



Who can join [Plan Name] (HMO)?

Almost anyone who meets all of the following criteria is eligible to join our plan. You must be eligible for Medicare Part A, enrolled in Medicare Part B, and Medicare Part D and enrolled in the state Medicaid/AHCCCS (Arizona Healthcare Cost Containment System). You must live in the service area where the plan is being offered ([County], Arizona) and you can not currently have End Stage Renal Disease (ESRD).

What are Medicare Parts A, B, C, and D?

- **Medicare Part A** typically pays for your inpatient hospital expenses.
- **Medicare Part B** typically covers your outpatient healthcare expenses, including doctor fees.
- **Medicare Part C** also known as Medicare Advantage (formerly Medicare+Choice) offers a choice of options including Medicare managed care plans (like Medicare HMOs and PPOs) and Medicare private fee-for-service plans.
- **Medicare Part D** is the outpatient prescription drug benefit resulting from the Medicare Modernization Act of 2003 that went into effect on January 1, 2006.

How much does [Plan Name] (HMO) cost?

If you are eligible to join, our plan has no monthly premium for medical services Medicare Part A and Part B services. Because members are eligible for benefits from Medicaid, the State is required to cover Medicare cost-sharing amounts that the member would otherwise be required to pay in most cases. These amounts may differ based on what kind of Medicaid benefits the member has. In addition, some members may be responsible for some portion of the prescription drug premium, deductible and co-pays, depending on their eligibility for extra assistance. Details on cost-sharing amounts are included in [Plan Name] (HMO) Summary of Benefits and Evidence of Coverage.

I already have Medicaid and Original Medicare. Why join [Plan Name] (HMO)?

With *[Plan Name]* (HMO), you'll get more benefits and services than you have now with Original Medicare. And, you will keep your Medicaid coverage.

Do I have to pick a primary care physician?

Yes. *[Plan Name]*(HMO) is a managed care plan. That means all your health care goes through one main doctor (a primary care physician) you pick when you join. You'll see this doctor for most medical care. If you need to go to a specialist or to the hospital, your primary care doctor must coordinate it, except for emergency care. There's a good chance your current doctor is already in our network.

Which doctors can I see?

[Plan Name] (HMO) has a network of doctors, specialists, and hospitals that meet strict standards for quality of care. You can use any doctor who is part of our network.

Do I need a referral to see a specialist?

Yes. Keep in mind that your primary care physician coordinates all of your care except for emergencies. If you need to see a specialist, your primary care physician will give you a referral.

What is a Formulary?

A formulary is a list of the drugs that we cover. We will generally cover the drugs listed in our formulary as long as the drug is medically necessary, the prescription is filled at a network pharmacy and other coverage rules are followed. The drugs on the formulary are selected by our Plan with the help of a team of health care providers. Both brand-name drugs and generic drugs are included on the formulary. We can mail you a list of our Providers, Pharmacies and Formulary.

What Pharmacies can I go to?

A network pharmacy is a pharmacy that has a contract with us to provide your covered prescription drugs. The term "covered drugs" means all of the outpatient prescription drugs that are covered by our Plan. Covered drugs are listed in our formulary. In most cases, your prescriptions are covered only if they are filled at one of our network pharmacies. You aren't required to always go to the same pharmacy to fill your prescription; you may go to any of our network pharmacies. However, if you switch to a different network pharmacy than the one you have previously used, you must either have a new prescription written by a doctor or have the previous pharmacy transfer the existing prescription to the new pharmacy if any refills remain. To find a network pharmacy in your area, please review your Pharmacy Directory. We can mail you one if you would like.

What is the Formulary Transition Process?

New members in our Plan may be taking drugs that aren't on our formulary or that are subject to certain restrictions, such as prior authorization or step therapy. Current members may also be affected by changes in our formulary from one year to the next. Members should talk to their doctors to decide if they should switch to a different drug that we cover or request a formulary exception in order to get coverage for the drug. If you would like more information on this process we can send you an Explanation of Coverage for your review.

If I don't join [Plan Name] (HMO), will Medicaid still pay for my prescriptions?

