services you'll receive,
- who'll provide you with each service,
- the things you're going to do yourself or with help from family, friends, or other resources in your community,
- your health care goals including healthcare preferences such as care management interventions related to medication reviews, care transitions, health education and prevention and screening services **and**
- a timeline for getting the services you need.

Your care team meets with you after your comprehensive assessment. They ask you about services you need. They also tell you about services you may want to think about getting. Your care plan is created based on your needs and goals. Your care team works with you to update your care plan at least every year.

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## H. Summary of important costs

Your costs may include the following:

- Plan premium (**Section H1**)
- Monthly Medicare Part B Premium (**Section H2**)
- Medicare Prescription Payment Plan Amount (**Section H4**)

**In some situations, your plan premium could be less.**



**If you have questions**, please call iCare Family Care Partnership at 1-800-777-4376 (TTY: 711), 24 hours a day, 7 days a week. The call is free. **For more information**, visit [www.icarehealthplan.org](http://www.icarehealthplan.org).

There are programs to help people with limited resources pay for their drugs. These include “Extra Help” and State Pharmaceutical Assistance Programs (SPAPs). Learn more about these programs in **Chapter 2, Section H2**. If you qualify, enrolling in the program might lower your monthly plan premium.

If you already get help from one of these programs, **the information about premiums in this Evidence of Coverage does not apply to you**. We sent you a separate insert, called the “Evidence of Coverage Rider for People Who Get Extra Help Paying for Prescription Drugs” (also known as the “Low Income Subsidy Rider” or the “LIS Rider”), which tells you about your drug coverage. If you don’t have this insert, please call Customer Care at the number at the bottom of this page and ask for the “LIS Rider”.

## H1. Plan Premium

You do not pay a separate monthly plan premium for iCare Family Care Partnership.

## H2. Monthly Medicare Part B Premium

### Many members are required to pay other Medicare premiums

Some members are required to pay other Medicare premiums. As explained in **Section E** above to be eligible for our plan, you must maintain your eligibility for Medicaid as well as have both Medicare Part A and Medicare Part B. For most iCare Family Care Partnership members, Medicaid pays for your Medicare Part A premium (if you don’t qualify for it automatically) and Part B premium.

**If Medicaid isn’t paying your Medicare premiums for you, you must continue to pay your Medicare premiums to stay a member of our plan.** This includes your premium for Medicare Part B. You may also pay a premium for Medicare Part A if you aren’t eligible for premium-free Medicare Part A. **In addition, please contact Customer Care or your care manager and inform them of this change.**

## H3. Medicare Prescription Payment Amount

If you’re participating in the Medicare Prescription Payment Plan, you’ll get a bill from your plan for your drugs (instead of paying the pharmacy). Your monthly bill is based on what you owe for any prescriptions you get, plus your previous month’s balance, divided by the number of months left in the year.

**Chapter 2** tells more about the Medicare Prescription Payment Plan. If you disagree with the amount billed as part of this payment option, you can follow the steps in **Chapter 9** to make a complaint or appeal.

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## I. This Evidence of Coverage

This *Evidence of Coverage* is part of our contract with you. This means that we must follow all rules in this document. If you think we’ve done something that goes against these rules, you may be able to appeal our decision. For information about appeals, refer to **Chapter 9** of this *Evidence of Coverage* or call 1-800-MEDICARE (1-800-633-4227).

You can ask for an *Evidence of Coverage* by calling Customer Care at the numbers at the bottom of the page. You can also refer to the *Evidence of Coverage* found on our website.

The contract is in effect for the months you’re enrolled in our plan between January 1 and December 31, 2026.



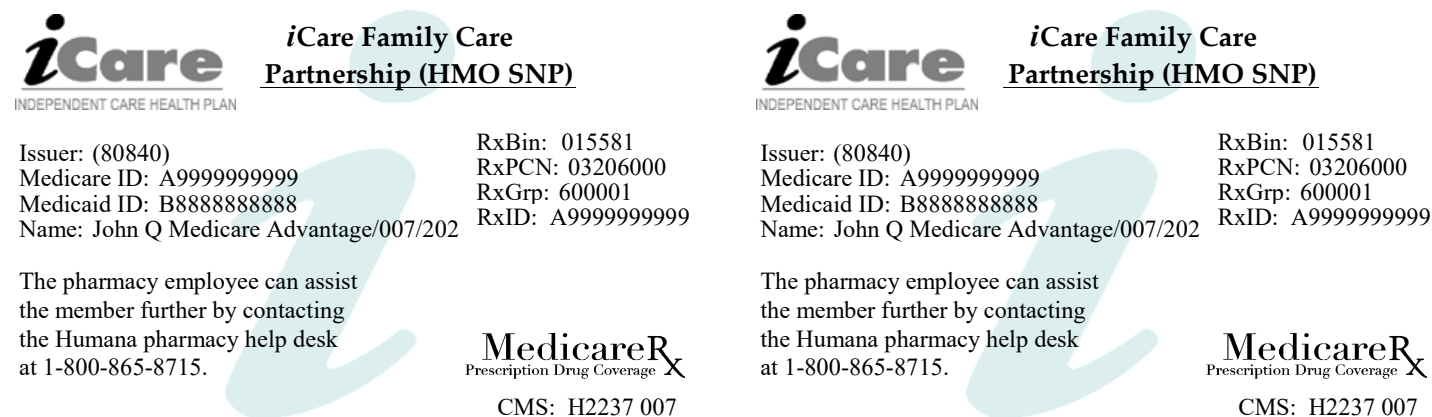
**If you have questions**, please call iCare Family Care Partnership at 1-800-777-4376 (TTY: 711), 24 hours a day, 7 days a week. The call is free. **For more information**, visit [www.icarehealthplan.org](http://www.icarehealthplan.org).

## J. Other important information you get from us

Other important information we provide to you includes your Member ID Card, information about how to access a *Provider and Pharmacy Directory*, and information about how to access a *List of Covered Drugs*, also known as a *Drug List* or *Formulary*.

### J1. Your Member ID Card

Under our plan, you have one card for your Medicare and Family Care Partnership services, including LTSS, certain behavioral health services, and prescriptions. You show this card when you get any services or prescriptions. Here is a sample Member ID Card:



If your Member ID Card is damaged, lost, or stolen, call Customer Care at the number at the bottom of the page right away. We'll send you a new card.

As long as you're a member of our plan, you don't need to use your red, white, and blue Medicare card or your ForwardHealth card to get most services. Keep those cards in a safe place, in case you need them later. If you show your Medicare card instead of your Member ID Card, the provider may bill Medicare instead of our plan, and you may get a bill. You may be asked to show your Medicare card if you need hospital services, hospice services, or participate in Medicare-approved clinical research studies (also called clinical trials). Refer to **Chapter 7** of this *Evidence of Coverage* to find out what to do if you get a bill from a provider.

### J2. Provider and Pharmacy Directory

The *Provider and Pharmacy Directory* lists the providers and pharmacies in our plan's network. While you're a member of our plan, you must use network providers to get covered services.

You can ask for a *Provider and Pharmacy Directory* (electronically or in hard copy form) by calling Customer Care at the number at the bottom of the page. Requests for hard copy *Provider and Pharmacy Directories* will be mailed to you within three business days. You can also refer to the *Provider and Pharmacy Directory* at <https://www.icarehealthplan.org/Find-a-Provider.htm>. This lists our current network providers, pharmacies, and durable medical equipment suppliers. The directory also includes participating Medicaid providers.

### Definition of network providers

- Our network providers include:



If you have questions, please call iCare Family Care Partnership at 1-800-777-4376 (TTY: 711), 24 hours a day, 7 days a week. The call is free. For more information, visit [www.icarehealthplan.org](https://www.icarehealthplan.org).

- doctors, nurses, and other health care professionals that you can use as a member of our plan;
- clinics, hospitals, nursing facilities, and other places that provide health services in our plan; **and**
- LTSS, behavioral health services, home health agencies, durable medical equipment (DME) suppliers, and others who provide goods and services that you get through Medicare or Medicaid.

Network providers have agreed to accept payment from our plan for covered services as payment in full.

### Definition of network pharmacies

- Network pharmacies are pharmacies that agree to fill prescriptions for our plan members. Use the *Provider and Pharmacy Directory* to find the network pharmacy you want to use.
- Except during an emergency, you must fill your prescriptions at one of our network pharmacies if you want our plan to help you pay for them.

Call Customer Care at the number at the bottom of the page for more information. Both Customer Care and our website can give you the most up-to-date information about changes in our network pharmacies and providers.

### J3. List of Covered Drugs

Our plan has a *List of Covered Drugs*. We call it the *Drug List* for short. It tells you which drugs our plan covers. The drugs on this list are selected by our plan with the help of doctors and pharmacists. The *Drug List* must meet Medicare's requirements. Drugs with negotiated prices under the Medicare Drug Price Negotiation Program will be included on your *Drug List* unless they have been removed and replaced as described in **Chapter 5, Section E**. Medicare approved the Family Care Partnership *Drug List*.

The *Drug List* also tells you if there are any rules or restrictions on any drugs, such as a limit on the amount you can get. Refer to **Chapter 5** of this *Evidence of Coverage* for more information.

Each year, we send you a copy of the *Drug List*, but some changes may occur during the year. To get the most up-to-date information about which drugs are covered, call Customer Care or visit our website at the address at the bottom of the page.

### J4. The Explanation of Benefits

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

The *SmartSummary* tells you the total amount you, or others on your behalf, spent on your Medicare Part D drugs and the total amount we paid for each of your Medicare Part D drugs during the month. This *SmartSummary* isn't a bill. The *SmartSummary* has more information about the drugs you take such as increases in price and other drugs with lower cost sharing that may be available. You can talk to your prescriber about these lower cost options. **Chapter 6** of this *Evidence of Coverage* gives more information about the *SmartSummary* and how it helps you track your drug coverage.

You can also ask for an *SmartSummary*. To get a copy, contact Customer Care at the number at the bottom of the page.



**If you have questions**, please call iCare Family Care Partnership at 1-800-777-4376 (TTY: 711), 24 hours a day, 7 days a week. The call is free. **For more information**, visit [www.icarehealthplan.org](http://www.icarehealthplan.org).

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## K. Keeping your membership record up to date

You can keep your membership record up to date by telling us when your information changes.

We need this information to make sure that we have your correct information in our records. The doctors, hospitals, pharmacists, and other providers in our plan's network use your membership record to know what services and drugs are covered and your cost sharing amounts. Because of this, it's very important to help us keep your information up to date.

Tell us right away about the following:

- changes to your name, address, or phone number;
- changes to any other health insurance coverage, such as from your employer, your spouse's employer, or your domestic partner's employer, or workers' compensation;
- any liability claims, such as claims from an automobile accident;
- admission to a nursing facility or hospital;
- care from a hospital or emergency room;
- changes in your caregiver (or anyone responsible for you); **and**
- you participate in a clinical research study. (**Note:** You're not required to tell us about a clinical research study you intend to participate in, but we encourage you to do so.)

If any information changes, call Customer Care at the number at the bottom of the page.

It's 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** of this *Evidence of Coverage*.

You should also call your county's income maintenance agency directly to report changes to the State program. See **Chapter 2, Section 9** of this *Evidence of Coverage* for contact information.

### K1. Privacy of personal health information (PHI)

Information in your membership record may include personal health information (PHI). Federal and state laws require that we keep your PHI private. We protect your PHI. For more details about how we protect your PHI, refer to **Chapter 8** of this *Evidence of Coverage*.



**If you have questions**, please call iCare Family Care Partnership at 1-800-777-4376 (TTY: 711), 24 hours a day, 7 days a week. The call is free. **For more information**, visit [www.icarehealthplan.org](http://www.icarehealthplan.org).

# Chapter 2: Important phone numbers and resources

## Introduction

This chapter gives you contact information for important resources that can help you answer your questions about our plan and your health care benefits. You can also use this chapter to get information about how to contact your care manager and others to advocate on your behalf. Key terms and their definitions appear in alphabetical order in the last chapter of this *Evidence of Coverage*.

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## A. Customer Care

<b>CALL</b>	1-800-777-4376. This call is free.  We are available 24 hours a day, 7 days a week. Our office hours are Monday – Friday, 8:30 a.m. – 5:00 p.m.  We have free interpreter services for people who don’t speak English.
<b>TTY</b>	1-800-947-3529 or 711 (Wisconsin Relay) This call is free.
<b>FAX</b>	1-414-231-1092
<b>WRITE</b>	1555 North RiverCenter Drive Suite 206 Milwaukee, Wisconsin 53212
<b>EMAIL</b>	info@icarehealthplan.org
<b>WEBSITE</b>	www.icarehealthplan.org

Contact Customer Care to get help with:

- questions about the plan
- questions about claims or billing
- coverage decisions about your health care
  - A coverage decision about your health care is a decision about:
    - your benefits and covered services, **or**
    - the amount we pay for your health services.
  - Call us if you have questions about a coverage decision about health care.
  - To learn more about coverage decisions, refer to **Chapter 9** of this *Evidence of Coverage*.
- appeals about your health care
  - An appeal is a formal way of asking us to review a decision we made about your coverage and asking us to change it if you think we made a mistake or disagree with the decision.
  - To learn more about making an appeal, refer to **Chapter 9** of this *Evidence of Coverage* or contact Customer Care.
- complaints about your health care
  - You can make a complaint about us or any provider (including a non-network or network provider). A network provider is a provider who works with our plan. You can also make a complaint to us or to the



**If you have questions**, please call iCare Family Care Partnership at 1-800-777-4376 (TTY: 711), 24 hours a day, 7 days a week. The call is free. **For more information**, visit [www.icarehealthplan.org](http://www.icarehealthplan.org).

Quality Improvement Organization (QIO) about the quality of the care you received (refer to **Section F**).

- You can call us and explain your complaint at 1-800-777-4376.
- If your complaint is about a coverage decision about your health care, you can make an appeal (refer to the section above).
- You can send a complaint about our plan to Medicare. You can use an online form at [www.medicare.gov/my/medicare-complain](http://www.medicare.gov/my/medicare-complain). Or you can call 1-800- MEDICARE (1-800-633-4227) to ask for help.
- Your Care 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 isn't connected with us. You can always contact MetaStar, the state's Quality Improvement Organization. For more information refer to **Section D**. They can answer your questions, give you more information, and offer guidance on what to do. Their services are free.

DHS Family Care Grievances MetaStar  
2909 Landmark Place  
Madison, WI 53713  
Phone: 1-888-203-8338  
Fax: 1-608-274-8340  
Email: [dhsfamcare@dhs.wisconsin.gov](mailto:dhsfamcare@dhs.wisconsin.gov)

- You can also call your Ombudsman Program. The Wisconsin Department of Health Services has arrangements with Disability Rights Wisconsin (for members ages 18 to 59) and the Wisconsin Board on Aging and Long-term Care (for members aged 60 and over) to offer ombudsman assistance free of charge. See **Section G** for information on how to contact your Ombudsman Program.
- To learn more about making a complaint about your health care, refer to **Chapter 9** of this *Evidence of Coverage*.
- coverage decisions about your drugs
  - A coverage decision about your drugs is a decision about:
    - your benefits and covered drugs or
    - the amount we pay for your drugs.
  - This applies to your Medicare Part D drugs.
  - For more on coverage decisions about your drugs, refer to **Chapter 9** of this *Evidence of Coverage*.
- appeals about your drugs
  - An appeal is a way to ask us to change a coverage decision.
  - For more on making an appeal about your drugs, refer to **Chapter 9** of this *Evidence of Coverage*.
- complaints about your drugs
  - You can make a complaint about us or any pharmacy. This includes a complaint about your drugs.
  - If your complaint is about a coverage decision about your drugs, you can make an appeal. (Refer to the section above.)



**If you have questions**, please call iCare Family Care Partnership at 1-800-777-4376 (TTY: 711), 24 hours a day, 7 days a week. The call is free. **For more information**, visit [www.icarehealthplan.org](http://www.icarehealthplan.org).



- You can send a complaint about our plan to Medicare. You can use an online form at [www.medicare.gov/my/medicare-complaint](http://www.medicare.gov/my/medicare-complaint). Or you can call 1-800- MEDICARE (1-800-633-4227) to ask for help.
- For more on making a complaint about your drugs, refer to **Chapter 9** of this *Evidence of Coverage*.
- payment for health care or drugs you already paid for
  - For more on how to ask us to pay you back, or to pay a bill you got, refer to **Chapter 7** of this *Evidence of Coverage*.
  - If you ask us to pay a bill and we deny any part of your request, you can appeal our decision. Refer to **Chapter 9** of this *Evidence of Coverage*.

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## B. Your Care Manager

With iCare Family Care Partnership, you have a whole care team to work with to help support meeting your health needs and goals. This service is part of this plan and there is no cost to you.

You are key to your care team and will be able to visit with your own personal care manager by telephone.

In-person visits occur quarterly with members in the Family Care Partnership program and are required to be conducted in the members' residence annually at a minimum. Your care manager will work with you and any family members or other caregivers you choose. Your care manager can help you stay healthy by making sure that you and your providers work together to meet all of your health care needs. We are here to help you understand and follow their treatment plan and instructions. Working with you, your care manager may also involve other health professionals like nurses, social workers, long term service and behavioral health specialists – this is your care team.

Our care managers are here to help keep you safe and healthy. For example, your care manager may:

- Support you in finding ways to manage your health
- Answer your health questions
- Work with you and your doctors to develop a care plan that meets all your needs
- Help you make sure you have all your medicines and know how to take them
- Support you if you have chronic conditions such as diabetes, heart disease and other illnesses
- Support your health goals and help you reach them
- Help connect you with community services where you live
- Provide care support after a hospitalization
- Help you return to the community after a nursing home or inpatient stay
- Develop a crisis plan to help keep you safe in times of emergency
- Make your home safer for you to stay in

Refer to the chart below to contact your care manager. If you do not yet have one, ask for one by using the same chart.



**If you have questions**, please call iCare Family Care Partnership at 1-800-777-4376 (TTY: 711), 24 hours a day, 7 days a week. The call is free. **For more information**, visit [www.icarehealthplan.org](http://www.icarehealthplan.org).

<b>CALL</b>	1-800-777-4376. This call is free.  We are available 24 hours a day, 7 days a week. Our office hours are Monday – Friday, 8:30 a.m. – 5:00 p.m.  We have free interpreter services for people who don’t speak English.
<b>TTY</b>	1-800-947-3529 or 711 (Wisconsin Relay) This call is free.  This number is for people who have difficulty with hearing or speaking. You must have special telephone equipment to call it.
<b>FAX</b>	1-414-231-1092
<b>WRITE</b>	1555 North RiverCenter Drive Suite 206 Milwaukee, Wisconsin 53212
<b>EMAIL</b>	<a href="mailto:info@icarehealthplan.org">info@icarehealthplan.org</a>
<b>WEBSITE</b>	<a href="http://www.icarehealthplan.org">www.icarehealthplan.org</a>

Contact your care manager to get help with:

- questions about your health care
- questions about getting behavioral health (mental health and substance use disorder) services
- questions about transportation
- questions about long-term care services and supports as listed in **Chapter 4**.

## C. Wisconsin State Health Insurance Program

The State Health Insurance Assistance Program (SHIP) is a government program with trained counselors in every state that offers free help, information, and answers to your Medicare questions. In Wisconsin, the SHIP is called the Medigap Helpline. This is a toll-free helpline run by the Wisconsin Board on Aging and Long-term Care to offer SHIP services to you.

The Wisconsin State Health Insurance Assistance Program is an independent state program (not connected with any insurance company or health plan) that gets money from the federal government to give free local health insurance counseling to people with Medicare.

<b>CALL</b>	The Medigap Helpline 1-800-242-1060
<b>TTY</b>	711



**If you have questions**, please call iCare Family Care Partnership at 1-800-777-4376 (TTY: 711), 24 hours a day, 7 days a week. The call is free. **For more information**, visit [www.icarehealthplan.org](http://www.icarehealthplan.org).

<b>WRITE</b>	1402 Pankratz Street #111 Madison, WI 53704
<b>WEBSITE</b>	<a href="http://www.longtermcare.wi.gov/Pages/Medigap/Medigap.aspx">www.longtermcare.wi.gov/Pages/Medigap/Medigap.aspx</a>

Contact the Medigap Helpline for help with:

- questions about Medicare
- SHIP counselors can answer your questions about changing to a new plan and help you:
  - understand your rights,
  - understand your plan choices,
  - answer questions about switching plans,
  - make complaints about your health care or treatment, **and**
  - straighten out problems with your bills.

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## D. Quality Improvement Organization (QIO)

Our state has an organization called MetaStar. This is a group of doctors and other health care professionals who help improve the quality of care for people with Medicare and Medicaid. MetaStar is an independent organization. It's not connected with our plan.

<b>CALL</b>	1-888-203-8338
<b>TTY</b>	711
<b>WEBSITE</b>	<a href="http://metastar.com/">metastar.com/</a>

Contact MetaStar for help with:

- questions about your health care rights
- making a complaint about the care you got if you:
  - have a problem with the quality of care such as getting the wrong medication, unnecessary tests or procedures, or a misdiagnosis,
  - think your hospital stay is ending too soon, **or**
  - think your home health care, skilled nursing facility care, or comprehensive outpatient rehabilitation facility (CORF) services are ending too soon.

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## E. Medicare

Medicare is the federal health insurance program for people 65 years of age or over, some people under age



**If you have questions**, please call iCare Family Care Partnership at 1-800-777-4376 (TTY: 711), 24 hours a day, 7 days a week. The call is free. **For more information**, visit [www.icarehealthplan.org](http://www.icarehealthplan.org).

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, or CMS. This agency contracts with Medicare Advantage organizations including our plan.

<b>CALL</b>	1-800-MEDICARE (1-800-633-4227) Calls to this number are free, 24 hours a day, 7 days a week.
<b>TTY</b>	1-877-486-2048. This call is free. This number is for people who have difficulty with hearing or speaking. You must have special telephone equipment to call it.
<b>CHAT LIVE</b>	Chat live at <a href="http://www.Medicare.gov/talk-to-someone">www.Medicare.gov/talk-to-someone</a>
<b>WRITE</b>	Write to Medicare at PO Box 1270, Lawrence, KS 66044
<b>WEBSITE</b>	<a href="http://www.medicare.gov">www.medicare.gov</a> <ul style="list-style-type: none"> <li>• Get information about the Medicare health and drug plans in your area, including what they cost and what services they provide.</li> <li>• Find Medicare-participating doctors or other health care providers and suppliers.</li> <li>• Find out what Medicare covers, including preventative services (like screenings, shots, or vaccines, and yearly “wellness” visits).</li> <li>• Get Medicare appeals information and forms.</li> <li>• Get information about the quality of care provided by plans, nursing homes, hospitals, doctors, home health agencies, dialysis facilities, hospice centers, inpatient rehabilitation facilities, and long-term care hospitals.</li> <li>• Look up helpful websites and phone numbers.</li> </ul> <p>To submit a complaint to Medicare, go to <a href="http://www.medicare.gov/my/medicare-complaint">www.medicare.gov/my/medicare-complaint</a>. Medicare takes your complaints seriously and will use this information to help improve the quality of the Medicare program.</p>

## F. ForwardHealth

ForwardHealth helps with medical and long-term services and supports costs for people with limited incomes and resources.

You’re enrolled in Medicare and in Medicaid. If you have questions about the help you get from Medicaid, call ForwardHealth Customer Care.

**All Medicaid applicants and members can use ACCESS.** ACCESS is a website ([www.access.wi.gov](http://www.access.wi.gov)) that you



**If you have questions**, please call iCare Family Care Partnership at 1-800-777-4376 (TTY: 711), 24 hours a day, 7 days a week. The call is free. **For more information**, visit [www.icarehealthplan.org](http://www.icarehealthplan.org).

can use to:

- see which programs can help you,
- apply for benefits,
- check your benefits,
- report changes,
- renew your benefits, **and**
- get a new ForwardHealth Card.

**You can call ForwardHealth Customer Care to get:**

- general information about Medicaid, **and**
- a new ForwardHealth Card.

**You can contact your local county or tribal agency to:**

- Ask questions about enrollment rules for BadgerCare Plus, Medicaid, or FoodShare;
- Find out if your application was approved or why it was denied;
- Report changes to your information (for example, a change in address, a job, or health care); **and**
- Send proof of eligibility.

To get the address and phone number of your agency, call 1-800-362-3002 or visit [www.dhs.wisconsin.gov/forwardhealth/imagency](http://www.dhs.wisconsin.gov/forwardhealth/imagency).

<b>CALL</b>	1-800-362-3002 Monday – Friday 8AM – 4:30PM
<b>TTY</b>	711 (Wisconsin Relay)
<b>WRITE</b>	1 West Wilson Street Madison, Wisconsin 53703
<b>EMAIL</b>	<a href="mailto:memberservices@wisconsin.gov">memberservices@wisconsin.gov</a>
<b>WEBSITE</b>	<a href="http://www.dhs.wisconsin.gov/medicaid">www.dhs.wisconsin.gov/medicaid</a>

## G. Ombudsman Program

The Ombudsman Program isn't connected with our plan or any insurance company or health plan. 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.



**If you have questions**, please call iCare Family Care Partnership at 1-800-777-4376 (TTY: 711), 24 hours a day, 7 days a week. The call is free. **For more information**, visit [www.icarehealthplan.org](http://www.icarehealthplan.org).

The organization to contact depends on your age.

### G1. Disability Rights Wisconsin

The ombudsman from this agency helps people under age 60.

<b>CALL</b>	1-800-928-8778
<b>TTY</b>	1-888-758-6049
<b>WRITE</b>	1502 West Broadway, Suite 201 Madison, WI 53713
<b>EMAIL</b>	<a href="mailto:info@drwi.org">info@drwi.org</a>
<b>WEBSITE</b>	<a href="http://disabilityrightswi.org/program/family-care-and-iris-ombudsman-program/">disabilityrightswi.org/program/family-care-and-iris-ombudsman-program/</a> See website for contact information for other locations.
<b>FAX</b>	1-833-635-1968

### G2. Wisconsin Board on Aging and Long Term Care

Ombudsmen from this agency help people aged 60 and older.

<b>CALL</b>	1-800-815-0015
<b>WRITE</b>	1402 Pankratz Street, Suite 111 Madison, WI 53704-4001
<b>EMAIL</b>	<a href="mailto:BOALTC@wisconsin.gov">BOALTC@wisconsin.gov</a>
<b>WEBSITE</b>	<a href="http://longtermcare.wi.gov/Pages/Home.aspx">longtermcare.wi.gov/Pages/Home.aspx</a>

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## H. Programs to Help People Pay for Drugs

The Medicare website ([www.medicare.gov/basics/costs/help/drug-costs](http://www.medicare.gov/basics/costs/help/drug-costs)) provides information on how to lower your drug costs. For people with limited incomes, there are also other programs to assist, as described below.

### H1. Extra Help from Medicare

Because you're eligible for Medicaid, you qualify for and are getting "Extra Help" from Medicare to pay for your drug plan costs. You don't need to do anything to get this "Extra Help."



**If you have questions**, please call iCare Family Care Partnership at 1-800-777-4376 (TTY: 711), 24 hours a day, 7 days a week. The call is free. **For more information**, visit [www.icarehealthplan.org](http://www.icarehealthplan.org).

<b>CALL</b>	1-800-MEDICARE (1-800-633-4227)  Calls to this number are free, 24 hours a day, 7 days a week.
<b>TTY</b>	1-877-486-2048. This call is free.  This number is for people who have difficulty with hearing or speaking. You must have special telephone equipment to call it.
<b>WEBSITE</b>	<a href="http://www.medicare.gov">www.medicare.gov</a>

If you think you're paying an incorrect amount for your prescription at a pharmacy, our plan has a process to help get evidence of your correct copayment amount. If you already have evidence of the right amount, we can help you share this evidence with us.

- Please contact Customer Care at 1-800-777-4376 (TTY 711), 24 hours-a-day, 7 days-a-week (office hours: Monday-Friday, 8:30 a.m. to 5:00 p.m.) for assistance with obtaining evidence of your proper co-payment level or for more information on providing this information to us.
- When we get the evidence showing the right copayment level, we'll update our system so you can pay the right copayment amount when you get your next prescription. If you overpay your copayment, we'll pay you back either by check or a future copayment credit. If the pharmacy didn't collect your copayment and you owe them a debt, we may make the payment directly to the pharmacy. If a state paid on your behalf, we may make payment directly to the state. Call Customer Care at the number at the bottom of the page if you have questions.

## H2. HIV Drug Assistance Program (HDAP)

HDAP helps HDAP-eligible people living with HIV/AIDS have access to life-saving HIV drugs. Medicare Part D drugs that are also on the HDAP formulary qualify for prescription cost sharing help through the HIV Drug Assistance Program (HDAP).

Note: To be eligible for the Wisconsin HDAP, people must be living in Wisconsin, have a household income at or below 300% of the federal poverty level, and be living with HIV, as confirmed by a doctor. If you change plans, notify your HDAP enrollment worker so you can continue to receive assistance for information on eligibility criteria, covered drugs, or how to enroll in the program, please call 800-991-5532.

## H3. The Medicare Prescription Payment Plan

The Medicare Prescription Payment Plan is a payment option that works with your current drug coverage, to help you manage your out-of-pocket Medicare Part D drugs covered by our plan by spreading them across the calendar year (January-December). Anyone with a Medicare drug plan or Medicare health plan with drug coverage (like a Medicare Advantage plan with drug coverage) can use this payment option. **This payment option might help you manage your expenses, but it doesn't save you money or lower your drug costs. If you're participating in the Medicare Prescription Payment Plan and stay in the same plan, you don't need to do anything to continue this option.** "Extra Help" from Medicare and help from your HDAP, for those who qualify, is more advantageous than participation in this payment option, no matter your income level, and plans with drug coverage must offer this payment option. To learn more about this payment option, call Customer Care at the phone number at the bottom of the page or visit [www.medicare.gov](http://www.medicare.gov).



If you have questions, please call iCare Family Care Partnership at 1-800-777-4376 (TTY: 711), 24 hours a day, 7 days a week. The call is free. For more information, visit [www.icarehealthplan.org](http://www.icarehealthplan.org).



## I. Social Security

Social Security determines Medicare eligibility and handles Medicare enrollment.

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

<b>CALL</b>	1-800-772-1213 Calls to this number are free. Available 8:00 am to 7:00 pm, Monday through Friday. You can use their automated telephone services to get recorded information and conduct some business 24 hours a day.
<b>TTY</b>	1-800-325-0778 This number is for people who have difficulty with hearing or speaking. You must have special telephone equipment to call it.
<b>WEBSITE</b>	<a href="http://www.ssa.gov">www.ssa.gov</a>

## J. Railroad Retirement Board (RRB)

The RRB is an independent Federal agency that administers comprehensive benefit programs for the nation's railroad workers and their families. If you get Medicare through the RRB, let them know if you move or change your mailing address. For questions about your benefits from the RRB, contact the agency.

<b>CALL</b>	1-877-772-5772 Calls to this number are free. Press "0" to speak with a RRB representative from 9 a.m. to 3:30 p.m., Monday, Tuesday, Thursday and Friday, and from 9 a.m. to 12 p.m. on Wednesday. Press "1" to access the automated RRB Help Line and get recorded information 24 hours a day, including weekends and holidays.
<b>TTY</b>	1-312-751-4701 This number is for people who have difficulty with hearing or speaking. You must have special telephone equipment to call it. Calls to this number aren't free.
<b>WEBSITE</b>	<a href="http://www.rrb.gov">www.rrb.gov</a>



**If you have questions**, please call iCare Family Care Partnership at 1-800-777-4376 (TTY: 711), 24 hours a day, 7 days a week. The call is free. **For more information**, visit [www.icarehealthplan.org](http://www.icarehealthplan.org).



## K. Group insurance or other insurance from an employer

If you (or your spouse or domestic partner) get benefits from your (or your spouse's or domestic partner's) employer or retiree group as part of this plan, call the employer/union benefits administrator or Customer Care at the phone number at the bottom of the page with any questions. You can ask about your (or your spouse's or domestic partner's) employer or retiree health benefits, premiums, or the enrollment period. You can also call 1-800-MEDICARE (1- 800-633-4227) with questions about your Medicare coverage under this plan. TTY users call 1- 877-486-2048.

If you have other drug coverage through your (or your spouse's or domestic partner's) employer or retiree group, contact **that group's benefits administrator**. The benefits administrator can help you understand how your current drug coverage will work with our plan.

## L. FoodShare Wisconsin

FoodShare helps people with limited money buy the food they need for good health. People all over Wisconsin get help from FoodShare. The program helps people of all ages who have low income jobs, live on a small or fixed income, have lost their jobs, or have a disability and can't work. You can:

- get general information about your Quest card,
- report that you didn't get a Quest card,
- report a lost, stolen, or damaged Quest card, and
- get your current account balance.

<b>CALL</b>	Quest Card Services at 877-415-5164
<b>TTY</b>	711 (Relay Wisconsin)
<b>WEBSITE</b>	<a href="http://www.dhs.wisconsin.gov/foodshare/index.htm">www.dhs.wisconsin.gov/foodshare/index.htm</a>

## M. Aging and Disability Resource Centers (ADRCs)

If you have questions about aging or living with a disability, your local aging and disability resource center (ADRC) can help. The ADRC provides information on a variety of programs and services. That includes long-term care options. The ADRC also helps people apply for programs and benefits, including publicly funded long-term care.

The ADRC can connect you to resources about:

- adaptive equipment,
- caregiver support,
- dementia care services,
- health, nutrition, and home-delivery meal programs,



**If you have questions**, please call iCare Family Care Partnership at 1-800-777-4376 (TTY: 711), 24 hours a day, 7 days a week. The call is free. **For more information**, visit [www.icarehealthplan.org](http://www.icarehealthplan.org).

- housekeeping and chore services,
- housing options,
- in-home personal care and nursing,
- long-term care programs,
- Medicaid, Medicare, and Social Security,
- safety updates to the home,
- transportation, **and**
- wellness programs.

It also provides other services. Visit [www.dhs.wisconsin.gov/adrc/consumer/index.htm](http://www.dhs.wisconsin.gov/adrc/consumer/index.htm) for more information about ADRCs or call 1-844-947-2372.

The Wisconsin Department of Health Services partners with counties and tribes to provide eligibility services for people who are applying for or are enrolled in programs like Medicaid, BadgerCare Plus, and FoodShare. County agencies that provide eligibility services are often called income maintenance or economic support agencies. These county agencies have joined together to form 11 consortiums across the state. Each consortium has its own call center to help you with eligibility services. The letters and other communications you get from the State of Wisconsin refer to both local county agencies and the consortium as “agencies.”

You can contact the Income Maintenance Consortium for your county of residence. 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’re eligible for Medicaid and iCare Family Care Partnership.

Report these changes to your county’s income maintenance consortium and iCare Family Care Partnership. Information about income maintenance can be found at [www.dhs.wisconsin.gov/forwardhealth/imagency/index.htm](http://www.dhs.wisconsin.gov/forwardhealth/imagency/index.htm).

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## N. Other resources

ADRC Adams County  
569 N. Cedar  
St. Adams, WI 53910  
Toll-free: 877-883-5378 TTY/TDD/Relay 711

ADRC Jefferson County  
1541 Annex Road  
Jefferson, WI 53549  
Phone: 866-740-2372  
TTY/TDD/Relay: 800-947-3529

ADRC Kenosha County  
8600 Sheridan Rd. Suite 500  
Kenosha, WI 53143  
Toll-free: 1-800-472-8008 TTY: 711

ADRC Columbia County  
111 E. Mullett Street  
P.O. Box 136  
Portage, WI 53901  
Phone: 888-742-9233  
TTY/TDD/Relay: 608-742 9229

ADRC Marquette County  
428 Underwood Ave.  
P.O. Box 405  
Montello, WI 53949-0405  
Toll Free: 855-440-2372 TTY: 711



**If you have questions**, please call iCare Family Care Partnership at 1-800-777-4376 (TTY: 711), 24 hours a day, 7 days a week. The call is free. **For more information**, visit [www.icarehealthplan.org](http://www.icarehealthplan.org).

ADRC Dane County  
2865 N. Sherman Ave  
Madison, WI 53704  
Local Phone: 1-608-240-7400 TTY: 711

ADRC Milwaukee County  
1230 W. Cherry St.  
Milwaukee, WI 53205  
Local: 414-289-6874 TTY/TDD: 711

ADRC Dodge County  
199 County Road DF, 3rd Floor  
Juneau, WI 53039  
Toll-free: 800-924-6407  
TTY/TDD/Relay: 920-386-3883

ADRC Racine County  
14200 Washington Ave.  
Sturtevant, WI 53177  
Toll-free: 1-866-219-1043 TTY: 711

ADRC Rock County  
1717 Center Ave.  
Janesville, WI 53546  
Phone: 855-741-3600 TTY/TDD/Relay: 711

ADRC Green Lake County  
571 County Road A  
Green Lake, WI 54941-0588  
Toll Free: 833-694-0192 TTY/TDD/Relay 711

ADRC Sauk County  
505 Broadway St.  
Baraboo, WI 53913  
Phone: 800-482-3700 TTY/TDD/Relay: 711

ADRC Waushara County  
380 S. Townline Road,  
Wautoma, WI 54982  
Toll Free: 877-883-5378 TTY/TDD/Relay 711



**If you have questions**, please call iCare Family Care Partnership at 1-800-777-4376 (TTY: 711), 24 hours a day, 7 days a week. The call is free. **For more information**, visit [www.icarehealthplan.org](http://www.icarehealthplan.org).

# Chapter 3: Using our plan’s coverage for your health care and other covered services

## Introduction

This chapter has specific terms and rules you need to know to get health care and other covered services with our plan. It also tells you about your care manager, how to get care from different kinds of providers and under certain special circumstances (including from out-of- network providers or pharmacies), what to do if you’re billed directly for services we cover, and the rules for owning Durable Medical Equipment (DME). Key terms and their definitions appear in alphabetical order in the last chapter of this *Evidence of Coverage*.

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## A. Information about “services,” “covered services,” “providers,” and “network providers”

**Services** are health care, long-term services and supports (LTSS), supplies, behavioral health services, prescription and over-the-counter drugs, equipment and other services. **Covered services** are any of these services that our plan pays for. Covered health care, behavioral health, and LTSS are in **Chapter 4** of this *Evidence of Coverage*. Your covered services for prescription and over-the-counter drugs are in **Chapter 5** of this *Evidence of Coverage*.

**Providers** are doctors, nurses, and other people who give you services and care and are licensed by the state. Providers also include hospitals, home health agencies, clinics, and other places that give you health care services, behavioral health services, medical equipment, and certain LTSS.

**Network providers** are providers who work with our plan. These providers agree to accept our payment as full payment. We arranged for these providers to deliver covered services to you. Network providers bill us directly for care they give you. When you use a network provider, you usually pay nothing for covered services.



If you have questions, please call iCare Family Care Partnership at 1-800-777-4376 (TTY: 711), 24 hours a day, 7 days a week. The call is free. For more information, visit [www.icarehealthplan.org](http://www.icarehealthplan.org).

## B. Rules for getting services our plan covers

Our plan covers all services covered by Medicare and Family Care Partnership. This includes behavioral health and LTSS.

Our plan will generally pay for health care services, behavioral health services, and LTSS you get when you follow our rules. To be covered by our plan:

- The care you get must be included in our Medical Benefits Chart in **Chapter 4** of this *Evidence of Coverage*.
- The care must be **medically necessary**. By medically necessary, we mean you need services to prevent, diagnose, or treat your condition or to maintain your current health status. This includes care that keeps you from going into a hospital or nursing facility. It also means the services, supplies, or drugs meet accepted standards of medical practice.
- For medical services, you must have a network **primary care provider (PCP)** providing and overseeing your care. As a plan member, you must choose a network provider to be your PCP (for more information, go to **Section D1** of this chapter) unless you're an Indian member who is permitted to obtain covered services from out-of-network Indian Health Care Providers.
  - In most cases, our plan must give you approval before you can use a provider that isn't your PCP or use other providers in our plan's network. This is called a **referral**. If you don't get approval, we may not cover the services.
  - You don't need referrals from your PCP for emergency care or urgently needed care or to use a woman's health provider. You can get other kinds of care without having a referral from your PCP (for more information, go to **Section D1** in this chapter).
- **You must get your care from network providers** (for more information, go to **Section D** in this chapter). Usually, we won't cover care from a provider who doesn't work with our health plan. This means that you'll have to pay the provider in full for services you get. Here are some cases when this rule doesn't apply:
  - We cover emergency or urgently needed care from an out-of-network provider (for more information, go to **Section I** in this chapter).
  - If you need care that our plan covers and our network providers can't give it to you, you can get care from an out-of-network provider. Authorization must be obtained from the plan prior to seeking care. In this situation, we cover the care at no cost to you. For information about getting approval to use an out-of-network provider, go to **Section D4** in this chapter.
  - We cover kidney dialysis services when you're outside our plan's service area for a short time or when your provider is temporarily unavailable or not accessible. The cost sharing you pay for dialysis can never be higher than the cost sharing in Original Medicare. If you're outside our plan's service area and get dialysis from a provider outside the plan's network, your cost sharing can't be higher than the cost sharing you pay in-network. However, if your usual in-network provider for dialysis is temporarily unavailable and you choose to get services inside our service area from an out-of-network provider, your cost sharing for the dialysis may be higher. If possible, call Customer Care at the number at the bottom of the page before you leave the service area so we can help arrange for you to have maintenance dialysis while you're away.



**If you have questions**, please call iCare Family Care Partnership at 1-800-777-4376 (TTY: 711), 24 hours a day, 7 days a week. The call is free. **For more information**, visit [www.icarehealthplan.org](http://www.icarehealthplan.org).

- You're an Indian member who is permitted to obtain covered services from out-of-network Indian Health Care Providers.

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## C. Your care manager

### C1. What a care manager is

A care coordinator is known as a care manager or social service coordinator. They're required to be one of the following:

- a social worker certified in Wisconsin with a minimum of one year's experience working with at least one of the Family Care target populations;
- an individual with a four-year bachelor's degree or more advanced degree in the human services area and a minimum of one year's experience working with at least one of the Family Care target populations; **or**
- an individual with a four-year bachelor's degree or more advanced degree in any area other than human services with a minimum of three years' experience working with at least one of the Family Care target populations.

### C2. How you can contact your care manager and care team

Refer to Chapter 2, Section B for information about how to contact your care manager and care team.

### C3. How you can change your care manager

You can change interdisciplinary teams, including the care manager, up to two times per calendar year. iCare Family Care Partnership may not always be able to meet your request or give you the specific team you want.

Contact 1-800-777-4376 to request a new care manager or care team.

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## D. Care from providers

### D1. Care from a primary care provider (PCP)

You must choose a PCP to provide and manage your care.

#### Definition of a PCP and what a PCP does do for you

Your PCP is the provider who works with your care team and our plan to oversee your health care. When you become a member of Partnership, you must choose a network provider to be your PCP. If you're an American Indian or Alaska Native, you can choose to see an Indian Health Care Provider outside of our network.

There are several types of providers who may be your PCP. Please talk to your care team about your options.

Talk with your care team about getting care from your PCP. You'll 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 Care Team. Your care team will arrange or



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

iCare is a provider of the Family Care Partnership Program. 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 care team consists of:

- you, the partnership member
- your family and significant others (at your option)
- your PCP
- your partnership nurse practitioner
- your partnership registered nurse
- your partnership care manager
- other people you choose to include on your care team

### Your choice of PCP

You may choose a PCP by using the provider network list. You can also get help from Customer Care or your care team. PCPs don't always accept new patients. You may keep your current PCP if the provider is part of our network. You can tell us your choice of PCP by calling your care team. If there's a certain specialist or hospital you want to use, be sure to ask if your PCP makes referrals to that specialist or uses that hospital.

Talk with your care team about choosing and getting care from your PCP. You'll see your PCP for most of your routine health care needs.

### Option to change your PCP

You can change your PCP for any reason, at any time. It's also possible that your PCP may leave our plan's network. If your PCP leaves our network, we can help you find a new PCP in our network.

To change your PCP, call your care team. When you call, be sure to tell your care team if you're seeing specialists or getting other covered services that needed your PCP's approval. (This might be things like home health services and durable medical equipment.) Your care team will tell you when the change to your new PCP will take effect.

