SecureHorizons® MedicareComplete® Retiree Plan (HMO)

Benefits Effective January 1, 2011

Evidence of Coverage

The Evidence of Coverage is an important legal document for you to keep and use as a reference during 2011. It explains:

The details of your Medicare health coverage, including your prescription drugs

How to get the care you need

Insured by: PACIFICARE OF WASHINGTON, INC.

Group Name (Plan Sponsor): City of Seattle
Group Number: 801855
Plan Year: January 01, 2011 through December 31, 2011

Washington
H5005-803

Table of Contents

This list of chapters and page numbers is just your starting point. For more help in finding information you need, go to the first page of a chapter. You will find a detailed list of topics at the beginning of each chapter.

CHAPTER 1: Getting started as a member of SecureHorizons® MedicareComplete® Retiree Plan (HMO)

SECTION 1 Introduction

Chapter 1
Section 1.1

What is the Evidence of Coverage about?

The Evidence of Coverage gives information about how to get your Medicare medical care and prescription drugs through our Plan. The Evidence of Coverage explains your rights and responsibilities, what is covered, and what you pay as a member of the Plan.

- You are covered by Medicare, and you have chosen to get your Medicare health care and your prescription drug coverage through our Plan.
- There are different types of Medicare Advantage Plans. Our Plan is a Medicare Advantage HMO Plan (HMO stands for Health Maintenance Organization).

In the Evidence of Coverage, the terms "the Plan," "our Plan," and "your Plan," all refer to SecureHorizons® MedicareComplete® Retiree Plan (HMO). The Plan is offered by PACIFICARE OF WASHINGTON, INC., referred throughout the Evidence of Coverage as "we", "us" or "our."

When the Agreement is purchased by the Group to provide benefits under a welfare plan governed by the Employee Retirement Income Security Act (ERISA), 29 U.S.C. §1001 et seq., we are not the plan administrator or named fiduciary of the welfare plan, as those terms are used in ERISA.

The word "coverage" and "covered services" refers to the medical care and services and the prescription drugs available to you as a member of the Plan.

Chapter 1
Section 1.2

What does this Chapter tell you?

Look through Chapter 1 of the Evidence of Coverage to learn:

- What makes you eligible to be a Plan member?
- What materials will you get from us?
- What is your Plan premium (if you have one) and how you can pay it?
- What is your Plan's service area?
- How do you keep the information in your membership record up to date?

Questions? *Call our Customer Service Department listed in Chapter 2.*

Chapter 1
Section 1.3

What if you are new to the Plan?

If you are a new member, then it's important for you to learn how the Plan operates – what the rules are and what services are available to you. We encourage you to set aside some time to look through the Evidence of Coverage.

If you are confused or concerned or just have a question, please contact our Plan's Customer Service (contact information is in Chapter 2 of the Evidence of Coverage).

Chapter 1
Section 1.4

Legal information about the Evidence of Coverage

It's part of our contract with you

The Evidence of Coverage is part of our contract with you about how the Plan covers your care. Other parts of this contract include: your enrollment form or your verbal or electronic election of our Plan, the *List of Covered Drugs (Formulary)*, and any notices you receive from us about changes or extra conditions that can affect your coverage. These notices are sometimes called "riders" or "amendments."

The contract is in effect for the months in which you are enrolled in the Plan during your Plan Sponsor's plan year.

Medicare must approve our Plan each year

Medicare (the Centers for Medicare & Medicaid Services) must approve our Plan each calendar year. You can continue to get Medicare coverage as a member of our Plan only as long as we choose to continue to offer the Plan for the year in question and the Centers for Medicare & Medicaid Services renews its approval of our Plan.

SECTION 2 What makes you eligible to be a Plan member?