No. As of January 1, 2006, Medicaid stopped paying for prescription drugs for people who have both Medicare and Medicaid. Now, Medicare pays for prescription drugs, but only if you are in a Medicare-approved plan like [Plan Name] (HMO).

The government picked my drug plan for me. Can I switch Plans?

Yes. Even if the government sent you a letter and told you what drug plan you are in, you don't have to stay in it. You can switch to [Plan Name] (HMO) and get coverage plus many more health benefits than you have now - for \$0 per month. All you need to do is send in a completed enrollment form. We will do the rest.

What programs does [Plan Name] (HMO) offer to help keep me healthy?

We believe it's important for members to take an active role in their health care. We offer a full range of programs to help members live healthy and stay healthy!

Do I have to send in my bills or claim forms?

No. In most cases, you'll just show your [Plan Name] (HMO) ID card and your Medicaid card. We will take care of the rest.

What is a low-income subsidy for prescription drug coverage?

Medicare prescription drug coverage and Medicare Advantage plans with prescription drug coverage are available to everyone with Medicare, regardless of your income and resources, health status or current prescription expenses. There is "extra help" (also called a "low-income subsidy") available to assist Medicare enrollees who have limited income and resources to pay for prescription drug coverage.

If you qualify for this, you can receive financial help paying your prescription drug premium and co-pays. The amount of extra help will be based on your income and resources. You can apply or get more information about this program by calling Social Security at 1-800-772-1213 (TTY 1-800-325-0778) 7 a.m. to 7 p.m., Monday through Friday. This information is also available by visiting www.socialsecurity.gov

Do I qualify for low-income subsidy?

If you have limited income and resources, you may qualify for a low-income subsidy. When you join [*Plan Name*] (HMO), Medicare will tell us how much extra help you are getting. Then, we will let you know the amount you will pay. If you qualify, your drug costs will also be lower.

You can see if you qualify for a low-income subsidy by calling:

- 1-800-MEDICARE (1-800-633-4227) (TTY/TDD: 1-877-486-2048), open 24 hours a day 7 days a week
- STATE MEDICAID OFFICE 1-800-654-8713 (TTY/TDD: 1-602-417-4191) hours of operation are 8:00 am to 8:00pm, Monday through Friday.
- The Social Security Administration at 1-800-772-1213 (TTY/TDD: 1-800-325-0778), hours of operation are 7 a.m. to 7 p.m., Monday through Friday.

What is my current TrOOP status?

As a member of [*Plan Name*] (HMO) we can help you with your True-Out-Of Pocket costs. Our member services department or one of our Licensed Representatives can help you with this question and your status, may I have one of them call you or may I transfer you to a Representative right now?

How can I get more information/forms?

For *Maricopa Care Advantage* (HMO) you can call us toll-free at 1-877-874-3938

For *University Physicians Care Advantage* (HMO) you can call us toll-free at 1-877-874-3938 or at (520) 874-3938 locally.

(TTY/TDD) users please call: 1-800-367-8939

Hours of Operation:

8:00 am to 8:00 pm 7 days a week from November 1st through March 1st and from 8:00 am to 5:00 pm Monday through Friday outside of November 1st through March 1st (excluding holidays).

You can also request a home visit or attend one of our seminars at a location near you.

I am already a Member of [*Plan Name*] (HMO), how do I get an ID card?

ID cards are mailed on a weekly basis by (Plan Name) (HMO) if you have not received yours I would be happy to take your name, address and ID number and have one mailed to you.

What if I enroll in *[Plan Name]* (HMO) and find that the plan is not right for me?

If you find that *[Plan Name]* (HMO) is not best suited for your needs and you would like to discontinue your membership, you have the option to enroll in another plan or return to traditional Medicare at any time. You may have additional rights depending on your previous coverage.

What is covered by *[Plan Name]* (HMO)?