### Services you can get without approval from your PCP

In most cases, you need approval from your PCP before using other providers. This approval is called a **referral**. You can get services like the ones listed below without getting approval from your PCP first:



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- Emergency services from network providers or out-of-network providers.
- Urgently needed covered services that require immediate medical attention (but not an emergency) if you're either temporarily outside our plan's service area, or if it's unreasonable given your time, place, and circumstances to get this service from network providers. Examples of urgently needed services are unforeseen medical illnesses and injuries or unexpected flare-ups of existing conditions. Medically necessary routine provider visits (like annual checkups) aren't considered urgently needed even if you're outside our plan's service area or our network is temporarily unavailable.
- Kidney dialysis services that you get at a Medicare-certified dialysis facility when you're outside our plan's service area. Call Customer Care before you leave the service area. We can help you get dialysis while you're away.
- Flu shots and COVID-19 vaccines, as well as hepatitis B vaccines and pneumonia vaccines as long as you get them from a network provider.
- Routine women's health care and family planning services. This 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.
- Additionally, if eligible to get services from Indian health providers, you may use these providers without a referral.

## D2. Care from specialists and other network providers

A specialist is a doctor who provides health care for a specific disease or part of the body. There are many kinds of specialists, such as:

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

Contact your care team if you need care from a specialist. You may need to get prior approval from your care team.

A referral is usually not required to see a specialist with the exception of second and all additional opinions. If you do need a referral, your provider will coordinate it.

iCare must authorize certain visits and procedures. For example, if you receive a referral for an out-of-network provider, you will need to obtain a Prior Authorization. Your provider should contact iCare for Prior Authorizations. Refer to Chapter 4 for information about which services require Prior Authorization.

Whatever PCP you choose, you are not limited to use only specialists or hospitals to which that PCP refers. For example, if your provider is a member of a health care system, the provider can refer you to a different health care system. Your PCP should refer you to any provider within the iCare Family Care Partnership network.

## D3. When a provider leaves our plan

A network provider you use may leave our plan. If one of your providers leaves our plan, you have these rights and protections that are summarized below:



**If you have questions**, please call iCare Family Care Partnership at 1-800-777-4376 (TTY: 711), 24 hours a day, 7 days a week. The call is free. **For more information**, visit [www.icarehealthplan.org](http://www.icarehealthplan.org).

- Even if our network of providers change during the year, we must give you uninterrupted access to qualified providers.
- We'll notify you that your provider is leaving our plan so that you have time to select a new provider.
  - If your primary care or behavioral health provider leaves our plan, we'll notify you if you visited that provider within the past three years.
  - If any of your other providers leave our plan, we'll notify you if you're assigned to the provider, currently get care from them, or visited them within the past three months.
- We help you select a new qualified in-network provider to continue managing your health care needs.
- If you're currently undergoing medical treatment or therapies with your current provider, you have the right to ask to continue getting medically necessary treatment or therapies. We'll work with you so you can continue to get care.
- We'll give you information about available enrollment periods and options you may have for changing plans.
- If we can't find a qualified network specialist accessible to you, we must arrange an out-of-network specialist to provide your care when an in-network provider or benefit is unavailable or inadequate to meet your medical needs.
- If you find out one of your providers is leaving our plan, contact us. We can help you choose a new provider to manage your care.
- If you think we haven't replaced your previous provider with a qualified provider or that we aren't managing your care well, you have the right to file a quality of care complaint to the Quality Improvement Organization (QIO), a quality of care grievance, or both. (Refer to Chapter 9 for more information.)

#### D4. 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 authorization to see an out of-network doctor, contact your Care Team (see Chapter 2 for contact information).

If you use an out-of-network provider, the provider must be eligible to participate in Medicare and/or Family Care Partnership.

- We can't pay a provider who isn't eligible to participate in Medicare and/or Family Care Partnership.
- If you use a provider who isn't eligible to participate in Medicare, you must pay the full cost of the services you get.
- Providers must tell you if they aren't eligible to participate in Medicare.



**If you have questions**, please call iCare Family Care Partnership at 1-800-777-4376 (TTY: 711), 24 hours a day, 7 days a week. The call is free. **For more information**, visit [www.icarehealthplan.org](http://www.icarehealthplan.org).

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## E. Long-term services and supports (LTSS)

You and the Care Team develop your plan of care based on your outcomes. iCare Family Care Partnership has a responsibility to support your outcomes in the most cost-effective manner possible. To accomplish this, your Care 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 care plan. As stated above, you and others are part of the Care Team who take an active role in decision-making regarding the medical care, long-term care and home and community-based services you need to support your outcomes.

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## F. Behavioral health (mental health and substance use disorder) services

Behavioral health services support mental health and substance abuse treatment needs you may have. This can include medication, counseling (therapy), social support and education. This care may be given in a community setting, day program or a doctor's office, or in another place that's easier for you, like your home.

For behavioral health services, please call Customer Care at 1-800-777-4376 (TTY: 711). We're available Monday – Friday, from 8:30 a.m. – 5 p.m. The call is free.

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## G. How to get self-directed care

Under self-directed care a member may choose to purchase long-term care benefits if they are determined by the interdisciplinary team (IDT) as consistent with the members outcomes reflected in their member centered plan.

**G1. What self-directed care is:** Members enrolled in the Family Care Partnership program are all offered to chose self-directed long term care benefits as they are defined in the DHS Managed Care Organization (MCO) contract as the home and community-based waiver services (except for residential care services and care/case management), if they are identified by the IDT as consistent with members outcomes.

**G2. Who can get self-directed care (for example, if it's limited to waiver populations):** Members enrolled in iCare's Family Care Partnership program are offered a choice to self-direct part or all of their care.

**G3. How to get help in employing personal care providers (if applicable):** iCare Family Care Partnership can assist members in establishing a caregiver of their choosing to be their supportive homecare and/or personal care worker through self-direction. iCare is contracted with several fiscal agents and co-employment agencies who the care team can refer members and their preferred caregivers to in order to initiate employment. The fiscal agents provide training and orientation and serve as the fiscal intermediary for the member and caregiver.

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## H. Transportation services

**If you have a medical emergency, dial 911.**

Call 911 if you need emergency transportation. You don't need prior approval in an emergency.

Non-emergency group ambulance aren't covered by this plan. **Other transportation services are covered.**



**If you have questions**, please call iCare Family Care Partnership at 1-800-777-4376 (TTY: 711), 24 hours a day, 7 days a week. The call is free. **For more information**, visit [www.icarehealthplan.org](http://www.icarehealthplan.org).

## I. Covered services in a medical emergency, when urgently needed, or during a disaster

### I1. Care in a medical emergency

A medical emergency is a medical condition with symptoms such as illness, severe pain, serious injury, or a medical condition that's quickly getting worse. The condition is so serious that, if it doesn't get immediate medical attention, you or anyone with an average knowledge of health and medicine could expect it to result in:

- serious risk to your life and, if you're pregnant, loss of an unborn child; **or**
- loss of or serious harm to bodily functions; **or**
- loss of a limb or function of a limb; **or**
- in the case of a pregnant woman in active labor, when:
  - There is not enough time to safely transfer you to another hospital before delivery.
  - A transfer to another hospital may pose a threat to your health or safety or to that of your unborn child.

If you have a medical emergency:

- **Get help as fast as possible.** Call 911 or use the nearest emergency room or hospital. Call for an ambulance if you need it. You **don't** need approval or a referral from your PCP. You don't need to use a network provider. You can get covered emergency medical care whenever you need it, anywhere in the U.S. or its territories, from any provider with an appropriate state license even if they're not part of our network.
- **Please make sure our plan knows 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 number on the back of your Partnership membership ID card.

### Covered services in a medical emergency

Our plan covers ambulance services in situations where getting to the emergency room in any other way could endanger your health. We also cover medical services during the emergency. To learn more, refer to the Benefits Chart in **Chapter 4** of this *Evidence of Coverage*.

The providers who give you emergency care decide when your condition is stable and the medical emergency is over. They'll continue to treat you and will contact us to make plans if you need follow-up care to get better.

Our plan covers your follow-up care. If you get your emergency care from out-of-network providers, we'll try to get network providers to take over your care as soon as possible.

### Getting emergency care if it wasn't an emergency

Sometimes it can be hard to know if you have a medical or behavioral health emergency. You may go in for emergency care and the doctor says it wasn't really an emergency. As long as you reasonably thought your health was in serious danger, we cover your care.



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However, after the doctor says it wasn't an emergency, we cover your additional care only if:

- you go to a network provider, **or**
- the additional care you get is considered "urgently needed care" and you follow the rules for getting this care. (Refer to the next section.)

## **I2. Urgently needed care**

### **Definition of urgently needed care**

Urgently needed care is care you get for a situation that isn't an emergency but needs care right away. For example, you might have a flare-up of an existing condition or an unforeseen illness or injury.

### **Urgently needed care in our plan's service area**

In most cases, we cover urgently needed care only if:

- you get this care from a network provider, **and**
- you follow the rules described in this chapter.

If it isn't possible or reasonable to get to a network provider, given your time, place or circumstances we cover urgently needed care you get from an out-of-network provider.

If you think you need urgent care, you can:

1. Call your PCP for advice. You can reach your PCP or a back-up doctor, 24-hours a day, 7 days a week.

OR

2. Call our 24-hour nurse advice line at 1-800-679-9874 (TTY: 711) 24-hours a day, 7 days a week.

OR

3. Go to a participating urgent care center. They are listed in the Provider and Pharmacy Directory. Or you can always find them on our website at [www.icarehealthplan.org/Find-a-Provider.htm](http://www.icarehealthplan.org/Find-a-Provider.htm). After you go, always call your PCP to schedule follow up care.

### **Urgently needed care outside our plan's service area**

When you're outside our plan's service area, you may not be able to get care from a network provider. In that case, our plan covers urgently needed care you get from any provider. However, medically necessary routine provider visits, such as annual checkups, aren't considered urgently needed even if you're outside our plan's service area or our plan network is temporarily unavailable.

Our plan doesn't cover urgently needed care or any other care that you get outside the United States and its territories.

## **I3. 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



**If you have questions**, please call iCare Family Care Partnership at 1-800-777-4376 (TTY: 711), 24 hours a day, 7 days a week. The call is free. **For more information**, visit [www.icarehealthplan.org](http://www.icarehealthplan.org).

States declares a state of disaster or emergency in your geographic area, you're still entitled to care from our plan.

Visit our website for information on how to get care you need during a declared disaster: [www.icarehealthplan.org](http://www.icarehealthplan.org).

During a declared disaster, if you can't use a network provider, you can get care from out-of-network providers at the in-network cost sharing rate. If you can't use a network pharmacy during a declared disaster, you can fill your drugs at an out-of-network pharmacy. Refer to **Chapter 5** of this *Evidence of Coverage* for more information.

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## J. What if you're billed directly for covered services

If you paid for your covered service or if you got a bill for covered medical services, refer to **Chapter 7** of this *Evidence of Coverage* to find out what to do.

**You shouldn't pay the bill yourself. If you do, we may not be able to pay you back.**

### J1. What to do if our plan doesn't cover services

Our plan covers all services:

- that are determined medically necessary, **and**
- that are listed in our plan's Benefits Chart (refer to **Chapter 4** of this *Evidence of Coverage*), **and**
- that you get by following plan rules.

If you get services that our plan doesn't cover, **you pay the full cost yourself.**

If you want to know if we pay for any medical service or care, you have the right to ask us. You also have the right to ask for this in writing. If we say we won't pay for your services, you have the right to appeal our decision.

**Chapter 9** of this *Evidence of Coverage* explains what to do if you want us to cover a medical service or item. It also tells you how to appeal our coverage decision. Call Customer Care to learn more about your appeal rights.

We pay for some services up to a certain limit. If you go over the limit, you pay the full cost to get more of that type of service. Refer to **Chapter 4** for specific benefit limits. Call Customer Care to find out what the benefit limits are and how much of your benefits you've used.

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## K. Coverage of health care services in a clinical research study

### K1. Definition of a clinical research study

A clinical research study (also called a clinical trial) is a way doctors test new types of health care or drugs. A clinical research study approved by Medicare typically asks for volunteers to be in the study. When you're in a clinical research study, you can stay enrolled in our plan and continue to get the rest of your care (care that's



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not related to the study) through our plan.

If you want to take part in any Medicare-approved clinical research study, you **don't** need to tell us or get approval from us or your primary care provider. Providers that give you care as part of the study **don't** need to be network providers. This doesn't apply to covered benefits that require a clinical trial or registry to assess the benefit, including certain benefits requiring coverage with evidence development (NCDs-CED) and investigational device exemption (IDE) studies. These benefits may also be subject to prior authorization and other plan rules.

**We encourage you to tell us before you take part in a clinical research study.**

If you plan to be in a clinical research study, covered for enrollees by Original Medicare, we encourage you or your care manager to contact Customer Care to let us know you'll take part in a clinical trial.

**K2. Payment for services when you're in a clinical research study**

If you volunteer for a clinical research study that Medicare approves, you pay nothing for the services covered under the study. Medicare pays for services covered under the study as well as routine costs associated with your care. Once you join a Medicare-approved clinical research study, you're covered for most services and items you get as part of the study. This includes:

- 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 that's part of the research study
- treatment of any side effects and complications of the new care

If you're part of a study that Medicare **hasn't** approved, you pay any costs for being in the study.

**K3. More about clinical research studies**

You can learn more about joining a clinical research study by reading "Medicare & Clinical Research Studies" on the Medicare website ([www.medicare.gov/sites/default/files/2019-09/02226-medicare-and-clinical-research-studies.pdf](http://www.medicare.gov/sites/default/files/2019-09/02226-medicare-and-clinical-research-studies.pdf)). You can also call 1-800-MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048.

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**L. How your health care services are covered in a religious non-medical health care institution**

**L1. Definition of a religious non-medical health care institution**

A religious non-medical health care institution is a place that provides care you would normally get in a hospital or skilled nursing facility. If getting care in a hospital or a skilled nursing facility is against your religious beliefs, we cover care in a religious non-medical health care institution.

This benefit is only for Medicare Part A inpatient services (non-medical health care services).

**L2. Care from a religious non-medical health care institution**

To get care from a religious non-medical health care institution, you must sign a legal document that says you're against getting medical treatment that's "non-excepted."



**If you have questions**, please call iCare Family Care Partnership at 1-800-777-4376 (TTY: 711), 24 hours a day, 7 days a week. The call is free. **For more information**, visit [www.icarehealthplan.org](http://www.icarehealthplan.org).

- “Non-excepted” medical treatment is any care or treatment that’s **voluntary and not required** by any federal, state, or local law.
- “Excepted” medical treatment is any care or treatment that’s **not voluntary and 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 only covers non-religious aspects of care.
- If you get services from this institution provided to you in a facility:
  - You must have a medical condition that would allow you to get covered services for inpatient hospital care or skilled nursing facility care.
  - You must get approval from us before you’re admitted to the facility, or your stay **won’t** be covered.

There’s unlimited coverage for this benefit.

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## M. Durable medical equipment (DME)

### M1. DME as a member of our plan

DME includes certain medically necessary items ordered by a provider, such as wheelchairs, crutches, powered mattress systems, diabetic supplies, hospital beds ordered by a provider for use in the home, intravenous (IV) infusion pumps, speech generating devices, oxygen equipment and supplies, nebulizers, and walkers.

You always own some DME items, such as prosthetics.

Other types of DME you must rent. As a member of our plan, you **won’t** own the rented DME items, no matter how long you rent it.

Even if you had DME for up to 12 months in a row under Medicare before you joined our plan, you **won’t** own the equipment.

### M2. DME ownership if you switch to Original Medicare

In the Original Medicare program, people who rent certain types of DME own it after 13 months. In a Medicare Advantage (MA) plan, the plan can set the number of months people must rent certain types of DME before they own it.

You’ll have to make 13 payments in a row under Original Medicare, or you’ll have to make the number of payments in a row set by the MA plan, to own the DME item if:

- you didn’t become the owner of the DME item while you were in our plan, **and**
- you leave our plan and get your Medicare benefits outside of any health plan in the Original Medicare program or an MA plan.



**If you have questions**, please call iCare Family Care Partnership at 1-800-777-4376 (TTY: 711), 24 hours a day, 7 days a week. The call is free. **For more information**, visit [www.icarehealthplan.org](http://www.icarehealthplan.org).



If you made payments for the DME item under Original Medicare or an MA plan before you joined our plan, **those Original Medicare or MA plan payments don't count toward the payments you need to make after leaving our plan.**

- You'll have to make 13 new payments in a row under Original Medicare or a number of new payments in a row set by the MA plan to own the DME item.
- There are no exceptions to this when you return to Original Medicare or an MA plan.

### **M3. Oxygen equipment benefits as a member of our plan**

If you qualify for oxygen equipment covered by Medicare we cover:

- rental of oxygen equipment
- delivery of oxygen and oxygen contents
- tubing and related accessories for the delivery of oxygen and oxygen contents
- maintenance and repairs of oxygen equipment

Oxygen equipment must be returned when it's no longer medically necessary for you or if you leave our plan.

### **M4. Oxygen equipment when you switch to Original Medicare or another Medicare Advantage (MA) plan**

When oxygen equipment is medically necessary and **you leave our plan and switch to Original Medicare**, you rent it from a supplier for 36 months. Your monthly rental payments cover the oxygen equipment and the supplies and services listed above.

If oxygen equipment is medically necessary **after you rent it for 36 months**, your supplier must provide:

- oxygen equipment, supplies, and services for another 24 months
- oxygen equipment and supplies for up to 5 years if medically necessary

If oxygen equipment is still medically necessary **at the end of the 5-year period**:

- Your supplier no longer has to provide it, and you may choose to get replacement equipment from any supplier.
- A new 5-year period begins.
- You rent from a supplier for 36 months.
- Your supplier then provides the oxygen equipment, supplies, and services for another 24 months.
- A new cycle begins every 5 years as long as oxygen equipment is medically necessary.

When oxygen equipment is medically necessary and **you leave our plan and switch to another MA plan**, the plan will cover at least what Original Medicare covers. You can ask your new MA plan what oxygen equipment and supplies it covers and what your costs will be.



**If you have questions**, please call iCare Family Care Partnership at 1-800-777-4376 (TTY: 711), 24 hours a day, 7 days a week. The call is free. **For more information**, visit [www.icarehealthplan.org](http://www.icarehealthplan.org).

# Chapter 4: Benefits Chart

## Introduction

This chapter tells you about the services our plan covers and any restrictions or limits on those services. It also tells you about benefits not covered under our plan. Key terms and their definitions appear in alphabetical order in the last chapter of this *Evidence of Coverage*.

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## A. Your covered services

This chapter tells you about services our plan covers. You can also learn about services that aren’t covered. Information about drug benefits is in **Chapter 5** of this *Evidence of Coverage*. This chapter also explains limits on some services.

Because you get help from Family Care Partnership, you pay nothing for your covered services as long as you follow our plan’s rules. Refer to **Chapter 3** of this *Evidence of Coverage* for details about our plan’s rules.

If you need help understanding what services are covered, call your care manager and/or Customer Care at 1-800-777-4376.

## B. Rules against providers charging you for services

We don’t allow our providers to bill you for in network covered services. We pay our providers directly, and we protect you from any charges. This is true even if we pay the provider less than the provider charges for a service.

**You should never get a bill from a provider for covered services.** If you do, refer to **Chapter 7** of this *Evidence of Coverage* or call Customer Care.

## C. About our plan’s Benefits Chart

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



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cover, like long-term care, some over-the-counter drugs, home and community-based services, or other Medicaid-only services. iCare Family Care Partnership fully integrates both Medicare and Medicaid benefits. You pay nothing for covered Medicare and Medicaid benefits

The Benefits Chart tells you the services our plan pays for. It lists covered services in alphabetical order and explains them. **We pay for the services listed in the Benefits Chart when the following rules are met.** You **don't** pay anything for the services listed in the Benefits Chart, as long as you meet the requirements described below.


- We provide covered Medicare and Medicaid covered services according to the rules set by Medicare and iCare Family Care Partnership.
- The services including medical care, behavioral health and substance use services, long-term services and supports, supplies, equipment, and drugs must be “medically necessary.” Medically necessary describes services, supplies, or drugs you need to prevent, diagnose, or treat a medical condition or to maintain your current health status. This includes care that keeps you from going into a hospital or nursing facility. It also means the services, supplies, or drugs meet accepted standards of medical practice.
- For new enrollees, for the first 90 days we may not require you to get approval in advance for any active course of treatment, even if the course of treatment was for a service that began with an out-of-network provider.
- You get your care from a network provider. A network provider is a provider who works with us. In most cases, care you get from an out-of-network provider won't be covered unless it's an emergency or urgently needed care, or unless your plan or a network provider gave you a referral. **Chapter 3** of this *Evidence of Coverage* has more information about using network and out-of-network providers.
- You have a primary care provider (PCP) or a care team providing and managing your care. In most cases, your PCP must give you approval before you can use a provider that isn't your PCP or use other providers in our plan's network. This is called a referral. **Chapter 3** of this *Evidence of Coverage* has more information about getting a referral and when you **don't** need one.
- We cover some services listed in the Benefits Chart only if your doctor or other network provider gets our approval first. This is called prior authorization (PA). We mark covered services in the Benefits Chart that need PA in **bold italic** type. In addition, you must get PA for the following services that are not listed in the Benefits Chart:
  - Transplants
  - All codes and procedures listed in iCare's Prior Authorization List found in the provider area of [www.icarehealthplan.org](http://www.icarehealthplan.org)
  - Transcutaneous Electrical Nerve Stimulation (TENS)
  - Urine Drug Screen
  - Referrals to non-participating providers outside the member's home state
  - For non-Medicaid certified Providers – all Services other than Emergency Services
- If your plan provides approval of a PA request for a course of treatment, the approval must be valid for as long as medically reasonable and necessary to avoid disruptions in care based on coverage criteria, your medical history, and the treating provider's recommendations.



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All preventive services are free. You will find this apple  next to preventive services in the Benefits Chart.

## D. Our plan's Benefits Chart

Services that our plan pays for	What you must pay
 <b>Abdominal aortic aneurysm screening</b> We pay for a one-time ultrasound screening for people at risk. Our 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.	\$0
<b>Acupuncture</b> We pay for up to 20 acupuncture visits in 90 days if you have chronic low back pain, defined as: <ul style="list-style-type: none"> <li>• lasting 12 weeks or longer;</li> <li>• not specific (having no systemic cause that can be identified, such as not associated with metastatic, inflammatory, or infectious disease);</li> <li>• not associated with surgery; <b>and</b></li> <li>• not associated with pregnancy.</li> </ul> In addition, we pay for an additional eight sessions of acupuncture for chronic low back pain if you show improvement. You may not get more than 20 acupuncture treatments for chronic low back pain each year. Acupuncture treatments must be stopped if you don't get better or if you get worse. Provider Requirements: Physicians (as defined in 1861(r)(1) of the Social Security Act (the Act)) may furnish acupuncture in accordance with applicable state requirements. Physician assistants (PAs), nurse practitioners (NPs)/clinical nurse specialists (CNSs) (as identified in 1861(aa) (5) of the Act), and auxiliary personnel may furnish acupuncture if they meet all applicable state requirements and have: <ul style="list-style-type: none"> <li>• a master's or doctoral level degree in acupuncture or Oriental Medicine from a school accredited by the Accreditation Commission on Acupuncture and Oriental Medicine (ACAOM); and,</li> </ul> <b>This benefit is continued on the next page.</b>	\$0 20 visits per year <b>Prior authorization may be required.</b>







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Services that our plan pays for	What you must pay
<p><b>Acupuncture (continued)</b></p> <ul style="list-style-type: none"> <li>a current, full, active, and unrestricted license to practice acupuncture in a State, Territory, or Commonwealth (i.e., Puerto Rico) of the United States, or District of Columbia.</li> </ul> <p>Auxiliary personnel furnishing acupuncture must be under the appropriate level of supervision of a physician, PA, or NP/CNS required by our regulations at 42 CFR §§ 410.26 and 410.27.</p>	
<p> <b>Alcohol misuse screening and counseling</b></p> <p>We pay for one alcohol-misuse screening for adults who misuse alcohol but aren't alcohol dependent. This includes pregnant women.</p> <p>If you screen positive for alcohol misuse, you can get up to four brief, face-to-face counseling sessions each year (if you're able and alert during counseling) with a qualified primary care provider (PCP) or practitioner in a primary care setting.</p>	\$0
<p><b>Ambulance services</b></p> <p>Covered ambulance services, whether for an emergency or non-emergency situation, include ground and air (airplane and helicopter), and ambulance services. The ambulance will take you to the nearest place that can give you care.</p> <p>Your condition must be serious enough that other ways of getting to a place of care could risk your health or life.</p> <p>Ambulance services for other cases (non-emergent) must be approved by us. In cases that aren't emergencies, we may pay for an ambulance. Your condition must be serious enough that other ways of getting to a place of care could risk your life or health.</p>	<p>\$0</p> <p><b>Prior authorization may be required.</b></p>
<p> <b>Annual wellness visit</b></p> <p>You can get an annual checkup. This is to make or update a prevention plan based on your current risk factors. We pay for this once every 12 months.</p> <p><b>Note:</b> Your first annual wellness visit can't take place within 12 months of your <b>"Welcome to Medicare"</b> visit. However, you don't need to have had a <b>"Welcome to Medicare"</b> visit to get annual wellness visits after you've had Part B for 12 months.</p>	\$0





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Services that our plan pays for	What you must pay
 <b>Bone mass measurement</b> We pay for certain procedures for members who qualify (usually, someone at risk of losing bone mass or at risk of osteoporosis). These procedures identify bone mass, find bone loss, or find out bone quality.  We pay for the services once every 24 months, or more often if medically necessary. We also pay for a doctor to look at and comment on the results.	\$0
 <b>Breast cancer screening (mammograms)</b> We pay for the following services: <ul style="list-style-type: none"> <li>• one baseline mammogram between the ages of 35 and 39</li> <li>• one screening mammogram every 12 months for women aged 40 and older</li> <li>• clinical breast exams once every 24 months</li> </ul>	\$0
<b>Cardiac (heart) rehabilitation services</b> We pay for cardiac rehabilitation services such as exercise, education, and counseling. Members must meet certain conditions and have a doctor's order.  We also cover intensive cardiac rehabilitation programs, which are more intense than cardiac rehabilitation programs.	\$0  <b><i>Prior authorization may be required.</i></b>
 <b>Cardiovascular (heart) disease risk reduction visit (therapy for heart disease)</b> We pay for one visit a year, or more if medically necessary, with your primary care provider (PCP) to help lower your risk for heart disease. During the visit, your doctor may: <ul style="list-style-type: none"> <li>• discuss aspirin use,</li> <li>• check your blood pressure, <b>and/or</b></li> <li>• give you tips to make sure you are eating well.</li> </ul>	\$0
 <b>Cardiovascular (heart) disease screening tests</b> We pay for blood tests to check for cardiovascular disease once every five years (60 months). These blood tests also check for defects due to high risk of heart disease.	\$0




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Services that our plan pays for	What you must pay
 <b>Cervical and vaginal cancer screening</b> We pay for the following services: <ul style="list-style-type: none"> <li>• For all women: Pap tests and pelvic exams once every 24 months</li> <li>• For women who are at high risk of cervical or vaginal cancer: one Pap test every 12 months</li> <li>• For women who have had an abnormal Pap test within the last three years and are of childbearing age: one Pap test every 12 months</li> </ul>	\$0
<b>Chiropractic services</b> We pay for the following services: <ul style="list-style-type: none"> <li>• adjustments of the spine to correct alignment.</li> </ul>	\$0 <b><i>Prior authorization may be required.</i></b>
<b>Chronic pain management and treatment services</b> Covered monthly services for people living with chronic pain (persistent or recurring pain lasting longer than 3 months). Services may include pain assessment, medication management, and care coordination and planning.	\$0 Cost sharing for this service will vary depending on individual services provided under the course of treatment.
 <b>Colorectal cancer screening</b> We pay for the following services: <ul style="list-style-type: none"> <li>• Colonoscopy has no minimum or maximum age limitation and is covered once every 120 months (10 years) for patients not at high risk, or 48 months after a previous flexible sigmoidoscopy for patients who aren't at high risk for colorectal cancer, and once every 24 months for high risk patients after a previous screening colonoscopy.</li> <li>• Computed tomography colonography for patients 45 years and older who aren't at high risk of colorectal cancer is covered when at least 59 months have passed following the month in which the last screening computed tomography colonography was performed, or when 47 months have passed following the month in which the last screening flexible sigmoidoscopy or screening colonoscopy was performed. For patients at high risk for colorectal cancer, payment may be made for a screening computed tomography colonography</li> </ul> <b>This benefit is continued on the next page.</b>	\$0



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Services that our plan pays for	What you must pay
<p> <b>Colorectal cancer screening (continued)</b></p> <p>performed after at least 23 months have passed following the month in which the last screening computed tomography colonography or the last screening colonoscopy was performed.</p> <ul style="list-style-type: none"> <li>• Flexible sigmoidoscopy for patients 45 years and older. Once every 120 months for patients not at high risk after the patient got a screening colonoscopy. Once every 48 months for high risk patients from the last flexible sigmoidoscopy or computed tomography colonography.</li> <li>• Screening fecal-occult blood tests for patients 45 years and older. Once every 12 months.</li> <li>• Multitarget stool DNA for patients 45 to 85 years of age and not meeting high risk criteria. Once every 3 years.</li> <li>• Blood-based Biomarker Tests for patients 45 to 85 years of age and not meeting high risk criteria. Once every 3 years.</li> <li>• Colorectal cancer screening tests include a follow-on screening colonoscopy after a Medicare covered non-invasive stool-based colorectal cancer screening test returns a positive result.</li> <li>• Colorectal cancer screening tests include a planned screening flexible sigmoidoscopy or screening colonoscopy that involves the removal of tissue or other matter, or other procedure furnished in connection with, as a result of, and in the same clinical encounter as the screening test.</li> </ul>	
<p><b>Dental services</b></p> <p>Certain dental services, including cleanings, fillings, and dentures, are available through Family Care Partnership .</p> <p>We pay for some dental services when the service is an integral part of specific treatment of a person's primary medical condition. Examples include reconstruction of the jaw after a fracture or injury, tooth extractions done in preparation for radiation treatment for cancer involving the jaw, or oral exams prior to organ transplantation.</p> <p>Because you have Medicaid, we cover:</p> <ul style="list-style-type: none"> <li>• dental services covered by Wisconsin Medicaid</li> </ul> <p><b>This benefit is continued on the next page.</b></p>	<p>\$0</p> <p><b><i>Prior authorization required for Comprehensive Dental Care.</i></b></p>





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Services that our plan pays for	What you must pay
<p><b>Dental services (continued)</b></p> <ul style="list-style-type: none"> <li>• routine dental care, including exams, cleanings and x-rays</li> <li>• fillings</li> <li>• surgery of the jaw or related structures</li> <li>• setting fractures of the jaw or facial bones</li> <li>• extraction of teeth</li> <li>• services that would be covered when provided by a doctor.</li> </ul> <p>We provide a supplemental benefit under Medicare Part C for preventive and comprehensive dental services limited to a maximum benefit coverage of \$4,000 per calendar year.</p> <p><b>Preventive Dental Care</b></p> <ul style="list-style-type: none"> <li>• Oral Exams: Up to three (3) per calendar year, includes emergency diagnostic exam up to 1 per year, and periodic oral exam up to 2 per year.</li> <li>• Prophylaxis (Cleaning): Up to six (6) per calendar year, includes periodontal maintenance up to 4 per year and prophylaxis (cleaning) up to 2 per year.</li> <li>• Fluoride Treatment: Up to two (2) per calendar year.</li> <li>• Dental X-rays: Include bitewing x-rays and intraoral x-rays up to 1 set(s) per year, and panoramic film or diagnostic x-rays up to 1 every 5 years.</li> </ul> <p><b>Co-pay for Comprehensive Dental Care</b></p> <ul style="list-style-type: none"> <li>• Non-routine Services: Include emergency treatment for pain up to two (2) per year.</li> <li>• Diagnostic Services: Include comprehensive oral evaluation or periodontal exam up to one (1) every three (3) years.</li> <li>• Restorative Services: Include fillings up to unlimited per year, re-cementation of crown and re-cementation of bridges up to 1 every 5 years, crown up to 1 per tooth per lifetime.</li> <li>• Endodontics: Include root canal, root canal retreatment up to 1 per tooth per lifetime.</li> <li>• Periodontics: Include scaling and root planning (deep</li> </ul> <p><b>This benefit is continued on the next page.</b></p>	





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Services that our plan pays for	What you must pay
<p><b>Dental services (continued)</b></p> <p>cleaning) up to 1 per quadrant every 3 years, scaling for moderate inflammation up to 1 every 3 years.</p> <ul style="list-style-type: none"> <li>• Extractions: Includes simple or surgical extractions up to unlimited per year.</li> <li>• Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services: Include partial dentures and complete dentures up to 1 set(s) every 5 years, denture adjustment, denture reline, denture repair, denture rebase, tissue conditioning up to 1 per year, occlusal adjustments up to 1 every 3 years, oral surgery up to 2 per year, bridges up to 1 every 5 years.</li> <li>• Periodontics: Include scaling and root planning (deep cleaning) up to 1 per quadrant every 3 years, scaling for moderate inflammation up to 1 every 3 years.</li> <li>• Extractions: Includes simple or surgical extractions up to unlimited per year.</li> <li>• Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services: Include partial dentures and complete dentures up to 1 set(s) every 5 years, denture adjustment, denture reline, denture repair, denture rebase, tissue conditioning up to 1 per year, occlusal adjustments up to 1 every 3 years, oral surgery up to 2 per year, bridges up to 1 every 5 years.</li> </ul>	
<p> <b>Depression screening</b></p> <p>We pay for one depression screening each year. The screening must be done in a primary care setting that can give follow-up treatment and/or referrals.</p>	\$0
<p> <b>Diabetes screening</b></p> <p>We pay for this screening (includes fasting glucose tests) if you have any of the following risk factors:</p> <ul style="list-style-type: none"> <li>• high blood pressure (hypertension)</li> <li>• history of abnormal cholesterol and triglyceride levels (dyslipidemia)</li> <li>• obesity</li> <li>• history of high blood sugar (glucose)</li> </ul> <p><b>This benefit is continued on the next page.</b></p>	\$0



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Services that our plan pays for	What you must pay
 <b>Diabetes screening (continued)</b> Tests may be covered in some other cases, such as if you're overweight and have a family history of diabetes. You may qualify for up to two diabetes screenings every 12 months following the date of your most recent diabetes screening test.	
 <b>Diabetic self-management training, services, and supplies</b> The plan will cover the following services for all people who have diabetes (whether they use insulin or not): <ul style="list-style-type: none"> <li>• Supplies to monitor your blood glucose, including the following:               <ul style="list-style-type: none"> <li>○ a blood glucose monitor</li> <li>○ blood glucose test strips</li> <li>○ lancet devices and lancets</li> <li>○ glucose-control solutions for checking the accuracy of test strips and monitors</li> </ul> </li> <li>• For people with diabetes who have severe diabetic foot disease, we pay for the following:               <ul style="list-style-type: none"> <li>○ one pair of therapeutic custom-molded shoes (including inserts), including the fitting, and two extra pairs of inserts each calendar year, <b>or</b></li> <li>○ one pair of depth shoes, including the fitting, and three pairs of inserts each year (not including the non-customized removable inserts provided with such shoes)</li> </ul> </li> <li>• In some cases, we pay for training to help you manage your diabetes. To find out more, contact Customer Care.</li> </ul>	\$0 <b>Prior authorization may be required.</b>
<b>Durable Medical Equipment and related supplies</b> Refer to <b>Chapter 12</b> of this <i>Evidence of Coverage</i> for a definition of “Durable medical equipment (DME).” We cover the following items: <ul style="list-style-type: none"> <li>• wheelchairs</li> <li>• crutches</li> <li>• powered mattress systems</li> </ul> <b>This benefit is continued on the next page.</b>	\$0 Your cost sharing won't change after being enrolled for 36 months. <b>Prior authorization may be required.</b>



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Services that our plan pays for	What you must pay
<p><b>Durable Medical Equipment and related supplies (continued)</b></p> <ul style="list-style-type: none"> <li>• diabetic supplies</li> <li>• hospital beds ordered by a provider for use in the home</li> <li>• intravenous (IV) infusion pumps and pole</li> <li>• speech generating devices</li> <li>• oxygen equipment and supplies</li> <li>• nebulizers</li> <li>• walkers</li> <li>• standard curved handle or quad cane and replacement supplies</li> <li>• cervical traction (over the door)</li> <li>• bone stimulator</li> <li>• dialysis care equipment</li> </ul> <p>Other items may be covered.</p> <p>We pay for all medically necessary DME that Medicare and Medicaid usually pay for. If our supplier in your area doesn't carry a particular brand or maker, you may ask them if they can special order it for you.</p> <p>Generally, our plan covers any DME covered by Medicare and Medicaid from the brands and makers on this list. We don't cover other brands and makers unless your doctor or other provider tells us that you need the brand. If you're new to our plan and using a brand of DME not on our list, we'll continue to pay for this brand for you for up to 90 days. During this time, talk with your doctor to decide what brand is medically right for you after the 90-day period. (If you disagree with your doctor, you can ask them to refer you for a second opinion.)</p> <p>If you (or your doctor) don't agree with our plan's coverage decision, you or your doctor can file an appeal. You can also file an appeal if you don't agree with your doctor's decision about what product or brand is appropriate for medical condition. For more information about appeals, refer to <b>Chapter 9</b> of this <i>Evidence of Coverage</i>.</p>	



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Services that our plan pays for	What you must pay
<p><b>Emergency care</b></p> <p>Emergency care means services that are:</p> <ul style="list-style-type: none"> <li>• given by a provider trained to give emergency services, <b>and</b></li> <li>• needed to evaluate or treat a medical emergency.</li> </ul> <p>A medical emergency is an illness, injury, severe pain, or medical condition that's quickly getting worse. The condition is so serious that, if it doesn't get immediate medical attention, anyone with an average knowledge of health and medicine could expect it to result in:</p> <ul style="list-style-type: none"> <li>• serious risk to your life or to that of your unborn child; <b>or</b></li> <li>• serious harm to bodily functions; <b>or</b></li> <li>• loss of a limb, or loss of function of a limb.</li> <li>• In the case of a pregnant woman in active labor, when: There isn't enough time to safely transfer you to another hospital before delivery.</li> </ul> <p>A transfer to another hospital may pose a threat to your health or safety or to that of your unborn child.</p> <p>Coverage is only for care provided within the U.S. and its territories.</p>	<p>\$0</p> <p>If you get emergency care at an out-of-network hospital and need inpatient care after your emergency is stabilized, you must move to a network hospital for your care to continue to be paid for. You can stay in the out-of-network hospital for your inpatient care</p>
<p><b>Family planning services</b></p> <p>The law lets you choose any provider – whether a network provider or out-of-network provider – for certain family planning services. This means any doctor, clinic, hospital, pharmacy or family planning office.</p> <p>We pay for the following services:</p> <ul style="list-style-type: none"> <li>• family planning exam and medical treatment</li> <li>• family planning lab and diagnostic tests</li> <li>• family planning methods (IUC/IUD, implants, injections, birth control pills, patch, or ring)</li> <li>• family planning supplies with prescription (condom, sponge, foam, film, diaphragm, cap)</li> <li>• counseling and diagnosis of infertility and related services</li> <li>• counseling, testing, and treatment for sexually transmitted infections (STIs)</li> </ul> <p><b>This benefit is continued on the next page.</b></p>	<p>\$0</p> <p><b><i>Prior authorization may be required.</i></b></p>




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Services that our plan pays for	What you must pay
<p><b>Family planning services (continued)</b></p> <ul style="list-style-type: none"> <li>• counseling and testing for HIV and AIDS, and other HIV-related conditions</li> <li>• permanent contraception (You must be age 21 or over to choose this method of family planning. You must sign a federal sterilization consent form at least 30 days, but not more than 180 days before the date of surgery.)</li> <li>• genetic counseling</li> </ul> <p>We also pay for some other family planning services. However, you must use a provider in our provider network for the following services:</p> <ul style="list-style-type: none"> <li>• treatment for medical conditions of infertility (This service doesn't include artificial ways to become pregnant.)</li> <li>• treatment for AIDS and other HIV-related conditions</li> <li>• genetic testing</li> </ul>	
<p><b>Health and wellness education programs</b></p> <p>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.</p>	\$0
<p><b>Hearing services</b></p> <p>We pay for hearing and balance tests done by your provider. These tests tell you whether you need medical treatment. They're covered as outpatient care when you get them from a physician, audiologist, or other qualified provider.</p> <p>Because you have Medicaid, we cover:</p> <ul style="list-style-type: none"> <li>• routine hearing exams</li> <li>• diagnostic hearing exams</li> <li>• hearing aids, batteries and repairs as needed</li> <li>• evaluations for fitting hearing aids.</li> </ul> <p>In addition, we cover <b>Mandatory Supplemental Hearing Benefits</b> which include a routine hearing exam and hearing aid coverage.</p> <p><b>This benefit is continued on the next page.</b></p>	<p>\$0</p> <p><b><i>Prior authorization may be required.</i></b></p>



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Services that our plan pays for	What you must pay
<p><b>Hearing services (continued)</b></p> <p>Routine: <b>You must see a TruHearing provider to use the routine hearing benefit. Call 1-844-255-7144 to schedule an appointment (for TTY, dial 711).</b></p> <ul style="list-style-type: none"> <li>• \$0 copay for a routine hearing exam up to 1 per year.</li> <li>• \$0 copay for unlimited follow-up provider visits during the first year following TruHearing hearing aid purchase.</li> <li>• \$0 copay for Advanced level hearing aid up to 1 per ear every 3 years.</li> <li>• Note: Includes 80 batteries, 60 day trial period, and 3 year warranty.</li> </ul> <p>Benefit does not include or cover any of the following:</p> <ul style="list-style-type: none"> <li>• OTC hearing aids</li> <li>• Additional cost for optional hearing aid rechargeability</li> <li>• Ear molds</li> <li>• Hearing aid accessories</li> <li>• Additional provider visits</li> <li>• Additional batteries (or batteries when a rechargeable hearing aid is purchased)</li> <li>• Hearing aids that are not TruHearing-branded Advanced hearing aids</li> <li>• Costs associated with loss &amp; damage warranty claims</li> </ul> <p>Costs associated with excluded items are the responsibility of the member and are not covered by the plan.</p>	
<p> <b>HIV screening</b></p> <p>We pay for one HIV screening exam every 12 months for people who:</p> <ul style="list-style-type: none"> <li>• ask for an HIV screening test, <b>or</b></li> <li>• are at increased risk for HIV infection.</li> </ul> <p>If you're pregnant, we pay for up to three HIV screening tests during a pregnancy.</p>	\$0



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Services that our plan pays for	What you must pay
<p><b>Home health agency care</b></p> <p>Before you can get home health services, a doctor must tell us you need them, and they must be provided by a home health agency. You must be homebound, which means leaving home is a major effort.</p> <p>We pay for the following services, and maybe other services not listed here:</p> <ul style="list-style-type: none"> <li>• 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.)</li> <li>• physical therapy, occupational therapy, and speech therapy</li> <li>• medical and social services</li> <li>• medical equipment and supplies</li> </ul>	<p>\$0</p> <p><b><i>Prior authorization may be required.</i></b></p>
<p><b>Home infusion therapy</b></p> <p>Our plan pays for home infusion therapy, defined as drugs or biological substances administered into a vein or applied under the skin and provided to you at home. The following are needed to perform home infusion:</p> <ul style="list-style-type: none"> <li>• the drug or biological substance, such as an antiviral or immune globulin;</li> <li>• equipment, such as a pump; <b>and</b></li> <li>• supplies, such as tubing or a catheter.</li> </ul> <p>Our plan covers home infusion services that include but aren't limited to:</p> <ul style="list-style-type: none"> <li>• professional services, including nursing services, provided in accordance with your care plan;</li> <li>• member training and education not already included in the DME benefit;</li> <li>• remote monitoring; <b>and</b></li> <li>• monitoring services for the provision of home infusion therapy and home infusion drugs furnished by a qualified home infusion therapy supplier.</li> </ul>	<p>\$0</p> <p><b><i>Prior authorization may be required.</i></b></p>




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Services that our plan pays for	What you must pay
<p><b>Hospice care</b></p> <p>You have the right to elect hospice if your provider and hospice medical director determine you have a terminal prognosis. This means you have a terminal illness and are expected to have six months or less to live. You can get care from any hospice program certified by Medicare. Our plan must help you find Medicare-certified hospice programs in the plan's service area, including programs we own, control, or have a financial interest in. Your hospice doctor can be a network provider or an out-of-network provider.</p> <p>Covered services include:</p> <ul style="list-style-type: none"> <li>• drugs to treat symptoms and pain</li> <li>• short-term respite care</li> <li>• home care</li> </ul> <p><b>For hospice services and services covered by Medicare Part A or Medicare Part B that relate to your terminal prognosis are billed to Medicare:</b></p> <ul style="list-style-type: none"> <li>• Original Medicare (rather than our plan) will pay your hospice provider for your hospice services and any Part A or B services related to your terminal illness. While you're in the hospice program, your hospice provider will bill Original Medicare for the services Original Medicare pays for.</li> </ul> <p><b>For services covered by our plan but not covered by Medicare Part A or Medicare Part B:</b></p> <ul style="list-style-type: none"> <li>• Our plan covers services not covered under Medicare Part A or Medicare Part B. We cover the services whether or not they relate to your terminal prognosis. You pay our plan's cost sharing amount for these services.</li> </ul> <p><b>For drugs that may be covered by our plan's Medicare Part D benefit:</b></p> <ul style="list-style-type: none"> <li>• Drugs are never covered by both hospice and our plan at the same time. For more information, refer to <b>Chapter 5</b> of this <i>Evidence of Coverage</i>.</li> </ul> <p><b>Note:</b> If you need non-hospice care, call your care coordinator and/or Customer Care to arrange the services. Non-hospice care is care that <b>isn't</b> related to your terminal prognosis.</p>	<p>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 iCare Family Care Partnership.</p>



