Medicare
ADVANTAGE PLAN

Certification and Training

July 2024

Certification Training Disclosure

- This training presentation is intended for use by licensed agents to understand the basics of Medicare Advantage Prescription Drug (MAPD) plans offered by UCLA Health Medicare Advantage Plans.
- When making presentations, agents must rely upon the plan's Summary of Benefits, formulary, pharmacy and provider directories, and other plan documentation to address the specific needs of each prospective member.
- Information contained in this document regarding 2025 plan service areas, benefits, costs, etc. is confidential until general release to the public on October 1, 2024. Distribution to consumers, other insurers, or any other person or company is strictly prohibited. Failure to comply with this requirement will result in the loss of appointment with UCLA HEALTH Medicare Advantage Plans and may result in a civil monetary judgement.
- Agent shall promptly notify Carrier and Berwick, in writing, of any employee, contractor or subcontractor who, after the Effective Date of this Agreement, is convicted of a criminal felony involving dishonesty or breach of trust or violation of the VCCLEA. (Also included in Section 5.3 of the Producer Agreement)

Training Content

- Part 1: UCLA Health Medicare Advantage Plan Background
- Part 2: CMS – Required Agent Training
  - Medicare basics
  - Communication and Marketing requirements
  - Eligibility/Enrollment/Disenrollment
- Part 3: UCLA Health Medicare Advantage HMO Plans
  - Enrollment
  - 2025 Plan Overview
  - Broker Tools and resources
- Part 4: Certification Test

UCLA Health | Medicare ADVANTAGE PLAN

Part 1: UCLA Health Medicare Advantage Plan Background

Background

- UCLA Health provides care at **4 hospitals** and more than **280 locations** throughout Southern California and is ranked as one of America's top hospitals by U.S. News and World Reports. Their mission is to deliver leading-edge patient care, research, education and community engagement. UCLA Health has a strong background in clinical and business capabilities with over 30 years of experience in delegated capitation management, extensive experience in managing complex care, risk-based contracts and population health infrastructure.
- Guided by its mission and dedication to provide unparalleled quality care and quality service to all members of its community, The Regents of the University of California newly formed a California corporation to provide a Medicare Advantage and Part D prescription drug benefit plan (MAPD).
- **UCLA Health Medicare Advantage Plan** will offer **two HMO benefit plans** for Medicare enrollees in the **Los Angeles County service area effective January 1, 2025**.

Doctor-Designed Plans for Patient-Centered Care and Healthy Outcomes

- **Our two plans offer comprehensive coverage in one affordable package**. Low monthly premiums, prescription drug coverage, and dental, vision, and hearing benefits. Plus, a smart benefit card to help keep out-of-pocket costs low.

- **A 7,000+ strong provider network** with high-quality care from local providers and access to a broader network with UCLA Health's world-class care and innovative research.

- **Our exclusive Care Concierge offers personalized support** to help find the right doctor, navigate benefits, coordinate care, and more.

- **Extra benefits to keep members healthy and active.** Transportation to doctor visits, fitness memberships, nutrition education, meal planning, and more.

UCLA Health | Medicare ADVANTAGE PLAN

Part 2:
CMS-Required Agent Training

Medicare Basics

- Medicare Basics for 2025 is covered by taking and passing the 2025 AHIP Course. Your 2025 AHIP Course Certificate of Completion (and a copy of E&O insurance) must be submitted to UCLA Health Medicare Advantage by emailing to **UCLAcontracting@berwickinsurance.com** and certification must be successfully completed to move forward in the contracting process.

- Due to their importance, a review of Election Periods, Part D Late Enrollment Penalties, Star Ratings, and Scope of Appointment is contained in the next slides.

Medicare Advantage Election Periods

- An Election Period is a defined time when Medicare beneficiaries may enroll or make changes to their plan.