As a member of *[Plan Name]* (HMO), you will receive all of the services that are covered by Medicare in one health plan. These include the following:

- Physician services (primary care and specialists)
- Preventive services, including but not limited to:
 - Colorectal screening exams
 - Mammograms
 - Pap smears and pelvic exams
 - Prostate cancer screenings
 - 24 hour nurse hotline
 - Hospital inpatient services
 - Inpatient and outpatient surgery
 - Emergency services
 - Prescription drug coverage
 - Home health care
 - Post-acute skilled nursing facility services
 - Rehabilitation services - physical therapy, occupational therapy, and speech therapy
 - Diagnostic tests, radiology and lab services
 - Durable medical equipment
 - Podiatry services
 - Prosthetic devices

In addition, *[Plan Name]* (HMO) offers additional benefits to assist you in meeting your needs. These include:

- Dental Care (with \$0 co-pay)
 - 1 oral exam(s) and cleaning every six (6) months
 - 1 fluoride treatment(s) and dental x-ray every year
- Vision Services
 - 1 routine eye exam(s) every year
 - \$150 for glasses or contact lenses every two (2) years
- Hearing Services
 - 1 routine hearing test(s) and hearing aid fitting-evaluation every year
 - \$1600 limit for routine hearing aids every three years (limited to \$800 per ear)

What is your service area?

[Plan Name] (HMO) is available to residents of *[County, Arizona]*.

What if my provider is not in your network?

[Plan Name] (HMO) has a network of providers who have met strict standards for quality care. We can help you to choose a provider depending on your medical needs. You can choose from any of the providers in our Provider Directory. If you do not have a Provider Directory, please contact 1-877-874-3938 8:00 am to 8:00 pm 7 days a week from November 1st through March 1st and from 8:00 am to 5:00 pm Monday through Friday outside of November 1st through March 1st (excluding holidays) or visit our website.

(TTY/TDD) users please call: 1-800-367-8939

Can I see providers who are not in *[Plan Name]* (HMO) network?

Members may use out of network providers under certain circumstances, such as for emergency care or urgent care when traveling outside of the service area. For more information on out of network coverage, please see the Evidence of Coverage. We can mail you one if you would like.

How can I be sure that my information will be kept confidential?

[Plan Name] (HMO) is very concerned about the privacy and security of member's confidential information. Our systems and processes are fully compliant with the government's required standards and we will not release any of your health information without your written authorization. If you would like a copy of our privacy policy, please contact 1-877-874-3938 8:00 am to 8:00 pm 7 days a week from November 1st through March 1st and from 8:00 am to 5:00 pm Monday through Friday outside of November 1st through March 1st (excluding holidays).

(TTY/TDD) users please call: 1-800-367-8939

How can I file and appeal or grievance?

What is an appeal or grievance?

An "appeal" is the type of complaint you make when you want us to reconsider and change a decision we have made about what services or benefits are covered for you or what we will pay for a service or benefit. For example, you can file an appeal if:

- *[Plan Name]* (HMO) refuses to cover or pay for services you think we should cover

- *[Plan Name]* (HMO) or one of our plan providers refuses to give you a service you think should be covered
- *[Plan Name]* (HMO) or one of our plan providers reduces or cuts back on services or benefits you have been receiving
- You think we are stopping your coverage of a service or benefit too soon

There are different time frames and terms that *[Plan Name]* (HMO) uses when we receive an appeal, depending on whether the appeal concerns your prescription drug coverage or your other Medicare services. Please see below for specific information about how your appeal will be handled.

What is a grievance?

A “grievance” is a complaint about any other type of problem with *[Plan Name]* (HMO) or one of our plan providers. For example, you could file a grievance if you have a problem with:

- The quality of the care you receive from one of our plan providers
- Waiting times for appointments or in the waiting room
- The way your doctors or others behave
- Being able to reach someone by phone or get the information you need
- The cleanliness or condition of the doctor's office.

Members of *[Plan Name]* (HMO) have the right to file a grievance or complaint with us about our plan, our network pharmacies or participating providers.

What does PA stand for on the formulary?

This medication will need to be Prior Authorized before it is paid for by UPCA/MCA. The primary care physician must submit a request for these medications, with notes indicating why this particular medication is needed for treatment. There are NO guarantees it will be provided; all requests will be reviewed by our Medical Management team.