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Services that our plan pays for	What you must pay
<p><b>iCare Meal Program</b></p> <p>Receive two (2) meals per day for 7 days (up to 14 meals) delivered to member's home after an inpatient stay in a hospital or nursing facility. Meal delivery must be scheduled within 30 days of discharge event. Limited to four (4) times per year.</p>	<p>There is no coinsurance, copayment, or deductible to participate.</p> <p><b><i>Prior authorization may be required.</i></b></p>
<p> <b>Immunizations</b></p> <p>The plan will cover the following services:</p> <ul style="list-style-type: none"> <li>• pneumonia vaccine</li> <li>• flu/influenza shots, once each flu/influenza season in the fall and winter, with additional flu/influenza shots if medically necessary</li> <li>• hepatitis B vaccines if you're at high or intermediate risk of getting hepatitis B</li> <li>• COVID-19 vaccine</li> <li>• other vaccines if you're at risk and they meet Medicare Part B coverage rules</li> </ul> <p>We pay for other vaccines that meet the Medicare Part D coverage rules. Refer to <b>Chapter 6</b> of this <i>Evidence of Coverage</i> to learn more.</p>	<p>\$0</p>
<p><b>Inpatient hospital care</b></p> <p>Includes inpatient acute, inpatient rehabilitation, long-term care hospitals and other types of inpatient hospital services. Inpatient hospital care starts the day you're formally admitted to the hospital with a doctor's order. The day before you're discharged is your last inpatient day.</p> <p>We pay for the following services and other medically necessary services not listed here:</p> <ul style="list-style-type: none"> <li>• private room (or a private room if medically necessary)</li> <li>• meals, including special diets</li> <li>• regular nursing services</li> <li>• costs of special care units, such as intensive care or coronary care units</li> <li>• drugs and medications</li> <li>• lab tests</li> </ul> <p><b>This benefit is continued on the next page.</b></p>	<p>\$0</p> <p>You must get approval from our plan to get inpatient care at an out-of-network hospital after your emergency is stabilized.</p> <p><b><i>Prior authorization may be required.</i></b></p>



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Services that our plan pays for	What you must pay
<p><b>Inpatient hospital care (continued)</b></p> <ul style="list-style-type: none"> <li>• X-rays and other radiology services</li> <li>• needed surgical and medical supplies</li> <li>• appliances, such as wheelchairs</li> <li>• operating and recovery room services</li> <li>• physical, occupational, and speech therapy</li> <li>• inpatient substance abuse services</li> <li>• in some cases, the following types of transplants: corneal, kidney, kidney/pancreas, heart, liver, lung, heart/lung, bone marrow, stem cell, and intestinal/multivisceral.</li> </ul> <p>If you need a transplant, a Medicare-approved transplant center will review your case and decide if you're a candidate for a transplant. Under certain conditions, the following types of transplants are covered:</p> <ul style="list-style-type: none"> <li>• corneal</li> <li>• kidney</li> <li>• kidney-pancreatic</li> <li>• heart</li> <li>• liver</li> <li>• lung</li> <li>• heart/lung</li> <li>• bone marrow</li> <li>• stem cell, and</li> <li>• intestinal/multivisceral</li> </ul> <p>If you need a transplant, we'll arrange to have your case reviewed by a Medicare-approved transplant center that'll decide whether you're a candidate for a transplant. Transplant providers may be local or outside of the service area. If our in-network transplant services are outside the community pattern of care, you may choose to go locally as long as the local transplant providers are willing to accept the Original Medicare rate.</p> <p>If Family Care Partnership provides transplant services at a location outside the pattern of care for transplants in your</p> <p><b>This benefit is continued on the next page.</b></p>	



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Services that our plan pays for	What you must pay
<p><b>Inpatient hospital care (continued)</b></p> <p>community and you choose to obtain transplants at this distant location, we'll arrange or pay for appropriate lodging and transportation costs for you and a companion.</p> <ul style="list-style-type: none"> <li>• blood, including storage and administration</li> <li>• physician services</li> </ul> <p><b>Note:</b> 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're not sure if you're an inpatient or an outpatient, ask the hospital staff.</p> <p>Get more information in the Medicare fact sheet Medicare Hospital Benefits. This fact sheet is available at <a href="https://www.medicare.gov/publications/11435-Medicare-Hospital-Benefits.pdf">Medicare.gov/publications/11435-Medicare-Hospital-Benefits.pdf</a> or by calling 1-800-MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048.</p>	
<p><b>Inpatient services in a psychiatric hospital</b></p> <p>We pay for mental health care services that require a hospital stay.</p>	<p>\$0</p> <p><b>Prior authorization may be required.</b></p>
<p><b>Inpatient stay: Covered services in a hospital or skilled nursing facility (SNF) during a non-covered inpatient stay</b></p> <p>We don't pay for your inpatient stay if you've used all of your inpatient benefit or if the stay isn't reasonable and medically necessary.</p> <p>However, in certain situations where inpatient care isn't covered, we may pay for services you get while you're in a hospital or nursing facility. To find out more, contact Customer Care.</p> <p>We pay for the following services, and maybe other services not listed here:</p> <ul style="list-style-type: none"> <li>• doctor services</li> <li>• diagnostic tests, like lab tests</li> <li>• X-ray, radium, and isotope therapy, including technician materials and services</li> <li>• surgical dressings</li> </ul> <p><b>This benefit is continued on the next page.</b></p>	<p>\$0</p> <p><b>Prior authorization may be required.</b></p>





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Services that our plan pays for	What you must pay
<p><b>Inpatient stay: Covered services in a hospital or skilled nursing facility (SNF) during a non-covered inpatient stay (continued)</b></p> <ul style="list-style-type: none"> <li>• splints, casts, and other devices used for fractures and dislocations</li> <li>• prosthetics and orthotic devices, other than dental, including replacement or repairs of such devices. These are devices that replace all or part of: <ul style="list-style-type: none"> <li>○ an internal body organ (including contiguous tissue), <b>or</b></li> <li>○ the function of an inoperative or malfunctioning internal body organ.</li> </ul> </li> <li>• leg, arm, back, and neck braces, trusses, and artificial legs, arms, and eyes. This includes adjustments, repairs, and replacements needed because of breakage, wear, loss, or a change in your condition</li> <li>• physical therapy, speech therapy, and occupational therapy</li> </ul>	
<p><b>Kidney disease services and supplies</b></p> <p>We pay for the following services:</p> <ul style="list-style-type: none"> <li>• Kidney disease education services to teach kidney care and help you make good decisions about your care. You must have stage IV chronic kidney disease, and your doctor must refer you. We cover up to six sessions of kidney disease education services.</li> <li>• Outpatient dialysis treatments, including dialysis treatments when temporarily out of the service area, as explained in <b>Chapter 3</b> of this <i>Evidence of Coverage</i>, or when your provider for this service is temporarily unavailable or inaccessible.</li> <li>• Inpatient dialysis treatments if you're admitted as an inpatient to a hospital for special care.</li> <li>• Self-dialysis training, including training for you and anyone helping you with your home dialysis treatments.</li> <li>• Home dialysis equipment and supplies.</li> <li>• Certain home support services, such as necessary visits by trained dialysis workers to check on your home</li> </ul> <p><b>This benefit is continued on the next page.</b></p>	<p>\$0</p> <p><b><i>Prior authorization may be required.</i></b></p>




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Services that our plan pays for	What you must pay
<p><b>Kidney disease services and supplies (continued)</b></p> <p>dialysis, to help in emergencies, and to check your dialysis equipment and water supply.</p> <p>Medicare Part B pays for some drugs for dialysis. For information, refer to “Medicare Part B drugs” in this chart.</p>	
<p> <b>Lung cancer screening with low dose computed tomography (LDCT)</b></p> <p>Our plan pays for lung cancer screening every 12 months if you:</p> <ul style="list-style-type: none"> <li>• are aged 50-77, <b>and</b></li> <li>• have a counseling and shared decision-making visit with your doctor or other qualified provider, <b>and</b></li> <li>• have smoked at least 1 pack a day for 20 years with no signs or symptoms of lung cancer or smoke now or have quit within the last 15 years.</li> </ul> <p>After the first screening, our plan pays for another screening each year with a written order from your doctor or other qualified provider. If a provider elects to provide a lung cancer screening counseling and shared decision-making visit for lung cancer screenings, the visit must meet the Medicare criteria for such visits.</p>	\$0
<p> <b>Medical nutrition therapy</b></p> <p>This benefit is for people with diabetes or kidney disease without dialysis. It’s also for after a kidney transplant when ordered by your doctor.</p> <p>This benefit is for people with diabetes or kidney disease without dialysis. It’s also for after a kidney transplant when ordered by your doctor.</p> <p>We pay for three hours of one-on-one counseling services during the first year you get medical nutrition therapy services under Medicare. We may approve additional services if medically necessary.</p> <p>We pay for two hours of one-on-one counseling services each year after that. If your condition, treatment, or diagnosis changes, you may be able to get more hours of treatment with a doctor’s order. A doctor must prescribe these services and renew the order each year if you need treatment in the next calendar year. We may approve additional services if medically necessary.</p>	\$0



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Services that our plan pays for	What you must pay
 <b>Medicare Diabetes Prevention Program (MDPP)</b> Our plan pays for MDPP services for eligible people. MDPP is designed to help you increase healthy behavior. It provides practical training in: <ul style="list-style-type: none"> <li>• long-term dietary change, <b>and</b></li> <li>• increased physical activity, <b>and</b></li> <li>• ways to maintain weight loss and a healthy lifestyle.</li> </ul>	\$0
<b>Medicare Part B drugs</b> These drugs are covered under Part B of Medicare. Our plan pays for the following drugs: <ul style="list-style-type: none"> <li>• drugs you don't usually give yourself and are injected or infused while you get doctor, hospital outpatient, or ambulatory surgery center services</li> <li>• insulin furnished through an item of durable medical equipment (such as a medically necessary insulin pump)</li> <li>• other drugs you take using durable medical equipment (such as nebulizers) that our plan authorized</li> <li>• the Alzheimer's drug, Leqembi® (generic lecanemab) which is given intravenously (IV)</li> <li>• clotting factors you give yourself by injection if you have hemophilia</li> <li>• transplant/immunosuppressive drugs: Medicare covers transplant drug therapy if Medicare paid for your organ transplant. You must have Part A at the time of the covered transplant, and you must have Part B at the time you get immunosuppressive drugs. Medicare Part D covers immunosuppressive drugs if Part B doesn't cover them</li> <li>• osteoporosis drugs that are injected. We pay for these drugs if you're homebound, have a bone fracture that a doctor certifies was related to post-menopausal osteoporosis, and can't inject the drug yourself</li> <li>• some antigens: Medicare covers antigens if a doctor prepares them and a properly instructed person (who could be you, the patient) gives them under appropriate supervision</li> <li>• certain oral anti-cancer drugs: Medicare covers some oral cancer drugs you take by mouth if the same drug is available in injectable form or the drug is a prodrug</li> </ul> <b>This benefit is continued on the next page.</b>	\$0 <b>Prior authorization may be required.</b>



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Services that our plan pays for	What you must pay
<p><b>Medicare Part B drugs (continued)</b></p> <p>(an oral form of a drug that, when ingested, breaks down into the same active ingredient found in the injectable drug). As new oral cancer drugs become available, Part B may cover them. If Part B doesn't cover them, Part D does</p> <ul style="list-style-type: none"> <li>oral anti-nausea drugs: Medicare covers oral anti-nausea drugs you use as part of an anti-cancer chemotherapeutic regimen if they're administered before, at, or within 48 hours of chemotherapy or are used as a full therapeutic replacement for an intravenous anti-nausea drug</li> <li>certain oral End-Stage Renal Disease (ESRD) drugs covered under Medicare Part B</li> <li>calcimimetic and phosphate binder medications under the ESRD payment system, including the intravenous medication Parsabiv®, and the oral medication Sensipar</li> <li>certain drugs for home dialysis, including heparin, the antidote for heparin (when medically necessary) and topical anesthetics</li> <li>erythropoiesis-stimulating agents: Medicare covers erythropoietin by injection if you have ESRD or you have ESRD or you need this drug to treat anemia related to certain other conditions (such as Epogen®, Procrit®, Retacrit®, Epoetin Alfa, Aranesp®, Darbepoetin Alfa®, Mircera®, or Methoxy polyethylene glycol-epotin beta)</li> <li>IV immune globulin for the home treatment of primary immune deficiency diseases</li> <li>parenteral and enteral nutrition (IV and tube feeding)</li> </ul> <p>We also cover some vaccines under our Medicare Part B and most adult vaccines under our Medicare Part D drug benefit.</p> <p><b>Chapter 5</b> of this <i>Evidence of Coverage</i> explains our drug benefit. It explains rules you must follow to have prescriptions covered.</p> <p><b>Chapter 6</b> of this <i>Evidence of Coverage</i> explains what you pay for your drugs through our plan.</p>	
<p><b>Nursing facility care</b></p> <p>A nursing facility (NF) is a place that provides care for people who can't get care at home but who don't need to be in a hospital.</p> <p><b>This benefit is continued on the next page.</b></p>	<p>\$0</p> <p><b>Prior authorization may be required.</b></p>




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Services that our plan pays for	What you must pay
<p><b>Nursing facility care (continued)</b></p> <p>Services that we pay for include, but aren't limited to, the following:</p> <ul style="list-style-type: none"> <li>• semiprivate room (or a private room if medically necessary)</li> <li>• meals, including special diets</li> <li>• nursing services</li> <li>• physical therapy, occupational therapy, and speech therapy</li> <li>• respiratory therapy</li> <li>• drugs given to you as part of your plan of care. (This includes substances that are naturally present in the body, such as blood-clotting factors.)</li> <li>• blood, including storage and administration</li> <li>• medical and surgical supplies usually given by nursing facilities</li> <li>• lab tests usually given by nursing facilities</li> <li>• X-rays and other radiology services usually given by nursing facilities</li> <li>• use of appliances, such as wheelchairs usually given by nursing facilities</li> <li>• physician/practitioner services</li> <li>• durable medical equipment</li> <li>• dental services, including dentures</li> <li>• vision benefits</li> <li>• hearing exams</li> <li>• chiropractic care</li> <li>• podiatry services</li> </ul> <p>You usually get your care from network facilities. However, you may be able to get your care from a facility not in our network. You can get care from the following places if they accept our plan's amounts for payment:</p> <ul style="list-style-type: none"> <li>• a nursing facility or continuing care retirement community where you were living right before you went</li> </ul> <p><b>This benefit is continued on the next page.</b></p>	



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Services that our plan pays for	What you must pay
<p><b>Nursing facility care (continued)</b></p> <p>to the hospital (as long as it provides nursing facility care).</p> <ul style="list-style-type: none"> <li>a nursing facility where your spouse or domestic partner is living at the time you leave the hospital.</li> </ul>	
<p> <b>Obesity screening and therapy to keep weight down</b></p> <p>If you have a body mass index of 30 or more, we pay for counseling to help you lose weight. You must get the counseling in a primary care setting. That way, it can be managed with your full prevention plan. Talk to your primary care provider to find out more.</p>	\$0
<p><b>Opioid treatment program (OTP) services</b></p> <p>Our plan pays for the following services to treat opioid use disorder (OUD) through an OTP which includes the following services:</p> <ul style="list-style-type: none"> <li>intake activities</li> <li>periodic assessments</li> <li>medications approved by the FDA and, if applicable, managing and giving you these medications</li> <li>substance use counseling</li> <li>individual and group therapy</li> <li>testing for drugs or chemicals in your body (toxicology testing)</li> </ul>	<p>\$0</p> <p><b><i>Prior authorization may be required.</i></b></p>
<p><b>Outpatient diagnostic tests and therapeutic services and supplies</b></p> <p>We pay for the following services and other medically necessary services not listed here:</p> <ul style="list-style-type: none"> <li>X-rays</li> <li>radiation (radium and isotope) therapy, including technician materials and supplies</li> <li>surgical supplies, such as dressings</li> <li>splints, casts, and other devices used for fractures and dislocations</li> <li>lab tests</li> </ul> <p><b>This benefit is continued on the next page.</b></p>	<p>\$0</p> <p><b><i>Prior authorization may be required.</i></b></p>



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Services that our plan pays for	What you must pay
<p><b>Outpatient diagnostic tests and therapeutic services and supplies (continued)</b></p> <ul style="list-style-type: none"> <li>• blood, including storage and administration</li> <li>• diagnostic non-laboratory tests such as CT scans, MRIs, EKGs, and PET scans when your doctor or other health care provider orders them to treat a medical condition</li> <li>• other outpatient diagnostic tests</li> </ul>	
<p><b>Outpatient hospital observation</b></p> <p>We pay for outpatient hospital observation services to determine if you need to be admitted as an inpatient or can be discharged.</p> <p>The services must meet Medicare criteria and be considered reasonable and necessary. Observation services are covered only when provided by the order of a physician or another person authorized by state law and hospital staff bylaws to admit patients to the hospital or order outpatient tests.</p> <p><b>Note:</b> Unless the provider has written an order to admit you as an inpatient to the hospital, you're an outpatient. Even if you stay in the hospital overnight, you might still be considered an outpatient. If you aren't sure if you're an outpatient, ask hospital staff.</p> <p>Get more information in the Medicare fact sheet Medicare Hospital Benefits. This fact sheet is available at <a href="https://www.medicare.gov/publications/11435-Medicare-Hospital-Benefits.pdf">Medicare.gov/publications/11435-Medicare-Hospital-Benefits.pdf</a></p>	<p>\$0</p> <p><b>Prior authorization may be required.</b></p>
<p><b>Outpatient hospital services</b></p> <p>We pay for medically necessary services you get in the outpatient department of a hospital for diagnosis or treatment of an illness or injury, such as:</p> <ul style="list-style-type: none"> <li>• Services in an emergency department or outpatient clinic, such as outpatient surgery or observation services <ul style="list-style-type: none"> <li>○ Observation services help your doctor know if you need to be admitted to the hospital as "inpatient."</li> <li>○ Sometimes you can be in the hospital overnight and still be "outpatient."</li> </ul> </li> </ul> <p><b>This benefit is continued on the next page.</b></p>	<p>\$0</p> <p><b>Prior authorization may be required.</b></p>



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Services that our plan pays for	What you must pay
<p><b>Outpatient hospital services (continued)</b></p> <ul style="list-style-type: none"> <li>○ You can get more information about being inpatient or outpatient in this fact sheet: <a href="https://www.medicare.gov/publications/11435-Medicare-Hospital-Benefits.pdf">es.medicare.gov/publications/11435-Medicare-Hospital-Benefits.pdf</a>.</li> <li>• Labs and diagnostic tests billed by the hospital</li> <li>• Mental health care, including care in a partial-hospitalization program, if a doctor certifies that inpatient treatment would be needed without it</li> <li>• X-rays and other radiology services billed by the hospital</li> <li>• Medical supplies, such as splints and casts</li> <li>• Preventive screenings and services listed throughout the Benefits Chart</li> <li>• Some drugs that you can't give yourself</li> </ul>	
<p><b>Outpatient mental health care</b></p> <p>We pay for mental health services provided by:</p> <ul style="list-style-type: none"> <li>• a state-licensed psychiatrist or doctor</li> <li>• a clinical psychologist</li> <li>• a clinical social worker</li> <li>• a clinical nurse specialist</li> <li>• a licensed professional counselor (LPC)</li> <li>• a licensed marriage and family therapist (LMFT)</li> <li>• a nurse practitioner (NP)</li> <li>• a physician assistant (PA)</li> <li>• any other Medicare-qualified mental health care professional as allowed under applicable state laws</li> </ul>	<p>\$0</p> <p><b><i>Prior authorization may be required.</i></b></p>
<p><b>Outpatient rehabilitation services</b></p> <p>We pay for physical therapy, occupational therapy, and speech therapy.</p> <p>You can get outpatient rehabilitation services from hospital outpatient departments, independent therapist offices, comprehensive outpatient rehabilitation facilities (CORFs), and other facilities.</p>	<p>\$0</p> <p><b><i>Prior authorization may be required.</i></b></p>



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Services that our plan pays for	What you must pay
<p><b>Outpatient substance use disorder services</b></p> <p>We pay for the following services, and maybe other services not listed here:</p> <ul style="list-style-type: none"> <li>• alcohol misuse screening and counseling</li> <li>• treatment of drug abuse</li> <li>• group or individual counseling by a qualified clinician</li> <li>• subacute detoxification in a residential addiction program</li> <li>• alcohol and/or drug services in an intensive outpatient treatment center</li> <li>• extended-release Naltrexone (vivitrol) treatment</li> </ul>	<p>\$0</p> <p><b>Prior authorization may be required.</b></p>
<p><b>Outpatient surgery</b></p> <p>We pay for outpatient surgery and services at hospital outpatient facilities and ambulatory surgical centers.</p> <p><b>Note:</b> If you're having surgery in a hospital facility, you should check with your provider about whether you'll be an inpatient or outpatient. Unless the provider writes an order to admit you as an inpatient to the hospital, you're an outpatient. Even if you stay in the hospital overnight, you might still be considered an outpatient.</p>	<p>\$0</p> <p><b>Prior authorization may be required.</b></p>
<p><b>Over-the-Counter (OTC) Mail Order</b></p> <p>You have a \$45 quarterly allowance to buy approved over-the-counter health and wellness products available through our OTC Mail Order provider.</p> <ul style="list-style-type: none"> <li>• The allowance is available to use the first day of each quarter - January, April, July, October.</li> <li>• Any unused amount rolls over to the next quarter and expires at the end of the year.</li> <li>• Limitation and restrictions may apply.</li> </ul> <p>Please contact Customer Care for additional benefit details or to obtain an order form.</p>	<p>\$0</p> <p><b>Prior authorization may be required.</b></p>



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Services that our plan pays for	What you must pay
<p><b>Partial hospitalization services and intensive outpatient services</b></p> <p><b>Partial hospitalization</b> is a structured program of active psychiatric treatment. It's offered as a hospital outpatient service or by a community mental health center that's more intense than the care you get in your doctor's, therapist's, licensed marriage and family therapist's (LMFT), or licensed professional counselor's office. It can help keep you from having to stay in the hospital.</p> <p><b>Intensive outpatient service</b> is a structured program of active behavioral (mental) health therapy treatment provided as a hospital outpatient service, a community mental health center, a federally qualified health center, or a rural health clinic that's more intense than care you get in your doctor's, therapist's, LMFT, or licensed professional counselor's office but less intense than partial hospitalization.</p>	<p>\$0</p> <p><i>Prior authorization may be required.</i></p>
<p><b>Physician/provider services, including doctor's office visits</b></p> <p>We pay for the following services:</p> <ul style="list-style-type: none"> <li>• medically necessary health care or surgery services given in places such as:</li> <li>• physician's office</li> <li>• certified ambulatory surgical center</li> <li>• hospital outpatient department</li> <li>• consultation, diagnosis, and treatment by a specialist</li> <li>• basic hearing and balance exams given by your primary care provider, if your doctor orders them to find out whether you need treatment</li> <li>• Certain telehealth services, including consultation, diagnosis, and treatment by a physician or practitioner, for patients in certain rural areas or other places approved by Medicare. <ul style="list-style-type: none"> <li>○ You have the option of getting these services through an in-person visit or by telehealth. If you choose to get one of these services by telehealth, you must use a network provider who offers the service by telehealth.</li> </ul> </li> </ul> <p><b>This benefit is continued on the next page.</b></p>	<p>\$0</p> <p><i>Prior authorization may be required.</i></p>





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Services that our plan pays for	What you must pay
<p><b>Physician/provider services, including doctor's office visits (continued)</b></p> <ul style="list-style-type: none"> <li>• telehealth services for monthly end-stage renal disease (ESRD) related visits for home dialysis members in a hospital-based or critical access hospital-based renal dialysis center, renal dialysis facility, or at home</li> <li>• telehealth services to diagnose, evaluate, or treat symptoms of a stroke</li> <li>• telehealth services for members with a substance use disorder or co-occurring mental health disorder</li> <li>• telehealth services for diagnosis, evaluation, and treatment of mental health disorders if: <ul style="list-style-type: none"> <li>○ You have an in-person visit within 6 months prior to your first telehealth visit</li> <li>○ You have an in-person visit every 12 months while receiving these telehealth services</li> <li>○ Exceptions can be made to the above for certain circumstances</li> </ul> </li> <li>• telehealth services for mental health visits provided by rural health clinics and federally qualified health centers.</li> <li>• virtual check-ins (for example, by phone or video chat) with your doctor for 5-10 minutes <b>if</b> <ul style="list-style-type: none"> <li>○ you're not a new patient <b>and</b></li> <li>○ the check-in isn't related to an office visit in the past 7 days <b>and</b></li> <li>○ the check-in doesn't lead to an office visit within 24-hours or the soonest available appointment</li> </ul> </li> <li>• Evaluation of video and/or images you send to your doctor and interpretation and follow-up by your doctor within 24 hours <b>if</b>: <ul style="list-style-type: none"> <li>○ you're not a new patient <b>and</b></li> <li>○ the evaluation isn't related to an office visit in the past 7 days <b>and</b></li> <li>○ the evaluation doesn't lead to an office visit within 24-hours or the soonest available appointment</li> </ul> </li> <li>• Consultation your doctor has with other doctors by</li> </ul> <p><b>This benefit is continued on the next page.</b></p>	




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Services that our plan pays for	What you must pay
<p><b>Physician/provider services, including doctor's office visits (continued)</b></p> <p>phone, the Internet, or electronic health record if you're not a new patient</p> <ul style="list-style-type: none"> <li>• Second opinion by another network provider before surgery</li> </ul>	
<p><b>Podiatry services</b></p> <p>We pay for the following services:</p> <ul style="list-style-type: none"> <li>• diagnosis and medical or surgical treatment of injuries and diseases of the foot (such as hammer toe or heel spurs)</li> <li>• routine foot care for members with conditions affecting the legs, such as diabetes</li> </ul>	<p>\$0</p> <p><b><i>Prior authorization may be required.</i></b></p>
<p> <b>Pre-exposure prophylaxies (PrEP) for HIV prevention</b></p> <p>If you don't have HIV, but your doctor or other health care practitioner determines you're at an increased risk for HIV, we cover pre-exposure prophylaxis (PrEP) medication and related services.</p> <p>If you qualify, covered services include:</p> <ul style="list-style-type: none"> <li>• FDA-approved oral or injectable PrEP medication. If you're getting an injectable drug, we also cover the fee for injecting the drug.</li> <li>• Up to 8 individual counseling sessions (including HIV risk assessment, HIV risk reduction, and medication adherence) every 12 months.</li> <li>• Up to 8 HIV screenings every 12 months.</li> <li>• A one-time hepatitis B virus screening.</li> </ul>	<p>\$0</p>
<p> <b>Prostate cancer screening exams</b></p> <p>For men aged 50 and over, we pay for the following services once every 12 months:</p> <ul style="list-style-type: none"> <li>• a digital rectal exam</li> <li>• a prostate specific antigen (PSA) test</li> </ul>	<p>\$0</p>




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Services that our plan pays for	What you must pay
<p><b>Prosthetic and orthotic devices and related supplies</b></p> <p>Prosthetic devices replace all or part of a body part or function. These include but aren't limited to:</p> <ul style="list-style-type: none"> <li>• testing, fitting, or training in the use of prosthetic and orthotic devices</li> <li>• colostomy bags and supplies related to colostomy care</li> <li>• pacemakers</li> <li>• braces</li> <li>• prosthetic shoes</li> <li>• artificial arms and legs</li> <li>• breast prostheses (including a surgical brassiere after a mastectomy)</li> </ul> <p>We pay for some supplies related to prosthetic and orthotic devices. We also pay to repair or replace prosthetic and orthotic devices.</p> <p>We offer some coverage after cataract removal or cataract surgery. Refer to "Vision care" later in this chart for details.</p>	<p>\$0</p> <p><b><i>Prior authorization may be required.</i></b></p>
<p><b>Pulmonary rehabilitation services</b></p> <p>We pay for pulmonary rehabilitation programs for members who have moderate to very severe chronic obstructive pulmonary disease (COPD). You must have an order for pulmonary rehabilitation from the doctor or provider treating the COPD.</p>	<p>\$0</p> <p><b><i>Prior authorization may be required.</i></b></p>
<p> <b>Screening for Hepatitis C Virus infection</b></p> <p>We cover one Hepatitis C screening if your primary care doctor or other qualified health care provider orders one and you meet one of these conditions:</p> <ul style="list-style-type: none"> <li>• You're at high risk because you use or have used illicit injection drugs.</li> <li>• You had a blood transfusion before 1992.</li> <li>• You were born between 1945-1965.</li> <li>• If you were born between 1945-1965 and aren't considered high risk, we pay for a screening once.</li> </ul> <p>If you're at high risk (for example, you've continued to use illicit injection drugs since your previous negative Hepatitis C screening test), we cover yearly screenings.</p>	<p>\$0</p>




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Services that our plan pays for	What you must pay
 <b>Sexually transmitted infections (STIs) screening and counseling</b> <p>We pay for screenings for chlamydia, gonorrhea, syphilis, and hepatitis B. These screenings are covered for pregnant women and for some people who are at increased risk for an STI. A primary care provider must order the tests. We cover these tests once every 12 months or at certain times during pregnancy.</p> <p>We also pay for up to two face-to-face, high-intensity behavioral counseling sessions each year for sexually active adults at increased risk for STIs. Each session can be 20 to 30 minutes long. We pay for these counseling sessions as a preventive service only if given by a primary care provider. The sessions must be in a primary care setting, such as a doctor's office.</p>	<p>\$0</p>
<p><b>Skilled nursing facility (SNF) care</b></p> <p>For a definition of skilled nursing facility care, go to <b>Chapter 12</b>.</p> <p>We pay for the following services, and maybe other services not listed here:</p> <ul style="list-style-type: none"> <li>• a semi-private room, or a private room if it's medically necessary</li> <li>• meals, including special diets</li> <li>• skilled nursing services</li> <li>• physical therapy, occupational therapy, and speech therapy</li> <li>• drugs you get as part of your plan of care, including substances that are naturally in the body, such as blood-clotting factors</li> <li>• blood, including storage and administration</li> <li>• medical and surgical supplies given by SNFs</li> <li>• lab tests given by SNFs</li> <li>• X-rays and other radiology services given by nursing facilities</li> <li>• appliances, such as wheelchairs, usually given by nursing facilities</li> <li>• physician/provider services</li> </ul> <p><b>This benefit is continued on the next page.</b></p>	<p>\$0</p> <p><b><i>Prior authorization may be required.</i></b></p>



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Services that our plan pays for	What you must pay
<p><b>Skilled nursing facility (SNF) care (continued)</b></p> <p>You usually get SNF care from network facilities. Under certain conditions you may be able to get your care from a facility not in our network. You can get care from the following places if they accept our plan's amounts for payment:</p> <ul style="list-style-type: none"> <li>• a nursing facility or continuing care retirement community where you lived before you went to the hospital (as long as it provides nursing facility care)</li> <li>• a nursing facility where your spouse or domestic partner lives at the time you leave the hospital</li> </ul>	
<p> <b>Smoking and tobacco use cessation</b></p> <p>Smoking and tobacco use cessation counseling is covered for outpatient and hospitalized patients who meet these criteria:</p> <ul style="list-style-type: none"> <li>• use tobacco, regardless of whether they exhibit signs or symptoms of tobacco-related disease</li> <li>• are competent and alert during counseling</li> <li>• a qualified physician or other Medicare-recognized practitioner provides counseling</li> </ul> <p>We cover two cessation attempts per year (each attempt may include a maximum of four intermediate or intensive sessions, with up to eight sessions per year).</p>	<p>\$0</p>
<p><b>Supervised exercise therapy (SET)</b></p> <p>We pay for SET for members with symptomatic peripheral artery disease (PAD) who have a referral for PAD from the physician responsible for PAD treatment.</p> <p>Our plan pays for:</p> <ul style="list-style-type: none"> <li>• up to 36 sessions during a 12-week period if all SET requirements are met</li> <li>• an additional 36 sessions over time if deemed medically necessary by a health care provider</li> </ul> <p>The SET program must be:</p> <ul style="list-style-type: none"> <li>• 30 to 60-minute sessions of a therapeutic exercise-training program for PAD in members with leg cramping due to poor blood flow (claudication)</li> </ul> <p><b>This benefit is continued on the next page.</b></p>	<p>\$0</p> <p><b><i>Prior authorization may be required.</i></b></p>




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Services that our plan pays for	What you must pay
<p><b>Supervised exercise therapy (SET) (continued)</b></p> <ul style="list-style-type: none"> <li>• in a hospital outpatient setting or in a physician's office</li> <li>• delivered by qualified personnel who make sure benefit exceeds harm and who are trained in exercise therapy for PAD</li> <li>• under the direct supervision of a physician, physician assistant, or nurse practitioner/clinical nurse specialist trained in both basic and advanced life support techniques</li> </ul>	
<p><b>Urgently needed care</b></p> <p>Urgently needed care is care given to treat:</p> <ul style="list-style-type: none"> <li>• a non-emergency that requires immediate medical care, <b>or</b></li> <li>• an unforeseen medical illness, <b>or</b></li> <li>• an injury, <b>or</b></li> <li>• a condition that needs care right away.</li> </ul> <p>If you require urgently needed care, you should first try to get it from a network provider. However, you can use out-of-network providers when you can't get to a network provider because given your time, place, or circumstances, it's not possible, or it's unreasonable to get this service from network providers (for example, when you're outside the plan's service area and you require medically needed immediate services for an unseen condition but it's not a medical emergency).</p>	\$0
<p><b>Vision care</b></p> <p>We pay for outpatient doctor services for the diagnosis and treatment of diseases and injuries of the eye. For example, treatment for age-related macular degeneration.</p> <p>For people at high risk of glaucoma, we pay for one glaucoma screening each year. People at high risk of glaucoma include:</p> <ul style="list-style-type: none"> <li>• people with a family history of glaucoma</li> <li>• people with diabetes</li> <li>• African-Americans who are 50 and over</li> <li>• Hispanic Americans who are 65 and over</li> </ul> <p><b>This benefit is continued on the next page.</b></p>	<p>\$0</p> <p><b><i>Prior authorization is required for eye exams and eyewear (contacts and eyeglasses).</i></b></p>



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Services that our plan pays for	What you must pay
<p><b>Vision care (continued)</b></p> <p>For people with diabetes, we pay for screening for diabetic retinopathy once per year.</p> <p>We pay for one pair of glasses or contact lenses after each cataract surgery when the doctor inserts an intraocular lens.</p> <p>If you have two separate cataract surgeries, you must get one pair of glasses after each surgery. You can't get two pairs of glasses after the second surgery, even if you didn't get a pair of glasses after the first surgery.</p> <p><b>This plan provides a supplemental benefit under Medicare Part C for:</b></p> <ul style="list-style-type: none"> <li>○ \$0 co-pay for routine exam up to one (1) per year. \$50 combined maximum benefit coverage amount per year for routine exam.</li> <li>● \$400 combined maximum benefit coverage amount per year for contact lenses or eyeglasses — lenses and frames, fitting for eyeglasses — lenses and frames.</li> <li>● Eyeglass lens options may be available with the maximum benefit coverage amount up to one (1) pair per year. Maximum benefit coverage amount is limited to one time use per year.</li> </ul>	
<p> <b>“Welcome to Medicare” Preventive Visit</b></p> <p>The plan covers the one-time “Welcome to Medicare” preventive visit. The visit includes:</p> <ul style="list-style-type: none"> <li>● a review of your health,</li> <li>● education and counseling about the preventive services you need (including screenings and shots), <b>and</b></li> <li>● referrals for other care if you need it.</li> </ul> <p><b>Note:</b> We cover the “Welcome to Medicare” preventive visit only during the first 12 months that you have Medicare Part B. When you make your appointment, tell your doctor's office you want to schedule your “Welcome to Medicare” preventive visit.</p>	<p>\$0</p>



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Services that our plan pays for	What you must pay
<p><b>Medicaid Benefits</b></p> <p>Listed below are the Wisconsin Medicaid benefits covered by Family Care Partnership. Because you're a member of this program, your Medicare deductible and coinsurance amounts are paid on your behalf.</p> <p>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.</p> <p>All members of Family Care Partnership receive coverage for health care and drugs. These benefits include but aren't limited to:</p> <ul style="list-style-type: none"> <li>• Alcohol and other drug abuse (AODA) services</li> <li>• Audiology</li> <li>• Case management</li> <li>• Chiropractic</li> <li>• Dental services</li> <li>• Diagnostic testing services</li> <li>• Dialysis services</li> <li>• Durable medical equipment and medical supplies</li> <li>• Home care services (Home health, nursing and personal care)</li> <li>• Hospice care services</li> <li>• Hospital services</li> <li>• Medicare deductible and coinsurance</li> <li>• Mental health services</li> <li>• Nursing home services.</li> <li>• Physician services</li> <li>• Podiatry services</li> <li>• Respiratory care for ventilator-assisted recipients</li> <li>• Therapy – physical therapy, occupational therapy and speech and language pathology services</li> <li>• Transportation</li> <li>• Vision care services</li> </ul>	<p><i>Members are required to use network providers for all types of service, except emergency care.</i></p> <p><i>There are no deductibles or copays for covered, authorized services.</i></p> <p><i>Prior authorization is required for most types of services. Contact your Care Team for details.</i></p> <p><i>Services AREN'T covered outside of the United States and its territories, except under limited circumstances.</i></p> <p><i>As a member of Family Care Partnership, 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.</i></p> <p><i>iCare Family Care Partnership will bill you for the cost share each month. (The federal government refers to this as the "post-eligibility treatment of income.").</i></p> <p><i>If you reside in substitute care, you must also pay for room and board. iCare Family Care Partnership will also bill you for room and board each month.</i></p> <p><i>Providers may not bill you for covered benefits that were authorized by Family Care Partnership and received while you were enrolled in our plan. Providers may bill you for non-covered services that you've agreed to pay.</i></p>



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Services that our plan pays for	What you must pay
<p>All members of Family Care Partnership are also eligible to receive the following long-term care benefits which are covered by Medicaid:</p> <p><b>Adult day care</b></p> <p>Adult day care services are provided to a group of adults in a setting outside the home for part of the day. It's for adults who need social interaction. It's also for those who need supervision, help with daily activities, and support to be healthy and safe. Services may include personal care, light meals, medical care, and transportation to and from the day care site.</p> <p><b>Assistive technology</b></p> <p>Assistive technology includes items that help people with daily activities at home, work, and in the community. They may include technology like tablets, mobile devices, or software, items called adaptive aids, and a fully trained service dog from a reputable provider. The service may also include an assessment of a person's assistive technology needs and repair or maintenance of devices or items.</p> <p><b>Competitive integrated employment (CIE) exploration</b></p> <p>CIE exploration services help members explore career pathways. They also help members decide if they want to work in the community alongside people who don't have disabilities. Services include business tours, job shadowing, informational interviews, or employment planning. Members can also get education about employment services for people with disabilities and help with identifying interests, knowledge, and skills that may be useful for finding a job.</p> <p><b>Communication assistance</b></p> <p>Communication assistance includes items and services needed to help with hearing, speaking, reading, or other forms of communication. Items may include alternative or augmentative communication systems, speech amplification devices, electronic technology, mobile applications, and software. Services may include sign language interpretation or facilitation, assessment of communication needs, repair and maintenance of communication devices, and training to be able to use communication devices.</p>	<p><i>As a member of Family Care Partnership, 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.").</i></p> <p><i>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.</i></p> <p><i>Providers may not bill you for covered benefits that were authorized by Family Care Partnership and received while you were enrolled in our plan. Providers may bill you for non-covered services that you've agreed to pay.</i></p>



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Services that our plan pays for	What you must pay
<p><b>Consultative clinical and therapeutic services for caregivers</b></p> <p>Consultative clinical and therapeutic services help unpaid caregivers and paid support staff carry out a treatment or support plan. Services include assessments, development of home treatment plans, support plans, intervention plans, and training and assistance to carry out the plans. Services also include training for caregivers and staff who serve members with complex needs (beyond routine care).</p> <p><b>Consumer education and training</b></p> <p>Consumer education and training services help people with disabilities develop self-advocacy skills, support self-determination, exercise civil rights, and get the skills needed for control and responsibility over other support services. These services include education and training for members and their caregivers or legal decision makers. It may pay for enrollment fees, books and other educational materials, and transportation to training courses, conferences, and other similar events.</p> <p><b>Counseling and therapeutic services</b></p> <p>Counseling and therapeutic services treat personal, social, physical, medical, behavioral, emotional, cognitive, mental health, or alcohol or other drug abuse disorders. It may include help adjusting to aging and disability, help with relationships, and recreational, art, or music therapy. It may also include nutrition, medical, weight, or grief counseling.</p> <p><b>Daily living skills training</b></p> <p>Daily living skills training helps members do everyday tasks. This includes skills that help the member be independent and take part in community life. Examples include teaching money management, home care maintenance, food preparation, mobility training, self-care skills, and the skills necessary for accessing and using community resources.</p> <p><b>Day services</b></p> <p>Day services are regularly scheduled activities provided outside the home to a group of adults. Day services help members participate in the community, learn social skills, and develop the skills needed for activities of daily living and community living.</p>	



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Services that our plan pays for	What you must pay
<p><b>Financial management services</b></p> <p>Financial management services help with managing service dollars or personal finances. If a member chooses to self-direct one or more services, this service includes a person or agency paying service providers after the member authorizes payment. These services also help members budget to ensure money is available for housing and other needs.</p> <p><b>Health and wellness</b></p> <p>Health and wellness services help members maintain or improve their health, well-being, social skills, and inclusion in the community. They include activities that focus on developing healthy habits; classes, lessons, and events related to physical activity and nutrition; wellness services like yoga and mindfulness classes; and sexuality education and training.</p> <p><b>Home-delivered meals</b></p> <p>Home delivered meals (sometimes called "meals on wheels") include the preparation and delivery of one or two meals a day if a member is unable to make or get healthy meals without help. Home delivered meals can also help members if they're unable to manage a special diet recommended by a health care provider for a medical condition.</p> <p><b>Home modifications</b></p> <p>Home modifications include items and services that make a member's home safer and easier to get around in. This may include ramps, stair lifts, wheelchair lifts, kitchen or bathroom modifications, specialized accessibility or safety adaptations, and voice-, light-, or motion-activated electronic devices that increase the member's self-reliance and ability to live independently.</p> <p><b>Housing counseling</b></p> <p>Housing counseling helps members find accessible, affordable, and safe housing in the community. Housing counseling includes exploring home ownership and rental options, identifying financial resources, identifying preferences of location and type of housing, identifying accessibility and modification needs, and locating available housing. Housing counseling doesn't include payment for rent or mortgage.</p>	



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Services that our plan pays for	What you must pay
<p><b>Personal emergency response system (PERS)</b></p> <p>PERS directly connects a member with health professionals in case of an emergency. It's a phone or other electronic system.</p> <p><b>Prevocational services</b></p> <p>Prevocational services are learning and work experiences that help members develop general strengths and skills to get jobs in community settings. Members can learn how to work with supervisors, coworkers, and customers. They can also learn about how to dress, follow directions, do tasks, solve problems, stay safe, and get around. These services help members get jobs in the community that pay them the usual wage and benefits paid to employees who don't have disabilities.</p> <p><b>Relocation services</b></p> <p>Relocation services include one-time expenses that help members move from an institution or residential care setting to their own home or apartment in the community. They can help pay for moving expenses, cleaning and organization, a security deposit, and utility connection costs. They can also help with furniture, cooking utensils, cleaning and household supplies, and basic furnishings and appliances.</p> <p><b>Remote monitoring and support</b></p> <p>Remote monitoring and support services help members get live support from a remote caregiver. The remote caregiver can make sure the member is safe and provide support in case of an emergency. This service provides technology like sensors, monitors, and other two-way communication devices. It also includes the support provided by remote caregivers and the repair and maintenance of devices. The member has to say in writing that they want this service.</p> <p><b>Residential services</b></p> <p>Residential services are provided in a homelike community-based residential setting. They include 1-2 bed adult family homes and settings for three or more adults (like 3-4 bed adult family homes or residential care apartment complexes). Services usually include personal care, help with daily activities, home care, treatment, and general support and supervision. Services may also include transportation and recreational or social activities, behavior</p>	



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Services that our plan pays for	What you must pay
<p>and social support, and daily living skills training.</p> <p><b>Respite care</b></p> <p>Respite services provide short-term breaks for family or other primary caregivers. This helps relieve daily stress and care demands. Respite care may be provided in the member's home, a residential facility, a licensed camp, a hospital, or a nursing home.</p> <p><b>Self-directed personal care services</b></p> <p>Self-directed personal care services help members with daily activities and housekeeping needed to live in the community. This includes help with bathing, eating, dressing, managing medications, oral, hair, and skin care, meal preparation, paying bills, getting around, going to the bathroom, transferring, and using transportation. The member chooses the person or agency that provides their services and may act as their employer or co-employer. A physician must write an order for a member to get this service.</p> <p><b>Skilled nursing</b></p> <p>Skilled nursing is care that can only be provided by an advanced practice nurse, a registered nurse (RN), or a licensed practical nurse supervised by an RN. Skilled nursing includes tracking symptoms and reactions, general nursing duties, and may include keeping an eye on a medical condition.</p> <p><b>Specialized medical equipment and supplies</b></p> <p>Specialized medical equipment and supplies are items that maintain the member's health, manage a medical or physical condition, and improve functioning or independence. Items may include over-the-counter medications, medically necessary prescribed skin lotions, prescribed Vitamin D, multi-vitamins or calcium supplements, and books or therapy aids.</p> <p><b>Support broker</b></p> <p>A support broker is a person or agency the member chooses to help plan, get, and direct self-directed supports. A support broker knows about local services and can help recruit, hire, train, manage, and schedule workers.</p>	



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Services that our plan pays for	What you must pay
<p><b>Supported employment services</b></p> <p>Supported employment services help members get and keep jobs. The goal is to keep a job in the community at or above minimum wage, working alongside people who don't have disabilities. The job should also meet their personal and career goals.</p> <ul style="list-style-type: none"> <li>• Individual employment services help members get a job, grow skills for that job, and get interviews. It could also include job coaching and training, rides to work, workplace personal assistance, benefits counseling, career advancement services, or self-employment support.</li> <li>• Small group employment services are services and training provided in a business, industry, or community setting for groups of two to six workers with disabilities. Examples include mobile crews and other business-based workgroups employing small groups of workers with disabilities in community workplaces. Services may include small group career exploration and education, skill development, employment planning, job placement, meeting with employers, job coaching and training, rides to work, and work experiences matched to the member's interests and skills.</li> <li>• Vocational futures planning and support helps members get, keep, or advance in a job in the community. This may include assistive technology assessment, creating an employment plan, career exploration, job seeking support, job coaching and training, and ongoing personal assistance at their job. Members can also learn more about work incentives and how employment may impact their benefits.</li> </ul> <p><b>Supportive home care</b></p> <p>Supportive home care helps with daily living activities and personal needs at home or in the community. Services help with staying safe in the home and community, routine housekeeping tasks like cleaning, cooking, and laundry, and major household tasks like yard care and snow removal. Services may also help with dressing, bathing, managing medications, eating, going to the bathroom, grooming, getting around, paying bills, using transportation, and household chores.</p>	



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Services that our plan pays for	What you must pay
<p><b>Training services for unpaid caregivers</b></p> <p>Training services for unpaid caregivers help those who provide unpaid care, training, companionship, supervision, or other support to a member. It trains unpaid caregivers how to do treatments and use equipment in treatments and other services included in the member's care plan and gives guidance on how to keep the member safe in the community.</p> <p><b>Transportation services</b></p> <ul style="list-style-type: none"> <li>• Community transportation services help members access community services, activities, and resources included in their care plan. This may include tickets or fare cards, reimbursement for mileage, as well as transportation of members and their attendants to destinations. It excludes emergency (ambulance) transportation.</li> <li>• Non-emergency medical transportation services help members get non-emergency, Medicaid-covered medical services. Services may include tickets or fare cards, reimbursement for mileage, as well as transportation of members and their attendants to destinations. It excludes non-medical transportation, which is provided under community transportation—see above. It also excludes emergency (ambulance) transportation.</li> </ul> <p><b>Vehicle Modifications</b></p> <p>Vehicle modifications are disability-related changes to the vehicle that's the member's primary means of getting around. These services help the member access the community and improves their independence. It may include changes to seats and seatbelts, driver control devices, vehicle lifts, platforms, ramps, and tie-downs or wheelchair docking systems. The service also includes the cost of materials, services, inspections, and maintenance of these changes. The service doesn't include the purchase of a vehicle or general maintenance.</p>	

## E. Benefits covered outside of our plan

The following services aren't covered by iCare Family Care Partnership but are available through Wisconsin Medicaid on a fee-for-services basis:

- Behavioral treatment services (Autism Services) as defined in ForwardHealth Online Handbook;
- Comprehensive community services;



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- Community recovery services;
- Prenatal care coordination;
- School-based services;
- Medication therapy management;
- Tuberculosis related services;
- Prescription drugs administered by a physician as part of a physician office visit or incident to a physician's services that aren't covered under Medicare;
- Covered outpatient drugs that aren't reimbursable as part of the rate paid for a physician office visit or a stay in a hospital or nursing home;
- Substance Use Disorder (SUD) Health Home Pilot Program; and
- Residential substance use disorder treatment.