Chapter 1
Section 2.1

Your eligibility requirements

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

- You meet the eligibility requirements of your former employer, union group or trust administrator (Plan Sponsor)
- **and** you live in our geographic service area (Section 2.3 below describes our service area)
- **and** you are entitled to Medicare Part A
- **and** you are enrolled in Medicare Part B
- **and** you do **not** have End Stage Renal Disease (ESRD), or receive routine kidney dialysis. However, if either of these conditions applies to you, in some instances, you may still be eligible to enroll through a Plan Sponsored Medicare Advantage (MA) health plan or as an individual. You may be newly eligible or able to continue your enrollment under the following circumstances:
- Individuals with ESRD who age into Medicare can enroll in any Medicare Advantage plan sponsored by their Plan Sponsor regardless of prior commercial coverage affiliation (your health plan coverage prior to you becoming eligible for Medicare).
- If a Plan Sponsor offers a Medicare Advantage plan as a new option to its employees and retirees, regardless of whether it has been an option in the past, retirees with ESRD may select this new Medicare Advantage plan option as the Plan Sponsor's open enrollment rules allow. You should contact your Plan Sponsor to determine what their rules allow.
- If a Plan Sponsor that has been offering a variety of coverage options consolidates its employee/retiree offerings (for example, it drops one or more plans), current members of the dropped plans may be accepted into a Medicare Advantage plan that is offered by the group.
- If a Plan Sponsor has contracted locally with a Medicare Advantage Organization (MAO) in more than one geographic area (for example, in two or more states), a retiree with ESRD who relocates permanently from one geographic location to another may remain with the Medicare Advantage Organization in the Plan Sponsor's local Medicare Advantage plan.

Questions? *Call our Customer Service Department listed in Chapter 2.*

- Individuals with ESRD who are affected by the contract termination, non-renewal or service area reduction of another Medicare Advantage Organization (MAO) may make one election to enroll in a Medicare Advantage plan offered by a different Medicare Advantage Organization during the appropriate election period.
- Once enrolled in a Medicare Advantage plan, an individual with ESRD may elect other Medicare Advantage plans offered by the same Medicare Advantage Organization (within the same CMS contract) during an allowable election period. Standard Medicare Advantage eligibility rules apply.
- **Note:** If you have received a transplant that has restored your kidney function and you no longer require a regular course of dialysis, you **are not** considered to have ESRD and you **are** eligible to enroll in the Plan.

Chapter 1
Section 2.2

What are Medicare Part A and Medicare Part B?

When you originally signed up for Medicare, you received information about how to get Medicare Part A and Medicare Part B. Remember:

- Medicare Part A generally covers services furnished by institutional providers such as hospitals, skilled nursing facilities or home health agencies.
- Medicare Part B is for most other medical services, such as physician's services and other outpatient services.

To learn whether you have Medicare Part A and Part B, you can look on your red, white, and blue Medicare card. Or, call Medicare at **1-800-MEDICARE (1-800-633-4227)** 24 hours a day, 7 days a week. TTY users call **1-877-486-2048**.

If you are not entitled to Medicare Part A, please refer to your Plan Sponsor's enrollment materials, or contact your Plan Sponsor directly to determine if you are eligible to enroll in our Plan. Some Plan Sponsors have made arrangements with us to purchase Medicare Part A on your behalf.

Chapter 1
Section 2.3

Here is the geographic service area for our Plan

Although Medicare is a Federal program, our Plan is available only to individuals who live in our geographic service area. To join our Plan, you must live in this service area. To stay a member of our Plan, you must keep living in this service area. The service area is described below.

Our service area includes these counties in Washington: Clark County, Cowlitz County, Island County, King County, Lewis County, Pierce County, Snohomish County, and Thurston County.

If you are not sure whether you live in the service area, or if you plan to move out of the service area, please contact Customer Service.

SECTION 3 What other materials will you get from us?

Chapter 1
Section 3.1

Your member ID card – use it to get all covered care and drugs

While you are a member of our Plan, you must use our member ID card whenever you get any services covered by this Plan and for prescription drugs you get at network pharmacies.

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

Here's why this is so important: If you get covered services using your red, white, and blue Medicare card instead of using our member ID card while you are a Plan member, you may have to pay the full cost yourself.

If your member ID card is damaged, lost, or stolen, call Customer Service right away and we will send you a new card.

Chapter 1
Section 3.2

The *Provider Directory*: your guide to all providers in the Plan's network

We will send you a new Provider Directory as often as we are required to by federal law, or upon your request. Please call Customer Service if you need one. This directory lists our network providers.

What are "network providers?"