Do I need to obtain authorization for medical services?

You will need to obtain authorization from *[Plan Name]* (HMO) before you are admitted to a hospital if it is not an emergency. You may also need authorization for certain procedures. You or your doctor can request authorization by calling 1-877-874-3930 (*University Physicians Care Advantage*) (HMO) or 1-877-874-3935 (*Maricopa Care Advantage*) (HMO) 8:00 am to 8:00 pm 7 days a week from November 1st through March 1st and from 8:00 am to 5:00 pm Monday through Friday outside of November 1st through March 1st (excluding holidays). (TTY/TDD) users please call: 1-800-367-8939

You can ask for a “standard” decision or a “fast” decision regarding coverage for medical services. Standard decisions are made within the standard time frame (typically within 14 days). “Expedited” or fast decisions are made more quickly (typically within 72 hours).

You can ask for a fast decision if you or any doctor believe that waiting for a standard decision could seriously harm your health or your ability to function. (Fast decisions apply only to requests for medical care. You cannot get a fast decision on requests for payment for care you have already received.)

Members may also request an appeal for any coverage determination made by *[Plan Name]* (HMO). When *[Plan Name]* (HMO) makes a coverage determination, we are deciding whether to provide or pay for covered medical services or prescription drugs and what your share of the cost will be. Members have the right to file an appeal if they would like *[Plan Name]*(HMO) to reconsider and change a decision made concerning medical services, prescription drug benefits, or the share of the costs that the member is responsible for paying.

What is the difference between a standard and a "fast" or "expedited" coverage determination for Part D Prescription Drug Coverage?

A decision about whether we will cover a Part D prescription drug can be a “standard” coverage determination that is made within the standard timeframe (typically within 72 hours), or it can be an “expedited” or “fast” coverage determination that is made more quickly (typically within 24 hours). A fast decision is sometimes called a “24-hour”.

You can ask for a fast decision if you or your doctor believe that waiting for a standard decision could seriously harm your health or your ability to function. (Fast decisions apply only to requests for Part D drugs that you have not received yet. You cannot get a fast decision if you are requesting payment for a Part D drug that you already received.)

What is an exception for prescription drug coverage?

An exception request is a type of coverage determination that applies to your Medicare prescription drug coverage. There are several types of exceptions you can request:

- You can ask us to cover your drug even if it is not on our formulary.
- You can ask us to waive coverage restrictions or limits on your drug. For example, for certain drugs, we limit the amount of the drug that we will cover. If your drug has a quantity limit, you can ask us to waive the limit and cover more.
- You can ask us to provide a higher level of coverage for your drug. For example, if your drug is usually considered a brand-name drug, you can ask us to cover it as a generic drug instead. This would lower the co-insurance amount you must pay for your drug. Please note, if we grant your request to cover a drug that is not on our formulary, you may not ask us to provide a higher level of coverage for the drug.

Generally, we will only approve your request for an exception if the alternative drugs included on the plan's formulary or the low-tiered drug would not be as effective in treating your condition and/or would cause you to have adverse medical effects.

How Do I File a Grievance or Appeal?

To file a grievance or request an appeal, please:

- Call 1-877-874-3930 (*University Physicians Care Advantage*) (HMO) or 1-877-874-3935 (*Maricopa Care Advantage*) (HMO). 1-800-367-8939. TTY users should call 1-800-367-8939 8:00 am to 8:00 pm 7 days a week from November 1st through March 1st and from 8:00 am to 5:00 pm Monday through Friday outside of November 1st through March 1st (excluding holidays). (TTY/TDD) users please call: 1-800-367-8939
- Send a fax to 520-874-3462 (Tucson Local), or 1-866-465-8340 (Toll-free)
- Send a letter to: 2701 E. Elvira, Tucson AZ 85756

Representatives are available Monday through Friday, 8:00 am to 5:00 pm.

Can I be in more than one Medicare Advantage plan at the same time?