If you want to access the services listed above, contact your Team for coordination of the services with Wisconsin Medicaid.

We don't cover the following services, but they're available through ForwardHealth.

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## F. Benefits not covered by our plan, Medicare, or Family Care Partnership

This section tells you about benefits excluded by our plan. "Excluded" means that we don't pay for these benefits. Medicare and Medicaid don't pay for them either.

The list below describes some services and items not covered by us under any conditions and some excluded by us only in some cases.

We don't pay for excluded medical benefits listed in this section (or anywhere else in this *Evidence of Coverage*) except under specific conditions listed. Even if you get the services at an emergency facility, the plan won't pay for the services. If you think that our plan should pay for a service that isn't covered, you can request an appeal. For information about appeals, refer to **Chapter 9** of this *Evidence of Coverage*.

In addition to any exclusions or limitations described in the Benefits Chart, our plan doesn't cover the following items and services:

- services considered not "reasonable and medically necessary", according Medicare and Family Care Partnership standards, unless we list these as covered services
- experimental medical and surgical treatments, items, and drugs, unless Medicare, a Medicare-approved clinical research study, or our plan covers them. Refer to Chapter 3 of this *Evidence of Coverage* for more information on clinical research studies. Experimental treatment and items are those that aren't generally accepted by the medical community.
- surgical treatment for morbid obesity, except when medically necessary and Medicare pays for it
- a private room in a hospital, except when medically necessary



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- personal items in your room at a hospital or a nursing facility, such as a telephone or television
- elective or voluntary enhancement procedures or services (including weight loss, hair growth, sexual performance, athletic performance, cosmetic purposes, anti-aging and mental performance), except when medically necessary
- cosmetic surgery or other cosmetic work, unless it's needed because of an accidental injury or to improve a part of the body that isn't shaped right. However, we pay for reconstruction of a breast after a mastectomy and for treating the other breast to match it
- chiropractic care, other than manual manipulation of the spine consistent with coverage guidelines
- radial keratotomy, LASIK surgery, and other low-vision aids
- reversal of sterilization procedures and non-prescription contraceptive supplies
- naturopath services (the use of natural or alternative treatments)
- services provided to veterans in Veterans Affairs (VA) facilities. However, when a veteran gets emergency services at a VA hospital and the VA cost sharing is more than the cost sharing under our plan, we'll reimburse the veteran for the difference. You're still responsible for your cost sharing amounts.



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# Chapter 5: Getting your outpatient drugs

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## Introduction

This chapter explains rules for getting your outpatient drugs. These are drugs that your provider orders for you that you get from a pharmacy or by mail-order. They include drugs covered under Medicare Part D and Family Care Partnership. **Chapter 6** of this *Evidence of Coverage* tells you what you pay for these drugs. Key terms and their definitions appear in alphabetical order in the last chapter of this *Evidence of Coverage*.

We also cover the following drugs, although they're not discussed in this chapter:

- **Drugs covered by Medicare Part A.** These generally include drugs given to you while you're in a hospital or nursing facility.
- **Drugs covered by Medicare Part B.** These include some chemotherapy drugs, some drug injections given to you during an office visit with a doctor or other provider, and drugs you're given at a dialysis clinic. To learn more about what Medicare Part B drugs are covered, refer to the Benefits Chart in **Chapter 4** of this *Evidence of Coverage*.
- In addition to the plan's Medicare Part D and medical benefits coverage, your drugs may be covered by Original Medicare if you're in Medicare hospice. For more information, please refer to **Chapter 5, Section D** "If you're in a Medicare-certified hospice program."

## Rules for our plan's outpatient drug coverage

We usually cover your drugs as long as you follow the rules in this section.

You must have a provider (doctor, dentist, or other prescriber) write your prescription, which must be valid under applicable state law. This person often is your primary care provider (PCP). It could also be another provider if your PCP has referred you for care.

Your prescriber must **not** be on Medicare's Exclusion or Preclusion Lists.

You generally must use a network pharmacy to fill your prescription (Refer to **Section A1** for more information). Or you can fill your prescription through the plan's mail-order service.

Your prescribed drug must be on our plan's List of Covered Drugs. We call it the "Drug List" for short. (Refer to **Section B** of this chapter.)

- If it isn't on the *Drug List*, we may be able to cover it by giving you an exception.
- Refer to **Chapter 9** to learn about asking for an exception.

Your drug must be used for a medically accepted indication. This means that use of the drug is either approved by the Food and Drug Administration (FDA) or supported by certain medical references. Your prescriber may be able to help identify medical references to support the requested use of the prescribed drug.

Your drug may require approval from our plan based on certain criteria before we'll cover it. (Refer to **Section C** in this chapter.)



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## A. Getting your prescriptions filled

### A1. Filling your prescription at a network pharmacy

In most cases, we pay for prescriptions only when filled at any of our network pharmacies. A network pharmacy is a drug store that agrees to fill prescriptions for our plan members. You may use any of our network pharmacies. (Refer to **Section A8** for information about when we cover prescriptions filled at out-of-network pharmacies.)

To find a network pharmacy, refer to the *Provider and Pharmacy Directory*, visit our website or contact Customer Care or your care manager.

### A2. Using your Member ID Card when you fill a prescription

To fill your prescription, **show your Member ID Card** at your network pharmacy. The network pharmacy bills us for our share of the cost of your covered drug. You may need to pay the pharmacy a copay when you pick up your prescription.

If you don't have your Member ID Card with you when you fill your prescription, ask the pharmacy to call us to get the necessary information, or you can ask the pharmacy to look up your plan enrollment information.

If the pharmacy can't get the necessary information, you may have to pay the full cost of the prescription when you pick it up. Then you can ask us to pay you back for our share. **If you can't pay for the drug, contact Customer Care right away.** We'll do everything we can to help.

- To ask us to pay you back, refer to **Chapter 7** of this *Evidence of Coverage*.
- If you need help getting a prescription filled, contact Customer Care or your care manager.

### A3. What to do if you change your network pharmacy

If you change pharmacies and need a prescription refill, you can either ask to have a new prescription written by a provider or ask your pharmacy to transfer the prescription to the new pharmacy if there are any refills left.

If you need help changing your network pharmacy, contact Customer Care or your care manager.

### A4. What to do if your pharmacy leaves the network

If the pharmacy you use leaves our plan's network, you need to find a new network pharmacy.

To find a new network pharmacy, refer to the *Provider and Pharmacy Directory*, visit our website, or contact Customer Care or your care manager.

### A5. Using a specialized pharmacy

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

- Pharmacies that supply drugs for home infusion therapy.
- Pharmacies that supply drugs for residents of a long-term care facility, such as a nursing facility.



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- Usually, long-term care facilities have their own pharmacies. If you're a resident of a long-term care facility, we make sure you can get the drugs you need at the facility's pharmacy.
- If your long-term care facility's pharmacy isn't in our network or you have difficulty getting your drugs in a long-term care facility, contact Customer Care.
- Pharmacies that serve the Indian Health Service/Tribal/Urban Indian Health Program. Except in emergencies, only Native Americans or Alaska Natives may use these pharmacies.
- Pharmacies that dispense drugs 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 find a specialized pharmacy, refer to the Provider and Pharmacy Directory, visit our website, or contact Customer Care or your care manager.

## A6. Using mail-order services to get your drugs

For certain kinds of drugs, you can use our plan's network mail-order services. Generally, drugs available through mail-order are drugs that you take on a regular basis for a chronic or long-term medical condition. Drugs available through our plan's mail-order service are marked as mail-order drugs in our Drug List. Drugs **not** available through our plan's mail-order service are marked with "NM" or "Non-Mail Order Drug" in our *Drug List*.

Our plan's mail-order service allows you to order up to a 100-day supply of the drug. A 100-day supply has the same copay as a one-month supply.

### Filling prescriptions by mail

To get information about filling your prescriptions by mail, call Customer Care or visit our website at [www.icarehealthplan.org](http://www.icarehealthplan.org).

Usually, a mail-order prescription arrives within 10 days. If your mail order is delayed, please call Customer Care. We can help you obtain a supply of medication from a local pharmacy while you wait for your delivery.

### Mail-order processes

Mail-order service has different procedures for new prescriptions it gets from you, new prescriptions it gets directly from your provider's office, and refills on your mail-order prescriptions.

#### 1. New prescriptions the pharmacy gets from you

The pharmacy automatically fills and delivers new prescriptions it gets from you.

#### 2. New prescriptions the pharmacy gets from your provider's office

The pharmacy automatically fills and delivers new prescriptions it gets from health care providers, without checking with you first, if:

- You used mail-order services with our plan in the past, **or**
- You sign up for automatic delivery of all new prescriptions you get directly from health care providers.



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You may ask for automatic delivery of all new prescriptions now or at any time by calling Customer Care.

If you get a prescription automatically by mail that you don't want, and you weren't contacted to find out if you wanted it before it shipped, you may be eligible for a refund.

If you used mail-order in the past and don't want the pharmacy to automatically fill and ship each new prescription, contact us by calling Customer Care.

If you never used our mail-order delivery and/or decide to stop automatic fills of new prescriptions, the pharmacy contacts you each time it gets a new prescription from a health care provider to find out if you want the medication filled and shipped immediately.

- This gives you an opportunity to make sure the pharmacy is delivering the correct drug (including strength, amount, and form) and, if necessary, allows you to cancel or delay the order before you're billed and it's shipped.
- Respond each time the pharmacy contacts you, to let them know what to do with the new prescription and to prevent any delays in shipping.

To opt out of automatic deliveries of new prescriptions you get directly from your health care provider's office, contact us by calling Customer Care.

### 3. Refills on mail-order prescriptions

For refills of your drugs, you have the option to sign up for an automatic refill program. Under this program we start to process your next refill automatically when our records show you should be close to running out of your drug.

- The pharmacy contacts you before shipping each refill to make sure you need more medication, and you can cancel scheduled refills if you have enough medication or your medication has changed.
- If you choose not to use our auto refill program, contact your pharmacy 10 days before your current prescription will run out to make sure your next order is shipped to you in time.

To opt out of our program that automatically prepares mail-order refills, contact us by calling Customer Care.

Let the pharmacy know the best ways to contact you so they can reach you to confirm your order before shipping. Please call Customer Care to inform us of your communication.

### A7. Getting a long-term supply of drugs

You can get a long-term supply of maintenance drugs on our plan's *Drug List*. Maintenance drugs are drugs you take on a regular basis, for a chronic or long-term medical condition.

Some network pharmacies allow you to get a long-term supply of maintenance drugs. A 100-day supply has the same copay as a one-month supply. The *Provider and Pharmacy Directory* tells you which pharmacies can give you a long-term supply of maintenance drugs. You can also call your care manager or Customer Care for more information.

You can use our plan's network mail-order services to get a long-term supply of maintenance drugs. Refer to **Section A6** to learn about mail-order services.



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## A8. Using a pharmacy that is not in the plan's network

Generally, we pay for drugs filled at an out-of-network pharmacy only when you aren't able to use a network pharmacy. We have network pharmacies outside of our service area where you can get prescriptions filled as a member of our plan. In these cases, check with your care manager or Customer Care first to find out if there's a network pharmacy nearby.

We pay for prescriptions filled at an out-of-network pharmacy in the following cases:

- If you're 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're trying to fill a prescription drug that is not regularly stocked at an accessible network retail pharmacy (including high cost and unique drugs).
- You were eligible for Medicaid at the time you got the prescription, even if you weren't enrolled yet. This is called retroactive enrollment.
- You're evacuated from your home because of a state, federal, or public health emergency and don't have access to an in-network pharmacy.
- If you get a covered prescription drug from an institutional based pharmacy while a patient in an emergency room, provider based clinic, outpatient surgery clinic, or other outpatient setting.

## A9. Paying you back for a prescription

If you must use an out-of-network pharmacy, you must generally pay the full cost when you get your prescription. You can ask us to pay you back.

To learn more about this, refer to **Chapter 7** of this *Evidence of Coverage*.

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## B. Our Plan's Drug List

The plan has a *List of Covered Drugs*. We call it the *Drug List* for short.

The drugs on the *Drug List* are selected by the plan with the help of a team of doctors and pharmacists. The *Drug List* also tells you if there are any rules you need to follow to get your drugs.

We will generally cover a drug on the plan's *Drug List* as long as you follow the rules explained in this chapter.

### B1. Drugs on our Drug List

Our *Drug List* includes drugs covered under Medicare Part D. In addition to the drugs covered by Medicare, some prescription and over-the-counter (OTC) drugs are covered for you under your Medicaid benefits.

Certain drugs may be covered for some medical conditions but considered non-formulary for other medical conditions. These drugs will be identified on our *Drug List* and in [Medicare.gov](https://www.medicare.gov), along with the specific medical condition that they cover.

Our Drug List includes brand name drugs, generic drugs, and biological products (which may include



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biosimilars).

A brand name drug is a drug sold under a trademarked name owned by the drug manufacturer. Biological products are drugs that are more complex than typical drugs. On our *Drug List*, when we refer to “drugs” this could mean a drug or a biological product.

Generic drugs have the same active ingredients as brand name drugs. Biological products have alternatives called biosimilars. Generally, generic drugs and biosimilars work just as well as brand name or original biological products and usually cost less. There are generic drug substitutes available for many brand name drugs and biosimilar alternatives for some original biological products. Some biosimilars are interchangeable biosimilars and, depending on state law, may be substituted for the original biological product at the pharmacy without needing a new prescription, just like generic drugs can be substituted for brand name drugs.

Refer to **Chapter 12** for definitions of the types of drugs that may be on the *Drug List*.

Our plan also covers certain OTC drugs and products. Some OTC drugs cost less than prescription drugs and work just as well. For more information, call Customer Care.

## **B2. How to find a drug on our *Drug List***

To find out if a drug you take is on our Drug List, you can:

- Visit our plan’s website at [www.icarehealthplan.org](http://www.icarehealthplan.org). The Drug List on our website is always the most current one.
- Call Customer Care to find out if a drug is on our Drug List or to ask for a copy of the list.
- Use our “Real Time Benefit Tool” at <https://www.icarehealthplan.org/Members/Plans-Benefits/Medicare-Plans/Prescription-Drugs.htm> to search for drugs on the Drug List to get an estimate of what you’ll pay and if there are alternative drugs on the Drug List that could treat the same condition. You can also call Customer Care.
- Ask your care team if a particular drug is on the plan’s Drug List or to ask for a copy of the list.

## **B3. Drugs not on our *Drug List***

We don’t cover all drugs.

- Some drugs aren’t on our Drug List because the law doesn’t allow us to cover those drugs.
- In other cases, we decided not to include a drug on our Drug List.
- In some cases, you may be able to get a drug that isn’t on our Drug List. For more information refer to **Chapter 9**.

Our plan doesn’t pay for the kinds of drugs described in this section. These are called excluded drugs. If you get a prescription for an excluded drug, you may need to pay for it yourself. If you think we should pay for an excluded drug because of your case, you can make an appeal. Refer to **Chapter 9** of this *Evidence of Coverage* for more information about appeals.

Here are three general rules for excluded drugs:



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1. Our plan's outpatient drug coverage (which includes Medicare Part D drugs) can't pay for a drug that Medicare Part A or Medicare Part B already covers. Our plan covers drugs covered under Medicare Part A or Medicare Part B for free, but these drugs aren't considered part of your outpatient drug benefits.
2. Our plan can't cover a drug purchased outside the United States and its territories.
3. Use of the drug must be approved by the FDA or supported by certain medical references as a treatment for your condition. Your doctor or other provider may prescribe a certain drug to treat your condition, even though it wasn't approved to treat the condition. This is called "off-label use." Our plan usually doesn't cover drugs prescribed for off-label use.

Also, by law, Medicare can't cover the types of drugs listed below, however they may be covered by Family Care Partnership.

- Drugs used to promote fertility
- Drugs used for the relief of cough or cold symptoms
- Drugs used for cosmetic purposes or to promote hair growth
- Prescription vitamins and mineral products, except prenatal vitamins and fluoride preparations
- Drugs used for the treatment of sexual or erectile dysfunction
- Drugs used for the treatment of anorexia, weight loss or weight gain
- Outpatient drugs made by a company that says you must have tests or services done only by them

#### **B4. Drug List cost sharing tiers**

Every drug on our *Drug List* is in a single cost sharing tier. A tier is a group of drugs of generally the same type (for example, brand name, generic, or OTC drugs). In general, the higher the cost sharing tier, the higher your cost for the drug.

To find out which cost sharing tier your drug is in, look for the drug on our *Drug List*.

**Chapter 6** of this *Evidence of Coverage* tells the amount you pay for drugs in each tier.

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### **C. Limits on some drugs**

For certain drugs, special rules limit how and when our plan covers them. Generally, our rules encourage you to get a drug that works for your medical condition and is safe and effective.

When a safe, lower-cost drug works just as well as a higher-cost drug, we expect your provider to prescribe the lower-cost drug.

Note that sometimes a drug may appear more than once in our Drug List. This is because the same drugs can differ based on the strength, amount, or form of the drug prescribed by your provider, and different restrictions may apply to the different versions of the drugs (for example, 10 mg versus 100 mg; one per day versus two per day; tablet versus liquid.)

**If there's a special rule for your drug, it usually means that you or your provider must take extra steps**



**If you have questions**, please call iCare Family Care Partnership at 1-800-777-4376 (TTY: 711), 24 hours a day, 7 days a week. The call is free. **For more information**, visit [www.icarehealthplan.org](http://www.icarehealthplan.org).



**for us to cover the drug.** For example, your provider may have to tell us your diagnosis or provide results of blood tests first. If you or your provider thinks our rule shouldn't apply to your situation, ask us to use the coverage decision process to make an exception. We may or may not agree to let you use the drug without taking extra steps.

To learn more about asking for exceptions, refer to **Chapter 9** of this *Evidence of Coverage*.

**1. Limiting use of a brand name drug or original biological products when a generic version or interchangeable biosimilar is available**

Generally, a generic drug or interchangeable biosimilar works the same as a brand name drug or original biological product and usually costs less. In most cases, if there's a generic or interchangeable biosimilar version of a brand name drug or original biological product available, our network pharmacies give you the generic or interchangeable biosimilar version.

- We usually don't pay for the brand name drug or original biological product when there's an available generic version.
- However, if your provider told us the medical reason that the generic drug or interchangeable biosimilar won't work for you or wrote "No substitutions" on your prescription for a brand name drug or original biological product or told us the medical reason that the generic drug, interchangeable biosimilar, or other covered drugs that treat the same condition won't work for you, then we cover the brand name drug.
- Your copay may be greater for the brand name drug or original biological product than for the generic drug or interchangeable biosimilar.

**2. Getting plan approval in advance**

For some drugs, you or your prescriber must get approval from our plan before you fill your prescription. This is called prior authorization. This is put in place to ensure medication safety and help guide appropriate use of certain drugs. If you don't get approval, we may not cover the drug. Call Customer Care at the number at the bottom of the page or on our website at <https://www.icarehealthplan.org/Members/Plans-Benefits/Medicare-Plans/Prescription-Drugs.htm> for more information about prior authorization.

**3. Trying a different drug first**

In general, we want you to try lower-cost drugs that are as effective before we cover drugs that cost more. For example, if Drug A and Drug B treat the same medical condition, and Drug A costs less than Drug B, we may require you to try Drug A first.

If Drug A doesn't work for you, then we cover Drug B. This is called step therapy. Call Customer Care at the number at the bottom of the page or on our website at <https://www.icarehealthplan.org/Members/Plans-Benefits/Medicare-Plans/Prescription-Drugs.htm> for more information about step therapy.

**4. Quantity limits**

For some drugs, we limit the amount of the drug you can have. This is called a quantity limit. For example, if it's normally considered safe to take only one pill per day for a certain drug, we might limit how much of a drug you can get each time you fill your prescription.



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To find out if any of the rules above apply to a drug you take or want to take, check our Drug List. For the most up-to-date information, call Customer Care or check our website at <https://www.icarehealthplan.org/Members/Plans-Benefits/Medicare-Plans/Prescription-Drugs.htm>. If you disagree with our coverage decision based on any of the above reasons you may request an appeal. Please refer to **Chapter 9** of this *Evidence of Coverage*.

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## D. Reasons your drug might not be covered

We try to make your drug coverage work well for you, but sometimes a drug may not be covered in the way that you like. For example:

- Our plan doesn't cover the drug you want to take. The drug may not be on our *Drug List*. We may cover a generic version of the drug but not the brand name version you want to take. A drug may be new, and we haven't reviewed it for safety and effectiveness yet.
- Our plan covers the drug, but there are special rules or limits on coverage. As explained in the section above, some drugs our plan covers have rules that limit their use. In some cases, you or your prescriber may want to ask us for an exception.

There are things you can do if we don't cover a drug the way you want us to cover it.

### D1. Getting a temporary supply

In some cases, we can give you a temporary supply of a drug when the drug isn't on our *Drug List* or is limited in some way. This gives you time to talk with your provider about getting a different drug or to ask us to cover the drug.

**To get a temporary supply of a drug, you must meet the two rules below:**

1. The drug you've been taking:
  - is no longer on our *Drug List*, **or**
  - was never on our *Drug List*, **or**
  - is now limited in some way.
2. You must be in one of these situations:
  - You were in our plan last year.
    - We cover a temporary supply of your drug during the first 90 days of the calendar year.
    - This temporary supply is for up to 30 or 31 days.
    - If your prescription is written for fewer days, we allow multiple refills to provide up to a maximum of 30 or 31 days of medication. You must fill the prescription at a network pharmacy.
    - Long-term care pharmacies may provide your drug in small amounts at a time to prevent waste.
  - You're new to our plan.
    - We cover a temporary supply of your drug **during the first 90 days of your membership in our plan.**



**If you have questions**, please call iCare Family Care Partnership at 1-800-777-4376 (TTY: 711), 24 hours a day, 7 days a week. The call is free. **For more information**, visit [www.icarehealthplan.org](http://www.icarehealthplan.org).

- This temporary supply is for up to 30 or 31 days.
- If your prescription is written for fewer days, we allow multiple refills to provide up to a maximum of 30 or 31 days of medication. You must fill the prescription at a network pharmacy.
- Long-term care pharmacies may provide your drug in small amounts at a time to prevent waste.
- You've been in our plan for more than 90 days, live in a long-term care facility, and need a supply right away.
  - We cover one 31-day supply, or less if your prescription is written for fewer days. This is in addition to the temporary supply above.

## D2. Asking for a temporary supply

To ask for a temporary supply of a drug, call Customer Care.

**When you get a temporary supply of a drug, talk with your provider as soon as possible to decide what to do when your supply runs out.** Here are your choices:

- Change to another drug.

Our plan may cover a different drug that works for you. Call Customer Care to ask for a list of drugs we cover that treat the same medical condition. The list can help your provider find a covered drug that may work for you.

**OR**

- Ask for an exception.

You and your provider can ask us to make an exception. For example, you can ask us to cover a drug that isn't on our *Drug List* or ask us to cover the drug without limits. If your provider says you have a good medical reason for an exception, they can help you ask for one.

## D3. Asking for an exception

If a drug you take will be taken off our *Drug List* or limited in some way next year, we allow you to ask for an exception before next year.

- We tell you about any change in the coverage for your drug for next year. Ask us to make an exception and cover the drug for next year the way you would like.
- We answer your request for an exception within 72 hours after we get your request (or your prescriber's supporting statement).
- If we approve your request, we'll authorize coverage for the drug before the change takes effect.

To learn more about asking for an exception, refer to **Chapter 9** of this *Evidence of Coverage*.

If you need help asking for an exception, contact Customer Care.



**If you have questions**, please call iCare Family Care Partnership at 1-800-777-4376 (TTY: 711), 24 hours a day, 7 days a week. The call is free. **For more information**, visit [www.icarehealthplan.org](http://www.icarehealthplan.org).

## E. Coverage changes for your drugs

Most changes in drug coverage happen on January 1, but we may add or remove drugs on our *Drug List* during the year. We may also change our rules about drugs. For example, we may:

- Decide to require or not require prior approval (PA) for a drug (permission from us before you can get a drug).
- Add or change the amount of a drug you can get (quantity limits).
- Add or change step therapy restrictions on a drug (you must try one drug before we cover another drug).

We must follow Medicare requirements before we change our plan's *Drug List*. For more information on these drug rules, refer to **Section C**.

If you take a drug that we covered at the beginning of the year, we generally won't remove or change coverage of that drug **during the rest of the year** unless:

- a new, cheaper drug comes on the market that works as well as a drug on our *Drug List* now, **or**
- we learn that a drug isn't safe, **or**
- a drug is removed from the market.

### What happens if coverage changes for a drug you're taking?

To get more information on what happens when our *Drug List* changes, you can always:

- Check our current Drug List online at [www.icarehealthplan.org](http://www.icarehealthplan.org) **or**
- Call Customer Care at the number at the bottom of the page to check our current *Drug List*.

### Changes we may make to the *Drug List* that affect you during the current plan year

Some changes to the *Drug List* will happen immediately. For example:

- A new generic drug becomes available. Sometimes, a new generic drug or biosimilar comes on the market that works as well as a brand name drug or original biological product on the *Drug List* now. When that happens, we may remove the brand name drug and add the new generic drug, but your cost for the new drug will stay the same or will be lower. When we add the new generic drug, we may also decide to keep the brand name drug on the list but change its coverage rules or limits.
  - We may not tell you before we make this change, but we'll send you information about the specific change we made once it happens.
  - You or your provider can ask for an "exception" from these changes. We'll send you a notice with the steps you can take to ask for an exception. Please refer to **Chapter 9** of this handbook for more information on exceptions.

**Removing unsafe drugs and other drugs that are taken off the market.** Sometimes a drug may be found unsafe or taken off the market for another reason. If this happens, we may immediately take it off our *Drug List*. If you're taking the drug, we'll send you a notice after we make the change.



**If you have questions**, please call iCare Family Care Partnership at 1-800-777-4376 (TTY: 711), 24 hours a day, 7 days a week. The call is free. **For more information**, visit [www.icarehealthplan.org](http://www.icarehealthplan.org).

**We may make other changes that affect the drugs you take.** We tell you in advance about these other changes to our *Drug List*. These changes might happen if:

- The FDA provides new guidance or there are new clinical guidelines about a drug.

When these changes happen, we:

- Tell you at least 30 days before we make the change to our Drug List **or**
- Let you know and give you a 30 or 31-day supply of the drug after you ask for a refill.

This gives you time to talk to your doctor or other prescriber. They can help you decide:

- If you should switch to the generic or interchangeable biosimilar or if there's a similar drug on the Drug List you can take instead or
- Whether to ask for an exception from these changes. To learn more about asking for exceptions, refer to Chapter 9.

### **Changes to the *Drug List* that don't affect you during this plan year**

We may make changes to drugs you take that aren't described above and don't affect you now. For such changes, if you're taking a drug we covered at the **beginning** of the year, we generally don't remove or change coverage of that drug **during the rest of the year**.

For example, if we remove a drug you're taking or limit its use, then the change doesn't affect your use of the drug for the rest of the year.

If any of these changes happen for a drug you're taking (except for the changes noted in the section above), the change won't affect your use until January 1 of the next year.

We won't tell you about these types of changes directly during the current year. You'll need to check the *Drug List* for the next plan year (when the list is available during the open enrollment period) to see if there are any changes that will impact you during the next plan year.

---

## **F. Drug coverage in special cases**

### **F1. In a hospital or a skilled nursing facility for a stay that our plan covers**

If you're admitted to a hospital or skilled nursing facility for a stay our plan covers, we generally cover the cost of your drugs during your stay. You won't pay a copay. Once you leave the hospital or skilled nursing facility, we cover your drugs as long as the drugs meet all of our coverage rules.

To learn more about drug coverage and what you pay, refer to **Chapter 6** of this *Evidence of Coverage*.

### **F2. In a long-term care facility**

Usually, a long-term care facility, such as a nursing facility, has its own pharmacy or a pharmacy that supplies drugs for all of their residents. If you live in a long-term care facility, you may get your drugs through the facility's pharmacy if it's part of our network.



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

### F3. In a Medicare-certified hospice program

Drugs are never covered by both hospice and our plan at the same time.

- You may be enrolled in a Medicare hospice and require certain drugs (e.g., pain, anti-nausea drugs, laxative, or anti-anxiety drugs) that your hospice doesn't cover because it isn't related to your terminal prognosis and conditions. In that case, our plan must get notification from the prescriber or your hospice provider that the drug is unrelated before we can cover the drug.
- To prevent delays in getting any unrelated drugs that our plan should cover, 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.

If you leave hospice, our plan covers all of your drugs. To prevent any delays at a pharmacy when your Medicare hospice benefit ends, take documentation to the pharmacy to verify that you left hospice.

Refer to earlier parts of this chapter that tell about drugs our plan covers. Refer to **Chapter 4** of this *Evidence of Coverage* for more information about the hospice benefit.

---

## G. Programs on drug safety and managing drugs

### G1. Programs to help you use drugs safely

Each time you fill a prescription, we look for possible problems, such as drug errors or drugs that:

- may not be needed because you take another similar drug that does the same thing
- may not be safe for your age or gender
- could harm you if you take them at the same time
- have ingredients that you are or may be allergic to
- may be an error in the amount (dosage)
- have unsafe amounts of opioid pain medications

If we find a possible problem in your use of drugs, we work with your provider to correct the problem.

### G2. Programs to help you manage your drugs

Our plan has a program to help members with complex health needs. In such cases, you may be eligible to get services, at no cost to you, through a medication therapy management (MTM) program. This program is voluntary and free. This program helps you and your provider make sure that your medications are working to improve your health. If you qualify for the program, a pharmacist or other health professional will give you a comprehensive review of all of your medications and talk with you about:

- how to get the most benefit from the drugs you take



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- any concerns you have, like medication costs and drug reactions
- how best to take your medications
- any questions or problems you have about your prescription and over-the-counter medication

Then, they'll give you:

- A written summary of this discussion. The summary has a medication action plan that recommends what you can do for the best use of your medications.
- A personal medication list that includes all medications you take, how much you take, and when and why you take them.
- Information about safe disposal of prescription medications that are controlled substances.

It's a good idea to talk to your prescriber about your action plan and medication list.

- Take your action plan and medication list to your visit or anytime you talk with your doctors, pharmacists, and other health care providers.
- Take your medication list with you if you go to the hospital or emergency room.

MTM programs are voluntary and free to members who qualify. If we have a program that fits your needs, we enroll you in the program and send you information. If you don't want to be in the program, let us know, and we'll take you out of it.

If you have questions about these programs, contact Customer Care at 1-800-777-4376 (TTY: 711).

### **G3. Drug management program (DMP) to help members safely use opioid medications**

We have a program that helps make sure members safely use prescription opioids and other frequently abused medications. This program is called a Drug Management Program (DMP).

If you use opioid medications that you get from several prescribers or pharmacies or if you had a recent opioid overdose, we may talk to your prescriber to make sure your use of opioid medications is appropriate and medically necessary. Working with your prescriber, if we decide your use of prescription opioid or benzodiazepine medications may not be safe, we may limit how you can get those medications. If we place you in our DMP, limitations may include:

- Requiring you to get all prescriptions for opioid or benzodiazepine medications from a certain pharmacy(ies)
- Requiring you to get all your prescriptions for opioid or benzodiazepine medications from a certain prescriber(s)
- Limiting the amount of opioid or benzodiazepine medications we'll cover for you

If we plan on limiting how you get these medications or how much you can get, we'll send you a letter in advance. The letter will tell you if we'll limit coverage of these drugs for you, or if you'll be required to get the prescriptions for these drugs only from a specific provider or pharmacy.

**You'll have a chance to tell us which prescribers or pharmacies you prefer to use and any information you**



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**think is important for us to know.** After you've had the opportunity to respond, if we decide to limit your coverage for these medications, we'll send you another letter that confirms the limitations.

If you think we made a mistake, you disagree with our decision or the limitation, you and your prescriber can make an appeal. If you appeal, we'll review your case and give you a new decision. If we continue to deny any part of your appeal related to limitations that apply to your access to medications, we'll automatically send your case to an Independent Review Organization (IRO). (To learn more about appeals and the IRO, refer to **Chapter 9** of this *Evidence of Coverage*.)

The DMP may not apply to you if you:

- have certain medical conditions, such as cancer or sickle cell disease,
- are getting hospice, palliative, or end-of-life care, **or**
- live in a long-term care facility.



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# Chapter 6: What you pay for your Medicare and Family Care Partnership drugs

## Introduction

This chapter tells what you pay for your outpatient drugs. By “drugs,” we mean:

- Medicare Part D drugs, **and**
- Drugs and items covered under Medicaid, **and**

Because you’re eligible for Family Care Partnership you get Extra Help from Medicare to help pay for your Medicare Part D drugs. We sent you a separate insert, called the “Evidence of Coverage Rider for People Who Get Extra Help Paying for Prescription Drugs” (also known as the “Low Income Subsidy Rider” or the LIS Rider”), which tells you about your drug coverage. If you don’t have this insert, please call Customer Care and ask for the “LIS Rider.”

**Extra Help** is a Medicare program that helps people with limited incomes and resources reduce Medicare Part D drug costs, such as premiums, deductibles, and copays. Extra Help is also called the “Low-Income Subsidy,” or “LIS.”

Other key terms and their definitions appear in alphabetical order in the last chapter of this *Evidence of Coverage*.

To learn more about drugs, you can look in these places:

- *Our List of Covered Drugs.*
  - We call this the *Drug List*. It tells you:
    - Which drugs we pay for
    - If there are any limits on the drugs
  - If you need a copy of our *Drug List*, call Customer Care. You can also find the most current copy of our *Drug List* on our website at [www.icarehealthplan.org](http://www.icarehealthplan.org).
- **Chapter 5** of this *Evidence of Coverage*.
  - It tells how to get your outpatient drugs through our plan.
  - It includes rules you need to follow. It also tells which types of drugs our plan doesn’t cover.
  - When you use the plan’s “Real Time Benefit Tool” to look up drug coverage (refer to **Chapter 5, Section B2**), the cost shown is an estimate of the out-of-pocket costs you’re expected to pay. You can call or Customer Care for more information.
- *Our Provider and Pharmacy Directory:*
  - In most cases, you must use a network pharmacy to get your covered drugs. Network pharmacies are pharmacies that agree to work with us.
  - The *Provider and Pharmacy Directory* lists our network pharmacies. Refer to **Chapter 5** of this



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*Evidence of Coverage* more information about network pharmacies.

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### A. The *Explanation of Benefits* (SmartSummary)

Our plan keeps track of your drug costs and the payments you make when you get prescriptions at the pharmacy. We track two types of costs:

- Your **out-of-pocket costs**. This is the amount of money you, or others on your behalf, pay for your prescriptions. This includes what you paid when you get a covered Part D drug, any payments for your drugs made by family or friends, any payments made for your drugs by Extra Help from Medicare, employer or union health plans, Indian Health Service, AIDS drug assistance programs, charities, and most State Pharmaceutical Assistance Programs (SPAPs).
- Your **total drug costs**. This is the total of all payments made for your covered Part D drugs. It includes what our plan paid, and what other programs or organizations paid for your covered Part D drugs.

When you get drugs through our plan, we send you a summary called the *Explanation of Benefits*. We call



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it the SmartSummary for short. The SmartSummary isn't a bill. The SmartSummary has more information about the drugs you take. The SmartSummary includes:

- **Information for the month.** The summary tells what drugs you got for the previous month. It shows the total drug costs, what we paid, and what you and others paid for you.
- **Totals for the year since January 1.** This shows the total drug costs and total payments for your drugs since the year began.
- **Drug price information.** This is the total price of the drug and changes in the drug price since the first fill for each prescription claim of the same quantity.
- **Lower cost alternatives.** When applicable, information about other available drugs with lower cost sharing for each prescription.

We offer coverage of drugs not covered under Medicare.

- Payments made for these drugs don't count towards your total out-of-pocket costs.
- To find out which drugs our plan covers, refer to our *Drug List*. In addition to the drugs covered under Medicare, some prescription and over-the-counter drugs are covered under Family Care Partnership. These drugs are included in the *Drug List*.

---

## B. How to keep track of your drug costs

To keep track of your drug costs and the payments you make, we use records we get from you and from your pharmacy. Here is how you can help us:

### 1. Use your Member ID Card.

Show your Member ID Card every time you get a prescription filled. This helps us know what prescriptions you fill and what you pay.

### 2. Make sure we have the information we need.

Give us copies of receipts for covered drugs that you paid for. You can ask us to pay you back for the drug.

Here are examples of when you should give us copies of your receipts:

- When you buy a covered drug at a network pharmacy at a special price or use a discount card that isn't part of our plan's benefit
- When you pay a copay for drugs that you get under a drug maker's patient assistance program
- When you buy covered drugs at an out-of-network pharmacy
- When you pay the full price for a covered drug under special circumstances

For more information about asking us to pay you back for a drug, refer to **Chapter 7** of this *Evidence of Coverage*.

### 3. Send us information about payments others make for you.



**If you have questions**, please call iCare Family Care Partnership at 1-800-777-4376 (TTY: 711), 24 hours a day, 7 days a week. The call is free. **For more information**, visit [www.icarehealthplan.org](http://www.icarehealthplan.org).

Payments made by certain other people and organizations also count toward your out-of-pocket costs. For example, payments made by a State Pharmaceutical Assistance Program, an AIDS drug assistance program (ADAP), the Indian Health Service, and most charities count toward your out-of-pocket costs. This can help you qualify for catastrophic coverage. When you reach the Catastrophic Coverage Stage, our plan pays all of the costs of your Medicare Part D drugs for the rest of the year.

#### 4. Check the SmartSummaries we send you.

When you get an SmartSummary in the mail, make sure it's complete and correct.

- **Do you recognize the name of each pharmacy?** Check the dates. Did you get drugs that day?
- **Did you get the drugs listed?** Do they match those listed on your receipts? Do the drugs match what your doctor prescribed?

#### What if you find mistakes on this summary?

If something is confusing or doesn't seem right on this SmartSummary, please call us at Customer Care. You can also find answers to many questions on our website: [www.icarehealthplan.org](http://www.icarehealthplan.org).

#### What about possible fraud?

If this summary shows drugs you're not taking or anything else that seems suspicious to you, please contact us.

- Call us at 1-800-777-4376.
- Or call Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048. You can call these numbers for free.
- If you suspect anyone of misusing public assistance funds, including Family Care, call the fraud hotline 877-865-3432 or file a report at [dhs.wi.gov/fraud](http://dhs.wi.gov/fraud).

If you think something is wrong or missing, or if you have any questions, call Customer Care. Keep these SmartSummaries. They're an important record of your drug expenses.

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### C. Drug Payment Stages for Medicare Part D drugs

There are two payment stages for your Medicare Part D drug coverage under our plan. How much you pay for each prescription depends on which stage you're in when you get a prescription filled or refilled. These are the two stages:

Stage 1: Initial Drug Coverage	Stage 2: Catastrophic Coverage Stage
During this stage, we pay part of the costs of your drugs, and you pay your share. Your share is called the copay.  You begin in this stage when you fill your first prescription of the year.	During this stage, we pay all of the costs of your drugs through December 31, 2026.  You begin this stage when you've paid a certain amount of out-of-pocket costs.



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C1. Our plan has a single cost sharing tier

Cost sharing tiers are groups of drugs with the same copay. Every drug on our *Drug List* is in a single cost sharing tier. To find the cost sharing tiers for your drugs, refer to our *Drug List*.