Network providers are the doctors and other health care professionals, medical groups, hospitals, and other health care facilities that have an agreement with us to accept our payment in full. We have arranged for these providers to deliver covered services to members in our Plan.

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

It is important to know which providers are part of our network because, with limited exceptions, while you are a member of our Plan you will be required to use network providers to get your medical care and services. The only exceptions are emergencies, urgently needed care when the network is not available (generally, out of the area), out-of-area dialysis services, and cases in which our Plan authorizes use of out-of-network providers. See the chapter of the Evidence of Coverage titled: *Using the Plan's coverage for your medical services* for more specific information about emergency, out-of-network, and out-of-area coverage.

If you don't have your copy of the *Provider Directory*, you can request a copy from Customer Service. You may ask Customer Service for more information about our network providers, including their qualifications. You can also search for provider information on our Web site. Both Customer Service and the Web site can give you the most up-to-date information about changes in our network providers. (You can find our Web site and phone information in Chapter 2 of the Evidence of Coverage.)

Chapter 1
Section 3.3

The *Pharmacy Directory*: your guide to pharmacies in our network

What are "network pharmacies?"

Our *Pharmacy Directory* gives you a list of our network pharmacies – that means the pharmacies that have agreed to fill covered prescriptions for our Plan members.

Why do you need to know about network pharmacies?

You can use the *Pharmacy Directory* to find the network pharmacy you want to use. The directory lists pharmacies in your area based on your zip code. It also includes a list of national pharmacy chains that are in our network. This is important because, with few exceptions, you must get your prescriptions filled at one of our network pharmacies if you want our Plan to cover (help you pay for) them.

We will send you a *Pharmacy Directory* as often as we are required to by the Centers for Medicare and Medicaid Services (CMS), or upon your request. If you need a new *Pharmacy Directory* before then, you can get a copy from Customer Service (phone numbers are in Chapter 2 of the Evidence of Coverage). At any time, you can call Customer Service to get up-to-date information about changes in the pharmacy network. You can also find this information on our Web site (Web site information is located in Chapter 2 of the Evidence of Coverage).

Chapter 1
Section 3.4

The Plan's *List of Covered Drugs (Formulary)*

The Plan has a *List of Covered Drugs (Formulary)*. We call it the "Drug List" for short. It explains which Part D prescription drugs are covered by our Plan. The drugs on this list are selected by us with the help of a team of doctors and pharmacists. The list must meet requirements set by Medicare. Medicare has approved the Plan's Drug List.

We will send you a copy of the Drug List. To get the most complete and current information about which drugs are covered, you can visit our Web site or call Customer Service (phone numbers and Web site information is located in Chapter 2 of the Evidence of Coverage).

Chapter 1
Section 3.5

Reports with a summary of payments made for your prescription drugs

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

The *Explanation of Benefits* provides the total amount you have spent on your prescription drugs and the total amount we have paid for each of your prescription drugs during the month. The chapter in the Evidence of Coverage titled: *What you pay for your Part D prescription drugs* gives more information about the *Explanation of Benefits* and how it can help you keep track of your drug coverage.

Questions? *Call our Customer Service Department listed in Chapter 2.*

An *Explanation of Benefits* summary is also available upon request. To get a copy, please contact Customer Service.

SECTION 4 Your monthly premium for the Plan

Chapter 1
Section 4.1

How much is your monthly Plan premium?

Your former employer, union group or trust administrator (Plan Sponsor) is responsible for paying your monthly Plan premium to UnitedHealthcare on your behalf. Your Plan Sponsor determines the amount of any retiree contribution toward the monthly premium for our Plan. Your Plan Sponsor will notify you under separate cover if you must pay any portion of your monthly premium for our Plan.

In some situations, your Plan premium could be less

There are programs to help people with limited resources pay for their drugs. Chapter 2 explains more about these programs. If you qualify for one of these programs, enrolling in the program might help to lower the monthly Plan premium your Plan Sponsor pays on your behalf.

If you are already enrolled and getting help from one of these programs, we will send you a separate document, called the "*Evidence of Coverage Rider for People Who Get Extra Help Paying for Prescription Drugs*" (LIS Rider), which describes your drug coverage. If you don't receive this insert, please call Customer Service and ask for the "*Evidence of Coverage Rider for People Who Get Extra Help Paying for Prescription Drugs*" (LIS Rider). Phone numbers for Customer Service are in Chapter 2 of the Evidence of Coverage.