IEP/ICEP – Initial Enrollment Period / Initial Coverage Election Period

SEP – Special Election Period

AEP – Annual Enrollment Period

MA OEP – MA Open Enrollment Period

Initial Enrollment Period / Initial Coverage Election Period (IEP/ICEP)

- IEP is the first chance to enroll in Original Medicare (usually the 7-month window surrounding their 65th birthday).
- ICEP is for someone who is newly eligible for Medicare. Eligibility begins three months immediately before the beneficiary's first enrollment to both Medicare Part A and Part B and ends on the later of:
- The last day of the individual's Part B initial enrollment period, or;
- The last day of the month preceding entitlement to both Part A and Part B.
- Once the IEP/ICEP enrollment request has been made and the enrollment takes effect, the IEP/ICEP election has been used and there is only 1 IEP/ICEP election allowance. However, if a person enrolled in Medicare Part B under age 65, they would have a second IEP called IEP2. The consumer would then have three months prior to, the month of, and three months after their 65th birthday to enroll using IEP2 for either an MAPD or a PDP.

IEP/ICEP Examples

Example #1 – Mr. Seaver's 65th birthday is June 26, 2024. He is eligible for Part A and Part B beginning June 1, 2024 and has decided to enroll in Part B beginning on June 1, 2024. His IEP begins on March 1, 2024 and ends on September 30, 2024.

Example #2 – Mrs. Koosman's 65th birthday was April 22, 2023. She was eligible for Medicare Part A and Part B beginning April 1, 2023. Since she was still working and had health insurance provided by her employer, she decided not to enroll in Part B during her initial enrollment period for Part B. Now she has decided to retire and can enroll in Part B through a Part B Special Election Period. Her Employer Group Health Plan is ending May 31, 2024. She enrolled in Part B effective June 1, 2024. Her ICEP is March 1, 2024 through May 31, 2024.

Special Election Period (SEP)

- A Special Election Period (SEP) is a set time, outside of other election periods (such as ICEP or AEP), when a beneficiary can enroll or change his/her current plan enrollment.
- During an SEP, a beneficiary may discontinue enrollment in a Medicare Advantage (MA) plan, change to a different MA plan, or change to Original Medicare coverage.
- Once a beneficiary has elected the new MA plan, the SEP ends for that person (even if the time frame for the SEP is still in effect).

***Disaster SEP's can only be used if the beneficiary missed a valid enrollment period that was missed due to the specific disaster. In addition, an SEP for Disaster must never be marketed.

SEP Example

- Mr. Kershaw, a current Medicare Advantage plan member, currently lives in Nevada and plans to move to California on May 12. A Special Election Period is available for Mr. Kershaw starting April 1 and lasts through July 31.
- He can choose a plan effective date of up to three months after the application date for his new California MA plan.
- An application receipt date in the month of April or the month of May can result in a possible effective date of June 1, July 1, or August 1.
- An application receipt date in the month of June can result in a possible effective date of July 1, August 1, or September 1.

Dual/LIS Special Election Period

- Beginning on January 1, 2025, the current quarterly special enrollment period (SEP) will be replaced with a monthly SEP for dually eligible individuals to ONLY go back to Original Medicare and a Stand-alone PDP, and a new monthly "Integrated Care SEP" will be available to facilitate "aligned enrollment" for full-benefit dually eligible individuals.

Annual Enrollment Period (AEP)

- During the Annual Enrollment Period (AEP), Medicare beneficiaries can make a change to, enroll in, or disenroll from an MA plan or a Part D Plan.
- If a beneficiary chooses to keep their current plan during the AEP, a new card for the coming year will be sent to them.
- Beneficiaries should always review their Annual Notice of Change (ANOC) every September to check for changes to their plan for the coming year and compare their plan to others during the AEP.
- AEP occurs from October 15 – December 7 each year.
- Changes made during the AEP will take effect January 1.