C2. Your pharmacy choices

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

- a network pharmacy, **or**
- an out-of-network pharmacy. In limited cases, we cover prescriptions filled at out-of-network pharmacies. Refer to **Chapter 5** of this *Evidence of Coverage* to find out when we do that.
- Our plan's mail-order pharmacy.

Refer to **Chapter 9** of this *Evidence of Coverage* to learn about how to file an appeal if you're told a drug won't be covered. To learn more about these pharmacy choices, refer to **Chapter 5** of this *Evidence of Coverage* and our *Provider and Pharmacy Directory*.

C3. Getting a long-term supply of a drug

For some drugs, you can get a long-term supply (also called an “extended supply”) when you fill your prescription. A long-term supply is 100-day supply. It costs you the same as a one-month supply.

For details on where and how to get a long-term supply of a drug, refer to **Chapter 5** of this *Evidence of Coverage* or our *Provider and Pharmacy Directory*.

C4. What you pay

You may pay a copay when you fill a prescription. If your covered drug costs less than the copay, you pay the lower price.

Contact Customer Care to find out how much your copay is for any covered drug.

Your share of the cost when you get a one-month or long-term supply of a covered drug from:

	A network pharmacy A one-month or up to a 30-day supply	Our plan’s mail-order service A one-month or up to a 30-day supply	A network long-term care pharmacy Up to a 31-day supply	An out-of-network pharmacy A one-month or up to a 30-day supply. Coverage is limited to certain cases. Refer to <b>Chapter 5</b> of this <i>Evidence of Coverage</i> for details.
<b>Cost sharing</b> All Plan-Covered Part D Drugs	25%	25%	25%	25%

	<b>A network pharmacy</b> A one-month or up to a 30-day supply	<b>Our plan's mail-order service</b> A one-month or up to a 30-day supply	<b>A network long-term care pharmacy</b> Up to a 31-day supply	<b>An out-of-network pharmacy</b> A one-month or up to a 30-day supply. Coverage is limited to certain cases. Refer to <b>Chapter 5</b> of this <i>Evidence of Coverage</i> for details.
<b>Cost sharing</b> All Plan-Covered Part D Insulins	\$35	\$35	\$35	\$35

For information about which pharmacies can give you long-term supplies, refer to our plan's *Provider and Pharmacy Directory*.

## D. Stage 1: The Initial Coverage Stage

During the Initial Coverage Stage, we pay a share of the cost of your covered drugs, and you pay your share. Your share is called the copay. The copay depends on the cost sharing tier the drug is in and where you get it.

Cost sharing tiers are groups of drugs with the same copay. Every drug on our plan's *Drug List* is in a single cost share tier. In general, the higher the tier number, the higher the copay. To find the cost sharing tiers for your drugs, refer to our *Drug List*.

### D1. Your pharmacy choices

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

- A network retail pharmacy **or**
- An out-of-network pharmacy. In limited cases, we cover prescriptions filled at out-of-network pharmacies. Refer to **Chapter 5** of this *Evidence of Coverage* to find out when we do that.
- Our plan's mail-order pharmacy.

To learn more about these choices, refer to **Chapter 5** of this *Evidence of Coverage* and to our *Provider and Pharmacy Directory*.

### D2. Getting a long-term supply of a drug

For some drugs, you can get a long-term supply (also called an “extended supply”) when you fill your prescription. A long-term supply is up to a 100-day supply. It costs you the same as a one-month supply.

For details on where and how to get a long-term supply of a drug, refer to **Chapter 5** of this *Evidence of Coverage* or our plan's *Provider and Pharmacy Directory*.



**If you have questions**, please call iCare Family Care Partnership at 1-800-777-4376 (TTY: 711), 24 hours a day, 7 days a week. The call is free. **For more information**, visit [www.icarehealthplan.org](http://www.icarehealthplan.org).



D3. What you pay

During the Initial Coverage Stage, you may pay a copay each time you fill a prescription. If your covered drug costs less than the copay, you pay the lower price.

Contact Customer Care to find out how much your copay is for any covered drug.

Your share of the cost when you get a one-month or long-term supply of a covered drug from:

	A network pharmacy A one-month or up to a 30-day supply	Our plan’s mail-order service A one-month or up to a 30-day supply	A network long-term care pharmacy Up to a 31-day supply	An out-of-network pharmacy A one-month or up to a 30-day supply. Coverage is limited to certain cases. Refer to <b>Chapter 5</b> of this <i>Evidence of Coverage</i> for details.
<b>Cost sharing</b> All Plan-Covered Part D Drugs	25%	25%	25%	25%
<b>Cost sharing</b> All Plan-Covered Part D Insulins	\$35	\$35	\$35	\$35

For information about which pharmacies can give you long-term supplies, refer to our *Provider and Pharmacy Directory*.

D4. End of the Initial Coverage Stage

The Initial Coverage Stage ends when your total out-of-pocket costs reach **\$2,100**. At that point, the Catastrophic Coverage Stage begins. We cover all your drug costs from then until the end of the year.

Your SmartSummary helps you keep track of how much you’ve paid for your drugs during the year. We let you know if you reach the \$2,100 limit. Many people don’t reach it in a year.

E. Stage 2: The Catastrophic Coverage Stage

When you reach the out-of-pocket limit of **\$2,100** for your drugs, the Catastrophic Coverage Stage begins. You stay in the Catastrophic Coverage Stage until the end of the calendar year. During this stage, you pay nothing for your Part D covered drugs.

F. Your drug costs if your doctor prescribes less than a full month’s supply

Usually, you pay a copay to cover a full month’s supply of a covered drug. However, your doctor can prescribe



less than a month's supply of drugs.

- There may be times when you want to ask your doctor about prescribing less than a month's supply of a drug (for example, when you're trying a drug for the first time).
- If your doctor agrees, you don't pay for the full month's supply for certain drugs.

When you get less than a month's supply of a drug, the amount you pay is based on the number of days of the drug that you get. We calculate the amount you pay per day for your drug (the "daily cost sharing rate") and multiply it by the number of days of the drug you get.

- Here's an example: Let's say the copay for your drug for a full month's supply (a 30-day supply) is \$1.35. This means that the amount you pay for your drug is less than \$0.05 per day. If you get a 7 days' supply of the drug, your payment is less than \$.05 per day multiplied by 7 days, for a total payment less than \$0.35.
- Daily cost sharing allows you to make sure a drug works for you before you pay for an entire month's supply.
- You can also ask your provider to prescribe less than a full month's supply of a drug to help you:
  - Better plan when to refill your drugs,
  - Coordinate refills with other drugs you take, **and**
  - Take fewer trips to the pharmacy.

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## G. What you pay for Part D vaccines

**Important message about what you pay for vaccines:** Some vaccines are considered medical benefits and are covered under Medicare Part B. Other vaccines are considered Medicare Part D drugs. You can find these vaccines listed in our *Drug List*. Our plan covers most adult Medicare Part D vaccines at no cost to you. Refer to your plan's *Drug List* or contact Customer Care for coverage and cost sharing details about specific vaccines.

There are two parts to our coverage of Medicare Part D vaccines:

1. The first part is for the cost of the vaccine itself.
2. The second part is for the cost of giving you the vaccine. For example, sometimes you may get the vaccine as a shot given to you by your doctor.

### G1. What you need to know before you get a vaccine

We recommend that you call Customer Care if you plan to get a vaccine.

- We can tell you about how our plan covers your vaccine and explain your share of the cost.

### G2. What you pay for a vaccine covered by Medicare Part D

What you pay for a vaccine depends on the type of vaccine (what you're being vaccinated for).



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- Some vaccines are considered health benefits rather than drugs. These vaccines are covered at no cost to you. To learn about coverage of these vaccines, refer to the Benefits Chart in **Chapter 4** of this *Evidence of Coverage*.
- Other vaccines are considered Medicare Part D drugs. You can find these vaccines on our plan's Drug List. You may have to pay a copay for Medicare Part D vaccines. If the vaccine is recommended for adults by an organization called the **Advisory Committee on Immunization Practices (ACIP)** then the vaccine will cost you nothing.

Here are three common ways you might get a Medicare Part D vaccine.

1. You get the Medicare Part D vaccine and your shot at a network pharmacy.
  - For most adult Part D vaccines, you'll pay nothing.
  - For other Part D vaccines, you pay a copay for the vaccine.
2. You get the Medicare Part D vaccine at your doctor's office, and your doctor gives you the shot.
  - You pay a copay to the doctor for the vaccine.
  - Our plan pays for the cost of giving you the shot.
  - The doctor's office should call our plan in this situation so we can make sure they know you only have to pay a copay for the vaccine.
3. You get the Medicare Part D vaccine medication at a pharmacy, and you take it to your doctor's office to get the shot.
  - For most adult Part D vaccines, you'll pay nothing for the vaccine itself.
  - For other Part D vaccines, you pay a copay for the vaccine.
  - Our plan pays for the cost of giving you the shot.
  - For most adult Part D vaccines, you'll be reimbursed the full amount you paid. For other Part D vaccines, you'll be reimbursed the amount you paid less any coinsurance or copayment for the vaccine (including administration), and less any difference between the amount the doctor charges and what we normally pay. (If you get Extra Help, we'll reimburse you for this difference.)



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# Chapter 7: Asking us to pay a bill you got for covered services or drugs

## Introduction

This chapter tells you how and when to send us a bill to ask for payment. It also tells you how to make an appeal if you don't agree with a coverage decision. Key terms and their definitions appear in alphabetical order in the last chapter of this *Evidence of Coverage*.

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### A. Asking us to pay for your services or drugs

You shouldn't get a bill for in-network services or drugs. Our network providers must bill the plan for your covered services and drugs after you get them. A network provider is a provider who works with the health plan.

We don't allow iCare Family Care Partnership providers to bill you for these services or drugs. We pay our providers directly, and we protect you from any charges.

**If you get a bill for the full cost of health care or drugs, don't pay the bill and send the bill to us.** To send us a bill, refer to **Section B**.

- If we cover the services or drugs, we'll pay the provider directly.
- If we cover the services or drugs and you already paid the bill, it's your right to be paid back.
  - If you paid for services covered by Medicare, we'll pay you back.
  - If you paid for services covered by Family Care Partnership we can't pay you back, but the provider will. Customer Care or your care manager can help you contact the provider's office. Refer to the bottom of the page for the Customer Care phone number.
- If we don't cover the services or drugs, we'll tell you.

Contact Customer Care if you have any questions. If you get a bill and you don't know what to do about it, we can help. You can also call if you want to tell us information about a request for payment you already sent to us.

Examples of times when you may need to ask us to pay you back or to pay a bill you got include:

### 1. When you get emergency or urgently needed health care from an out-of-network provider

Ask the provider to bill us.

- If you pay the full amount when you get the care, ask us to pay you back. Send us the bill and proof of any payment you made.
- You may get a bill from the provider asking for payment that you think you don't owe. Send us the bill and proof of any payment you made.
  - If the provider should be paid, we'll pay the provider directly.
  - If you already paid for the Medicare service, we'll pay you back.

### 2. When a network provider sends you a bill

Network providers must always bill us. It's important to show your Member ID Card when you get any services or prescriptions. But sometimes they make mistakes and ask you to pay for your services or more than your share of the costs. **Call Customer Care** at the number at the bottom of this page **if you get any bills**.

- Because we pay the entire cost for your services, you aren't responsible for paying any costs. Providers shouldn't bill you anything for these services.
- Whenever you get a bill from a network provider, send us the bill. We'll contact the provider directly and take care of the problem.
- If you already paid a bill from a network provider for Medicare-covered services, send us the bill and proof of any payment you made. We'll pay you back.

### 3. If you're retroactively enrolled in our plan

Sometimes your enrollment in the plan can be retroactive. (This means that the first day of your enrollment has passed. It may have even been last year.)

- If you were enrolled retroactively and you paid a bill after the enrollment date, you can ask us to pay you back.
- Send us the bill and proof of any payment you made.

### 4. When you use an out-of-network pharmacy to fill a prescription

If you use an out-of-network pharmacy, you pay the full cost of your prescription.

- In only a few cases, we'll cover prescriptions filled at out-of-network pharmacies. Send us a copy of your receipt when you ask us to pay you back.
- Refer to **Chapter 5** of this *Evidence of Coverage* to learn more about out-of-network pharmacies.
- We may not pay you back the difference between what you paid for the drug at the out-of-network pharmacy and the amount that we'd pay at an in-network pharmacy.

### 5. When you pay the full Medicare Part D prescription cost because you don't have your Member ID Card with you



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If you don't have your Member ID Card with you, you can ask the pharmacy to call us or look up your plan enrollment information.

- If the pharmacy can't get the information right away, you may have to pay the full prescription cost yourself or return to the pharmacy with your Member ID Card.
- Send us a copy of your receipt when you ask us to pay you back.
- We may not pay you back the full cost you paid if the cash price you paid is higher than our negotiated price for the prescription.

## 6. When you pay the full Medicare Part D prescription cost for a drug that's not covered

You may pay the full prescription cost because the drug isn't covered.

- The drug may not be on our *List of Covered Drugs (Drug List)* on our website, or it may have a requirement or restriction that you don't know about or don't think applies to you. If you decide to get the drug, you may need to pay the full cost.
  - If you don't pay for the drug but think we should cover it, you can ask for a coverage decision (refer to **Chapter 9** of this *Evidence of Coverage*).
  - If you and your doctor or other prescriber think you need the drug right away, (within 24 hours), you can ask for a fast coverage decision (refer to **Chapter 9** of this *Evidence of Coverage*).
- Send us a copy of your receipt when you ask us to pay you back. In some cases, we may need to get more information from your doctor or other prescriber to pay you back for the drug. We may not pay you back the full cost you paid if the price you paid is higher than our negotiated price for the prescription.

When you send us a request for payment, we review it and decide whether the service or drug should be covered. This is called making a "coverage decision." If we decide the service or drug should be covered, we pay for it.

If we deny your request for payment, you can appeal our decision. To learn how to make an appeal, refer to **Chapter 9** of this *Evidence of Coverage*.

---

## B. Sending us a request for payment

Send us your bill and proof of any payment you made for Medicare services. Proof of payment can be a copy of the check you wrote or a receipt from the provider. It's a good idea to make a copy of your bill and receipts for your records. You can ask your care manager for help. You must send your information to us within 12 months of the date you received the service, item, or drug.

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

Independent Care Health Plan  
ATTN: Member Bills  
1555 North RiverCenter Drive  
Suite 206  
Milwaukee, Wisconsin 53212



**If you have questions**, please call iCare Family Care Partnership at 1-800-777-4376 (TTY: 711), 24 hours a day, 7 days a week. The call is free. **For more information**, visit [www.icarehealthplan.org](http://www.icarehealthplan.org).

Mail your request for payment together with any bills or receipts to this address for Part D drugs:

Independent Care Health Plan  
ATTN: Pharmacy Services DMR  
1555 North RiverCenter Drive  
Suite 206  
Milwaukee, Wisconsin 53212

You may also call us to ask for payment at the phone number listed in the footer of this document.

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## C. Coverage decisions

When we get your request for payment, we make a coverage decision. This means that we decide if our plan covers your service, item, or drug. We also decide the amount of money, if any, you must pay.

- We'll let you know if we need more information from you.
- If we decide that our plan covers the service, item, or drug and you followed all the rules for getting it, we'll pay for it. If you already paid for the service or drug, we'll mail you a check for what you paid. If you paid the full cost of a drug, you might not be reimbursed the full amount you paid (for example, if you got a drug at an out-of-network pharmacy or if the cash price you paid is higher than our negotiated price). If you haven't paid, we'll pay the provider directly.

**Chapter 3** of this *Evidence of Coverage* explains the rules for getting your services covered. **Chapter 5** of this *Evidence of Coverage* explains the rules for getting your Medicare Part D drugs covered.

- If we decide not to pay for the service or drug, we'll send you a letter with the reasons. The letter also explains your rights to make an appeal.
- To learn more about coverage decisions, refer to **Chapter 9**.

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## D. Appeals

If you think we made a mistake in turning down your request for payment, you can ask us to change our decision. This is called "making an appeal." You can also make an appeal if you don't agree with the amount we pay.

The formal appeals process has detailed procedures and deadlines. To learn more about appeals, refer to **Chapter 9** of this *Evidence of Coverage*:

- To make an appeal about getting paid back for a health care service, refer to **Section F**.
- To make an appeal about getting paid back for a drug, refer to **Section G**.



**If you have questions**, please call iCare Family Care Partnership at 1-800-777-4376 (TTY: 711), 24 hours a day, 7 days a week. The call is free. **For more information**, visit [www.icarehealthplan.org](http://www.icarehealthplan.org).

# Chapter 8: Your rights and responsibilities

## Introduction

This chapter includes your rights and responsibilities as a member of our plan. We must honor your rights. Key terms and their definitions appear in alphabetical order in the last chapter of this *Evidence of Coverage*.

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**If you have questions**, please call iCare Family Care Partnership at 1-800-777-4376 (TTY: 711), 24 hours a day, 7 days a week. The call is free. **For more information**, visit [www.icarehealthplan.org](http://www.icarehealthplan.org).



## A. Your right to get services and information in a way that meets your needs

We must ensure all services, both clinical and non-clinical, are provided to you in a culturally competent and accessible manner including for those with limited English proficiency, limited reading skills, hearing incapacity, or those with diverse cultural and ethnic backgrounds. We must also tell you about our plan's benefits and your rights in a way that you can understand. We must tell you about your rights each year that you're in our plan.

- To get information in a way that you can understand, call Customer Care. Our plan has free interpreter services available to answer questions in different languages.
- Our plan can also give you materials in languages other than English and in formats such as large print, braille, or audio. To get materials in one of these alternative formats, please call Customer Care or write to Independent Care Health Plan, 1555. N. Rivercenter Dr, Suite 206, Milwaukee, WI 53212.
- If you prefer to receive your written communications in an alternate format such as braille, large font, audio, or another language please contact Customer Care at 1-800-777-4376 (TTY: 711).
- Once we receive your alternative format request, all future state mandated communications will be provided in your chosen format. If we are unable to provide printed materials within your requested format, then the member will receive those communications over the phone with an interpreter.
- If you want to change your standing request, call Customer Care at 1-800-777-4376 (TTY: 711) to have your request updated. Please note: we can only accommodate standing requests for alternate formats.

If you have trouble getting information from our plan because of language problems or a disability and you want to file a complaint, call:

- Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877- 486-2048.
- Office for Civil Rights at 1-800-368-1019. TTY users should call 1-800-537-7697.

If you think a caregiver, agency, or facility has violated state or federal laws, you have the right to file a complaint with the Wisconsin Division of Quality Assurance. To file a complaint, call 800-642-6552.

## A. Su derecho a recibir servicios e información de una manera que satisfaga sus necesidades

Debemos asegurarnos de que **todos** los servicios, tanto clínicos como no clínicos, se le brinden de una manera culturalmente competente y accesible, incluso para aquellas personas con dominio limitado del inglés, habilidades de lectura limitadas, incapacidad auditiva o aquellos con orígenes culturales y étnicos diversos. También debemos informarle sobre los beneficios del plan y sus derechos de manera que pueda comprender. Debemos brindarle información sobre sus derechos cada año que usted esté en nuestro plan.

- Para obtener información en una forma que pueda comprender, llame a Atención al cliente. Nuestro plan tiene servicios de intérpretes gratuitos disponibles para responder preguntas en diferentes idiomas.
- Nuestro plan también puede proporcionarle materiales en idiomas que no sean inglés, como español, ruso, laosiano, hmong, árabe y en formatos como letra de imprenta grande, Braille o audio. Para obtener materiales en uno de estos formatos alternativos, llame a Atención al cliente o escriba a



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Independent Care Health Plan, 1555. N. Rivercenter Dr, Suite 206, Milwaukee, WI 53202.

- Si prefiere recibir sus comunicaciones escritas en un formato alternativo, como Braille, letra grande, audio u otro idioma, comuníquese con Atención al cliente llamando al 1-800-777-4736 (los usuarios de TTY deben llamar al 711).
- Una vez que recibamos su solicitud, todas las comunicaciones futuras exigidas por el estado se proporcionarán en el formato que elija. Si no podemos proporcionar materiales impresos en el formato solicitado, el afiliado recibirá esas comunicaciones por teléfono con un intérprete.
- Si desea cambiar su pedido permanente, llame a Atención al cliente al

1-800-777-4736 (los usuarios de TTY deben llamar al 711) para actualizar su solicitud.

Si tiene dificultades para recibir información de nuestro plan debido a limitaciones de idioma o a una discapacidad, y desea presentar una queja, puede comunicarse con:

- Medicare al 1-800-MEDICARE (1-800-633-4227). Los usuarios de TTY deben llamar al 1-877-486-2048.
- Oficina de Derechos Civiles al 1-800-368-1019. Los usuarios de TTY deben llamar al 1-800-537-7697.

Si cree que un cuidador, agencia o centro ha violado las leyes estatales o federales, tiene derecho a presentar una queja ante la División de Garantía de Calidad de Wisconsin. Para presentar una queja, llame al 800-642-6552.

#### **A. Ваше право получать услуги и информацию в форме, соответствующей вашим потребностям**

Мы обязаны обеспечить, чтобы **все** услуги — как клинические, так и неклинические — предоставлялись с учетом культурных особенностей и были доступны для всех участников, включая тех, кто владеет английским языком на ограниченном уровне, не умеет читать, плохо слышит или имеет различные культурные и этнические корни. Мы также обязаны изложить вам преимущества своего плана и разъяснить ваши права доступным способом. Мы должны информировать вас о ваших правах каждый год, пока вы участвуете в нашем плане.

- Чтобы получить информацию в удобной для вас форме, позвоните в службу поддержки клиентов. В рамках нашего плана предоставляются бесплатные услуги переводчика, чтобы вы могли получить ответы на вопросы на разных языках.
- В рамках нашего плана также могут предоставляться материалы на других языках, кроме английского, включая испанский, русский, лаосский, хмонг, арабский, а также в форматах с крупным шрифтом, шрифтом Брайля или в аудиоформате. Чтобы получить материалы в одном из альтернативных форматов, позвоните в службу поддержки клиентов или отправьте письмо по адресу: Independent Care Health Plan, 1555. N. Rivercenter Dr, Suite 206, Milwaukee, WI 53202.
- Если вы предпочитаете получать письменные материалы в альтернативном формате (например, шрифтом Брайля, крупным шрифтом, в аудиоформате или на другом языке), позвоните в службу поддержки клиентов по номеру 1-800-777-4736 (TTY: 711).
- Как только мы получим ваш запрос, вся последующая обязательная корреспонденция на уровне штата будет предоставляться в выбранном вами формате. Если мы не сможем предоставить печатные материалы в запрошенном формате, вы получите эту информацию по телефону при



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участии переводчика.

- Если вы хотите изменить свой постоянный запрос, позвоните в службу поддержки клиентов по номеру 1-800-777-4736 (TTY: 711), чтобы обновить информацию.

Если у вас возникли трудности с получением информации о нашем плане из-за языковых проблем или инвалидности и вы хотите подать жалобу, позвоните по следующему номеру:

- Medicare: 1-800-MEDICARE (1-800-633-4227). TTY: 1-877-486-2048.
- Офис по правам граждан: 1-800-368-1019. TTY: 1-800-537-7697.

Если вы считаете, что опекун, агентство или учреждение нарушили федеральные законы или законы штата, вы имеете право подать жалобу в Отдел обеспечения качества штата Висконсин (Wisconsin Division of Quality Assurance). Чтобы подать жалобу, позвоните по номеру 800-642-6552.

### A. Koj txoj cai tau txais cov kev pab cuam hauv ib txoj hau kev uas ua tau raws li koj cov kev xav tau

Peb yuav tsum xyuas kom paub tseeb tias tau muab **tag nrho** cov kev pab cuam, tag nrho hauv fab kev kho mob thiab tsis yog fab kev kho mob, rau koj hauv txoj hau kev uas tsim nyog rau fab kab lij kev cai thiab tus yam ntxwv uas nkag cuag tau suav nrog rau cov neeg uas muaj kev pab Lus Askiv tsawg, nyeem tau ntawv tsis tshua zoo, tsis muaj peev xwm hnov lus, los sis cov uas muaj keeb kwm ntau fab kab lij kev cai thiab ntau haiv neeg. Peb kuj yuav tsum tau qhia rau koj paub hais txog peb txoj phiaj xwm npaj tuav pov hwm cov txiaj ntsig kev pab thiab koj txoj cai hauv ib txoj hau kev uas koj nkag siab tau. Peb yuav tsum qhia rau koj paub hais txog koj txoj cai hauv txhua xyoo uas koj nyob rau hauv peb txoj phiaj xwm npaj tuav pov hwm.

- Yog xav kom tau txais ntaub ntawv qhia paub hauv ib txoj hau kev uas koj nkag siab tau, ces hu rau Lub Chaw Kev Saib Xyuas Tus Qhua. Peb txoj phiaj xwm npaj tuav pov hwm muaj cov kev pab cuam kws txhais lus pub dawb los teb cov lus nug hauv cov hom lus sib txawv.
- Peb txoj phiaj xwm npaj tuav pov hwm kuj tuaj yeem muab cov ntaub ntawv rau koj ua hom lus uas tsis yog Lus Askiv suav nrog Lus Mev, Lus Lav Xias, Lus Nplog, Lus Hmoob, Lus As Las Npiv thiab hauv cov hom ntawv xws li ntawv luam loj, ntawv xuas, los sis ua suab lus. Yog xav tau cov ntaub ntawv hauv ib qho ntawm lwm cov ntaub ntawv no, thov hu rau Lub Chaw Kev Saib Xyuas Tus Qhua los sis sau ntawv mus rau Independent Care Health Plan, 1555. N. Rivercenter Dr, Suite 206, Milwaukee, WI 53202.
- Yog tias koj xav kom tau txais koj cov ntaub ntawv sib txuas lus ua lwm hom ntawv xws li ntawv xuas, tus ntawv loj, ua suab lus, los sis lwm hom lus thov tiv tauj Lub Chaw Kev Saib Xyuas Tus Qhua ntawm 1-800-777-4736 (Cov neeg siv TTY hu rau 711).
- Thaum uas peb tau txais koj daim ntawv thov lawm, cov kev sib txuas lus raws lus txib ntawm lub xeev nyob yav pem suab tag nrho yuav tau txais ua koj hom ntawv uas xaiv tseg. Yog tias peb tsis muaj peev xwm muab tau cov ntaub ntawv ua ntawv luam tawm nyob hauv hom ntawv uas koj tau thov tuaj, ces tus tswv cuab yuav tau txais cov ntaub ntawv kev sib txuas lus ntawd hauv xov tooj nrog tus neeg txhais lus.
- Yog tias koj xav hloov koj daim ntawv thov uas thov ib zaug kav mus ib txhis, ces hu rau Lub Chaw Kev Saib Xyuas Tus Qhua ntawm 1-800-777-4736 (Cov neeg siv TTY hu rau 711) los thov kom hloov kho koj daim ntawv thov.

Yog tias koj muaj teeb meem txog kev tau txais ntaub ntawv qhia paub los ntawm peb txoj phiaj xwm npaj tuav



**If you have questions**, please call iCare Family Care Partnership at 1-800-777-4376 (TTY: 711), 24 hours a day, 7 days a week. The call is free. **For more information**, visit [www.icarehealthplan.org](http://www.icarehealthplan.org).

pov hwm vim tias muaj teeb meem txog hom lus los sis kev xiam oob qhab thiab koj xav ua ntawv kev tsis txaus siab, ces hu rau:

- Medicare ntawm 1-800-MEDICARE (1-800-633-4227). Cov neeg siv TTY yuav hu rau 1-877- 486-2048.
- Lub Chaw Ua Hauj Lwm Saib Xyuas Pej Xeem Cov Cai ntawm 1-800-368-1019. Cov neeg siv TTY tsim nyog hu rau 1-800-537-7697.

Yog tias koj xav tias tus neeg saib xyuas, lub chaw ua hauj lwm, los sis lub chaw kho mob tau yuam txoj cai lij choj ntawm lub xeev los sis ntawm tsoom fwv teb chaws, koj muaj cai yuav ua ntawv kev tsis txaus siab nrog Wisconsin Feem Hauj Lwm Saib Xyuas Kev Lav Txog Qhov Ua Tau Zoo Tsim Nyog. Yog xav ua ntawv kev tsis txaus siab, ces hu rau 800-642-6552.

## A. ສິດຂອງທ່ານທີ່ຈະໄດ້ຮັບບໍລິການ ແລະ ຂໍ້ມູນໃນວິທີທີ່ຕອບສະໜອງໄດ້ຕາມຄວາມຕ້ອງການຂອງທ່ານ

ພວກເຮົາຕ້ອງແນ່ໃຈວ່າ ການບໍລິການທັງໝົດ, ທັງທາງດ້ານຄລິນິກ ແລະ ທີ່ບໍ່ແມ່ນທາງຄລິນິກ, ໄດ້ຖືກສະໜອງໃຫ້ທ່ານໃນລັກສະນະທີ່ເໝາະສົມທາງດ້ານວັດທະນະທຳ ແລະ ເຂົ້າເຖິງໄດ້ ລວມທັງສໍາລັບຜູ້ທີ່ມີຂີດຈໍາກັດທາງພາສາອັງກິດ, ມີທັກສະການອ່ານທີ່ຈໍາກັດ, ບໍ່ໄດ້ຍິນດີ, ຫຼື ຜູ້ທີ່ມີພື້ນຖານດ້ານວັດທະນະທຳ ແລະ ຊົນເຜົ່າທີ່ຫຼາກຫຼາຍ. ພວກເຮົາຍັງຕ້ອງບອກທ່ານກ່ຽວກັບຜົນປະໂຫຍດຂອງແຜນການຂອງພວກເຮົາ ແລະ ສິດທິຂອງທ່ານ ໃນວິທີທີ່ທ່ານສາມາດເຂົ້າໃຈໄດ້. ພວກເຮົາຕ້ອງແຈ້ງໃຫ້ທ່ານຊາບກ່ຽວກັບສິດທິຂອງທ່ານທຸກໆປີທີ່ທ່ານຢູ່ໃນແຜນການຂອງພວກເຮົາ.

- ເພື່ອຮັບຂໍ້ມູນຈາກພວກເຮົາໃນແບບທີ່ເໝາະສົມກັບທ່ານ, ກະລຸນາໂທຫາສູນ ການດູແລລູກຄ້າ. ແຜນການຂອງພວກເຮົາມີບໍລິການນາຍພາສາໂດຍບໍ່ເສຍຄ່າ ເພື່ອຕອບຄໍາຖາມເປັນຫຼາຍພາສາ.
- ແຜນການຂອງພວກເຮົາຍັງສາມາດໃຫ້ເອກະສານແກ່ທ່ານ ເປັນພາສາອື່ນນອກຈາກພາສາອັງກິດ ລວມທັງ ພາສາ ສະເປນ, ຣັດເຊຍ, ລາວ, ມົງໂກນ, ອາຣັບ ແລະ ໃນຮູບແບບ ເຊັ່ນ ການພິມຂະໜາດ ໃຫຍ່, ອັກສອນນູນ ຫຼື ອັດສຽງ. ເພື່ອຮັບເອົາວັດສະດຸໃນຮູບແບບທາງເລືອກໃດໜຶ່ງ, ກະລຸນາໂທຫາສູນ ການດູແລລູກຄ້າ ຫຼື ຂຽນຈົດໝາຍຫາ Independent Care Health Plan, 1555. N. Rivercenter Dr, Suite 206, Milwaukee, WI 53202.
- ຖ້າທ່ານຕ້ອງການຮັບການສື່ສານຂອງທ່ານ ເປັນລາຍລັກອັກສອນໃນຮູບແບບທາງເລືອກເຊັ່ນ ເປັນອັກສອນນູນ, ຕົວພິມໃຫຍ່, ສຽງ, ຫຼື ພາສາອື່ນ ກະລຸນາຕິດຕໍ່ ສູນການດູແລລູກຄ້າ ທີ່ 1-800-777-4736 (ຜູ້ໃຊ້ TTY ໂທຫາ 711).
- ເມື່ອພວກເຮົາໄດ້ຮັບຄໍາຮ້ອງຂໍຂອງທ່ານ, ການສື່ສານຂອງລັດໃນອະນາຄົດທັງໝົດຈະຖືກສະໜອງໃນຮູບແບບທີ່ທ່ານເລືອກ. ຖ້າພວກເຮົາບໍ່ສາມາດສະໜອງເອກະສານໃນຮູບແບບທີ່ທ່ານໄດ້ຮ້ອງຂໍ, ຫຼັງຈາກນັ້ນສະມາຊິກຈະໄດ້ຮັບການສື່ສານຜ່ານໂທລະສັບກັບຜູ້ແປພາສາ.
- ຖ້າທ່ານຕ້ອງການປ່ຽນຄໍາຮ້ອງຂໍ ທີ່ຍັງລໍຖ້າຢູ່ຂອງທ່ານ, ໃຫ້ໂທຫາ ສູນການດູແລລູກຄ້າ ທີ່ 1-800-777-4736 (ຜູ້ໃຊ້ TTY ໃຫ້ໂທຫາ 711) ເພື່ອໃຫ້ຄໍາຮ້ອງຂໍຂອງທ່ານໄດ້ຮັບການປັບປຸງໃໝ່.

ຖ້າທ່ານມີບັນຫາໃນການໄດ້ຮັບຂໍ້ມູນຈາກແຜນການຂອງພວກເຮົາ ເນື່ອງຈາກບັນຫາພາສາ ຫຼື ຄວາມພິການ ແລະ ທ່ານຢາກຍືນຄໍາຮ້ອງທຸກ, ໃຫ້ໂທຫາ:

- Medicare ທີ່ 1-800-MEDICARE (1-800-633-4227). ຜູ້ໃຊ້ TTY ຄວນໂທຫາ 1-877- 486-2048.



**If you have questions**, please call iCare Family Care Partnership at 1-800-777-4376 (TTY: 711), 24 hours a day, 7 days a week. The call is free. **For more information**, visit [www.icarehealthplan.org](http://www.icarehealthplan.org).

- ຫ້ອງການສິດທິພົນລະເມືອງທີ່ 1-800-368-1019. ຜູ້ໃຊ້ TTY ຄວນໂທຫາ 1-800-537-7697.

ຖ້າທ່ານຄິດວ່າຜູ້ດູແລ, ອົງການ ຫຼື ສະຖານທີ່ບໍລິການໄດ້ລະເມີດກົດໝາຍຂອງລັດ ຫຼື ລັດຖະບານກາງ, ທ່ານມີສິດຍື່ນຄໍາຮ້ອງທຸກ ກັບ ພະແນກປະກັນຄຸນນະພາບຂອງລັດ Wisconsin (Wisconsin Division of Quality Assurance). ເພື່ອຍື່ນ ຄໍາຮ້ອງທຸກ, ໃຫ້ໂທຫາ 800-642-6552.

## A. ຫຼັກການໃນການໄດ້ຮັບຂໍ້ມູນ ແລະ ສະໜອງບໍລິການ

ເປົ້າໝາຍຂອງການໄດ້ຮັບຂໍ້ມູນ ແລະ ສະໜອງບໍລິການ ແມ່ນ ທຳນຽມໃຫ້ທ່ານໄດ້ຮັບຂໍ້ມູນ ແລະ ສະໜອງບໍລິການ ທີ່ທ່ານຕ້ອງການ. ທ່ານຈະໄດ້ຮັບຂໍ້ມູນ ແລະ ສະໜອງບໍລິການ ທີ່ທ່ານຕ້ອງການ ໃນພາສາ ຫຼື ສະຖານທີ່ທີ່ທ່ານຕ້ອງການ. ທ່ານຈະໄດ້ຮັບຂໍ້ມູນ ແລະ ສະໜອງບໍລິການ ທີ່ທ່ານຕ້ອງການ ໃນພາສາ ຫຼື ສະຖານທີ່ທີ່ທ່ານຕ້ອງການ. ທ່ານຈະໄດ້ຮັບຂໍ້ມູນ ແລະ ສະໜອງບໍລິການ ທີ່ທ່ານຕ້ອງການ ໃນພາສາ ຫຼື ສະຖານທີ່ທີ່ທ່ານຕ້ອງການ.

- ຈົ່ງ ໂທຫາ ພະແນກປະກັນຄຸນນະພາບຂອງລັດ Wisconsin ເພື່ອຍື່ນ ຄໍາຮ້ອງທຸກ ຖ້າທ່ານຕ້ອງການ ຂໍ້ມູນ ແລະ ສະໜອງບໍລິການ ທີ່ທ່ານຕ້ອງການ.

- ບໍ່ມີ ຄວາມຕ້ອງການ ທີ່ທ່ານຕ້ອງການ ຂໍ້ມູນ ແລະ ສະໜອງບໍລິການ ທີ່ທ່ານຕ້ອງການ. ທ່ານຈະໄດ້ຮັບຂໍ້ມູນ ແລະ ສະໜອງບໍລິການ ທີ່ທ່ານຕ້ອງການ ໃນພາສາ ຫຼື ສະຖານທີ່ທີ່ທ່ານຕ້ອງການ. ທ່ານຈະໄດ້ຮັບຂໍ້ມູນ ແລະ ສະໜອງບໍລິການ ທີ່ທ່ານຕ້ອງການ ໃນພາສາ ຫຼື ສະຖານທີ່ທີ່ທ່ານຕ້ອງການ.

- ຖ້າທ່ານຕ້ອງການ ຂໍ້ມູນ ແລະ ສະໜອງບໍລິການ ທີ່ທ່ານຕ້ອງການ, ຈົ່ງ ໂທຫາ ພະແນກປະກັນຄຸນນະພາບຂອງລັດ Wisconsin ເພື່ອຍື່ນ ຄໍາຮ້ອງທຸກ.

- ບໍ່ມີ ຄວາມຕ້ອງການ ທີ່ທ່ານຕ້ອງການ ຂໍ້ມູນ ແລະ ສະໜອງບໍລິການ ທີ່ທ່ານຕ້ອງການ. ທ່ານຈະໄດ້ຮັບຂໍ້ມູນ ແລະ ສະໜອງບໍລິການ ທີ່ທ່ານຕ້ອງການ ໃນພາສາ ຫຼື ສະຖານທີ່ທີ່ທ່ານຕ້ອງການ. ທ່ານຈະໄດ້ຮັບຂໍ້ມູນ ແລະ ສະໜອງບໍລິການ ທີ່ທ່ານຕ້ອງການ ໃນພາສາ ຫຼື ສະຖານທີ່ທີ່ທ່ານຕ້ອງການ.

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Medicare ໃນສະຫະລັດ (1-800-633-4227) ຫຼື 1-800-MEDICARE. ຈົ່ງ ໂທຫາ ພະແນກປະກັນຄຸນນະພາບຂອງລັດ Wisconsin ເພື່ອຍື່ນ ຄໍາຮ້ອງທຸກ.

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If you have questions, please call iCare Family Care Partnership at 1-800-777-4376 (TTY: 711), 24 hours a day, 7 days a week. The call is free. For more information, visit [www.icarehealthplan.org](http://www.icarehealthplan.org).



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## B. Our responsibility for your timely access to covered services and drugs

You have rights as a member of our plan.

- You have the right to choose a primary care provider (PCP) in our network. A network provider is a provider who works with us. You can find more information about what types of providers may act as a PCP and how to choose a PCP in **Chapter 3** of this *Evidence of Coverage*.
  - Call Customer Care or go to the *Provider and Pharmacy Directory* to learn more about network providers and which doctors are accepting new patients.
- You have the right to a women's health specialist without getting a referral. A referral is approval from your PCP to use a provider that isn't your PCP.
- You have the right to get covered services from network providers within a reasonable amount of time.
  - This includes the right to get timely services from specialists.
  - If you can't get services within a reasonable amount of time, we must pay for out-of-network care.
- You have the right to get emergency services or care that's urgently needed without prior approval (PA).
- You have the right to get your prescriptions filled at any of our network pharmacies without long delays.
- You have the right to know when you can use an out-of-network provider. To learn about out-of-network providers, refer to **Chapter 3** of this *Evidence of Coverage*.

**Chapter 9** of this *Evidence of Coverage* tells what you can do if you think you aren't getting your services or drugs within a reasonable amount of time. It also tells what you can do if we denied coverage for your services or drugs and you don't agree with our decision.

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## C. Our responsibility to protect your personal health information (PHI)

We protect your PHI as required by federal and state laws.

Your PHI includes the personal information you gave us when you enrolled in our plan. It also includes your medical records and other medical and health information.

You have rights when it comes to your information and controlling how your PHI is used. We give you a written notice that tells about these rights and explains how we protect the privacy of your PHI. The notice is called the "Notice of Privacy Practice."

### C1. How we protect your PHI

We make sure that no unauthorized people look at or change your records.

Except for the cases noted below, we don't give your PHI to anyone not providing your care or paying for your care. If we do, we must get written permission from you first. You, or someone legally authorized to make decisions for you, can give written permission.

Sometimes we don't need to get your written permission first. These exceptions are allowed or required by law:



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- We must release PHI to government agencies checking on our plan's quality of care.
- We must release PHI by court order.
- We must give Medicare your PHI including information about your Medicare Part D drugs. If Medicare releases your PHI for research or other uses, they do it according to federal laws.

## **C2. Your right to look at your medical records**

- You have the right to look at your medical records and to get a copy of your records. We may charge you a fee for making a copy of your medical records.
- You have the right to ask us to update or correct your medical records. If you ask us to do this, we work with your health care provider to decide if changes should be made.
- You have the right to know if and how we share your PHI with others for any purposes that aren't routine.

If you have questions or concerns about the privacy of your PHI, call Customer Care.

For more information about Independent Care Health Plan's (iCare) privacy practices please visit <https://www.icarehealthplan.org/Utility-Navigation/Privacy-Policy.htm> or if you would like a copy of iCare's Privacy Notice call Customer Care.

## **Insurance ACE**

### **Notice of Privacy Practices**

**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.**

**The privacy of your personal and health information is important. You do not need to do anything unless you have a request or complaint.**

This Notice of Privacy Practices applies to all entities that are part of the Insurance ACE, an Affiliated Covered Entity under HIPAA. The ACE is a group of legally separate covered entities that are affiliated and have designated themselves as a single covered entity for purposes of HIPAA. A complete list of the members of the ACE is available at <https://huma.na/insuranceace>.

We may change our privacy practices and the terms of this notice at any time, as allowed by law, including information we created or received before we made the changes. When we make a significant change in our privacy practices, we will change this notice and send the notice to our health plan subscribers.

### **What is nonpublic personal or health information?**

Nonpublic personal or health information includes both medical information and personal information, like your name, address, telephone number, Social Security number, account numbers, payment information, or demographic information. The term "information" in this notice includes any nonpublic personal and health information. This includes information created or received by a healthcare provider or health plan. The information relates to your physical or mental health or condition, providing healthcare to you, or the payment for such healthcare.



**If you have questions**, please call iCare Family Care Partnership at 1-800-777-4376 (TTY: 711), 24 hours a day, 7 days a week. The call is free. **For more information**, visit [www.icarehealthplan.org](https://www.icarehealthplan.org).



### **How do we collect information about you?**

We collect information about you and your family when you complete applications and forms. We also collect information from your dealings with us, our affiliates, or others. For example, we may receive information about you from participants in the healthcare system, such as your doctor or hospital, as well as from employers or plan administrators, credit bureaus, and the Medical Information Bureau.

### **What information do we receive about you?**

The information we receive may include such items as your name, address, telephone number, date of birth, Social Security number, premium payment history, and your activity on our website. This also includes information regarding your medical benefit plan, your health benefits, and health risk assessments.

### **How do we protect your information?**

We have a responsibility to protect the privacy of your information in all formats including electronic, and oral information. We have administrative, technical, and physical safeguards in place to protect your information in various ways including:

- Limiting who may see your information
- Limiting how we use or disclose your information
- Informing you of our legal duties about your information
- Training our employees about our privacy program and procedures

### **How do we use and disclose your information?**

We use and disclose your information:

- To you or someone who has the legal right to act on your behalf
- To the Secretary of the Department of Health and Human Services

We have the right to use and disclose your information:

- To a doctor, a hospital, or other healthcare provider so you can receive medical care.
- For payment activities, including claims payment for covered services provided to you by healthcare providers and for health plan premium payments.
- For healthcare operation activities, including processing your enrollment, responding to your inquiries, coordinating your care, improving quality, and determining premiums.
- For performing underwriting activities. However, we will not use any results of genetic testing or ask questions regarding family history.
- To your plan sponsor to permit them to perform, plan administration functions such as eligibility, enrollment and disenrollment activities. We may share summary level health information about you with your plan sponsor in certain situations. For example, to allow your plan sponsor to obtain bids from other health plans. Your detailed health information will not be shared with your plan sponsor. We will ask your permission, or your plan sponsor must certify they agree to maintain the privacy of your information.