In some situations, your Plan premium could be more

Some members are required to pay a **late enrollment penalty** because they did not join a Medicare drug plan when they first became eligible or because they had a continuous period of 63 days or more when they didn't keep their coverage. For these members, the Plan's monthly premium will be higher. It will be the amount of the monthly Plan premium the Plan Sponsor pays each month, plus the amount of their late enrollment penalty.

If you are required to pay the late enrollment penalty, the amount of your penalty depends on how long you waited before you enrolled in drug coverage or how many months you were without drug coverage after you became eligible. The chapter in the Evidence of Coverage titled: *What you pay for your Part D prescription drugs*, in the section titled: *Do you have to pay the Part D "late enrollment penalty?"* explains the late enrollment penalty.

Questions? *Call our Customer Service Department listed in Chapter 2.*

Many members are required to pay Medicare premiums

Some Plan members will be paying a premium for Medicare Part A and most Plan members will be paying a premium for Medicare Part B. You must continue paying your Medicare Part B premium for you to remain as a member of the Plan.

- Your copy of *Medicare & You 2011* includes information about these premiums in the section called "2011 Medicare Costs." This explains how the Part B premium differs for people with different incomes.
- Everyone with Medicare receives a copy of *Medicare & You* each year in the fall. Those new to Medicare receive it within a month after first signing up. You can also download a copy of *Medicare & You 2011* from the Medicare Web site (http://www.medicare.gov). Or, you can order a printed copy by phone at **1-800-MEDICARE (1-800-633-4227)** 24 hours a day, 7 days a week. TTY users call **1-877-486-2048**.

Chapter 1
Section 4.2

Can we change your monthly Plan premium during the plan year?

Monthly Plan premium changes and employer-sponsored benefit changes are subject to contractual arrangements between your Plan Sponsor and us, and as a result, monthly Plan premiums generally do not change during the Plan Sponsor's plan year. Your Plan Sponsor is responsible for notifying you of any monthly Plan premium changes or retiree contribution changes (the portion of your monthly Plan premium your Plan Sponsor requires you to pay) thirty (30) days prior to the date when the change becomes effective.

However, in some cases the part of the premium for Medicare Part D prescription drug coverage can change during the year. This happens if you become eligible for the Extra Help program or if you lose your eligibility for the Extra Help program during the year. If a member qualifies for Extra Help with their prescription drug costs, the Extra Help program will pay part of the member's monthly Plan premium. So a member who becomes eligible for Extra Help during the year would begin to pay less toward their monthly contribution. (If your Plan Sponsor does not require you to pay any portion of your monthly Plan premium, then your Plan Sponsor will pay less toward your monthly Plan premium.) And a member who loses their eligibility during the year may need to start paying a higher contribution. (If your Plan Sponsor does not require you to pay any portion of your monthly Plan premium, then your Plan Sponsor will pay more toward your monthly Plan premium.) You can find out more about Extra Help in Chapter 2, Section 7.

What if you believe you have qualified for "Extra Help?"

If you believe you have qualified for Extra Help and you believe that you are paying an incorrect copayment amount when you get your prescription at a pharmacy, our Plan has established a process that allows you to either request assistance in obtaining evidence of your proper copayment level, or, if you already have the evidence, to provide this evidence to us. Call Customer Service for assistance. You may be given instructions to mail in the following supporting documentation:

- Centers for Medicare & Medicaid Services (CMS) or Social Security Administration (SSA) Award letters dated August 1, 2010 or later;
- Award letters from State Medicaid agencies or a copy of a State Medicaid card that confirms Medicaid coverage during the discrepant period;
- Confirmation from a State or federal database/Web site that confirms an extra help subsidy during the discrepant period.

We can accept this documentation for a period of up to 90 days following the date your prescription(s) were filled.

When we receive the evidence showing your copayment level, we will update our system so that you can pay the correct copayment when you get your next prescription at the pharmacy. If you overpay your copayment, we will reimburse you. We will either forward a check to you in the amount of your overpayment or we will offset future copayments. If the pharmacy hasn't collected a copayment from you and is carrying your copayment as a debt owed by you, we may make the payment directly to the pharmacy. If a state paid on your behalf, we may make payment directly to the state. Please contact Customer Service if you have questions.