MA Open Enrollment Period (MA OEP)

- The MA Open Enrollment Period (MA OEP) runs from January 1 through March 31 each year. During this time, beneficiaries who are enrolled in an MA plan as of January 1 can use the MA OEP to make a one-time change to:
- A different MA or MAPD plan
- Go back to Original Medicare (Parts A and B) and a Stand-alone Part D Plan
- Note that if a person is enrolled in a Stand-alone Part D Plan and/or Original Medicare as of January 1, they cannot use the MA OEP to make a change.

Part D Late Enrollment Penalty

The Part D Late Enrollment Penalty (LEP) is an amount added to the MAPD or PDP plan premium for a beneficiary who did not have creditable prescription drug coverage (prescription drug coverage that is expected to pay at least as much as Medicare's standard prescription drug coverage) when they were first eligible for Part D or who had a break in creditable prescription drug coverage of at least 63 consecutive days.

Star Ratings

- The Medicare Part C & D Star Ratings program rates the quality and performance of MA and PDP plans.
- Plans are ranked each year on a scale of 1 to 5 Stars (1 is the lowest and 5 is the highest).
- Ratings are comprised of measures that cover Part C and Part D.
- If a 5-Star plan is available, a beneficiary can enroll in it using an SEP for a 5-Star plan from December 8 through November 30 of the following year in which the plan received the 5-Star overall rating.
- Every year, Medicare evaluates plans based on a 5-star rating system. Star ratings may vary by contract or market. For plan year 2025, UCLA Health Medicare Advantage Plan’s HMO plans are too new to be measured for a Star rating.

Scope of Appointment

- The Scope of Appointment (SOA) guidelines were established to ensure that Medicare Advantage and Part D Plan sponsors or agents do not market any health care related product outside the scope agreed upon by the beneficiary prior to a personal marketing appointment (whether face-to-face or telephonic).
- The documentation must be in writing, in the form of a signed and dated agreement by the beneficiary, or a recorded oral agreement.
- You must use the most current SOA form provided by the plan associated with the enrollment OR another SOA form that includes all CMS-required elements.
- At least 48 hours must pass between completing the SOA and conducting the personal marketing appointment. Exceptions to this 48-hour rule include:
  - If the SOA is completed during the last 4 days of a valid election period that is applicable to the beneficiary.
  - If the beneficiary was an unscheduled in-person “walk-in”. Beneficiaries who walk into an agent’s office, a kiosk, a plan’s office, or any other walk-in will NOT be subject to the 48-hour rule.
  - Unscheduled Inbound phone calls to agents are exempt from the 48-hour rule.

CMS Required List of Items to Cover during a Sales Presentation

Review Beneficiary-Specific Information

- Do a thorough Needs Analysis and ask the following questions:
- What kind of health plan does the beneficiary wish to enroll in (such as low premium and higher co-pay, or vice versa)?
- Are the beneficiary's current providers (primary care and specialists) in-network?
- Is the beneficiary's current pharmacy in-network? If not, explain that they will need to choose a new pharmacy.
- Are the beneficiary's prescriptions in the formulary? If not, explain that they may have to pay the full price of the prescription.
- Does the beneficiary require hearing, dental, and/or vision coverage?
- Does the beneficiary have any other healthcare needs, such as durable medical equipment or physical therapy?
- Is the beneficiary's preferred hospital in-network? If not, explain that they will need to pick a new one.
- Are there other preferred facilities that need to be in-network?
- Does the beneficiary have any other specific healthcare needs?

Other Items to Review or Explain

- Review premiums, including the Part B premium. If applicable, review premium for their current plan vs. another plan premium.
- Review beneficiary cost-sharing such as deductibles, copays, and coinsurances. Go over deductible costs, PCP copay, Specialist copay, inpatient hospital copay, and any other copays for services/items the beneficiary needs.
- Discuss the cost/limitations on dental, vision, and hearing.
- Review coverage for out-of-network providers and services (for example, except in emergency or urgent situations, plan does not cover services by out-of-network providers). These are doctors who are not listed in the provider directory.
- Review coverage outside of the United States.
- Explain the potential effect that enrolling in this plan will have on other current coverage, which may in some cases mean that the beneficiary is disenrolled from their current health coverage (such as another MA plan). Explain that this is not a hearing/dental/vision "rider" but a full plan.
- Explain that the plan operates on a calendar year basis, so benefits may change on January 1 of the following year.
- Explain that the Evidence of Coverage provides all of the costs, benefits, and rules for the plan.
- Review how to file a complaint.
- Inform the beneficiary of their right to cancel this enrollment as well as the specific date by which cancellation may occur.