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- To contact you with information about health-related benefits and services, appointment reminders, or treatment alternatives that may be of interest to you. If you have opted out, we will not contact you.
- To your family and friends if you are unavailable to communicate, such as in an emergency.
- To your family and friends, or any other person you identify. This applies if the information is directly relevant to their involvement with your health care or payment for that care. For example, if a family member or a caregiver calls us with prior knowledge of a claim, we may confirm if the claim has been received and paid.
- To provide payment information to the subscriber for Internal Revenue Service substantiation.
- To public health agencies, if we believe that there is a serious health or safety threat.
- To appropriate authorities when there are issues about abuse, neglect, or domestic violence.
- In response to a court or administrative order, subpoena, discovery request, or other lawful process.
- For law enforcement purposes, to military authorities and as otherwise required by law.
- To help with disaster relief efforts.
- For compliance programs and health oversight activities.
- To fulfill our obligations under any workers' compensation law or contract.
- To avert a serious and imminent threat to your health or safety or the health or safety of others.
- For research purposes in limited circumstances and provided that they have taken appropriate measures to protect your privacy.
- For procurement, banking, or transplantation of organs, eyes, or tissue.
- To a coroner, medical examiner, or funeral director.

Additional restriction on use and disclosure for specific types of information:

- Some federal and state laws may restrict the use and disclosure of certain sensitive health information such as: Substance Use Disorder; Biometric Information; Child or Adult Abuse or Neglect, including Sexual Assault; Communicable Diseases; Genetic Information; HIV/AIDS; Mental Health; Reproductive Health; and Sexually Transmitted Diseases.
- Reproductive Health Information: We will not use or disclose information to conduct an investigation into identifying (or the attempt to impose liability against) any person for the act of seeking, obtaining, providing, or facilitating lawful reproductive health care. In response to a government agency's (or other person's) request for information that might be related to reproductive health care, the person making the request must provide a signed attestation that the purpose of the request does not violate the prohibition on disclosing reproductive health care information.

### **Will we use your information for purposes not described in this notice?**

We will not use or disclose your information for any reason that is not described in this notice, without your written permission. You may cancel your permission at any time by notifying us in writing.



**If you have questions**, please call iCare Family Care Partnership at 1-800-777-4376 (TTY: 711), 24 hours a day, 7 days a week. The call is free. **For more information**, visit [www.icarehealthplan.org](http://www.icarehealthplan.org).

The following uses and disclosures will require your written permission:

- Most uses and disclosures of psychotherapy notes
- Marketing purposes
- Sale of personal and health information

### **What do we do with your information when you are no longer a member?**

Your information may continue to be used for purposes described in this notice. This includes when you do not obtain coverage through us. After the required legal retention period, we destroy the information following strict procedures to maintain the confidentiality.

### **What are my rights concerning my information?**

We are committed to responding to your rights request in a timely manner.

- **Access** – You have the right to review and obtain a copy of your information that may be used to make decisions about you. You also may receive a summary of this health information. As required under applicable law, we will make this personal information available to you or to your designated representative.
- **Adverse Underwriting Decision** – If we decline your application for insurance, you have the right to be provided a reason for the denial.
- **Alternate Communications** – To avoid a life-threatening situation, you have the right to receive your information in a different manner or at a different place. We will accommodate your request if it is reasonable.
- **Amendment** – You have the right to request correction of any of this personal information through amendment or deletion. Within 60 business days of receipt of your written request, we will notify you of our amendment or deletion of the information in dispute, or of our refusal to make such correction after further investigation.
- If we refuse to amend or delete the information in dispute, you have the right to submit to us a written statement of the reasons for your disagreement with our assessment of the information in dispute and what you consider to be the correct information. We shall make such a statement accessible to any and all parties reviewing the information in dispute.\*
- **Disclosure** – You have the right to receive a listing of instances in which we or our business associates have disclosed your information. This does not apply to treatment, payment, health plan operations, and certain other activities. We maintain this information and make it available to you for six years. If you request this list more than once in a 12-month period, we may charge you a reasonable, cost-based fee.
- **Notice** – You have the right to request and receive a written copy of this notice any time.
- **Restriction** – You have the right to ask to limit how your information is used or disclosed. We are not required to agree to the limit, but if we do, we will abide by our agreement. You also have the right to agree to or terminate a previously submitted limitation.



**If you have questions**, please call iCare Family Care Partnership at 1-800-777-4376 (TTY: 711), 24 hours a day, 7 days a week. The call is free. **For more information**, visit [www.icarehealthplan.org](http://www.icarehealthplan.org).

### **If I believe that my privacy has been violated, what should I do?**

If you believe that your privacy has been violated you may file a complaint with us by calling us at 866-861-2762 any time.

You may also submit a written complaint to the U.S. Department of Health and Human Services, Office for Civil Rights (OCR). We will give you the appropriate OCR regional address on request. You can also e-mail your complaint to **OCRComplaint@hhs.gov**. If you elect to file a complaint, your benefits will not be affected and we will not punish or retaliate against you in any way.

We support your right to protect the privacy of your personal and health information.

### **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 tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

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, in our office, and on our web site.

### **How do I exercise my rights or obtain a copy of this notice?**

All of your privacy rights can be exercised by obtaining the applicable forms. You may obtain any of the forms by:

- Contacting us at 866-861-2762
- Accessing our website at **Humana.com** and going to the Privacy Practices link
- Send completed request form to:  
Humana Inc.  
Privacy Office 003/10911  
101 E. Main Street  
Louisville, KY 40202

\* This right applies only to our Massachusetts residents in accordance with state regulations.

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## **D. Our responsibility to give you information**

As a member of our plan, you have the right to get information from us about our plan, our network providers, and your covered services.

If you don't speak English, we have interpreter services to answer questions you have about our plan. To get an interpreter, call Customer Care. This is a free service to you. Our plan can give you materials in languages



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other than English. We can also give you information in large print, braille, or audio.

If you want information about any of the following, call Customer Care:

- How to choose or change plans
- Our plan, including:
  - financial information
  - how plan members have rated us
  - the number of appeals made by members
  - how to leave our plan
- Our network providers and our network pharmacies, including:
  - how to choose or change primary care providers
  - qualifications of our network providers and pharmacies
  - how we pay providers in our network
- Covered services and drugs, including:
  - services (refer to **Chapters 3 and 4** of this *Evidence of Coverage*) and drugs (refer to **Chapters 5 and 6** of this *Evidence of Coverage*) covered by our plan
  - limits to your coverage and drugs
  - rules you must follow to get covered services and drugs
- Why something is not covered and what you can do about it (refer to **Chapter 9** of this *Evidence of Coverage*), including asking us to:
  - put in writing why something isn't covered
  - change a decision we made
  - pay for a bill you got

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## E. Inability of network providers to bill you directly

Doctors, hospitals, and other providers in our network can't make you pay for covered services. They also can't balance bill or charge you if we pay less than the amount the provider charged. To learn what to do if a network provider tries to charge you for covered services, refer to **Chapter 7** of this *Evidence of Coverage*.

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## F. Your right to leave our plan

No one can make you stay in our plan if you do not want to.

- You have the right to get most of your health care services through Original Medicare or another Medicare Advantage (MA) plan.
- You can get your Medicare Part D drug benefits from a drug plan or from another MA plan.



**If you have questions**, please call iCare Family Care Partnership at 1-800-777-4376 (TTY: 711), 24 hours a day, 7 days a week. The call is free. **For more information**, visit [www.icarehealthplan.org](http://www.icarehealthplan.org).

- Refer to **Chapter 10** of this *Evidence of Coverage*:
  - For more information about when you can join a new MA or drug benefit plan.
  - For information about how you'll get your Family Care Partnership benefits if you leave our plan.

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## G. Your right to make decisions about your health care

You have the right to full information from your doctors and other health care providers to help you make decisions about your health care.

### G1. Your right to know your treatment choices and make decisions

Your providers must explain your condition and your treatment choices in a way that you can understand. You have the right to:

- **Know your choices.** You have the right to be told about all treatment options.
- **Know the risks.** You have the right to be told about any risks involved. We must tell you in advance if any service or treatment is part of a research experiment. You have the right to refuse experimental treatments.
- **Get a second opinion.** You have the right to use another doctor before deciding on treatment.
- **Say no.** You have the right to refuse any treatment. This includes the right to leave a hospital or other medical facility, even if your doctor advises you not to. You have the right to stop taking a prescribed drug. If you refuse treatment or stop taking a prescribed drug, we'll not drop you from our plan. However, if you refuse treatment or stop taking a drug, you accept full responsibility for what happens to you.
- **Ask us to explain why a provider denied care.** You have the right to get an explanation from us if a provider denied care that you think you should get.
- **Ask us to cover a service or drug that was denied or is usually not covered.** This is called a coverage decision. **Chapter 9** of this *Evidence of Coverage* tells how to ask us for a coverage decision.

### G2. Your right to say what you want to happen if you can't make health care decisions for yourself

Sometimes people are unable to make health care decisions for themselves. Before that happens to you, you can:

- Fill out a written form **giving someone the right to make health care decisions for you** if you ever become unable to make decisions for yourself.
- **Give your doctors written instructions** about how to handle your health care if you become unable to make decisions for yourself, including care you **don't** want.

The legal document you use to give your directions is called an "advance directive." There are different types of advance directives and different names for them. Examples are a living will and a power of attorney for health care.

You aren't required to have an advance directive, but you can. Here's what to do if you want to use an



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advance directive:

- **Get the form.** You can get the form from your doctor, a lawyer, a social worker, or some office supply stores. Pharmacies and provider offices often have the forms. You can find a free form online and download it. You can also contact Customer Care to ask for the form.
- **Fill out the form and sign it.** The form is a legal document. Consider having a lawyer or someone else you trust, such as a family member or your PCP, help you complete it.
- **Give copies of the form to people who need to know.** Give a copy of the form to your doctor. You should also give a copy to the person you name to make decisions for you if you can't. You may want to give copies to close friends or family members. Keep a copy at home.
- If you're being hospitalized and you have a signed advance directive, **take a copy of it to the hospital.**
  - The hospital will ask if you have a signed advance directive form and if you have it with you.
  - If you don't have a signed advance directive form, the hospital has forms and will ask if you want to sign one.

You have the right to:

- Have your advance directive placed in your medical records.
- Change or cancel your advance directive at any time.
- **Make an advance directive.** This means you can give instructions about what you want done if you aren't able to make decisions because of an accident or serious illness.
  - 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.
  - You decide whether you want an advanced directive. Your care team can explain how to create and use an advance directive, but they can't force you to have one or treat you differently based on whether you have an advance directive.
  - Contact your care team to learn more about advance directives. You can also find advance directive forms at [dhs.wi.gov/forms/advdirectives](https://dhs.wi.gov/forms/advdirectives).

By law, no one can deny you care or discriminate against you based on whether you signed an advance directive. Call Customer Care for more information.

### G3. What to do if your instructions aren't followed

If you signed an advance directive and you think a doctor or hospital didn't follow the instructions in it, you can file a complaint with the Wisconsin Division of Quality Assurance if you think iCare Family Care Partnership isn't following your advance directive. To file a complaint, call 800-642-6552.

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## H. Your right to make complaints and ask us to reconsider our decisions

Chapter 9 of this *Evidence of Coverage* tells you what you can do if you have any problems or concerns about your covered services or care. For example, you can ask us to make a coverage decision, make an appeal to



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change a coverage decision, or make a complaint.

You have the right to get information about appeals and complaints that other plan members have filed against us. Call Customer Care to get this information.

## H1. What to do about unfair treatment or to get more information about your rights

If you think we treated you unfairly – and it **isn't** about discrimination for reasons listed in **Chapter 11** of this *Evidence of Coverage* – or you want more information about your rights, you can call:

- Customer Care.
- The Wisconsin State Health Insurance Assistance Program (SHIP) is the Medigap Helpline and users should call 800-242-1060.
- Anyone receiving Family Care Partnership services can get free help from an ombudsman. The organization to contact depends on the member's age.
  - If you're age 60 or older, contact the Board on Aging and Long-Term Care. Go to [longtermcare.wi.gov](http://longtermcare.wi.gov), call 800-815-0015 (TTY: 711), or email [BOALTC@wisconsin.gov](mailto:BOALTC@wisconsin.gov).
  - If you're 18 to 59 years old, contact Disability Rights Wisconsin. Go to [disabilityrightswi.org](http://disabilityrightswi.org), call 800-928-8778 (TTY: 711), or email [info@drwi.org](mailto:info@drwi.org).
- Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048. (You can also read or download "Medicare Rights & Protections," found on the Medicare website at [www.medicare.gov/publications/11534-medicare-rights-and-protections.pdf](http://www.medicare.gov/publications/11534-medicare-rights-and-protections.pdf).)
- Wisconsin Department of Health (DHS) Services at 1-800-362-3002 (toll free). TTY/TDD users should call the Wisconsin Relay System at 711. You can also visit the DHS website at [www.dhs.wisconsin.gov/Medicaid](http://www.dhs.wisconsin.gov/Medicaid).

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## I. Your responsibilities as a plan member

As a plan member, you have a responsibility to do the things that are listed below. If you have any questions, call Customer Care.

- **Read this *Evidence of Coverage*** to learn what our plan covers and the rules to follow to get covered services and drugs. For details about your:
  - Covered services, refer to **Chapters 3 and 4** of this *Evidence of Coverage*. Those chapters tell you what's covered, what isn't covered, what rules you need to follow, and what you pay.
  - Covered drugs, refer to **Chapters 5 and 6** of this *Evidence of Coverage*.
- **Tell us about any other health or drug coverage** you have. We must make sure you use all of your coverage options when you get health care. Call Customer Care if you have other coverage.
- **Tell your doctor and other health care providers** that you're a member of our plan. Show your Member ID Card when you get services or drugs.
- **Help your doctors** and other health care providers give you the best care.



**If you have questions**, please call iCare Family Care Partnership at 1-800-777-4376 (TTY: 711), 24 hours a day, 7 days a week. The call is free. **For more information**, visit [www.icarehealthplan.org](http://www.icarehealthplan.org).

- Give them information they need about you and your health. Learn as much as you can about your health problems. Follow the treatment plans and instructions that you and your providers agree on.
- Make sure your doctors and other providers know about all the drugs you take. This includes prescription drugs, over-the-counter drugs, vitamins, and supplements.
- Ask any questions you have. Your doctors and other providers must explain things in a way you can understand. If you ask a question and you don't understand the answer, ask again.
- Accept services without regard to the provider's race, color, religion, age, gender, sexual orientation, health, ethnicity, creed (beliefs), or national origin.
- **Be considerate.** We expect all plan members to respect the rights of others. We also expect you to act with respect in your doctor's office, hospitals, and other provider offices.
- Take part in your care planning by participating in monthly contacts and in-person visits, including home visits, with your care team.
- Take part in the decision process to find the most cost-effective ways to meet your needs and support your long-term care outcomes.
- Talk with your care team about ways your friends, family, or other community and volunteer organizations can help support you or ways you can do more for yourself.
- Follow the care plan that you and your care team agreed to.
- Be responsible for your actions if you refuse treatment or don't follow the instructions from your care team or providers.
- Use providers that are part of *iCare Family Care Partnership's* network unless you and your care team decide otherwise.
- Follow *iCare Family Care Partnership's* procedures for getting care after hours.
- **Pay what you owe.** As a plan member, you're responsible for these payments:
  - Medicare Part A and Medicare Part B premiums. For most *iCare Family Care Partnership* members, Medicaid pays for your Medicare Part A premium and for your Medicare Part B premium.
  - For some of your drugs covered by our plan, you must pay your share of the cost when you get the drug. **Chapter 6** tells what you must pay for your drugs.
  - **If you get any services or drugs that aren't covered by our plan, you must pay the full cost.** (Note: If you disagree with our decision to not cover a service or drug, you can make an appeal. Please refer to **Chapter 9** to learn how to make an appeal.)
- Take care of any durable medical equipment you get, such as wheelchairs and hospital beds.
- Report fraud or abuse by providers or *iCare Family Care Partnership* employees. If you suspect someone is committing or has committed fraud or abuse of public assistance funds, including Family Care Partnership, call the fraud hotline at 877-865-3432 or visit [dhs.wi.gov/fraud](https://dhs.wi.gov/fraud).
- Not engage in any fraudulent activity or abuse benefits. This includes:
  - Not being truthful about your level of disability.



**If you have questions**, please call *iCare Family Care Partnership* at 1-800-777-4376 (TTY: 711), 24 hours a day, 7 days a week. The call is free. **For more information**, visit [www.icarehealthplan.org](https://www.icarehealthplan.org).

- Not being truthful about your income and assets.
- Not being truthful about where you live.
- Selling medical equipment supplied by iCare Family Care Partnership.
- Any fraudulent activity may result in disenrollment from Family Care Partnership or possible criminal prosecution.
- Provide iCare Family Care Partnership with correct information about your health care needs, finances, and preferences and tell us as soon as possible about any changes. This includes signing a release of information form when we need other information you don't have easily available.
- **Tell us if you move.** If you plan to move, tell us right away. Call Customer Care.
  - **If you move outside of our service area, you can't stay in our plan.** Only people who live in our service area can be members of this plan. **Chapter 1** of this *Evidence of Coverage* tells about our service area.
  - Tell Medicare and Family Care Partnership your new address when you move. Refer to **Chapter 2** of this *Evidence of Coverage* for phone numbers for Medicare and Family Care Partnership.
  - **If you move and stay in our service area, we still need to know.** We need to keep your membership record up to date and know how to contact you.
  - **If you move, tell Social Security (or the Railroad Retirement Board).**
- **Call Customer Care for help if you have questions or concerns.**

Tell us how we're doing. We may ask if you want to take part in member interviews, satisfaction surveys, or other quality review activities. Your feedback will help us identify our strengths as well as the areas we need to improve. Let us know if you would like to know the results of any surveys.



**If you have questions**, please call iCare Family Care Partnership at 1-800-777-4376 (TTY: 711), 24 hours a day, 7 days a week. The call is free. **For more information**, visit [www.icarehealthplan.org](http://www.icarehealthplan.org).

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

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## Introduction

This chapter has information about your rights. Read this chapter to find out what to do if:

- You have a problem with or complaint about your plan.
- You need a service, item, or medication that your plan said it won't pay for.
- You disagree with a decision your plan made about your care.
- You think your covered services are ending too soon.

This chapter is in different sections to help you easily find what you're looking for. **If you have a problem or concern, read the parts of this chapter that apply to your situation.**

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**If you have questions**, please call iCare Family Care Partnership at 1-800-777-4376 (TTY: 711), 24 hours a day, 7 days a week. The call is free. **For more information**, visit [www.icarehealthplan.org](http://www.icarehealthplan.org).

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## A. What to do if you have a problem or concern

This chapter explains how to handle problems and concerns. The process you use depends on the type of problem you have. Use one process for **coverage decisions and appeals** and another for **making complaints** (also called grievances).

To ensure fairness and promptness, each process has a set of rules, procedures, and deadlines that we and you must follow.

### A1. About the legal terms

There are legal terms in this chapter for some rules and deadlines. Many of these terms can be hard to understand, so we use simpler words in place of certain legal terms when we can. We use abbreviations as little as possible.

For example, we say:

- “Making a complaint” instead of “filing a grievance”
- “Coverage decision” instead of “organization determination”, “benefit determination”, “at-risk determination”, or “coverage determination”
- “Fast coverage decision” instead of “expedited determination”
- “Independent Review Organization” (IRO) instead of “Independent Review Entity” (IRE)

Knowing the proper legal terms may help you communicate more clearly, so we provide those too.

---

## B. Where to get help

### B1. For more information and help

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

#### Help from the Wisconsin State Health Insurance Assistance Program (SHIP)

You can call the SHIP. The SHIP counselors can answer your questions and help you understand what to do about your problem. The SHIP isn’t connected with us or with any insurance company or health plan. The SHIP has trained counselors in every county, and services are free. The SHIP phone number is 1-800-242-1060.

#### Help and information from Medicare

For more information and help, you can contact Medicare. Here are two ways to get help from Medicare:

- Call 1-800-MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048.
- Visit the Medicare website ([www.medicare.gov](http://www.medicare.gov)).



**If you have questions**, please call iCare Family Care Partnership at 1-800-777-4376 (TTY: 711), 24 hours a day, 7 days a week. The call is free. **For more information**, visit [www.icarehealthplan.org](http://www.icarehealthplan.org).

## Help and information from Family Care Partnership

Your Care 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.

DHS Family Care Grievances MetaStar  
2909 Landmark Place  
Madison, WI 53713

Phone: 1-888-203-8338  
Fax: 608-274-8340  
Email: [dhsfamcare@dhs.wisconsin.gov](mailto:dhsfamcare@dhs.wisconsin.gov)

You can also call your Ombudsman Program. The Wisconsin Department of Health Services has arrangements with Disability Rights Wisconsin (for members ages 18 to 59) and the Wisconsin Board on Aging and Long-term Care (for members ages 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 2**, for information on how to contact your Ombudsman Program.

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## C. Understanding Medicare and Family Care Partnership complaints and appeals in our plan

You have Medicare and Family Care Partnership. Information in this chapter applies to **all** your Medicare and Family Care Partnership benefits. This is sometimes called an "integrated process" because it combines, or integrates, Medicare and Family Care Partnership processes.

Sometimes Medicare and Family Care Partnership processes can't be combined. In those situations, you use one process for a Medicare benefit and another process for a Family Care Partnership benefit. **Section F4** explains these situations.

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## D. Problems with your benefits

If you have a problem or concern, read the parts of this chapter that apply to your situation. The following chart helps you find the right section of this chapter for problems or complaints.

<b>Is your problem or concern about your benefits or coverage?</b>
--

This includes problems about whether particular medical care (medical items, services and/or Part B drugs) are covered or not, the way they're covered, and problems about payment for medical care.
--



**If you have questions**, please call iCare Family Care Partnership at 1-800-777-4376 (TTY: 711), 24 hours a day, 7 days a week. The call is free. **For more information**, visit [www.icarehealthplan.org](http://www.icarehealthplan.org).



Yes.	No.
My problem is about benefits or coverage. Refer to <b>Section E</b> , “Coverage decisions and appeals.”	My problem isn’t about benefits or coverage. Refer to <b>Section K</b> , “How to make a complaint.”

## E. Coverage decisions and appeals

The process for asking for a coverage decision and making an appeal deals with problems related to your benefits and coverage for your medical care (services, items and Part B drugs, including payment). To keep things simple we generally refer to medical items, services, and Part B drugs as **medical care**.

### E1. Coverage decisions

A coverage decision is a decision we make about your benefits and coverage or about the amount we pay for your medical services or drugs. For example, if your plan network provider refers you to a medical specialist outside of the network, this referral is considered a favorable decision unless either your network provider can show that you received a standard denial notice for this medical specialist, or the referred service is never covered under any condition (refer to **Chapter 4, Section H** of this *Evidence of Coverage*).

You or your doctor can also contact us and ask for a coverage decision. You or your doctor may be unsure whether we cover a specific medical service or if we may refuse to provide medical care you think you need. **If you want to know if we’ll cover a medical service before you get it, you can ask us to make a coverage decision for you.**

We make a coverage decision whenever we decide what’s covered for you and how much we pay. In some cases, we may decide a service or drug isn’t covered or is no longer covered for you by Medicare or Family Care Partnership. If you disagree with this coverage decision, you can make an appeal.

### E2. Appeals

If we make a coverage decision and you aren’t 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 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 if we followed all rules properly. Different reviewers than those who made the original unfavorable decision handle your appeal.

When we complete the review, we give you our decision. Under certain circumstances, explained later in this chapter, you can ask for an expedited or “fast coverage decision” or “fast appeal” of a coverage decision.

If we say **No** to part or all of what you asked for, we’ll send you a letter. If your problem is about coverage of a Medicare medical care, the letter will tell you that we sent your case to the Independent Review Organization (IRO) for a Level 2 Appeal. If your problem is about coverage of a Medicare Part D or Medicaid service or item, the letter will tell you how to file a Level 2 Appeal yourself. Refer to **Section F4** for more information about Level 2 Appeals. If your problem is about coverage of a service or item covered by both Medicare and Medicaid, the letter will give you information regarding both types of Level 2 Appeals.



**If you have questions**, please call iCare Family Care Partnership at 1-800-777-4376 (TTY: 711), 24 hours a day, 7 days a week. The call is free. **For more information**, visit [www.icarehealthplan.org](http://www.icarehealthplan.org).

If you aren't satisfied with the Level 2 Appeal decision, you may be able to go through additional levels of appeal.

### E3. Help with coverage decisions and appeals

You can ask for help from any of the following:

- **Customer Care** at the numbers at the bottom of the page.
- **Wisconsin State Health Insurance Assistance Program** contract information is the Medigap Helpline. Users should call 800-242-1060.
- **Your doctor or other provider.** Your doctor or other provider can ask for a coverage decision or appeal on your behalf.
- **A friend or family member.** You can name another person to act for you as your “representative” and ask for a coverage decision or make an appeal.
- **A lawyer.** You have the right to a lawyer, but **you aren't required to have a lawyer** to ask for a coverage decision or make an appeal.
  - Call your own lawyer, or get the name of a lawyer from the local bar association or other referral service. Some legal groups will give you free legal services if you qualify.
- You can work with an **ombudsman program**. These programs are available to help all Family Care members with grievances and appeals.
  - If you are age 60 or older, contact the Board on Aging and Long-Term Care. Go to [longtermcare.wi.gov](http://longtermcare.wi.gov), call 800-815-0015 (TTY: 711), or email [BOALTC@wisconsin.gov](mailto:BOALTC@wisconsin.gov).
  - If you are 18 to 59 years old, contact Disability Rights Wisconsin. Go to [disabilityrightswi.org](http://disabilityrightswi.org), call 800-928-8778 (TTY: 711), or email [info@drwi.org](mailto:info@drwi.org)

Fill out the Appointment of Representative form if you want a lawyer or someone else to act as your representative. The form gives someone permission to act for you.

Call Customer Care at the numbers at the bottom of the page and ask for the “Appointment of Representative” form. You can also get the form by visiting [www.cms.gov/Medicare/CMS-Forms/CMS-Forms/downloads/cms1696.pdf](http://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/downloads/cms1696.pdf). **You must give us a copy of the signed form.**

### E4. Which section of this chapter can help you

There are four situations that involve coverage decisions and appeals. Each situation has different rules and deadlines. We give details for each one in a separate section of this chapter. Refer to the section that applies:

- **Section F**, “Medical care”
- **Section G**, “Medicare Part D drugs”
- **Section H**, “Asking us to cover a longer hospital stay”
- **Section I**, “Asking us to continue covering certain medical services” (This section only applies to these services: home health care, skilled nursing facility care, and Comprehensive Outpatient Rehabilitation Facility (CORF) services.)



**If you have questions**, please call iCare Family Care Partnership at 1-800-777-4376 (TTY: 711), 24 hours a day, 7 days a week. The call is free. **For more information**, visit [www.icarehealthplan.org](http://www.icarehealthplan.org).

If you're not sure which section to use, call Customer Care at the numbers at the bottom of the page.

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## F. Medical care

This section explains 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 that's described in **Chapter 4** of this *Evidence of Coverage* in the benefits chart. In some cases, different rules may apply to a Medicare Part B drug. When they do, we explain how rules for Medicare Part B drugs differ from rules for medical services and items.

### F1. Using this section

This section explains what you can do in any of the five following situations:

1. You think we cover medical care you need but aren't getting.

**What you can do:** You can ask us to make a coverage decision. Refer to **Section F2**.

2. We didn't approve the medical care your doctor or other health care provider wants to give you, and you think we should.

**What you can do:** You can appeal our decision. Refer to **Section F3**.

3. You got medical care that you think we cover, but we won't pay.

**What you can do:** You can appeal our decision not to pay. Refer to **Section F5**.

4. You got and paid for medical care you thought we cover, and you want us to pay you back.

**What you can do:** You can ask us to pay you back. Refer to **Section F5**.

5. We reduced or stopped your coverage for certain medical care, and you think our decision could harm your health.

**What you can do:** You can appeal our decision to reduce or stop the medical care. Refer to **Section F4**.

- If the coverage is for hospital care, home health care, skilled nursing facility care, or CORF services, special rules apply. Refer to **Section H** or **Section I** to find out more.
- For all other situations involving reducing or stopping your coverage for certain medical care, use this section (**Section F**) as your guide.

### F2. Asking for a coverage decision

When a coverage decision involves your medical care, it's called an **integrated organization determination**.

You, your doctor, or your representative can ask us for a coverage decision by:

- Calling: 1-800-777-4376 (TTY: 711). Calls to this number are free. We are available 24 hours a day, 7 days a week. Our office hours are Monday – Friday, 8:30 a.m. – 5:00 p.m.



**If you have questions**, please call iCare Family Care Partnership at 1-800-777-4376 (TTY: 711), 24 hours a day, 7 days a week. The call is free. **For more information**, visit [www.icarehealthplan.org](http://www.icarehealthplan.org).

- Faxing: 414-918-7589.
- Writing: Independent Care Health Plan (iCare) Attention: Member Grievances 1555 North RiverCenter Drive Suite 206 Milwaukee, Wisconsin 53212.

### Standard coverage decision

When we give you our decision, we use the “standard” deadlines unless we agree to use the “fast” deadlines. A standard coverage decision means we give you an answer within:

- **7 calendar days** after we get your request **for a medical service or item that is subject to our prior authorization rules.**
- **14 calendar days** after we get your request **for all other medical services or items.**
- **72 hours** after we get your request **for a Medicare Part B drug.**

**For a medical item or service, we can take up to 14 more calendar days** if you ask for more time or if we need more information that may benefit you (such as medical records from out-of-network providers). If we take extra days to make the decision, we’ll tell you in writing. **We can’t take extra days if your request is for a Medicare Part B drug.**

If you think we **shouldn’t** take extra days, you can make a “fast complaint” about our decision to take extra days. When you make a fast complaint, we 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 making a complaint, including a fast complaint, refer to **Section K**.

### Fast coverage decision

The legal term for fast coverage decision is **expedited determination**.

When you ask us to make a coverage decision about your medical care and your health requires a quick response, ask us to make a “fast coverage decision.” A fast coverage decision means we’ll give you an answer within:

- **72 hours** after we get your request **for a medical service or item.**
- **24 hours** after we get your request **for a Medicare Part B drug.**

**For a medical item or service, we can take up to 14 more calendar days** if we find information that may benefit you is missing (such as medical records from out-of-network providers) or if you need time to get us information for the review. If we take extra days to make the decision, we’ll tell you in writing. **We can’t take extra time if your request is for a Medicare Part B drug.**

If you think we **shouldn’t** take extra days to make the coverage decision, you can make a “fast complaint” about our decision to take extra days. For more information about making a complaint, including a fast complaint, refer to **Section K**. We’ll call you as soon as we make the decision.

To get a fast coverage decision, you must meet two requirements:

- You’re asking for coverage for medical items and/or services that you **didn’t get**. You can’t ask for a fast coverage decision about payment for items or services you already got.



**If you have questions**, please call iCare Family Care Partnership at 1-800-777-4376 (TTY: 711), 24 hours a day, 7 days a week. The call is free. **For more information**, visit [www.icarehealthplan.org](http://www.icarehealthplan.org).

- Using the standard deadlines **could cause serious harm to your health** or hurt your ability to function.

**We automatically give you a fast coverage decision if your doctor tells us your health requires it.** If you ask without your doctor's support, we decide if you get a fast coverage decision.

- If we decide that your health doesn't meet the requirements for a fast coverage decision, we send you a letter that says so and we use the standard deadlines instead. The letter tells you:
  - We automatically give you a fast coverage decision if your doctor asks for it.
  - How you can file a "fast complaint" about our decision to give you a standard coverage decision instead of a fast coverage decision. For more information about making a complaint, including a fast complaint, refer to **Section K**.

**If we say No to part or all of your request,** we send you a letter explaining the reasons.

- If we say **No**, you have the right to make an appeal. If you think we made a mistake, making an appeal is a formal way of asking us to review our decision and change it.
- If you decide to make an appeal, you'll go on to Level 1 of the appeals process (refer to **Section F3**).

In limited circumstances we may dismiss your request for a coverage decision, which means we won't review the request. Examples of when a request will be dismissed include:

- if the request is incomplete,
- if someone makes the request on your behalf but isn't legally authorized to do so,  
**or**
- if you ask for your request to be withdrawn.

If we dismiss a request for a coverage decision, we'll send you a notice explaining why the request was dismissed and how to ask for a review of the dismissal. This review is called an appeal. Appeals are discussed in the next section.

### **F3. Making a Level 1 Appeal**

**To start an appeal,** you, your doctor, or your representative must contact us. Call us at 1-800-777-4376.

**Ask for a standard appeal or a fast appeal** in writing or by calling us at 1-800-777-4376.

- If your doctor or other prescriber asks to continue a service or item you're already getting during your appeal, you may need to name them as your representative to act on your behalf.
- If someone other than your doctor makes the appeal for you, include an Appointment of Representative form authorizing this person to represent you. You can get the form by visiting [www.cms.gov/Medicare/CMS-Forms/CMS-Forms/downloads/cms1696.pdf](http://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/downloads/cms1696.pdf).
- We can accept an appeal request without the form, but we can't begin or complete our review until we get it. If we don't get the form before our deadline for making a decision on your appeal:
  - We dismiss your request, and



**If you have questions,** please call iCare Family Care Partnership at 1-800-777-4376 (TTY: 711), 24 hours a day, 7 days a week. The call is free. **For more information,** visit [www.icarehealthplan.org](http://www.icarehealthplan.org).

- We send you a written notice explaining your right to ask the IRO to review our decision to dismiss your appeal.
- You must ask for an appeal within 65 calendar days from the date on the letter we sent to tell you our decision.
- If you miss the deadline and have a good reason for missing it, we may give you more time to make your appeal. Examples of good reasons are things like you had a serious illness or we gave you the wrong information about the deadline. Explain the reason why your appeal is late when you make your appeal.
- You have the right to ask us for a free copy of the information about your appeal. You and your doctor may also give us more information to support your appeal.

**If your health requires it, ask for a fast appeal.**

The legal term for “fast appeal” is “**expedited reconsideration**”.

- If you appeal a decision we made about coverage for care, you and/or your doctor decide if you need a fast appeal.

**We automatically give you a fast appeal if your doctor tells us your health requires it.** If you ask without your doctor’s support, we decide if you get a fast appeal.

- If we decide that your health doesn’t meet the requirements for a fast appeal, we send you a letter that says so and we use the standard deadlines instead. The letter tells you:
  - We automatically give you a fast appeal if your doctor asks for it.
  - How you can file a “fast complaint” about our decision to give you a standard appeal instead of a fast appeal. For more information about making a complaint, including a fast complaint, refer to **Section K**.

**If we tell you we are stopping or reducing services or items that you already get, you may be able to continue those services or items during your appeal.**

- If we decide to change or stop coverage for a service or item that you get, we send you a notice before we take action.
- If you disagree with our decision, you can file a Level 1 Appeal.
- We continue covering the service or item if you ask for a Level 1 Appeal within 10 calendar days of the date on our letter or by the intended effective date of the action, whichever is later.
  - If you meet this deadline, you’ll get the service or item with no changes while your Level 1 appeal is pending.
  - You’ll also get all other services or items (that aren’t the subject of your appeal) with no changes.
  - If you don’t appeal before these dates, then your service or item won’t be continued while you wait for your appeal decision.

**We consider your appeal and give you our answer.**



**If you have questions**, please call iCare Family Care Partnership at 1-800-777-4376 (TTY: 711), 24 hours a day, 7 days a week. The call is free. **For more information**, visit [www.icarehealthplan.org](http://www.icarehealthplan.org).



- When we review your appeal, we take another careful look at all information about your request for coverage of medical care.
- We check if we followed all the rules when we said **No** to your request.
- We gather more information if we need it. We may contact you or your doctor to get more information.

**There are deadlines for a fast appeal.**

- When we use the fast deadlines, we must give you our answer **within 72 hours after we get your appeal**. We'll give you our answer sooner if your health requires it.
- If you ask for more time or if we need more information that may benefit you, we **can take up to 14 more calendar days** if your request is for a medical item or service.
  - If we need extra days to make the decision, we tell you in writing.
  - If your request is for a Medicare Part B drug, we can't take extra time to make the decision.
  - If we don't give you an answer within 72 hours or by the end of the extra days we took, we must send your request to Level 2 of the appeals process. An IRO then reviews it. Later in this chapter **Section 6.4**, we tell you about this organization and explain the Level 2 appeals process.
- **If we say Yes to part or all of your request**, we must authorize or provide the coverage we agreed to provide within 72 hours after we get your appeal.
- **If we say No to part or all of your request**, we send your appeal to the IRO for a Level 2 Appeal.

**There are deadlines for a standard appeal.**

- When we use the standard deadlines, we must give you our answer **within 30 calendar days** after we get your appeal for coverage for services you didn't get.
- If your request is for a Medicare Part B drug you didn't get, we give you our answer **within 7 calendar days** after we get your appeal or sooner if your health requires it.
- If you ask for more time or if we need more information that may benefit you, we **can take up to 14 more calendar days** if your request is for a medical item or service.
  - If we need extra days to make the decision, we tell you in writing.
  - If your request is for a Medicare Part B drug, we can't take extra time to make the decision.
  - If you think we **shouldn't** take extra days, you can file a fast complaint about our decision. When you file a fast complaint, we give you an answer within 24 hours. For more information about making complaints, including fast complaints, refer to **Section K**.
  - If we don't give you an answer by the deadline or by the end of the extra days we took, we must send your request to Level 2 of the appeals process. An IRO then reviews it. Later in this chapter, we tell you about this organization and explain the Level 2 appeals process. If your problem is about coverage of a Medicaid service or item, you can file a Level 2 – Fair Hearing with the state yourself as soon as the time is up. In *Wisconsin* a Fair Hearing is called a State Fair Hearing.

**If we say Yes to part or all of your request**, we must authorize or provide the coverage we agreed to provide



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within 30 calendar days, or **within 7 calendar days** if your request is for a Medicare Part B drug, after we get your appeal.

If we say **No** to part or all of your request, **you have additional appeal rights:**

- If we say **No** to part or all of what you asked for, we send you a letter.
- If your problem is about coverage of a Medicare service or item, the letter tells you that we sent your case to the IRO for a Level 2 Appeal.
- If your problem is about coverage of a Family Care Partnership service or item, the letter tells you how to file a Level 2 Appeal yourself.

#### **F4. Making a Level 2 Appeal**

If we say **No** to part or all of your Level 1 Appeal, we send you a letter. This letter tells you if Medicare, Family Care Partnership, or both programs usually cover the service or item.

- If your problem is about a service or item that Medicare usually covers, we automatically send your case to Level 2 of the appeals process as soon as the Level 1 Appeal is complete.
- If your problem is about a service or item that Family Care Partnership usually covers, you can file a Level 2 Appeal yourself. The letter tells you how to do this. We also include more information later in this chapter.
- If your problem is about a service or item that **both Medicare and Family Care Partnership** may cover, you automatically get a Level 2 Appeal with the IRO. You can also ask for a Fair Hearing with the state.

If you qualified for continuation of benefits when you filed your Level 1 Appeal, your benefits for the service, item, or drug under appeal may also continue during Level 2. Refer to **Section F3** for information about continuing your benefits during Level 1 Appeals.

- If your problem is about a service usually covered only by Medicare, your benefits for that service don't continue during the Level 2 appeals process with the IRO.
- If your problem is about a service usually covered only by Family Care Partnership, your benefits for that service continue if you submit a Level 2 Appeal within 10 calendar days after getting our decision letter.

#### **When your problem is about a service or item Medicare usually covers**

The IRO reviews your appeal. It's an independent organization hired by Medicare.

The formal name for the Independent Review Organization (IRO) is the **Independent Review Entity**, sometimes called the **"IRE"**.

- This organization isn't connected with us and isn't a government agency. Medicare chose the company to be the IRO, and Medicare oversees their work.
- We send information about your appeal (your "case file") to this organization. You have the right to a free copy of your case file.



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- You have a right to give the IRO additional information to support your appeal.
- Reviewers at the IRO take a careful look at all information related to your appeal.

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

- If you had a fast appeal to us at Level 1, you automatically get a fast appeal at Level 2. The IRO must give you an answer to your Level 2 Appeal **within 72 hours** of getting your appeal.
- If your request is for a medical item or service and the IRO needs to gather more information that may benefit you, **it can take up to 14 more calendar days**. The IRO can't take extra time to make a decision if your request is for a Medicare Part B drug.

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

- If you had a standard appeal to us at Level 1, you automatically get a standard appeal at Level 2.
- If your request is for a medical item or service, the IRO must give you an answer to your Level 2 Appeal **within 30 calendar days** of getting your appeal.
- If your request is for a Medicare Part B drug, the IRO must give you an answer to your Level 2 Appeal **within 7 calendar days** of getting your appeal.
- If your request is for a medical item or service and the IRO needs to gather more information that may benefit you, **it can take up to 14 more calendar days**. The IRO take extra time to make a decision if your request is for a Medicare Part B drug.

The IRO gives you their answer in writing and explains the reasons.

- **If the IRO says Yes to part or all of a request for a medical item or service**, we must:
  - Authorize the medical care coverage **within 72 hours**, or
  - Provide the service within **14 calendar days** after we get the IRO's decision for **standard requests**, or
  - Provide the service **within 72 hours** from the date we get the IRO's decision for **expedited requests**.
- **If the IRO says Yes to part or all of a request for a Medicare Part B drug**, we must authorize or provide the Medicare Part B drug under dispute:
  - **within 72 hours** after we get the IRO's decision for **standard requests**, or
  - **within 24 hours** from the date we get the IRO's decision for **expedited requests**.
- **If the IRO says No to part or all of your appeal**, it means they agree that we shouldn't approve your request (or part of your request) for coverage for medical care. This is called "upholding the decision" or "turning down your appeal."
  - 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.
  - If your Level 2 Appeal is turned down and you meet the requirements to continue the appeals process, you must decide whether to go on to Level 3 and make a third appeal. The details about



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how to do this are in the written notice you get after your Level 2 Appeal.

- An Administrative Law Judge (ALJ) or attorney adjudicator handles a Level 3 Appeal. Refer to **Section J** for more information about Level 3, 4, and 5 Appeals.

### **When your problem is about a service or item Medicaid usually covers, or that's covered by both Medicare and Family Care Partnership**

A Level 2 Appeal for services that Family Care Partnership usually covers is a Fair Hearing with the state. In Family Care Partnership a Fair Hearing is called State Fair Hearing. You must ask for a State Fair Hearing in writing or by phone **within 90 calendar days** of the date we sent the decision letter on your Level 1 Appeal. The letter you get from us tells you where to submit your request for a Fair Hearing.

The process for Medicaid Level 2 Appeals, in which members must submit the Level 2 Appeal themselves is:

- Step 1: You can ask for a fair hearing with the state
  - Level 2 of the appeals process for services that are usually covered by Medicaid is a Fair Hearing with the state. You must ask for a Fair Hearing in writing or over the phone within 90 calendar days of the date that we sent the decision letter on your Level 1 appeal. The letter you get from us will tell you where to submit your hearing request. You can ask for a State Fair Hearing by sending a written request to:  
  
Wisconsin Department of Administration Division of Hearings and Appeals  
P.O. Box 7875  
Madison, WI 53707  
Fax: 608-264-9885
  - You need to ask for a Fair Hearing within 90 days of the date of iCare Family Care Partnership written decision to you on your appeal with iCare. If you choose to request a fair hearing with the State of Wisconsin's Division of Hearings and Appeals, you will have a hearing with an Administrative Law Judge. You may bring an advocate, friend, family member or witnesses. You may also present evidence at this hearing. If you request a State Fair Hearing, your appeal will automatically go through a Department of Health Services review.
- Step 2: The State Fair Hearing office gives you their answer.
  - **If the State Fair Hearing office says yes to part or all of a request for a medical item or service**, we must authorize or provide the service or item within 72 hours after we receive the decision from the State Fair Hearing office.
  - **If the Fair Hearing office says no to part or all of your appeal**, 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" or "turning down your appeal.")

If the decision is no for all or part of what I asked for, can I make another appeal?

If the independent review organization or Fair Hearing office decision is no for all or part of what you asked for, you have **additional appeal rights**.

The letter you get from the Fair Hearing office will describe this next appeal option. See **Section 10** of this chapter for more information on your appeal rights after Level 2.



**If you have questions**, please call iCare Family Care Partnership at 1-800-777-4376 (TTY: 711), 24 hours a day, 7 days a week. The call is free. **For more information**, visit [www.icarehealthplan.org](http://www.icarehealthplan.org).