No. You are only able to join, and get coverage under, one Medicare Advantage or Medicare prescription drug plan at a time.

Do I have to join the same Medicare Advantage Plan as my spouse?

No, you do not.

What do I do if I have a medical emergency?

Get medical help as quickly as possible. Call 911 for help or go to the nearest emergency room. You do not need to get permission first from [*Plan Name*] (HMO), your Primary Care Provider or other plan provider. Make sure your Primary Care Provider knows about your emergency, because he or she will need to be involved in following up on your emergency care. You or someone else should call to tell your Primary Care Provider about your emergency care as soon as possible, preferably within 48 hours.

If I travel to Mexico, will I be able to get medication filled there?

No, you cannot fill medications in other countries

I have asthma, and some insurance companies have determined this to be a pre-existing condition, will you exclude me from joining your plan because of this?

There are no pre-existence policies for enrolling into our SNP plans.

Does your health plan cover generic drugs in the coverage gap?

Our plan is a special needs plan, and members must have Medicaid/Medicare to join, generic medications are covered if they are on our formulary, I'd be happy to look up any medications you may have and / or mail you one of our drug formularies.

Can I have my Medicare premiums taken out of my social security check each month?

A Member may have their Medicare premium taken out of their social security check.

If a provider is no longer going to be contracted with your plan how long before you will notify me?

We will notify you within 30 days of the change.

Will diabetic supplies be covered under Part D of this plan?

Diabetic supplies will be covered under Part B of this Medicare advantage plan.

I don't use the Internet, how else can I find out about providers in this area.

You may call us to look up a provider, or we would be happy to mail out a provider book for you to look through.

If I use the insurance for an emergency transportation what will my co-pay be?

Our plan is a special needs plan which requires the member to have Both Medicaid, and full Medicare benefits in order to join. In this scenario Medicaid would pay 20% and Medicare would pay 80%, therefore leaving the member with a Zero co pay

I went to the doctor the other day and the doctor thinks it would be good to get a vaccine for Shingles (Zostavax), would it be covered?

Yes, this vaccine would be covered with ZERO co-pay.

I travel in an RV all over the country, would I be able to fill my medications in other states?

Yes, you can get your medications filled in other states. We recommend using a national chain like Walgreen's/CVS in order to facilitate this.

How often can I change my Medicare Advantage Plan?

A dual eligible member having both Medicare / Medicaid benefits enrolled in a Special Needs Plan may change plans up to once a month, at the first of each month. Enrollment will be effective the 1st day of the following month.

If I am on your SNP Plan and lose my Medicaid benefits, how long would I remain enrolled on your plan?

You would remain enrolled for 90 days.

If I go to Target and find that one of my medications is less expensive without having to use my SNP, can I pay for my medications WITHOUT using my insurance?

Yes, you can opt to NOT use your SNP benefits if you find a less expensive option.

How do I get more information about...?

General information or enrollment 1-877-874-3938 (Toll-free) or 520-874-3938 (Tucson Local)

(TTY/TDD) users please call: 1-800-367-8939

Current members with questions ***University Physicians Care Advantage*** (HMO) 1-877-874-3930 or 520-874-3930 (Tucson Local)
Maricopa Care Advantage (HMO) 1-877-874-3935

(TTY/TDD) users please call: 1-800-367-8939

TTY/TDD callers with questions 1-800-367-8939 for both plans

Network providers ***University Physicians Care Advantage*** (HMO) 1-877-874-3930 or 520-874-3930 (Tucson

Local)

Maricopa Care Advantage

(HMO) 1-877-874-3935

(TTY/TDD) users please call: 1-800-367-8939

Network pharmacies

University Physicians Care

Advantage (HMO) 1-877-874-

3930 or 520-874-3930 (Tucson

Local)

Maricopa Care Advantage

(HMO)1-877-874-3935

(TTY/TDD) users please call: 1-800-367-8939

Claims and claims inquiries

1-800-582-8686

Appeals and grievances

520-874-3462 (Tucson local)

1-866-465-8340 (Toll-free)

(TTY/TDD) users please call: 1-

800-367-8939

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