Enrollment and Disenrollment

Pre-Enrollment Checklist (PECL)

- For telephonic enrollments, agents must review the contents of the PECL with the prospective enrollee prior to the completion of the enrollment.
- This checklist helps the beneficiary in their full understanding of plan benefits and rules prior to enrollment.

Completing an Application - 1

Before an enrollment application is signed, an agent should review the plan information to ensure the prospect is making an informed decision. The agent should:

- Verify the beneficiary is eligible to enroll and has a qualifying election period
- Review and confirm the beneficiary’s existing coverage and how it will be impacted by the plan they are choosing
- Verify the application is signed and dated
- Inform the beneficiary they will receive an Outbound Enrollment Verification (OEV) letter

Completing an Application - 2

- The agent must submit the application within 24 hours of receipt either online, or through electronic enrollment. Paper applications should be submitted electronically and the paper application with signature should be held securely for the 10+ years that CMS requires.
- The “application date” is the date the agent receives the enrollment request.
- If a beneficiary asks you to hold an application, you must explain that you can either submit the application or cancel the application following established procedures.

Common Application Errors - 1

Missing or incorrect information may delay processing of the enrollment and the effective date. Examples include:

- Missing signature and/or date
- Missing or invalid Medicare Beneficiary Identification (MBI) number
- Selection of an invalid or incorrect election or enrollment period
  - This may also impact the effective date allowed for the beneficiary
  - Agents should only select ONE valid election period

Common Application Errors - 2

Make sure that the applicant's permanent address is in the service area of the plan. An application for a beneficiary who does not live in the plan's service area will be denied.

Review required personal data with the applicant to ensure accuracy:

- Full name as it appears on the Medicare card
- Date of Birth
- Gender
- Phone number (if no phone, use 999-999-9999)
- Valid email address (optional)
- Address (a P.O. Box may be used as a MAILING address but NOT as a PERMANENT address)
- If the person is homeless, you may use a shelter address or ask the beneficiary where they receive mail (NEVER use your own address).

CMS Rules About Taking Applications

The following rules from CMS must be followed about marketing a plan and submitting enrollment applications:

- **Marketing Plans:** You can start to market plans and talk about plan information for 2025 on October 1, 2024.
- **Taking and Submitting applications:** 2025 Plan enrollment applications cannot be accepted, or taken possession of, until October 15, 2024. Agent-assisted applications dated as received prior to October 15 will be rejected and denied.

The submission of a 2025 enrollment application prior to October 15, 2024 will result in a compliance infraction.

Effective Dates and Enrollment Reminders

Effective Dates

Outside of some Special Enrollment Periods and other circumstances, a beneficiary cannot request an enrollment effective date. The plan will use the selected election period to determine the effective date.

- With the exception of AEP and IEP, most applications received in the current month will be effective the first of the following month.

Enrollment Reminders

Remind the applicant:

- Generally, they can only be enrolled into one MA, MAPD, or PDP at a time
- Enrollment into a different MA, MAPD, or PDP will cause automatic disenrollment from their existing MA, MAPD, or PDP
- Enrollment into a Medicare Supplement (Medigap) plan will NOT cause an automatic disenrollment from a MA or MAPD plan and Vice versa
  - In this scenario, once enrollment into the new plan is confirmed, the old plan should be sent a request to disenroll

Enrollment Process

- An Outbound Verification Letter is sent by the plan to the applicant to verify understanding of their intent to enroll into the plan that was selected
- The applicant's plan will be effective the first day of the following month (or January 1 for AEP election, or the 1st of the 65th Birthday month if applied for in the 3 months prior to Birthday month for IEP) after the application is received by the plan (pending CMS approval)
- A health plan identification card (ID) card and Evidence of Coverage are issued approximately 14 days after the application has been received by the plan

Note that ID cards may take longer than 14 days to arrive during AEP. If the new enrollee has not received their ID card and needs to access benefits, they can use the plan acknowledgement letter.