SECTION 5 Please keep your Plan membership record up to date

Chapter 1
Section 5.1

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

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

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

Questions? *Call our Customer Service Department listed in Chapter 2.*

Call Customer Service to let us know about these changes:

- Changes to your name, your address, or your phone number
- Changes in any other health insurance coverage you have (such as from your employer, your spouse's employer, workers' compensation, or Medicaid)
- If you have any liability claims, such as claims from an automobile accident
- If you have been admitted to a nursing home

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

Medicare requires that we collect information from you about any other medical or drug insurance coverage that you have. That's because we must coordinate any other coverage you have with your benefits under our Plan.

Once each year, we will send you a letter that lists any other medical or drug insurance coverage that we know about. Please read over this information carefully. If it is correct, you don't need to do anything. If the information is incorrect, or if you have other coverage that is not listed, please call Customer Service (phone numbers are in Chapter 2 of the Evidence of Coverage).

CHAPTER 2: Important phone numbers and resources

SECTION 1 SecureHorizons® MedicareComplete® Retiree Plan (HMO) (how to contact us, including how to reach Customer Service at the Plan)

How to contact our Plan's Pre-enrollment Department

For assistance with enrollment, please call our Plan's Pre-enrollment Department. We look forward to talking with you.

Our Plan Pre-enrollment Department	
CALL	**1-800-610-2660** Calls to this number are free. Hours of operation: 8 a.m. - 8 p.m. local time, 7 days a week
TTY/TDD	**711** This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free. Hours of operation: 8 a.m. - 8 p.m. local time, 7 days a week
WRITE	UnitedHealthcare P.O. Box 29675 Hot Springs, AR 71903-9675
WEB SITE	www.UHCRetiree.com

How to contact our Plan's Customer Service

For assistance with claims, billing, member ID card questions, or if you need help with your coverage, please call or write to our Plan Customer Service. We will be happy to help you.

Our Plan Customer Service	
CALL	**1-888-867-5548** Calls to this number are free. Hours of operation: 8 a.m. to 8 p.m. local time, 7 days a week
TTY/TDD	**711** This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free. Hours of operation: 8 a.m. to 8 p.m. local time, 7 days a week
WRITE	UnitedHealthcare P.O. Box 29675 Hot Springs, AR 71903-9675
WEB SITE	www.UHCRetiree.com

How to contact us when you are asking for a coverage decision about your medical care

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

Coverage Decisions for Medical Care	
CALL	**1-888-867-5548** Calls to this number are free. Hours of operation: 8 a.m. - 8 p.m. local time, 7 days a week
TTY/TDD	**711** This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free.
WRITE	UnitedHealthcare P.O. Box 29675 Hot Springs, AR 71903-9675

For more information on asking for coverage decisions about your medical care, see the chapter in the Evidence of Coverage titled: *What to do if you have a problem or complaint (coverage decisions, appeals, complaints).*

How to contact us when you are making an appeal or complaint about your medical care

Appeals and Complaints for Medical Care	
CALL	**1-888-867-5548** Calls to this number are free. Hours of operation: 8 a.m. - 8 p.m. local time, 7 days a week For fast/expedited appeals and complaints for medical care: **1-877-262-9203** Hours of Operation: 8 a.m. - 8 p.m. local time, 7 days a week
TTY/TDD	**711** This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free.
FAX	**1-888-517-7113** For fast/expedited appeals and complaints for medical care only: **1-866-373-1081**
WRITE	Appeals and Grievance Department PO Box 6106, MS CA124-0157 Cypress, CA 90630

For more information on making an appeal or a complaint about your medical care, see the chapter in the Evidence of Coverage titled: *What to do if you have a problem or complaint (coverage decisions, appeals, complaints).*

How to contact us when you are asking for a coverage decision about your Part D prescription drugs