The Fair Hearing office gives you their decision in writing and explain the reasons.

- If the Fair Hearing office says **Yes** to part or all of a request for a medical item or service, we must authorize or provide the service or item **within 72 hours** after we get their decision.
- If the Fair Hearing office says **No** to part or all of your appeal, it means they agree that we shouldn't approve your request (or part of your request) for coverage for medical care. This is called "upholding the decision" or "turning down your appeal."

If the IRO or Fair Hearing office decision is **No** for all or part of your request, you have additional appeal rights.

If your Level 2 Appeal went to the **IRO**, you can appeal again only if the dollar value of the service or item you want meets a certain minimum amount. An ALJ or attorney adjudicator handles a Level 3 Appeal. **The letter you get from the IRO explains additional appeal rights you may have.**

The letter you get from the Fair Hearing office describes the next appeal option.

Refer to **Section J** for more information about your appeal rights after Level 2.

### F5. Payment problems

We don't allow our network providers to bill you for covered services and items. This is true even if we pay the provider less than the provider charges for a covered service or item. You're never required to pay the balance of any bill.

**We can't reimburse you directly for a Medicaid service or item.** If you get a bill for Medicaid covered services and items, send the bill to us. Don't pay the bill yourself. We'll contact the provider directly and take care of the problem. If you do pay the bill, you can get a refund from that health care provider if you followed the rules for getting services or items.

If you want us to reimburse you for a **Medicare** service or item or you're asking us to pay a health care provider for a Medicaid service or item you paid for, you'll ask us to make this a coverage decision. We'll check if the service or item you paid for is covered and if you followed all the rules for using your coverage. For more information, refer to **Chapter 7** of this *Evidence of Coverage*.

- If the service or item you paid for is covered and you followed all the rules, we'll send you or your provider the payment for the service **or** item typically within 30 calendar days, but no later than 60 calendar days after we get your request.
- If you haven't paid for the service or item yet, we'll 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 service or item isn't covered or you did not follow all the rules, we'll send you a letter telling you we won't pay for the service or item and explain why.

If you don't agree with our decision not to pay, **you can make an appeal.** Follow the appeals process described in **Section F3**. When you follow these instructions, note:

- If you make an appeal for us to pay you back, we must give you our answer within 30 calendar days after we get your appeal.

If our answer to your appeal is **No** and **Medicare** usually covers the service or item, we'll send your case to



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the IRO. We'll send you a letter if this happens.

- If the IRO reverses our decision and says we should pay you, we must send the payment 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 to you or to the health care provider within 60 calendar days.
- If the IRO says **No** to your appeal, it means they agree that we shouldn't approve your request. This is called "upholding the decision" or "turning down your appeal." You'll get a letter explaining additional appeal rights you may have. Refer to **Section J** for more information about additional levels of appeal.

If our answer to your appeal is **No** and Family Care Partnership usually covers the service or item, you can file a Level 2 Appeal yourself. Refer to **Section F4** for more information.

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## G. Medicare Part D drugs

Your benefits as a member of our plan include coverage for many drugs. Most of these are Medicare Part D drugs. There are a few drugs that Medicare Part D doesn't cover that Family Care Partnership may cover. **This section only applies to Medicare Part D drug appeals.** We'll say "drug" in the rest of this section instead of saying "Medicare Part D drug" every time.

To be covered, the drug must be used for a medically accepted indication. That means the drug is approved by the Food and Drug Administration (FDA) or supported by certain medical references. Refer to **Chapter 5** of this *Evidence of Coverage* for more information about a medically accepted indication.

### G1. Medicare Part D coverage decisions and appeals

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

- You ask us to make an exception, including asking us to:
  - cover a Medicare Part D drug that isn't on our plan's *Drug List* or
  - set aside a restriction on our coverage for a drug (such as limits on the amount you can get)
- You ask us if a drug is covered for you (such as when your drug is on our plan's *Drug List* but we must approve it for you before we cover it)

**NOTE:** If your pharmacy tells you that your prescription can't be filled as written, the pharmacy gives you a written notice explaining how to contact us to ask for a coverage decision.

An initial coverage decision about your Medicare Part D drugs is called a "**coverage determination**".

- You ask us to pay for a drug you already bought. This is asking for a coverage decision about payment.

If you disagree with a coverage decision we made, you can appeal our decision. This section tells you both how to ask for coverage decisions and how to make an appeal. Use the chart below to help you.



**If you have questions**, please call iCare Family Care Partnership at 1-800-777-4376 (TTY: 711), 24 hours a day, 7 days a week. The call is free. **For more information**, visit [www.icarehealthplan.org](http://www.icarehealthplan.org).



Which of these situations are you in?			
You need a drug that isn't on our <i>Drug List</i> or need us to set aside a rule or restriction on a drug we cover.	You want us to cover a drug on our <i>Drug List</i> , and you think you meet plan rules or restrictions (such as getting approval in advance) for the drug you need.	You want to ask us to pay you back for a drug you already got and paid for.	We told you that we won't cover or pay for a drug in the way that you want.
<b>You can ask us to make an exception.</b> (This is a type of coverage decision.)	<b>You can ask us for a coverage decision.</b>	<b>You can ask us to pay you back.</b> (This is a type of coverage decision.)	<b>You can make an appeal.</b> (This means you ask us to reconsider.)
Start with <b>Section G2</b> , then refer to <b>Sections G3 and G4</b> .	Refer to <b>Section G4</b> .	Refer to <b>Section G4</b> .	Refer to <b>Section G5</b> .

## G2. Medicare Part D exceptions

If we don't cover a drug in the way you would like, you can ask us to make an "exception." 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 needs to explain the medical reasons why you need the exception.

Asking for coverage of a drug not on our *Drug List* or for removal of a restriction on a drug is sometimes called asking for a "**formulary exception**".

Here are some examples of exceptions that you or your doctor or other prescriber can ask us to make:

### 1. Covering a drug that isn't on our *Drug List*

- If we agree to make an exception and cover a drug that isn't on our *Drug List*, you pay the copay that applies to all of our drugs.
- You can't get an exception to the required copay amount for the drug.

### 2. Removing a restriction for a covered drug

- Extra rules or restrictions apply to certain drugs on our *Drug List* (refer to **Chapter 5** of this *Evidence of Coverage* for more information).
- Extra rules and restrictions for certain drugs include:
  - Being required to use the generic version of a drug instead of the brand name drug.
  - Getting our approval in advance before we agree to cover the drug for you. This is sometimes called "prior authorization (PA)."
  - Being required to try a different drug first before we agree to cover the drug you ask for. This is sometimes called "step therapy."



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- Quantity limits. For some drugs, there are restrictions on the amount of the drug you can have.
  - If we agree to an exception for you and set aside a restriction, you can ask for an exception to the copay amount you're required to pay.
- 3. Changing coverage of a drug to a lower cost sharing tier.** Every drug on our *Drug List* is in a single cost share tier. In general, the lower the cost sharing tier number, the less your required copay amount is.
- Our *Drug List* often includes more than one drug for treating a specific condition. These are called “alternative” drugs.
  - If an alternative drug for your medical condition is in a lower cost-sharing tier than the drug you take, you can ask us to cover it at the cost sharing amount for the alternative drug. This would lower your copay amount for the drug.
  - You can't ask us to change the cost sharing tier for any drug in cost sharing tier 5 Specialty Tier.
  - If we approve your tiering exception request and there's more than one lower cost sharing tier with alternative drugs you can't take, you usually pay the lowest amount.

### G3. Important things to know about asking for an exception

#### Your doctor or other prescriber must tell us the medical reasons.

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

Our *Drug List* often includes more than one drug for treating a specific condition. These are called “alternative” drugs. If an alternative drug is just as effective as the drug you ask for and wouldn't cause more side effects or other health problems, we generally **don't** approve your exception request. If you ask us for a tiering exception, we generally **don't** approve your exception request unless all alternative drugs in the lower cost sharing tier(s) won't work as well for you or are likely to cause an adverse reaction or other harm.

#### We can say Yes or No to your request.

- If we say **Yes** to your exception request, the exception usually lasts until the end of the calendar 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 exception request, you can make an appeal. Refer to **Section G5** for information on making an appeal if we say **No**.

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

### G4. Asking for a coverage decision, including an exception

- Ask for the type of coverage decision you want by calling or faxing us. You, your representative, or your doctor (or other prescriber) can do this. Please include your name, contact information, and information about the claim.
- You or your doctor (or other prescriber) or someone else acting on your behalf can ask for a coverage decision. You can also have a lawyer act on your behalf.



**If you have questions**, please call iCare Family Care Partnership at 1-800-777-4376 (TTY: 711), 24 hours a day, 7 days a week. The call is free. **For more information**, visit [www.icarehealthplan.org](http://www.icarehealthplan.org).



- Refer to **Section E3** to find out how to name someone as your representative.
- You don't need to give written permission to your doctor or other prescriber to ask for a coverage decision on your behalf.
- If you want to ask us to pay you back for a drug, refer to **Chapter 7** of this *Evidence of Coverage*.
- If you ask for an exception, give us a "supporting statement." The supporting statement includes your doctor or other prescriber's medical reasons for the exception request.
- Your doctor or other prescriber can fax or mail us the supporting statement. They can also tell us by phone and then fax or mail the statement.

### If your health requires it, ask us for a "fast coverage decision."

We use the "standard deadlines" unless we agree to use the "fast deadlines."

- A **standard coverage decision** means we give you an answer within 72 hours after we get your doctor's statement.
- A **fast coverage decision** means we give you an answer within 24 hours after we get your doctor's statement.

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

You can get a fast coverage decision if:

- It's for a drug you didn't get. You can't get a fast coverage decision if you're asking us to pay you back for a drug you already bought.
- Your health or ability to function would be seriously harmed if we use the standard deadlines.

If your doctor or other prescriber tells us that your health requires a fast coverage decision, we agree and give it to you. We send you a letter that tells you.

- If you ask for a fast coverage decision without support from your doctor or other prescriber, we decide if you get a fast coverage decision.
- If we decide that your medical condition doesn't meet the requirements for a fast coverage decision, we use the standard deadlines instead.
  - We send you a letter that tells you. The letter also tells you how to make a complaint about our decision.
  - You can file a fast complaint and get a response within 24 hours. For more information making complaints, including fast complaints, refer to **Section K**.

### Deadlines for a fast coverage decision

- If we use the fast deadlines, we must give you our answer within 24 hours after we get your request. If you ask for an exception, we give you our answer within 24 hours after we get your doctor's supporting statement. We give you our answer sooner if your health requires it.
- If we don't meet this deadline, we send your request to Level 2 of the appeals process for review by



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an IRO. Refer to **Section G6** for more information about a Level 2 Appeal.

- If we say **Yes** to part or all of your request, we give you the coverage within 24 hours after we get your request or your doctor's supporting statement.
- If we say **No** to part or all of your request, we send you a letter with

#### **Deadlines for a standard coverage decision about a drug you didn't get**

- If we use the standard deadlines, we must give you our answer within 72 hours after we get your request. If you ask for an exception, we give you our answer within 72 hours after we get your doctor's supporting statement. We give you our answer sooner if your health requires it.
- If we don't meet this deadline, we send your request to Level 2 of the appeals process for review by an IRO.
- If we say **Yes** to part or all of your request, we give you the coverage within 72 hours after we get your request or your doctor's supporting statement for an exception.
- If we say **No** to part or all of your request, we send you a letter with the reasons. The letter also tells you how to make an appeal.

#### **Deadlines for a standard coverage decision about a drug you already bought**

- We must give you our answer within 14 calendar days after we get your request.
- If we don't meet this deadline, we send your request to Level 2 of the appeals process for review by an IRO.
- If we say Yes to part or all of your request, we pay you back within 14 calendar days.
- If we say No to part or all of your request, we send you a letter with the reasons. The letter also tells you how to make an appeal.

### **G5. Making a Level 1 Appeal**

An appeal to our plan about a Medicare Part D drug coverage decision is called a plan "**redetermination**".

- Start your **standard** or **fast appeal** by calling Humana Pharmacy Solutions at 1-800-451-4651, faxing to 1-877-556-7005, or writing to:  
Grievances and Appeals  
Humana Health Plans  
P.O. Box 14165  
Lexington, KY 40512-4165

You, your representative, or your doctor (or other prescriber) can do this. Please include your name, contact information, and information regarding your appeal.

- You must ask for an appeal **within 65 calendar days** from the date on the letter we sent to tell you our decision.
- If you miss the deadline and have a good reason for missing it, we may give you more time to make your appeal. Examples of good reasons are things like you had a serious illness or we gave you the



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wrong information about the deadline. Explain the reason why your appeal is late when you make your appeal.

- You have the right to ask us for a free copy of the information about your appeal. You and your doctor may also give us more information to support your appeal.

**If your health requires it, ask for a fast appeal.**

A fast appeal is also called an “**expedited redetermination**.”

- If you appeal a decision we made about a drug you didn’t get, you and your doctor or other prescriber decide if you need a fast appeal.
- Requirements for a fast appeal are the same as those for a fast coverage decision. Refer to **Section G4** for more information.

We consider your appeal and give you our answer.

- We review your appeal and take another careful look at all of the information about your coverage request.
- We check if we followed 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 at Level 1**

- If we use the fast deadlines, we must give you our answer **within 72 hours** after we get your appeal.
  - We give you our answer sooner if your health requires it.
  - If we don’t give you an answer within 72 hours, we must send your request to Level 2 of the appeals process. Then an IRO reviews it. Refer to **Section G6** for information about the review organization and the Level 2 appeals process.
- If we say **Yes** to part or all of your request, we must provide the coverage we agreed to provide within 72 hours after we get your appeal.
- If we say **No** to part or all of your request, we send you a letter that explains the reasons and tells you how you can make an appeal.

**Deadlines for a standard appeal at Level 1**

- If we use the standard deadlines, we must give you our answer **within 7 calendar days** after we get your appeal for a drug you didn’t get.
- We give you our decision sooner if you didn’t get the drug and your health condition requires it. If you believe your health requires it, ask for a fast appeal.
  - If we don’t give you a decision within 7 calendar days, we must send your request to Level 2 of the appeals process. Then an IRO reviews it. Refer to **Section G6** for information about the review organization and the Level 2 appeals process.

If we say **Yes** to part or all of your request:



**If you have questions**, please call iCare Family Care Partnership at 1-800-777-4376 (TTY: 711), 24 hours a day, 7 days a week. The call is free. **For more information**, visit [www.icarehealthplan.org](http://www.icarehealthplan.org).

- We must **provide the coverage** we agreed to provide as quickly as your health requires, but **no later than 7 calendar days** after we get your appeal.
- We must **send payment to you** for a drug you bought **within 30 calendar days** after we get your appeal.

If we say **No** to part or all of your request:

- We send you a letter that explains the reasons and tells you how you can make an appeal.
- We must give you our answer about paying you back for a drug you bought **within 14 calendar days** after we get your appeal.
  - If we don't give you a decision within 14 calendar days, we must send your request to Level 2 of the appeals process. Then an IRO reviews it. Refer to **Section G6** for information about the review organization and the Level 2 appeals process.
- If we say **Yes** to part or all of your request, we must pay you within 30 calendar days after we get your request.
- If we say **No** to part or all of your request, we send you a letter that explains the reasons and tells you how you can make an appeal.

## G6. Making a Level 2 Appeal

If we say **No** to your Level 1 Appeal, you can accept our decision or make another appeal. If you decide to make another appeal, you use the Level 2 Appeal appeals process. The **IRO** reviews our decision when we said **No** to your first appeal. This organization decides if we should change our decision.

The formal name for the “Independent Review Organization” (IRO) is the “**Independent Review Entity**”, sometimes called the “**IRE**”.

To make a Level 2 Appeal, you, your representative, or your doctor or other prescriber must contact the IRO **in writing** and ask for a review of your case.

- If we say **No** to your Level 1 Appeal, the letter we send you includes **instructions about how to make a Level 2 Appeal** with the IRO. The instructions tell who can make the Level 2 Appeal, what deadlines you must follow, and how to reach the organization.
- When you make an appeal to the IRO, we send the information we have about your appeal to the organization. This information is called your “case file”. **You have the right to a free copy of your case file.**
- You have a right to give the IRO additional information to support your appeal.

The IRO reviews your Medicare Part D Level 2 Appeal and gives you an answer in writing. Refer to **Section F4** for more information about the IRO.

## Deadlines for a fast appeal at Level 2

If your health requires it, ask the IRO for a fast appeal.



**If you have questions**, please call iCare Family Care Partnership at 1-800-777-4376 (TTY: 711), 24 hours a day, 7 days a week. The call is free. **For more information**, visit [www.icarehealthplan.org](http://www.icarehealthplan.org).

- If they agree to a fast appeal, they must give you an answer **within 72 hours** after getting your appeal request.
- If they say **Yes** to part or all of your request, we must provide the approved drug coverage **within 24 hours** after getting the IRO's decision.

### Deadlines for a standard appeal at Level 2

If you have a standard appeal at Level 2, the IRO must give you an answer:

- **within 7 calendar days** after they get your appeal for a drug you didn't get.
- **within 14 calendar days** after getting your appeal for repayment for a drug you bought.

If the IRO says **Yes** to part or all of your request:

- We must provide the approved drug coverage **within 72 hours** after we get the IRO's decision.
- We must pay you back for a drug you bought within 30 calendar days after we get the IRO's decision.
- If the IRO says **No** to your appeal, it means they agree with our decision not to approve your request. This is called "upholding the decision" or "turning down your appeal".

If the IRO says **No** to your Level 2 Appeal, you have the right to a Level 3 Appeal if the dollar value of the drug coverage you ask for meets a minimum dollar value. If the dollar value of the drug coverage you ask for is less than the required minimum, you can't make another appeal. In that case, the Level 2 Appeal decision is final. The IRO sends you a letter that tells you the minimum dollar value needed to continue with a Level 3 Appeal.

If the dollar value of your request meets the requirement, you choose if you want to take your appeal further.

- There are three additional levels in the appeals process after Level 2.
- If the IRO says **No** to your Level 2 Appeal and you meet the requirement to continue the appeals process, you:
  - Decide if you want to make a Level 3 Appeal.
  - Refer to the letter the IRO sent you after your Level 2 Appeal for details about how to make a Level 3 Appeal.

An ALJ or attorney adjudicator handles Level 3 Appeals. Refer to **Section J** for information about Level 3, 4, and 5 Appeals.

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## H. Asking us to cover a longer hospital stay

When you're admitted to a hospital, you have the right to get all hospital services that we cover that are necessary to diagnose and treat your illness or injury. For more information about our plan's hospital coverage, refer to **Chapter 4** of this *Evidence of Coverage*.

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



**If you have questions**, please call iCare Family Care Partnership at 1-800-777-4376 (TTY: 711), 24 hours a day, 7 days a week. The call is free. **For more information**, visit [www.icarehealthplan.org](http://www.icarehealthplan.org).

- The day you leave the hospital is called your “discharge date.”
- Your doctor or the hospital staff will tell you what your discharge date is.

If you think you’re being asked to leave the hospital too soon or you’re concerned about your care after you leave the hospital, you can ask for a longer hospital stay. This section tells you how to ask.

## H1. Learning about your Medicare rights

Within two days after you’re admitted to the hospital, someone at the hospital, such as a nurse or caseworker, will give you a written notice called “An Important Message from Medicare about Your Rights.” Everyone with Medicare gets a copy of this notice whenever they’re admitted to a hospital.

If you don’t get the notice, ask any hospital employee for it. If you need help, call Customer Care at the numbers at the bottom of the page. You can also call 1-800-MEDICARE (1-800- 633-4227). TTY users should call 1-877-486-2048.

- **Read the notice** carefully and ask questions if you don’t understand. The notice tells you about your rights as a hospital patient, including your rights to:
  - Get Medicare-covered services during and after your hospital stay. You have the right to know what these services are, who will pay for them, and where you can get them.
  - Be a part of any decisions about the length of your hospital stay.
  - Know where to report any concerns you have about the quality of your hospital care.
  - Appeal if you think you’re being discharged from the hospital too soon.
- **Sign the notice** to show that you got it and understand your rights.
  - You or someone acting on your behalf can sign the notice.
  - Signing the notice **only** shows that you got the information about your rights. Signing **doesn’t** mean you agree to a discharge date your doctor or the hospital staff may have told you.
- **Keep your copy** of the signed notice so you have the information if you need it.

If you sign the notice more than two days before the day you leave the hospital, you’ll get another copy before you’re discharged.

You can look at a copy of the notice in advance if you:

- Call Customer Care at the numbers at the bottom of the page.
- Call Medicare at 1-800 MEDICARE (1-800-633-4227). TTY users should call 1- 877-486-2048.
- Visit [www.cms.gov/medicare/forms-notices/beneficiary-notices-initiative/ffs-ma-im](http://www.cms.gov/medicare/forms-notices/beneficiary-notices-initiative/ffs-ma-im).

## H2. Making a Level 1 Appeal

To ask for us to cover your inpatient hospital services for a longer time, make an appeal. The Quality Improvement Organization (QIO) reviews the Level 1 Appeal to find out if your planned discharge date is medically appropriate for you.



**If you have questions**, please call iCare Family Care Partnership at 1-800-777-4376 (TTY: 711), 24 hours a day, 7 days a week. The call is free. **For more information**, visit [www.icarehealthplan.org](http://www.icarehealthplan.org).



The QIO is a group of doctors and other health care professionals paid by the federal government. These experts check and help improve the quality for people with Medicare. They aren't part of our plan.

In Wisconsin, the QIO is Commence Health. Call them at 1-855-524-9900. Contact information is also in the notice, "An Important Message from Medicare about Your Rights," and in **Chapter 2**.

**Call the QIO before you leave the hospital and no later than your planned discharge date.**

- **If you call before you leave**, you can stay in the hospital after your planned discharge date without paying for it while you wait for the QIO's decision about your appeal.
- **If you don't call to appeal**, and you decide to stay in the hospital after your planned discharge date, you may pay all costs for hospital care you get after your planned discharge date.

**Ask for help if you need it.** If you have questions or need help at any time:

- Call Customer Care at the numbers at the bottom of the page.
- Call the Wisconsin State Health Insurance Assistance Program (SHIP). Wisconsin State Health Insurance Assistance Program contract information is the Medigap Helpline. Users should call 800-242-1060.

**Ask for a fast review.** Act quickly and contact the QIO to ask for a fast review of your hospital discharge.

The legal term for "**fast review**" is "**immediate review**" or "**expedited review**."

**What happens during fast review**

- Reviewers at the QIO ask you or your representative why you think coverage should continue after the planned discharge date. You aren't required to write a statement, but you may.
- Reviewers look at your medical information, talk with your doctor, and review information that the hospital and our plan gave them.
- By noon of the day after reviewers tell our plan about your appeal, you get a letter with your planned discharge date. The letter also gives reasons why your doctor, the hospital, and we think that's the right discharge date that's medically appropriate for you.

The legal term for this written explanation is the "**Detailed Notice of Discharge**." You can get a sample by calling Customer Care at the numbers at the bottom of the page or 1-800-MEDICARE (1-800-633-4227). (TTY users should call 1-877-486- 2048.) You can also refer to a sample notice online at [www.cms.gov/medicare/forms-notices/beneficiary-notices-initiative/ffs-ma-im](http://www.cms.gov/medicare/forms-notices/beneficiary-notices-initiative/ffs-ma-im).

Within one full day after getting all of the information it needs, the QIO will give you their answer to your appeal.

If the QIO says **Yes** to your appeal:

- We'll provide your covered inpatient hospital services for as long as the services are medically necessary.



**If you have questions**, please call iCare Family Care Partnership at 1-800-777-4376 (TTY: 711), 24 hours a day, 7 days a week. The call is free. **For more information**, visit [www.icarehealthplan.org](http://www.icarehealthplan.org).



If the QIO says **No** to your appeal:

- They believe your planned discharge date is medically appropriate.
- Our coverage for your inpatient hospital services will end at noon on the day after the QIO gives you their answer to your appeal.
- You may have to pay the full cost of hospital care you get after noon on the day after the QIO gives you their answer to your appeal.
- You can make a Level 2 Appeal if the QIO turns down your Level 1 Appeal **and** you stay in the hospital after your planned discharge date.

### H3. Making a Level 2 Appeal

For a Level 2 Appeal, you ask the QIO to take another look at the decision they made on your Level 1 Appeal. Call them at 1-888-524-9900.

You must ask for this review **within 60 calendar days** after the day the QIO said **No** to your Level 1 Appeal. You can ask for this review **only** if you stay in the hospital after the date that your coverage for the care ended.

QIO reviewers will:

- Take another careful look at all of the information related to your appeal.
- Tell you their decision about your Level 2 Appeal within 14 calendar days of receipt of your request for a second review.

If the QIO says **Yes** to your appeal:

- We must pay you back for hospital care costs since noon on the day after the date the QIO turned down your Level 1 Appeal.
- We'll provide your covered inpatient hospital services for as long as the services are medically necessary.

If the QIO says **No** to your appeal:

- They agree with their decision about your Level 1 Appeal and won't change it.
- They give you a letter that tells you what you can do if you want to continue the appeals process and make a Level 3 Appeal.

An ALJ or attorney adjudicator handles Level 3 Appeals. Refer to **Section J** for information about Level 3, 4, and 5 Appeals.

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## I. Asking us to continue covering certain medical services

This section is only about three types of services you may be getting:

- home health care services



**If you have questions**, please call iCare Family Care Partnership at 1-800-777-4376 (TTY: 711), 24 hours a day, 7 days a week. The call is free. **For more information**, visit [www.icarehealthplan.org](http://www.icarehealthplan.org).

- skilled nursing care in a skilled nursing facility, **and**
- rehabilitation care as an outpatient at a Medicare-approved CORF. This usually means you're getting treatment for an illness or accident or you're recovering from a major operation.

With any of these three types of services, you have the right to get covered services for as long as the doctor says you need them.

When we decide to stop covering any of these, we must tell you **before** your services end. When your coverage for that service ends, we stop paying for it.

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

### **I1. Advance notice before your coverage ends**

We send you a written notice that you'll get at least two days before we stop paying for your care. This is called the "Notice of Medicare Non-Coverage." The notice tells you the date when we'll stop covering your care and how to appeal our decision.

You or your representative should sign the notice to show that you got it. Signing the notice **only** shows that you got the information. Signing **doesn't** mean you agree with our decision.

### **I2. Making a Level 1 Appeal**

If you think we're ending coverage of your care too soon, you can appeal our decision. This section tells you about the Level 1 Appeal process and what to do.

- **Meet the deadlines.** The deadlines are important. Understand and follow the deadlines that apply to things you must do. Our plan must follow deadlines too. If you think we're not meeting our deadlines, you can file a complaint. Refer to **Section K** for more information about complaints.
- **Ask for help if you need it.** If you have questions or need help at any time:
  - Call Customer Care at the numbers at the bottom of the page.
  - Call the Wisconsin State Health Insurance Assistance Program (SHIP). Wisconsin State Health Insurance Assistance Program contract information is the Medigap Helpline. Users should call 800-242-1060.
- **Contact the QIO.**
  - Refer to **Section H2** or refer to **Chapter 2** of this *Evidence of Coverage* for more information about the QIO and how to contact them.
  - Ask them to review your appeal and decide whether to change our plan's decision.
- **Act quickly and ask for a "fast-track appeal."** Ask the QIO if it's medically appropriate for us to end coverage of your medical services.

### **Your deadline for contacting this organization**

- You must contact the QIO to start your appeal by noon of the day before the effective date on the



**If you have questions**, please call iCare Family Care Partnership at 1-800-777-4376 (TTY: 711), 24 hours a day, 7 days a week. The call is free. **For more information**, visit [www.icarehealthplan.org](http://www.icarehealthplan.org).

“Notice of Medicare Non-Coverage” we sent you.

The legal term for the written notice is “**Notice of Medicare Non-Coverage**”. To get a sample copy, call Customer Care at the numbers at the bottom of the page or call Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486- 2048. Or get a copy online at [www.cms.gov/Medicare/Medicare-General-Information/BNI/FFS-Expedited-Determination-Notices](http://www.cms.gov/Medicare/Medicare-General-Information/BNI/FFS-Expedited-Determination-Notices).

### What happens during a fast-track appeal

- Reviewers at the QIO ask you or your representative why you think coverage should continue. You aren’t required to write a statement, but you may.
- Reviewers look at your medical information, talk with your doctor, and review information that our plan gave them.
- Our plan also sends you a written notice that explains our reasons for ending coverage of your services. You get the notice by the end of the day the reviewers inform us of your appeal.

The legal term for the notice explanation is “**Detailed Explanation of Non-Coverage**”.

- Reviewers tell you their decision within one full day after getting all the information they need.

If the QIO says **Yes** to your appeal:

- We’ll provide your covered services for as long as they’re medically necessary.

If the QIO says **No** to your appeal:

- Your coverage ends on the date we told you.
- We stop paying the costs of this care on the date in the notice.
- You pay the full cost of this care yourself if you decide to continue the home health care, skilled nursing facility care, or CORF services after the date your coverage ends.
- You decide if you want to continue these services and make a Level 2 Appeal.

### I3. Making a Level 2 Appeal

For a Level 2 Appeal, you ask the QIO to take another look at the decision they made on your Level 1 Appeal. Call them at 1-855-236-2423.

You must ask for this review **within 60 calendar days** after the day the QIO said **No** to your Level 1 Appeal. You can ask for this review **only** if you continue care after the date that your coverage for the care ended.

QIO reviewers will:

- Take another careful look at all of the information related to your appeal.
- Tell you their decision about your Level 2 Appeal within 14 calendar days of receipt of your request for a second review.

If the QIO says **Yes** to your appeal:



**If you have questions**, please call iCare Family Care Partnership at 1-800-777-4376 (TTY: 711), 24 hours a day, 7 days a week. The call is free. **For more information**, visit [www.icarehealthplan.org](http://www.icarehealthplan.org).

- We pay you back for the costs of care you got since the date when we said your coverage would end.
- We'll provide coverage for the care for as long as it's medically necessary.

If the QIO says **No** to your appeal:

- They agree with our decision to end your care and won't change it.
- They give you a letter that tells you what you can do if you want to continue the appeals process and make a Level 3 Appeal.

An ALJ or attorney adjudicator handles Level 3 Appeals. Refer to **Section J** for information about Level 3, 4, and 5 Appeals.

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## J. Taking your appeal beyond Level 2

### J1. Next steps for Medicare services and items

If you made a Level 1 Appeal and a Level 2 Appeal for Medicare services or items, and both of your appeals were turned down, you may have the right to additional levels of appeal.

If the dollar value of the Medicare service or item you appealed doesn't meet a certain minimum dollar amount, you can't appeal any further. If the dollar value is high enough, you can continue the appeals process. The letter you get from the IRO for your Level 2 Appeal explains who to contact and what to do to ask for a Level 3 Appeal.

#### Level 3 Appeal

Level 3 of the appeals process is an ALJ hearing. The person who makes the decision is an ALJ or an attorney adjudicator who works for the federal government.

If the ALJ or attorney adjudicator says **Yes** to your appeal, we have the right to appeal a Level 3 decision that's favorable to you.

- If we decide **to appeal** the decision, we 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 we decide **not to appeal** the decision, we must authorize or provide you with the service within 60 calendar days after getting the ALJ or attorney adjudicator's decision.
- If the ALJ or attorney adjudicator says **No** to your appeal, the appeals process may not be over.
- If you decide **to accept** this decision that turns down your appeal, the appeals process is over.
- If you decide **not to accept** this decision that turns down your appeal, you can continue to the next level of the review process. The notice you get will tell you what to do for a Level 4 Appeal.

#### Level 4 Appeal

The Medicare Appeals Council (Council) reviews your appeal and gives you an answer. The Council is part of the federal government.



**If you have questions**, please call iCare Family Care Partnership at 1-800-777-4376 (TTY: 711), 24 hours a day, 7 days a week. The call is free. **For more information**, visit [www.icarehealthplan.org](http://www.icarehealthplan.org).

If the Council says **Yes** to your Level 4 Appeal or denies our request to review a Level 3 Appeal decision favorable to you, we have the right to appeal to Level 5.

- If we decide **to appeal** the decision, we'll tell you in writing.
- If we decide **not to appeal** the decision, we must authorize or provide you with the service within 60 calendar days after getting the Council's decision.
  - If the Council says **No** or denies our review request, the appeals process may not be over.
- If you decide **to accept** this decision that turns down your appeal, the appeals process is over.
- If you decide **not to accept** this decision that turns down your appeal, you may be able to continue to the next level of the review process. The notice you get will tell you if you can go on to a Level 5 Appeal and what to do.

### Level 5 Appeal

- A Federal District Court judge will review your appeal and all of the information and decide **Yes** or **No**. This is the final decision. There are no other appeal levels beyond the Federal District Court.

## J2. Additional Family Care Partnership Appeals

You also have other appeal rights if your appeal is about services or items that Family Care Partnership usually covers. The letter you get from the Fair Hearing office will tell you what to do if you want to continue the appeals process.

If you disagree with Administrative Law Judge's decision on your State Fair Hearing, you have two options.

- Ask for a re-hearing. If you want the Wisconsin Division of Hearings and Appeals (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.
- 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.

The Member Rights Specialist can help if you wish to continue the appeals process.

## J3. Appeal Levels 3, 4 and 5 for Medicare Part D Drug Requests

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

If the value of the drug you appealed meets a certain dollar amount, you may be able to go on to additional levels of appeal. The written response you get to your Level 2 Appeal explains who to contact and what to do to ask for a Level 3 Appeal.



**If you have questions**, please call iCare Family Care Partnership at 1-800-777-4376 (TTY: 711), 24 hours a day, 7 days a week. The call is free. **For more information**, visit [www.icarehealthplan.org](http://www.icarehealthplan.org).

### Level 3 Appeal

Level 3 of the appeals process is an ALJ hearing. The person who makes the decision is an ALJ or an attorney adjudicator who works for the federal government.

If the ALJ or attorney adjudicator says **Yes** to your appeal:

- The appeals process is over.
- We must authorize or provide the approved drug coverage within 72 hours (or 24 hours for an expedited appeal) or make payment no later than 30 calendar days after we get the decision.

If the ALJ or attorney adjudicator says **No** to your appeal, the appeals process may not be over.

- If you decide **to accept** this decision that turns down your appeal, the appeals process is over.
- If you decide **not to accept** this decision that turns down your appeal, you can continue to the next level of the review process. The notice you get will tell you what to do for a Level 4 Appeal.

### Level 4 Appeal

The Council reviews your appeal and gives you an answer. The Council is part of the federal government.

If the Council says **Yes** to your appeal:

- The appeals process is over.
- We must authorize or provide the approved drug coverage within 72 hours (or 24 hours for an expedited appeal) or make payment no later than 30 calendar days after we get the decision.

If the Council says **No** to your appeal or if the Council denies the review request, the appeals process may not be over.

- If you decide **to accept** the decision that turns down your appeal, the appeals process is over.
- If you decide **not to accept** this decision that turns down your appeal, you may be able to continue to the next level of the review process. The notice you get will tell you if you can go on to a Level 5 Appeal and what to do.

### Level 5 Appeal

- A Federal District Court judge will review your appeal and all of the information and decide **Yes** or **No**. This is the final decision. There are no other appeal levels beyond the Federal District Court.

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## K. How to make a complaint

### K1. What kinds of problems should be complaints

The complaint process is used for certain types of problems only, such as problems about quality of care, waiting times, coordination of care, and customer service. Here are examples of the kinds of problems handled by the complaint process.



**If you have questions**, please call iCare Family Care Partnership at 1-800-777-4376 (TTY: 711), 24 hours a day, 7 days a week. The call is free. **For more information**, visit [www.icarehealthplan.org](http://www.icarehealthplan.org).



Complaint	Example
<b>Quality of your medical care</b>	<ul style="list-style-type: none"> <li>You're unhappy with the quality of care, such as the care you got in the hospital.</li> </ul>
<b>Respecting your privacy</b>	<ul style="list-style-type: none"> <li>You think that someone didn't respect your right to privacy or shared confidential information about you.</li> </ul>
<b>Disrespect, poor customer service, or other negative behaviors</b>	<ul style="list-style-type: none"> <li>A health care provider or staff was rude or disrespectful to you.</li> <li>Our staff treated you poorly.</li> <li>You think you're being pushed out of our plan.</li> </ul>
<b>Accessibility and language assistance</b>	<ul style="list-style-type: none"> <li>You can't physically access the health care services and facilities in a doctor or provider's office.</li> <li>Your doctor or provider doesn't provide an interpreter for the non-English language you speak (such as American Sign Language or Spanish).</li> <li>Your provider doesn't give you other reasonable accommodations you need and ask for.</li> </ul>
<b>Waiting times</b>	<ul style="list-style-type: none"> <li>You have trouble getting an appointment or wait too long to get it.</li> <li>Doctors, pharmacists, or other health professionals, Customer Care, or other plan staff keep you waiting too long.</li> </ul>
<b>Cleanliness</b>	<ul style="list-style-type: none"> <li>You think the clinic, hospital or doctor's office isn't clean.</li> </ul>
<b>Information you get from us</b>	<ul style="list-style-type: none"> <li>You think we failed to give you a notice or letter that you should have received.</li> <li>You think written information we sent you is too difficult to understand.</li> </ul>
<b>Timeliness related to coverage decisions or appeals</b>	<ul style="list-style-type: none"> <li>You think we don't meet our deadlines for making a coverage decision or answering your appeal.</li> <li>You think that, after getting a coverage or appeal decision in your favor, we don't meet the deadlines for approving or giving you the service or paying you back for certain medical services.</li> <li>You don't think we sent your case to the IRO on time.</li> </ul>

**There are different kinds of complaints.** You can make an internal complaint and/or an external complaint. An internal complaint is filed with and reviewed by our plan. An external complaint is filed with and reviewed by an organization not affiliated with our plan. If you need help making an internal and/or external complaint, you can call 1-800-777-4376.

The legal term for a "complaint" is a "**grievance.**"

The legal term for "making a complaint" is "**filing a grievance.**"



**If you have questions,** please call iCare Family Care Partnership at 1-800-777-4376 (TTY: 711), 24 hours a day, 7 days a week. The call is free. **For more information,** visit [www.icarehealthplan.org](http://www.icarehealthplan.org).



## K2. Internal complaints

To make an internal complaint, call Customer Care at 1-800-777-4376 (TTY: 711). You can make the complaint at any time unless it's about a Medicare Part D drug. If the complaint is about a Medicare Part D drug, you must make it **within 60 calendar days** after you had the problem you want to complain about.

- If there's anything else you need to do, Customer Care will tell you.
- You can also write your complaint and send it to us. If you put your complaint in writing, we'll respond to your complaint in writing.

### Medical Grievance Filing Instructions

- File a verbal grievance by calling Customer Care at 1-800-777-4376 (TTY: 711).
- Send a written grievance to:  
Independent Care Health Plan  
Attention: Member Grievances  
1555 N. RiverCenter Drive, Suite 206  
Milwaukee, WI 53212

### Part D Grievance Filing Instructions

- File a verbal grievance by calling Customer Care at 1-800-777-4376 (TTY: 711).
- Send a written grievance to:  
Grievance and Appeals  
P.O. Box 14165  
Lexington, Kentucky 40512-4165 or fax: 1-888-556-2128

When filing a grievance, please provide:

- Name
- Address
- Telephone number
- Member identification number
- A summary of the complaint and any previous contact with us related to the complaint
- The action you're requesting from us
- A signature from you or your authorized representative and the date. If you want a friend, relative, your doctor or other provider, or other person to be your representative, call Customer Care (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 [www.cms.gov/Medicare/CMS-Forms/CMS-Forms/downloads/cms1696.pdf](http://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/downloads/cms1696.pdf).) The form gives that person permission to act on your behalf. It must be signed by you and by the person who you'd like to act on your behalf. You must give us a copy of the signed form.



**If you have questions**, please call iCare Family Care Partnership at 1-800-777-4376 (TTY: 711), 24 hours a day, 7 days a week. The call is free. **For more information**, visit [www.icarehealthplan.org](http://www.icarehealthplan.org).

### Option for Fast Review of your Grievance

You may request a fast review, and we'll respond within 24 hours upon receipt, if your grievance concerns one of the following circumstances:

- We've extended the timeframe for making an organization determination/reconsiderations, and you believe you need a decision faster.
- We denied your request for a fast review of a 72-hour organization/coverage decision.
- We denied your request for a fast review of a 72-hour appeal.

It's best to call Customer Care if you want to request fast review of your grievance. If you mail your request, we'll call you to let you know we received it.

**Whether you call or write, you should contact Customer Care right away.** You can make the complaint at any time after you had the problem you want to complain about.

**The legal term** for “fast complaint” is “**expedited grievance.**”

If possible, we 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'll do that.

- We answer most complaints within 30 calendar days. If we don't make a decision within 30 calendar days because we need more information, we notify you in writing. We also provide a status update and estimated time for you to get the answer.
- If you make a complaint because we denied your request for a “fast coverage decision” or a “fast appeal,” we automatically give you a “fast complaint” and respond to your complaint within 24 hours.
- If you make a complaint because we took extra time to make a coverage decision or appeal, we automatically give you a “fast complaint” and respond to your complaint within 24 hours.

If we don't agree with some or all of your complaint, we'll tell you and give you our reasons. We respond whether we agree with the complaint or not.

### K3. External complaints

#### Medicare

You can tell Medicare about your complaint or send it to Medicare. The Medicare Complaint Form is available at: [www.medicare.gov/my/medicare-complaint](http://www.medicare.gov/my/medicare-complaint). You don't need to file a complaint with iCare Family Care Partnership before filing a complaint with Medicare.

Medicare takes your complaints seriously and uses this information to help improve the quality of the Medicare program.

If you have any other feedback or concerns, or if you feel the health plan isn't addressing your problem, you can also call 1-800-MEDICARE (1-800-633-4227). TTY users call 1-877-486- 2048. The call is free.

**If you disagree with iCare Family Care Partnership's response** on your complaint, or if iCare Family Care



**If you have questions**, please call iCare Family Care Partnership at 1-800-777-4376 (TTY: 711), 24 hours a day, 7 days a week. The call is free. **For more information**, visit [www.icarehealthplan.org](http://www.icarehealthplan.org).

Partnership fails to timely respond to your complaint, you can ask for a review by the Wisconsin Department of Health Services (DHS). DHS works with an outside organization called MetaStar to review grievances.

MetaStar is an independent organization that is hired by DHS. This organization is not connected with our plan and is not a government agency. This organization is a company chosen by DHS to handle the job of reviewing Medicaid grievances. DHS oversees its work.

**Before asking MetaStar to review your complaint, you must file your grievance with iCare Family Care Partnership and complete the iCare Family Care Partnership grievance process.**

You must request a review of your grievance by MetaStar within forty-five (45) calendar days from the date you received iCare Family Care Partnership's written decision on your grievance or, if iCare Family Care Partnership fails to provide you with a written decision on your grievance within the required amount of time, within forty-five calendar days from the date iCare Family Care Partnership's time frame to review your grievance expires.

- For example, iCare Family Care Partnership has until July 30 to send you its decision about your grievance. You receive the decision on June 1. You disagree with the decision. You have until July 16 to ask MetaStar to review iCare Family Care Partnership decision.
- For example, iCare Family Care Partnership has until July 30 to send you its decision about your grievance. When July 30 arrives, iCare Family Care Partnership has not sent you a decision. Starting on July 31, you have until September 13 to ask MetaStar to review your grievance.

MetaStar will reply in writing to let you know they received your request to review your grievance.

- MetaStar will review the facts surrounding your grievance.
- MetaStar has thirty (30) calendar days from the date it receives your request to review your grievance and issue a written, **binding** decision.
- If MetaStar determines that it needs more time to issue a decision, it will send you a written notice explaining:
  - The reason they need additional time.
  - The amount of additional time needed.
  - Your right to deny the MetaStar request for an extension (more time). If you deny the MetaStar request for an extension, iCare Family Care Partnership's decision on your grievance is the final decision.

MetaStar will send you and iCare Family Care Partnership its written, binding decision within seven (7) calendar days of completing the review of your grievance.

### Office for Civil Rights (OCR)

You can make a complaint to the Department of Health and Human Services (HHS) OCR if you think you haven't been treated fairly. For example, you can make a complaint about disability access or language assistance. The phone number for the OCR is 1-800-368-1019. TTY users should call 1-800-537-7697. You can visit [www.hhs.gov/ocr](http://www.hhs.gov/ocr) for more information.



**If you have questions**, please call iCare Family Care Partnership at 1-800-777-4376 (TTY: 711), 24 hours a day, 7 days a week. The call is free. **For more information**, visit [www.icarehealthplan.org](http://www.icarehealthplan.org).