Incomplete Applications

If the enrollment application is incomplete, the beneficiary will be notified that additional information is required before the plan can process the request.

Here are the guidelines for when missing information must be received by the plan:

- Missing information on a non-AEP submission – Missing info must be received by the plan within 21 calendar days or the last day of the month prior to the member's effective date, whichever is later.
- Missing information on AEP submission – Missing info must be received by the plan within 21 calendar days or December 7, whichever is later.
- Election period is the only missing information – Missing election period must be obtained within 7 calendar days of receipt of application, or it must be denied.

Disenrollment vs. Cancellation

A DISENROLLMENT applies if the coverage ends after a member's effective date. Disenrollment can be voluntary or involuntary.

- Voluntary disenrollments are initiated by the member and can generally only occur during specific periods such as AEP or MA OEP.
- Eligible members can disenroll voluntarily by submitting a written request to the plan. Disenrollment requests cannot be taken verbally.

A CANCELLATION applies if a request is received prior to a member's effective date or by the date in their OEV letter.

- Cancellation requests are initiated by the member and can be received either verbally or in writing.
- OEV letters will also advise the last day a member may cancel their plan; applications received by the end of the month do get 7 days to be cancelled after they are processed allowing for some cancellations to be accepted after the first of the month.

Involuntary Disenrollment

Involuntary disenrollment may automatically occur for the following reasons:

- Incarceration
- Moving out of a plan service area
- Loss of entitlement to either Medicare Part A or Part B
- Loss of Special Needs status
- Death

Grievances and Appeals

The Grievances and Appeals process has been established so members have a way to contact us regarding dissatisfaction with their plan or benefit determinations.

A complete explanation of the process for filing Grievances or Appeals can be found in the member's Evidence of Coverage.

<u>Grievances</u>

A member may express dissatisfaction with any aspect of the operations, activities, or behavior of a plan sponsor.

- The member may call or submit a grievance in writing to the plan.
- The member will receive notification of the outcome in writing.

<u>Appeals</u>

An appeal is a complaint or notification of a problem regarding decisions about the member's medical bills, health care, or denial of coverage.

- The member must request the appeal in writing within 60 calendar days of the denial.
- The plan must process Part D appeals no later than 7 calendar days of receipt.

UCLA Health | Medicare ADVANTAGE PLAN

Part 3: UCLA Health Medicare Advantage Plan - Principal and Prestige HMO Plans

Plan Network

Our network includes over 7,000 providers which includes UCLA Medical Group and 5+ best-in-class community medical group/IPAs. Our goal is for members to see their primary care physician in their community with access to UCLA Health's world-class providers and innovative research, if needed

- Our network is made up of best-in-class community providers bolstered by UCLA Health's providers
- Members are able to sign up with any of the primary care providers in our network and have the option to tap into UCLA Health's network of providers as needed. In fact, we encourage members to seek care with physicians in their community for convenience and someone that best understands their specific needs

Access Senior Healthcare: Access Medical IPA Healthly Medical Group
Advanced Medical Doctors of CA (AMDC)
Advantage Care IPA
Stewart Medical Group
UCLA Medical Group

Additional medical groups may be added at any time

Enrollment/Info Kit

PDF versions will be available for download
Agents can pre-order enrollment kits
Beneficiaries can order individual enrollment kits at no cost at UCLAHealthMedicareAdvantage.org

Included in the enrollment kit:

- Intro letter
- Scope of Appointment form
- Plan benefit highlights
- Pre-Enrollment Checklist
- Summary of Benefits
- Enrollment guide on How to Enroll
- Top 10 FAQ
- Enrollment Form and Business Reply Envelope (BRE)
- What happens next after enrollment
- MLI – Multi Language Insert
- Non-discrimination notice

Enrollment options

1. Beneficiary and Agent completes application Face-to-Face online using MedicareCENTER
2. Beneficiary and Agent completes application using Text or Email through MedicareCENTER.
3. Beneficiary completes paper application with SIGNATURE and agent enters information into MedicareCENTER within 24 hours. Agent must keep a copy of signed paper application for 10 years.

- **Must capture beneficiary's acknowledgement and consent to required key elements**
- **All marketing, sales and enrollment calls must be recorded in their entirety.**
- **Items on the Pre-Enrollment Checklist must be reviewed with beneficiary before completing the enrollment request**

What to expect after enrollment

- Welcome kit (contents on next slide)
- OEV Call & Letter
- Enrollment confirmation letter
- Smart Benefits Card with OTC catalog
- LIS Notice (if applicable) once they are eligible for Extra Help and receive the low-income subsidy

Welcome Kit Content

- Member care guide with welcome letter
- Next steps
- Summary of Benefits
- Evidence of Coverage
- ID Card
- Provider and pharmacy directory
- Formulary list
- Supplemental vendor one-pagers
- MLI – Multi Language Insert
- Non-discrimination notice

2025 Plan Benefits

	UHMAP Principal HMO Plan	UHMAP Prestige HMO Plan
Monthly Premium	$0	$39
Deductible	$0	$0
Annual Out of Pocket Max	$2,499	$1,499
Care Concierge	-	✓

Dental, Vision & Hearing

		UHMAP Principal HMO Plan	UHMAP Prestige HMO Plan
Delta Dental	Preventative Dental	Covered, cleaning/xray no copay	Covered, cleaning/xray no copay
	Prev Dental Limit (Annual)	1-2 visits	1-2 visits
	Comprehensive Dental	Covered, services available with copay	Covered, services available with copay
	Comprehensive Dental Limit (Annual)		Limit will not vary
EyeMed	Vision (Exam Covered)	✓	✓
	Vision Hardware Limit including Frames, Lenses or Contacts (Annual)	$150	$250
TruHearing	Hearing (Exam Covered)	✓	✓
	Hearing Aids - All Types	✓	✓

Copays

	UHMAP Principal HMO Plan	UHMAP Prestige HMO Plan
Primary Care	$0	$0
Specialty Care	$0	$0
Mental health (individual)	$15	$15
Emergency Room	$140 (waived if admitted)	$75 (waived if admitted)
Urgent Care	$15	$15
Inpatient Hospital	$200/Stay	$0/Stay

Additional benefits

Partner	Description	UHMAP Principal HMO Plan	UHMAP Prestige HMO Plan
WholeLife	Chiropractic Care	12 visits annually	12 visits annually
WholeLife	Acupuncture Care	12 visits annually	12 visits annually
Soda Health	&more Smart Benefits Card	Dental/Vision/Hearing $300/year allowance	Dental/Vision/Hearing $600/year allowance
Soda Health	&more Smart Benefits Card	$200/year allowance	$400/year allowance
Uber Health	Transportation to doctor appointments	12 rides/year allowance	24 rides/year allowance
Connect America	PERS device and 24/7 monitoring	✓	✓
Jukebox Health	Home safety evaluations	✓	✓
CareLinx	In-home personal care	8 hours/month	8 hours/month
CareLinx	24/7 Nursing Hotline	✓	✓
GA Foods	Prepared meals post-discharge	28 meals	28 meals
Rx Diet	Nutrition and meal-planning	✓	✓
Tivity ("SilverSneakers")	Online and in person fitness classes/gym membership	N/A	✓
Bold	Online fitness membership	✓	N/A
Benefits that apply to Special Supplemental Benefits for the Chronically Ill (SSBCI) beneficiaries only			
ProHealth	Grocery Benefit	N/A	$30 monthly allowance at select grocers
RxDiet	Medically tailored nutrition	N/A	13 orders annually
Jukebox Health	Home modification	N/A	Coordination, ordering, delivery, and installation scheduling. Projects by network of vetted & licensed installers who coordinate with occupational therapists for safety measures.