You may also contact the regional OCR office at:

**Office for Civil Rights**

U.S. Department of Health and Human Services  
233 N. Michigan Ave., Suite 240  
Chicago, IL 60601  
Customer Response Center: (800) 368-1019

Fax: (202) 619-3818  
TDD: (800) 537-7697  
Email: [ocrmail@hhs.gov](mailto:ocrmail@hhs.gov)

You may also have rights under the Americans with Disability Act (ADA).

**QIO**

When your complaint is about quality of care, you have two choices:

- You can make your complaint about the quality of care directly to the QIO.
- You can make your complaint to the QIO and to our plan. If you make a complaint to the QIO, we work with them to resolve your complaint.

The QIO 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 learn more about the QIO, refer to **Section H2** or refer to **Chapter 2** of this *Evidence of Coverage*.

In Wisconsin, the QIO is called Commence Health. The phone number for Commence Health is 1-888-524-9900.



**If you have questions**, please call iCare Family Care Partnership at 1-800-777-4376 (TTY: 711), 24 hours a day, 7 days a week. The call is free. **For more information**, visit [www.icarehealthplan.org](http://www.icarehealthplan.org).

# Chapter 10: Ending your membership in our plan

## Introduction

This chapter explains how you can end your membership with our plan and your health coverage options after you leave our plan. If you leave our plan, you'll still be in the Medicare and Family Care Partnership as long as you're eligible. Key terms and their definitions appear in alphabetical order in the last chapter of this *Evidence of Coverage*.

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## A. When you can end your membership in our plan

Most people with Medicare can end their membership during certain times of the year. Since you have Family Care Partnership, you have some choices to end your membership with our plan any month of the year.

In addition, you may end your membership in our plan during the following periods each year:

- The **Open Enrollment Period**, which lasts from October 15 to December 7. If you choose a new plan during this period, your membership in our plan ends on December 31 and your membership in the new plan starts on January 1.
- The **Medicare Advantage (MA) Open Enrollment Period**, which lasts from January 1 to March 31 and also for new Medicare beneficiaries who are enrolled in a plan, from the month of entitlement to Part A and Part B until the last day of the 3rd month of entitlement. If you choose a new plan during this period, your membership in the new plan starts the first day of the next month.

There may be other situations when you're eligible to make a change to your enrollment. For example, when:

- you move out of our service area,
- your eligibility for Family Care Partnership or Extra Help changed, or

 **If you have questions**, please call iCare Family Care Partnership at 1-800-777-4376 (TTY: 711), 24 hours a day, 7 days a week. The call is free. **For more information**, visit [www.icarehealthplan.org](http://www.icarehealthplan.org).

- if you recently moved into, currently are getting care in, or just moved out of a nursing facility or a long-term care hospital.

Your membership ends on the last day of the month that we get your request to change your plan. For example, if we get your request on January 18, your coverage with our plan ends on January 31. Your new coverage begins the first day of the next month (February 1, in this example).

If you leave our plan, you can get information about your:

- Medicare options in the table in **Section C1**.
- Medicaid services in **Section C2**.

You can get more information about how you can end your membership by calling:

- Customer Care at the number at the bottom of this page. The number for TTY users is listed too.
- Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877- 486-2048.
- The Wisconsin State Health Insurance Assistance Program (SHIP) is the Medigap Helpline and users should call 800-242-1060.

**NOTE:** If you're in a drug management program (DMP), you may not be able to change plans. Refer to **Chapter 5** of this *Evidence of Coverage* for information about drug management programs.

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## B. How to end your membership in our plan

If you decide to end your membership you can enroll in another Medicare plan or switch to Original Medicare. However, if you want to switch from our plan to Original Medicare but you haven't selected a separate Medicare 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 Care at the number at the bottom of this page if you need more information on how to do this.
- Call Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users (people who have difficulty with hearing or speaking) should call 1-877-486-2048. When you call 1-800-MEDICARE, you can also enroll in another Medicare health or drug plan. More information on getting your Medicare services when you leave our plan is in the chart on page 78.
- Call the Aging and Disability Resource Center (ADRC) for your county and tell them about your decision to disenroll. **Section C** below includes steps that you can take to enroll in a different plan, which will also end your membership in our plan.

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## C. How to get Medicare and Family Care Partnership services separately

For questions about your Wisconsin Medicaid benefits, contact the Aging and Disability Resource Center (ADRC) for your county. If you choose to end your membership in iCare Family Care Partnership, you must contact the ADRC in your county and tell them about your decision to disenroll. You can contact the ADRC by calling 1-844-947-2372 to be connected to your local office or use the following link to find an ADRC in your area: [www.dhs.wisconsin.gov/adrc/consumer/](http://www.dhs.wisconsin.gov/adrc/consumer/). Ask how joining another plan or returning to Original



**If you have questions**, please call iCare Family Care Partnership at 1-800-777-4376 (TTY: 711), 24 hours a day, 7 days a week. The call is free. **For more information**, visit [www.icarehealthplan.org](http://www.icarehealthplan.org).



Medicare affects how you get your Wisconsin Medicaid coverage.

You have choices about getting your Medicare and Medicaid services if you choose to leave our plan.

### C1. Your Medicare services

You have three options for getting your Medicare services listed below any month of the year. You have an additional option listed below during certain times of the year including the **Open Enrollment Period** and the **Medicare Advantage Open Enrollment Period** or other situations described in **Section A**. By choosing one of these options, you automatically end your membership in our plan.

<p><b>1. You can change to:</b></p> <p><b>Another plan that provides your Medicare and most or all of your Medicaid benefits and services in one plan, also known as an integrated dual- eligible special needs plan (D-SNP) or a Program of All-inclusive Care for the Elderly (PACE) plan, if you qualify.</b></p>	<p><b>Here is what to do:</b></p> <p>Call Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.</p> <p>For Program of All-Inclusive Care for the Elderly (PACE) inquiries, call 1-800-362-3002.</p> <p>If you need help or more information:</p> <ul style="list-style-type: none"><li>• Call the Medigap Helpline 1-800-242-1060; TTY 711, and visit the website at <a href="http://www.longtermcare.wi.gov/Pages/Medigap/Medigap.aspx">www.longtermcare.wi.gov/Pages/Medigap/Medigap.aspx</a>.</li></ul> <p><b>OR</b></p> <p>Enroll in a new integrated D-SNP.</p> <p>You'll automatically be disenrolled from our Medicare plan when your new plan's coverage begins.</p>
<p><b>2. You can change to:</b></p> <p><b>Original Medicare with a separate Medicare drug plan</b></p>	<p><b>Here is what to do:</b></p> <p>Call Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.</p> <p>If you need help or more information:</p> <ul style="list-style-type: none"><li>• Call the Medigap Helpline 1-800-242-1060; TTY 711, and visit the website at <a href="http://www.longtermcare.wi.gov/Pages/Medigap/Medigap.aspx">www.longtermcare.wi.gov/Pages/Medigap/Medigap.aspx</a>.</li></ul> <p><b>OR</b></p> <p>Enroll in a new Medicare drug plan.</p> <p>You'll automatically be disenrolled from our plan when your Original Medicare coverage begins.</p>



**If you have questions**, please call iCare Family Care Partnership at 1-800-777-4376 (TTY: 711), 24 hours a day, 7 days a week. The call is free. **For more information**, visit [www.icarehealthplan.org](http://www.icarehealthplan.org).



<p><b>3. You can change to:</b></p> <p><b>Original Medicare without a separate Medicare drug plan</b></p> <p><b>NOTE:</b> If you switch to Original Medicare and don't enroll in a separate Medicare drug plan, Medicare may enroll you in a drug plan, unless you tell Medicare you don't want to join.</p> <p>You should only drop drug coverage if you have drug coverage from another source, such as an employer or union. If you have questions about whether you need drug coverage, call the Medigap Helpline 1-800- 242-1060; TTY 711, Monday through Friday from 8:00 a.m. to 5:00 p.m. For more information or to find a local Medigap Helpline office in your area, please visit <a href="http://www.longtermcare.wi.gov/Pages/Medigap/Medigap.aspx">www.longtermcare.wi.gov/Pages/Medigap/Medigap.aspx</a>.</p>	<p><b>Here is what to do:</b></p> <p>Call Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.</p> <p>If you need help or more information:</p> <ul style="list-style-type: none"> <li>• Call the Medigap Helpline 1-800-242-1060; TTY 711, and visit the website at <a href="http://www.longtermcare.wi.gov/Pages/Medigap/Medigap.aspx">www.longtermcare.wi.gov/Pages/Medigap/Medigap.aspx</a>.</li> </ul> <p>You will automatically be disenrolled from our plan when your Original Medicare coverage begins.</p>
<p><b>4. You can change to:</b></p> <p><b>Any Medicare health plan</b> during certain times of the year including the <b>Open Enrollment Period</b> and the <b>Medicare Advantage Open Enrollment Period</b> or other situations described in <b>Section A</b>.</p>	<p><b>Here is what to do:</b></p> <p>Call Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.</p> <p>For Program of All-Inclusive Care for the Elderly (PACE) inquiries, call 1-800-362-3002.</p> <p>If you need help or more information:</p> <ul style="list-style-type: none"> <li>• Call the Medigap Helpline 1-800-242-1060; TTY 711, and visit the website at <a href="http://www.longtermcare.wi.gov/Pages/Medigap/Medigap.aspx">www.longtermcare.wi.gov/Pages/Medigap/Medigap.aspx</a>.</li> </ul> <p><b>OR</b></p> <p>Enroll in a new Medicare plan.</p> <p>You'll automatically be disenrolled from our Medicare plan when your new plan's coverage begins.</p>

## C2. Your Family Care Partnership services

For questions about your Wisconsin Medicaid benefits, contact the Aging and Disability Resource Center (ADRC) for your county. If you choose to end your membership in iCare Family Care Partnership Family Care Partnership, you must contact the ADRC in your county and tell them about your decision to disenroll. You can contact your local ADRC by calling 1-844-947-2372 or by following the link to find an ADRC in your area: [www.dhs.wisconsin.gov/adrc/contacts.htm](http://www.dhs.wisconsin.gov/adrc/contacts.htm). Ask how joining another plan or returning to Original Medicare affects how you get your Wisconsin Medicaid coverage.



**If you have questions**, please call iCare Family Care Partnership at 1-800-777-4376 (TTY: 711), 24 hours a day, 7 days a week. The call is free. **For more information**, visit [www.icarehealthplan.org](http://www.icarehealthplan.org).

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## D. Your medical items, services and drugs until your membership in our plan ends

If you leave our plan, it may take time before your membership ends and your new Medicare and Medicaid coverage begins. During this time, you keep getting your drugs and health care through our plan until your new plan begins.

- Use our network providers to receive medical care.
- Use our network pharmacies including through our mail-order pharmacy services to get your prescriptions filled.
- If you're hospitalized on the day that your membership in iCare Family Care Partnership ends, our plan will cover your hospital stay until you're discharged. This will happen even if your new health coverage begins before you're discharged.

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## E. Other situations when your membership in our plan ends

These are cases when we must end your membership in our plan:

- If there's a break in your Medicare Part A and Medicare Part B coverage.
- If you no longer qualify for Medicaid. Our plan is for people who qualify for both Medicare and Medicaid.
- If you lose your financial eligibility for Wisconsin Medicaid
- If you're 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.
- If you don't 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're away from our service area for more than six months.
  - If you move or take a long trip, call Customer Care to find out if where you're moving or traveling to is in our plan's service area.
- If you go to jail or prison for a criminal offense.
- If you lie about or withhold information about other insurance you have for drugs.
- If you're not a United States citizen or aren't lawfully present in the United States.
  - You must be a United States citizen or lawfully present in the United States to be a member of our plan.
  - The Centers for Medicare & Medicaid Services (CMS) notify us if you're not eligible to remain a member on this basis.
  - We must disenroll you if you don't meet this requirement.



**If you have questions**, please call iCare Family Care Partnership at 1-800-777-4376 (TTY: 711), 24 hours a day, 7 days a week. The call is free. **For more information**, visit [www.icarehealthplan.org](http://www.icarehealthplan.org).

We can make you leave our plan for the following reasons only if we get permission from Medicare and Medicaid first:

- If you intentionally give us incorrect information when you're enrolling in our plan and that information affects your eligibility for our plan.
- If you continuously behave in a way that's disruptive and makes it difficult for us to provide medical care for you and other members of our plan.
- If you let someone else use your Member ID Card to get medical care. (Medicare may ask the Inspector General to investigate your case if we end your membership for this reason.)

---

## F. Rules against asking you to leave our plan for any health-related reason

We can't ask you to leave our plan for any reason related to your health. If you think we're asking you to leave our plan for a health-related reason, **call Medicare** at 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

---

## G. Your right to make a complaint if we end your membership in our plan

If we end your membership in our plan, we must tell you our reasons in writing for ending your membership. We must also explain how you can file a grievance or make a complaint about our decision to end your membership. You can also refer to **Chapter 9** of this *Evidence of Coverage* for information about how to make a complaint.

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## H. How to get more information about ending your plan membership

If you have questions or would like more information on ending your membership, you can call Customer Care at the number at the bottom of this page.



**If you have questions**, please call iCare Family Care Partnership at 1-800-777-4376 (TTY: 711), 24 hours a day, 7 days a week. The call is free. **For more information**, visit [www.icarehealthplan.org](http://www.icarehealthplan.org).

# Chapter 11: Legal notices

## Introduction

This chapter includes legal notices that apply to your membership in our plan. Key terms and their definitions appear in alphabetical order in the last chapter of this *Evidence of Coverage*.

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### A. Notice about laws

Many laws apply to this *Evidence of Coverage*. These laws may affect your rights and responsibilities even if the laws aren’t included or explained in this *Evidence of Coverage*. The main laws that apply are federal laws about the Medicare and Family Care Partnership. Other federal and state laws may apply too.

### B. Notice about nondiscrimination

We don’t discriminate or treat you differently because of your race, ethnicity, national origin, color, religion, sex, 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:

- Call the Department of Health and Human Services, Office for Civil Rights at 1-800-368-1019. TTY users can call 1-800-537-7697. You can also visit [www.hhs.gov/ocr](http://www.hhs.gov/ocr) for more information.
- Call your local Office for Civil Rights at 1-800-368-1019 (TDD: 1-800-537-7697).
- If you have a disability and need help accessing health care services or a provider, call Customer Care. If you have a complaint, such as a problem with wheelchair access, Customer Care can help.

### C. Notice about Medicare as a second payer and Family Care Partnership as a payer of last resort

Sometimes someone else must pay first for the services we provide you. For example, if you’re in a car accident or if you’re injured at work, insurance or Workers Compensation must pay first.

We have the right and responsibility to collect for covered Medicare services for which Medicare isn’t the first payer.

We comply with federal and state laws and regulations relating to the legal liability of third parties for health

care services to members. We take all reasonable measures to ensure that Family Care Partnership is the payer of last resort.



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**If you have questions**, please call iCare Family Care Partnership at 1-800-777-4376 (TTY: 711), 24 hours a day, 7 days a week. The call is free. **For more information**, visit [www.icarehealthplan.org](http://www.icarehealthplan.org).

# Chapter 12: Definitions of important words

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## Introduction

This chapter includes key terms used throughout this *Evidence of Coverage* with their definitions. The terms are listed in alphabetical order. If you can't find a term you're looking for or if you need more information than a definition includes, contact Customer Care.

**Activities of daily living (ADL):** The things people do on a normal day, such as eating, using the toilet, getting dressed, bathing, or brushing teeth.

**Administrative law judge:** A judge that reviews a level 3 appeal.

**Ambulatory surgical center:** A facility that provides outpatient surgery to patients who don't need hospital care and who aren't expected to need more than 24 hours of care.

**Appeal:** A way for you to challenge our action if you think we made a mistake. You can ask us to change a coverage decision by filing an appeal. **Chapter 9** of this *Evidence of Coverage* explains appeals, including how to make an appeal.

**Behavioral Health:** An all-inclusive term referring to mental health and substance use disorders.

**Biological Product:** A drug that's made from natural and living sources like animal cells, plant cells, bacteria, or yeast. Biological products are more complex than other drugs and can't be copied exactly, so alternative forms are called biosimilars. (See also "Original Biological Product" and "Biosimilar").

**Biosimilar:** A biological product that's very similar, but not identical, to the original biological product. Biosimilars are as safe and effective as the original biological product. Some biosimilars may be substituted for the original biological product at the pharmacy without needing a new prescription. (Go to "Interchangeable Biosimilar").

**Brand name drug:** A drug that's made and sold by the company that originally made the drug. Brand name drugs have the same ingredients as the generic versions of the drugs. Generic drugs are usually made and sold by other drug companies and are generally not available until the patent on the brand name drug has ended.

**Care manager:** One main person who works with you, with the health plan, and with your care providers to make sure you get the care you need.

**Care plan:** Refer to "Member Centered Plan."

**Care team:** Refer to "Interdisciplinary Team" or "IDT."

**Catastrophic coverage stage:** The stage in the Medicare Part D drug benefit where our plan pays all costs of your Part D drugs until the end of the year. You begin this stage when you (or other qualified parties on your behalf) have spent \$2,100 for Part D covered drugs during the year.

**Centers for Medicare & Medicaid Services (CMS):** The federal agency in charge of Medicare. **Chapter 2** of this



**If you have questions**, please call iCare Family Care Partnership at 1-800-777-4376 (TTY: 711), 24 hours a day, 7 days a week. The call is free. **For more information**, visit [www.icarehealthplan.org](http://www.icarehealthplan.org).

*Evidence of Coverage* explains how to contact CMS.

**Complaint:** A written or spoken statement saying that you have a problem or concern about your covered services or care. This includes any concerns about the quality of service, quality of your care, our network providers, or our network pharmacies. The formal name for “making a complaint” is “filing a grievance”.

**Comprehensive outpatient rehabilitation facility (CORF):** A facility that mainly provides rehabilitation services after an illness, accident, or major operation. It provides a variety of services, including physical therapy, social or psychological services, respiratory therapy, occupational therapy, speech therapy, and home environment evaluation services.

**Copay:** A fixed amount you pay as your share of the cost each time you get certain drugs. For example, you might pay \$2 or \$5 for a drug.

**Cost sharing:** Amounts you have to pay when you get certain drugs. Cost sharing includes copays.

**Cost sharing tier:** A group of drugs with the same copay. Every drug on the *List of Covered Drugs* (also known as the *Drug List*) is in a single cost share tier. In general, the higher the cost sharing tier, the higher your cost for the drug.

**Coverage decision:** A decision about what benefits we cover. This includes decisions about covered drugs and services or the amount we pay for your health services. **Chapter 9** of this *Evidence of Coverage* explains how to ask us for a coverage decision.

**Covered drugs:** The term we use to mean all of the prescription and over-the-counter (OTC) drugs covered by our plan.

**Covered services:** The general term we use to mean all the health care, long-term services and supports, supplies, prescription and over-the-counter drugs, equipment, and other services our plan covers.

**Cultural competence training:** Training that provides additional instruction for our health care providers that helps them better understand your background, values, and beliefs to adapt services to meet your social, cultural, and language needs.

**Customer Care:** A department in our plan responsible for answering your questions about membership, benefits, grievances, and appeals. Refer to **Chapter 2** of this *Evidence of Coverage* for more information about Customer Care.

**Daily cost-sharing rate:** A rate that may apply when your doctor prescribes less than a full month’s supply of certain drugs for you and you’re required to pay a copay. A daily cost sharing rate is the copay divided by the number of days in a month’s supply.

Here is an example: Let’s say the copay for your drug for a full month’s supply (a 30-day supply) is \$1.35. This means that the amount you pay for your drug is less than \$0.05 per day. If you get a 7-day supply of the drug, your payment is less than \$0.05 per day multiplied by 7 days, for a total payment less than \$0.35.

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

**Drug management program (DMP):** A program that helps make sure members safely use prescription



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opioids and other frequently abused medications.

**Drugs:** Groups of drugs on our *Drug List*. Generic, brand name, or over-the-counter (OTC) drugs are examples of drug tiers. Every drug on the *Drug List* is in a single tier.

**Dual eligible special needs plan (D-SNP):** Health plan that serves individuals who are eligible for both Medicare and Medicaid. Our plan is a D-SNP.

**Durable medical equipment (DME):** Certain items your doctor orders for use in your own home. Examples of these items are 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 and supplies, nebulizers, and walkers.

**Emergency:** A medical emergency when you, or any other person with an average knowledge of health and medicine, believe that you have medical symptoms that need immediate medical attention to prevent death, loss of a body part, or loss of or serious impairment to a bodily function (and if you're a pregnant woman, loss of an unborn child). The medical symptoms may be an illness, injury, severe pain, or a medical condition that's quickly getting worse.

**Emergency care:** Covered services given by a provider trained to give emergency services and needed to treat a medical or behavioral health emergency.

**Evidence of Coverage and Disclosure Information:** This document, along with your enrollment form and any other attachments, or riders, which explain your coverage, what we must do, your rights, and what you must do as a member of our plan.

**Exception:** Permission to get coverage for a drug not normally covered or to use the drug without certain rules and limitations.

**Excluded Services:** Services that aren't covered by this health plan.

**Extra Help:** Medicare program that helps people with limited incomes and resources reduce Medicare Part D drug costs, such as premiums, deductibles, and copays. Extra Help is also called the "Low-Income Subsidy", or "LIS".

**Family Care Partnership:** This is the name of Wisconsin Medicaid program. Family Care Partnership is run by the state and is paid for by the state and the federal government. It helps people with limited incomes and resources pay for long-term services and supports and medical costs.

- It covers extra services and some drugs not covered by Medicare.
- Medicaid programs vary from state to state, but most health care costs are covered if you qualify for both Medicare and Medicaid.

**Generic drug:** A drug approved by the FDA to use in place of a brand name drug. A generic drug has the same ingredients as a brand name drug. It's usually cheaper and works just as well as the brand name drug.

**Grievance:** A complaint you make about us or one of our network providers or pharmacies. This includes a complaint about the quality of your care or the quality of service provided by your health plan.



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**Health plan:** An organization made up of doctors, hospitals, pharmacies, providers of long-term services, and other providers. It also has care managers to help you manage all your providers and services. All of them work together to provide the care you need.

**Health risk assessment (HRA):** A review of your medical history and current condition. It's used to learn about your health and how it might change in the future.

**HIV drug assistance program (HDAP):** A program that helps eligible individuals living with HIV/AIDS have access to life-saving HIV medications.

**Home health aide:** A person who provides services that don't need the skills of a licensed nurse or therapist, such as help with personal care (like bathing, using the toilet, dressing, or carrying out the prescribed exercises). Home health aides don't have a nursing license or provide therapy.

**Hospice:** A program of care and support to help people who have a terminal prognosis live comfortably. A terminal prognosis means that a person has been medically certified as terminally ill, meaning having a life expectancy of 6 months or less.

- An enrollee who has a terminal prognosis has the right to elect hospice.
- A specially trained team of professionals and caregivers provide care for the whole person, including physical, emotional, social, and spiritual needs.
- We're required to give you a list of hospice providers in your geographic area.

**Improper/inappropriate billing:** A situation when a provider (such as a doctor or hospital) bills you more than our cost sharing amount for services. Call Customer Care if you get any bills you don't understand.

Because we pay the entire cost for your services, you **don't** owe any cost sharing. Providers shouldn't bill you anything for these services.

**Independent review organization (IRO):** An independent organization hired by Medicare that reviews a level 2 appeal. It isn't connected with us and isn't a government agency. This organization decides whether the decision we made is correct or if it should be changed. Medicare oversees its work. The formal name is the **Independent Review Entity**.

**Initial coverage stage:** The stage before your total Medicare Part D drug expenses reach \$2,100. This includes amounts you paid, what our plan paid on your behalf, and the low-income subsidy. You begin in this stage when you fill your first prescription of the year. During this stage, we pay part of the costs of your drugs, and you pay your share.

**Inpatient:** A term used when you're formally admitted to the hospital for skilled medical services. If you're not formally admitted, you may still be considered an outpatient instead of an inpatient even if you stay overnight.

**Interdisciplinary Team (IDT or Care team):** A care team may include doctors, nurses, counselors, or other health professionals who are there to help you get the care you need. Your care team also helps you make a care plan.

**Integrated D-SNP:** A dual-eligible special needs plan that covers Medicare and most or all Medicaid services under a single health plan for certain groups of individuals eligible for both Medicare and Medicaid. These



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individuals are known as full-benefit dually eligible individuals.

**Interchangeable Biosimilar:** A biosimilar that may be substituted at the pharmacy without needing a new prescription because it meets additional requirements about the potential for automatic substitution. Automatic substitution at the pharmacy is subject to state law.

**List of Covered Drugs (Drug List):** A list of prescription and over-the-counter (OTC) drugs we cover. We choose the drugs on this list with the help of doctors and pharmacists. The *Drug List* tells you if there are any rules you need to follow to get your drugs. The *Drug List* is sometimes called a “formulary”.

**Long-term services and supports (LTSS):** Long-term services and supports help improve a long-term medical condition. Most of these services help you stay in your home so you don’t have to go to a nursing facility or hospital. LTSS include Community-Based Services and Nursing Facilities (NF).

**Low-income subsidy (LIS):** Refer to “Extra Help”

**Medicaid (or Medical Assistance):** A program run by the federal government and the state that helps people with limited incomes and resources pay for long-term services and supports and medical costs.

**Medically necessary:** This describes services, supplies, or drugs you need to prevent, diagnose, or treat a medical condition or to maintain your current health status. This includes care that keeps you from going into a hospital or nursing facility. It also means the services, supplies, or drugs meet accepted standards of medical practice.

**Medicare:** The federal health insurance program for people 65 years of age or older, some people under age 65 with certain disabilities, and people with end-stage renal disease (generally those with permanent kidney failure who need dialysis or a kidney transplant). People with Medicare can get their Medicare health coverage through Original Medicare or a managed care plan (refer to “Health plan”).

**Medicare Advantage:** A Medicare program, also known as “Medicare Part C” or “MA”, that offers MA plans through private companies. Medicare pays these companies to cover your Medicare benefits.

**Medicare Appeals Council (Council):** A council that reviews a level 4 appeal. The Council is part of the Federal government.

**Medicare-covered services:** Services covered by Medicare Part A and Medicare Part B. All Medicare health plans, including our plan, must cover all the services covered by Medicare Part A and Medicare Part B.

**Medicare diabetes prevention program (MDPP):** A structured health behavior change program that provides training in long-term dietary change, increased physical activity, and strategies for overcoming challenges to sustaining weight loss and a healthy lifestyle.

**Medicare-Medicaid enrollee:** A person who qualifies for Medicare and Medicaid coverage. A Medicare-Medicaid enrollee is also called a “dually eligible individual”.

**Medicare Part A:** The Medicare program that covers most medically necessary hospital, skilled nursing facility, home health, and hospice care.

**Medicare Part B:** The Medicare program that covers services (such as lab tests, surgeries, and doctor visits)



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and supplies (such as wheelchairs and walkers) that are medically necessary to treat a disease or condition. Medicare Part B also covers many preventive and screening services.

**Medicare Part C:** The Medicare program, also known as “Medicare Advantage” or “MA”, that lets private health insurance companies provide Medicare benefits through an MA Plan.

**Medicare Part D:** The Medicare drug benefit program. We call this program “Part D” for short. Medicare Part D covers outpatient drugs, vaccines, and some supplies not covered by Medicare Part A or Medicare Part B or Medicaid. Our plan includes Medicare Part D.

**Medicare Part D drugs:** Drugs covered under Medicare Part D. Congress specifically excludes certain categories of drugs from coverage under Medicare Part D. Medicaid may cover some of these drugs.

**Medication Therapy Management (MTM):** A Medicare Part D program for complex health needs provided to people who meet certain requirements or are in a Drug Management Program. MTM services usually include a discussion with a pharmacist or health care provider to review medications. Refer to **Chapter 5** of this *Evidence of Coverage* for more information.

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

**Member Centered Plan (MCP):** A plan for what services you’ll get and how you’ll get them. Your plan may include medical services, behavioral health services, and long-term services and supports.

**Network pharmacy:** A pharmacy (drug store) that agreed to fill prescriptions for our plan members. We call them “network pharmacies” because they agreed to work with our plan. In most cases, we cover your prescriptions only when filled at one of our network pharmacies.

**Network provider:** “Provider” is the general term we use for doctors, nurses, and other people who give you services and care. The term also includes hospitals, home health agencies, clinics, and other places that give you health care services, medical equipment, and long-term services and supports.

- They’re licensed or certified by Medicare and by the state to provide health care services.
- We call them “network providers” when they agree to work with our health plan, accept our payment, and don’t charge members an extra amount.
- While you’re a member of our plan, you must use network providers to get covered services. Network providers are also called “plan providers”.

**Nursing home or facility:** A place that provides care for people who can’t get their care at home but don’t need to be in the hospital.

**Ombudsperson:** An office in your state that works as an advocate on your behalf. They can answer questions if you have a problem or complaint and can help you understand what to do. The ombudsperson’s services are free. You can find more information in **Chapters 2 and 9** of this *Evidence of Coverage*.

**Organization determination:** Our plan makes an organization determination when we, or one of our providers, decide whether services are covered or how much you pay for covered services. Organization



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determinations are called “coverage decisions”. **Chapter 9** of this *Evidence of Coverage* explains coverage decisions.

**Original Biological Product:** A biological product that has been approved by the FDA and serves as the comparison for manufacturers making a biosimilar version. It’s also called a reference product.

**Original Medicare (traditional Medicare or fee-for-service Medicare):** The government offers Original Medicare. Under Original Medicare, services are covered by paying doctors, hospitals, and other health care providers amounts that Congress determines.

- You can use any doctor, hospital, or other health care provider that accepts Medicare. Original Medicare has two parts: Medicare Part A (hospital insurance) and Medicare Part B (medical insurance).
- Original Medicare is available everywhere in the United States.
- If you don’t want to be in our plan, you can choose Original Medicare.

**Out-of-network pharmacy:** A pharmacy that hasn’t agreed to work with our plan to coordinate or provide covered drugs to members of our plan. Our plan doesn’t cover most drugs you get from out-of-network pharmacies unless certain conditions apply.

**Out-of-network provider or Out-of-network facility:** A provider or facility that isn’t employed, owned, or operated by our plan and isn’t under contract to provide covered services to members of our plan. **Chapter 3** of this *Evidence of Coverage* explains out-of-network providers or facilities.

**Out-of-pocket costs:** The cost-sharing requirement for members to pay for part of the services or drugs they get is also called the “out-of-pocket” cost requirement. Refer to the definition for “cost sharing” above.

**Over-the-counter (OTC) drugs:** Over-the-counter drugs are drugs or medicines that a person can buy without a prescription from a health care professional.

**PART A:** Refer to "Medicare Part A."

**PART B:** Refer to "Medicare Part B."

**PART C:** Refer to "Medicare Part C."

**PART D:** Refer to "Medicare Part D."

**Personal health information (also called Protected health information) (PHI):** Information about you and your health, such as your name, address, social security number, physician visits, and medical history. Refer to our Notice of Privacy Practices for more information about how we protect, use, and disclose your PHI, as well as your rights with respect to your PHI.

**Preventive services:** Health care to prevent illness or detect illness at an early stage, when treatment is likely to work best (for example, preventive services include Pap tests, flu shots, and screening mammograms).

**Primary care provider (PCP):** The doctor or other provider you use first for most health problems. They make sure you get the care you need to stay healthy.

- They also may talk with other doctors and health care providers about your care and refer you to



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them.

- In many Medicare health plans, you must use your primary care provider before you use any other health care provider.
- Refer to **Chapter 3** of this *Evidence of Coverage* for information about getting care from primary care providers.

**Prior authorization (PA):** An approval you must get from us before you can get a specific service or drug or use an out-of-network provider. Our plan may not cover the service or drug if you don't get approval first.

Our plan covers some network medical services only if your doctor or other network provider gets PA from us.

- Covered services that need our plan's PA are marked in **Chapter 4** of this *Evidence of Coverage*.

Our plan covers some drugs only if you get PA from us.

- Covered drugs that need our plan's PA are marked in the *List of Covered Drugs* and the rules are posted on our website.

**Program of All-Inclusive Care for the Elderly (PACE):** A program that covers Medicare and Medicaid benefits together for people age 55 and over who need a higher level of care to live at home.

**Prosthetics and Orthotics:** Medical devices ordered by your doctor or other health care provider that include, but aren't 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 doctors and other health care experts who help improve the quality of care for people with Medicare. The federal government pays the QIO to check and improve the care given to patients. Refer to **Chapter 2** of this *Evidence of Coverage* for information about the QIO.

**Quantity limits:** A limit on the amount of a drug you can have. We may limit the amount of the drug that we cover per prescription.

**Real Time Benefit Tool:** A portal or computer application in which enrollees can look up complete, accurate, timely, clinically appropriate, enrollee-specific covered drugs and benefit information. This includes cost sharing amounts, alternative drugs that may be used for the same health condition as a given drug, and coverage restrictions (prior authorization, step therapy, quantity limits) that apply to alternative drugs.

**Referral:** A referral is your primary care provider's (PCP's) approval to use a provider other than your PCP. If you don't get approval first, we may not cover the services. You don't need a referral to use certain specialists, such as women's health specialists. You can find more information about referrals in **Chapters 3 and 4** of this *Evidence of Coverage*.

**Rehabilitation services:** Treatment you get to help you recover from an illness, accident or major operation. Refer to **Chapter 4** of this *Evidence of Coverage* to learn more about rehabilitation services.

**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 generally the area where you can get routine (non-emergency) services. Only people who live in our service area can enroll in our plan.



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**Share of cost:** The portion of your health care costs that you may have to pay each month before your benefits become effective. The amount of your share of cost varies depending on your income and resources.

**Skilled nursing facility (SNF):** A nursing facility with the staff and equipment to give skilled nursing care and, in most cases, skilled rehabilitative services and other related health services.

**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 (IV) injections that a registered nurse or a doctor can give.

**Specialist:** A doctor who provides health care for a specific disease or part of the body.

**State Fair Hearing:** If your doctor or other provider asks for a Medicaid service that we won't approve, or we won't continue to pay for a Medicaid service you already have, you can ask for a State Hearing. If the State Hearing is decided in your favor, we must give you the service you asked for.

**Step therapy:** A coverage rule that requires you to try another drug before we cover the drug you ask for.

**Supplemental Security Income (SSI):** A monthly benefit Social Security pays to people with limited incomes and resources who are disabled, blind, or age 65 and over. SSI benefits aren't the same as Social Security benefits.

**Urgently needed care:** Care you get for an unforeseen illness, injury, or condition that isn't an emergency but needs care right away. You can get urgently needed care from out-of-network providers when you can't get to them because given your time, place, or circumstances, it isn't possible, or it's unreasonable to obtain services from network providers (for example when you're outside our plan's service area and you require medically needed immediate services for an unseen condition but it isn't a medical emergency).



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# Notice of Availability - Auxiliary Aids and Services Notice

English: Free language, auxiliary aid, and alternate format services are available.  
Call **1-800-777-4376 (TTY: 711)**.

العربية [Arabic]: تتوفر خدمات اللغة والمساعدة الإضافية والتنسيق البديل مجانًا. اتصل على الرقم **1-800-777-4376 (الهاتف النصي: 711)**.

Հայերեն [Armenian]: Հասանելի են անվճար լեզվական, աջակցման և այլընտրանքային ձևաչափի ծառայություններ: Չանգահարե՛ք՝ **1-800-777-4376 (TTY: 711)**:

বাংলা [Bengali]: বিনামূল্যে ভাষা, আনুষঙ্গিক সহায়তা, এবং বিকল্প বিন্যাসে পরিষেবা উপলব্ধ। ফোন করুন **1-800-777-4376 (TTY: 711)** নম্বরে।

简体中文 [Simplified Chinese]: 我们可提供免费的语言、辅助设备以及其他格式版本服务。请致电 **1-800-777-4376 (听障专线: 711)**。

繁體中文 [Traditional Chinese]: 我們可提供免費的語言、輔助設備以及其他格式版本服務。請致電 **1-800-777-4376 (聽障專線: 711)**。

Kreyòl Ayisyen [Haitian Creole]: Lang gratis, èd oksilyè, ak lòt fòm sèvis disponib. Rele **1-800-777-4376 (TTY: 711)**.

Hrvatski [Croatian]: Dostupni su besplatni jezik, dodatna pomoć i usluge alternativnog formata. Nazovite **1-800-777-4376 (TTY: 711)**.

فارسی [Farsi]: خدمات زبان رایگان، کمک های اضافی و فرمت های جایگزین در دسترس است. با **1-800-777-4376 (TTY: 711)** تماس بگیرید.

Français [French]: Des services gratuits linguistiques, d'aide auxiliaire et de mise au format sont disponibles. Appeler le **1-800-777-4376 (TTY: 711)**.

Deutsch [German]: Es stehen kostenlose unterstützende Hilfs- und Sprachdienste sowie alternative Dokumentformate zur Verfügung. Telefon: **1-800-777-4376 (TTY: 711)**.

Ελληνικά [Greek]: Διατίθενται δωρεάν γλωσσικές υπηρεσίες, βοηθήματα και υπηρεσίες σε εναλλακτικές προσβάσιμες μορφές. Καλέστε στο **1-800-777-4376 (TTY: 711)**.

ગુજરાતી [Gujarati]: નિઃશુલ્ક ભાષા, સહાયક સહાય અને વૈકલ્પિક ફોર્મેટ સેવાઓ ઉપલબ્ધ છે. **1-800-777-4376 (TTY: 711)** પર કોલ કરો.

עברית [Hebrew]: שירותים אלה זמינים בחינם: שירותי תרגום, אביזרי עזר וטקסטים בפורמטים חלופיים. נא התקשר למספר **1-800-777-4376 (TTY: 711)**.

हिन्दी [Hindi]: निःशुल्क भाषा, सहायक मदद और वैकल्पिक प्रारूप सेवाएं उपलब्ध हैं। **1-800-777-4376 (TTY: 711)** पर कॉल करें।

Hmoob [Hmong]: Muaj kev pab txhais lus, pab kom hnov suab, thiab lwm tus qauv pab cuam. Hu **1-800-777-4376 (TTY: 711)**.

Italiano [Italian]: Sono disponibili servizi gratuiti di supporto linguistico, assistenza ausiliaria e formati alternativi. Chiama il numero **1-800-777-4376 (TTY: 711)**.

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日本語 [Japanese]: 言語支援サービス、補助支援サービス、代替形式サービスを無料でご利用いただけます。**1-800-777-4376 (TTY: 711)** までお電話ください。

ភាសាខ្មែរ [Khmer]: សេវាកម្មផ្នែកភាសា ជំនួយ និង សេវាកម្មជំនួសប្រភេទផ្សេងៗដល់អ្នកមានការប្រឈមនឹងការប្រើប្រាស់។ ទូរសព្ទទៅលេខ **1-800-777-4376 (TTY: 711)**។

한국어 [Korean]: 무료 언어, 보조 지원 및 대체 형식 서비스를 이용하실 수 있습니다.  
**1-800-777-4376 (TTY: 711)**번으로 문의하십시오.

ພາສາລາວ [Lao]: ມີການບໍລິການດ້ານພາສາ, ຊ່ວຍເຫຼືອຜູ້ທີ່ມີຄວາມສິ້ນສຸດ ແລະ ຮູບແບບທາງເລືອກອື່ນ  
ໃຫ້ໃຊ້ພຣິ. ໂທ **1-800-777-4376 (TTY: 711)**.

Diné [Navajo]: Saad t'áa jiik'eh, t'áadoole'é binahjí' bee adahodooníłgíí diné bich'í' anídahazt'í'í, dóó łahgo át'éego bee hada'dilyaaígíí bee bika'aanída'awo'í dahóló. Kohjí' hodíilnih **1-800-777-4376 (TTY: 711)**.

Polski [Polish]: Dostępne są bezpłatne usługi językowe, pomocnicze i alternatywne formaty. Zadzwoń pod numer **1-800-777-4376 (TTY: 711)**.

Português [Portuguese]: Estão disponíveis serviços gratuitos de ajuda linguística auxiliar e outros formatos alternativos. Ligue **1-800-777-4376 (TTY: 711)**.

ਪੰਜਾਬੀ [Punjabi]: ਮੁਫਤ ਭਾਸ਼ਾ, ਸਹਾਇਕ ਸਹਾਇਤਾ, ਅਤੇ ਵਿਕਲਪਿਕ ਫਾਰਮੈਟ ਸੇਵਾਵਾਂ ਉਪਲਬਧ ਹਨ।  
**1-800-777-4376 (TTY: 711)** 'ਤੇ ਕਾਲ ਕਰੋ।

Русский [Russian]: Предоставляются бесплатные услуги языковой поддержки, вспомогательные средства и материалы в альтернативных форматах. Звоните по номеру **1-800-777-4376 (TTY: 711)**.

Español [Spanish]: Los servicios gratuitos de asistencia lingüística, ayuda auxiliar y servicios en otro formato están disponibles. Llame al **1-800-777-4376 (TTY: 711)**.

Tagalog [Tagalog]: Magagamit ang mga libreng serbisyong pangwika, serbisyo o device na pantulong, at kapalit na format. Tumawag sa **1-800-777-4376 (TTY: 711)**.

தமிழ் [Tamil]: இலவச மொழி, துணை உதவி மற்றும் மாற்று வடிவ சேவைகள் உள்ளன.  
**1-800-777-4376 (TTY: 711)** ஐ அழைக்கவும்.

తెలుగు [Telugu]: ఉచిత భాష, సహాయక మద్దతు, మరియు ప్రత్యామ్నాయ ఛార్జిట్ సేవలు అందుబాటులో గలవు. **1-800-777-4376 (TTY: 711)** కి కాల్ చేయండి.

(TTY: 711) 1-800-777-4376 اردو [Urdu]: مفت زبان، معاون امداد، اور متبادل فارمیٹ کی خدمات دستیاب ہیں۔ کال

Tiếng Việt [Vietnamese]: Có sẵn các dịch vụ miễn phí về ngôn ngữ, hỗ trợ bổ sung và định dạng thay thế. Hãy gọi **1-800-777-4376 (TTY: 711)**.

## Notice of Non-Discrimination

Independent Care Health Plan complies with applicable Federal civil rights laws and does not discriminate or exclude people because of their race, color, religion, gender, gender identity, sex, sexual orientation, age, disability, national origin, military status, veteran status, genetic information, ancestry, ethnicity, marital status, language, health status, or need for health services. Independent Care Health Plan:

- Provides people with disabilities reasonable modifications and free appropriate auxiliary aids and services 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 assistance services to people whose primary language is not English, which may include:
  - Qualified interpreters
  - Information written in other languages.

If you need reasonable modifications, appropriate auxiliary aids, or language assistance services contact **1-800-777-4376 (TTY: 1-800-947-3529)**. If you believe that Independent Care Health Plan has not provided these services or discriminated on the basis of race, color, religion, gender, gender identity, sex, sexual orientation, age, disability, national origin, military status, veteran status, genetic information, ancestry, ethnicity, marital status, language, health status, or need for health services, you can file a grievance in person or by mail, fax, or email with Independent Care Health Plan's Non-Discrimination Coordinator at 1555 North RiverCenter Drive, Suite 206, Milwaukee, Wisconsin 53212, **1-800-777-4376 (TTY: 1-800-947-3529)**, Fax: 1-414-918-7589, or **advocate@icarehealthplan.org**. If you need help filing a grievance, Independent Care Health Plan's Non-Discrimination Coordinator can help you.

You can also file a 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, S.W., Room 509F, HHH Building Washington, D.C. 20201. **800-368-1019, 800-537-7697 (TDD)**

## iCare Family Care Partnership Customer Care

<b>CALL</b>	<p>1-800-777-4376</p> <p>Calls to this number are free. We are available 24 hours a day, 7 days a week. Our office hours are Monday – Friday, 8:30 a.m. – 5:00 p.m.</p> <p>Customer Care also has free language interpreter services available for non-English speakers.</p>
<b>TTY</b>	<p>1-800-947-3529 or 711</p> <p>This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.</p> <p>Calls to this number are free. We are available 24 hours a day, 7 days a week. Our office hours are Monday – Friday, 8:30 a.m. – 5:00 p.m.</p>
<b>FAX</b>	<p>414-231-1092</p>
<b>WRITE</b>	<p>Independent Care Health Plan (iCare) 1555 North River Center Drive Suite 206 Milwaukee, Wisconsin 53212</p>
<b>WEBSITE</b>	<p><a href="http://www.icarehealthplan.org">www.icarehealthplan.org</a></p>



**If you have questions**, please call iCare Family Care Partnership at 1-800-777-4376 (TTY: 711), 24 hours a day, 7 days a week. The call is free. **For more information**, visit [www.icarehealthplan.org](http://www.icarehealthplan.org).



1555 North RiverCenter Drive Suite 206  
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## Important Plan Information



INDEPENDENT CARE HEALTH PLAN  
iCare is a wholly-owned subsidiary of Humana