SSBCI benefits are only accessible for eligible chronically ill beneficiaries that qualify for SSBCI and enroll in the Prestige plan.

2025 Medicare Part D

In 2025, Medicare Part D coverage gap will go away. The most a person with Medicare will pay for prescription drug costs is $2,000. This is a savings in prescription drug costs for folks with Medicare, however, insurance carriers will be paying a lot more for medications. This could mean Medicare plans with drug coverage may have higher premiums.

	Deductible	Initial Coverage	Coverage Gap (Donut Hole)	Catastrophic Coverage
Enrollees pay:	100% of their drug costs until the Part D deductible is met. Deductible maximum is **$590** for plan year 2025.	25% of total drug costs A copayment or coinsurance for each formulary covered drug.	**Coverage Gap Eliminated in 2025** $2,000 TROOP (OOP savings of ~$1,300 from 2024)	
Part D Plans pay:		75% of generic drugs 65% of brand-name drugs		60% of total drug costs
Drug Manufacturers:		10% discount on brand-name drugs		20% discount on brand-name drugs
Medicare pays:				40% of generic drugs 20% of brand-name drugs

Part D

Retail & Mail Order	UHMAP Principal HMO Plan	UHMAP Prestige HMO Plan
Deductible	$0	$0
Tier 1 - 30/90 day supply	$0/$0	$0/$0
Tier 2 - 30/90 day supply	$0/$0	$0/$0
Tier 3- 30/90 day supply	$47/$141 (*$117.50)	$47/$141 (*$117.50)
Tier 4 - 30/90 day supply	45%/45%	45%/45%
Tier 5 - 30/90 day supply	33%/Not Covered	33%/Not Covered

**Mail Order discounts available for 90 day supply on Tier 3 medications*

Birdi is the mail order pharmacy provider for UCLA Health Medicare Advantage Plans

Provider Directory

Visit: https://uclahealthmedicareadvantage.org/providers

- You can filter the search by:
  - Search near me
  - Search by address provided
  - Search by neighborhood
  - Search by specialty/provider type
  - Search for primary care/provider type
  - Search doctors accepting new patients
  - Search by gender
  - Search by languages spoken

MyChart Member Portal

Members can sign up at my.UCLAHealthMedicareAdvantage.org

Members can….

- Access forms that to communicate important information to the plan
- Learn important information regarding the right to file a grievance and submit an appeal
- View their virtual member ID card
- View health plan activity – claims, authorizations, and Explanation of Benefits (EOBs)
- Compare costs with a Treatment Cost Calculator
- Manage communication preferences and sign up for text alerts
- Access health and wellness resources

Tools and Resources

- Eligibility verification – located in the Beneficiary Profile page in MedicareCENTER IQ&E (Quoting and Enrollment tool).
- Provider network verification – shown on Plan Comparison page and in the Plan Details within IQ&E. Or go to: **https://uclahealthmedicareadvantage.org/providers**
- Benefit/formulary questions – shown within Plan Details in IQ&E
- Commission inquiries – email: Commissions@berwickinsurance.com
- Support team email – email: AgentSupport@berwickinsurance.com
- Marketing support – email: Marketing@berwickinsurance.com
- Member self-service – SOB, ANOC, Member Care Guide, Formulary, Provider Directory

Congratulations!

You’ve completed the 2025 UCLA Health Medicare Advantage Plan Medicare Certification training module.

What’s next?

- Take the test to receive your certification
- When you complete your test, you will receive your score immediately
- You must pass the test with a score of 90%
  - You can take the test a maximum of 3 times