Coverage Decisions for Part D Prescription Drugs	
CALL	**1-888-867-5548** Calls to this number are free. Hours of Operation: 8 a.m. - 8 p.m. local time, 7 days a week
TTY/TDD	**711** This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free.
WRITE	UnitedHealthcare P.O. Box 29675 Hot Springs, AR 71903-9675

For more information on asking for coverage decisions about your Part D prescription drugs, see the chapter in the Evidence of Coverage titled: *What to do if you have a problem or complaint (coverage decisions, appeals, complaints).*

How to contact us when you are making an appeal or a complaint about your Part D prescription drugs

Appeals and Complaints for Part D Prescription Drugs	
CALL	**1-888-867-5548** Calls to this number are free. Hours of operation: 8 a.m. - 8 p.m. local time, 7 days a week For fast/expedited appeals and complaints for Part D prescription drugs: **1-800-595-9532** Hours of Operation: 8 a.m. - 8 p.m. local time, 7 days a week
TTY/TDD	**711** This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free.
FAX	**1-866-308-6294** For fast/expedited appeals and complaints for Part D prescriptions drugs only: **1-866-308-6296**
WRITE	Part D Appeal and Grievance Department PO Box 6106, MS CA124-0197 Cypress, CA 90630-9948

For more information on making an appeal or complaint about your Part D prescription drugs, see the chapter in the Evidence of Coverage titled: *What to do if you have a problem or complaint (coverage decisions, appeals, complaints).*

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

For more information on situations in which you may need to ask us for reimbursement or to pay a bill you have received from a provider, see the chapter in the Evidence of Coverage titled: *Asking the Plan to pay its share of a bill you have received for medical services or drugs.*

Please note: If you send us a payment request and we deny any part of your request, you can appeal our decision. See the chapter in the Evidence of Coverage titled: *What to do if you have a problem or complaint (coverage decisions, appeals, complaints)* for more information.

Payment Requests	
CALL	Part D Prescription drug payment requests: **1-888-867-5548** Calls to this number are free. Hours of Operation: 8 a.m. to 8 p.m. local time, 7 days a week Medical Claims requests: **1-888-867-5548** Calls to this number are free Hours of Operation: 8 a.m. to 8 p.m. local time, 7 days a week
TTY/TDD	**711** This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free.
WRITE	Part D Prescription drug payment requests: Prescription Solutions PO Box 29045 Hot Springs, AR 71903 Medical Claims payment requests: Pacificare of Washington P.O. Box 30976 Salt Lake City, UT 84130-0976

SECTION 2 **Medicare** (how to get help and information directly from the Federal Medicare program)

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

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

Medicare	
CALL	**1-800-MEDICARE, or 1-800-633-4227** Calls to this number are free. 24 hours a day, 7 days a week.
TTY	**1-877-486-2048** This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free.
WEB SITE	http://www.medicare.gov This is the official government Web site for Medicare. It gives you up-to-date information about Medicare and current Medicare issues. It also has information about hospitals, nursing homes, physicians, home health agencies, and dialysis facilities. It includes booklets you can print directly from your computer. It has tools to help you compare Medicare Advantage plans and Medicare drug plans in your area. You can also find Medicare contacts in your state by selecting "Help and Support" and then clicking on "Useful Phone Numbers and Websites." If you don't have a computer, your local library or senior center may be able to help you visit this Web site using its computer. Or, you can call Medicare at the number above and tell them what information you are looking for. They will find the information on the Web site, print it out, and send it to you.

Questions? *Call our Customer Service Department listed in Chapter 2.*

SECTION 3 State Health Insurance Assistance Program (free help, information, and answers to your questions about Medicare)

The State Health Insurance Assistance Program (SHIP) is a government program with trained counselors in every state. Your state specific State Health Insurance Assistance Program is listed below.

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

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

State Health Insurance Programs (SHIP)

CALL	**1-800-562-6900**
TTY/TDD	**1-360-586-0241** This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.
WRITE	**Office of the Insurance Commissioner** PO Box 40256 Olympia, WA 98504-0256

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

There is a Quality Improvement Organization (QIO) in each state. Your state specific Quality Improvement Organization is listed below.

Your state's QIO has a group of doctors and other health care professionals who are paid by the Federal government. This organization is paid by Medicare to check on and help improve the quality of care for people with Medicare. The state's QIO is an independent organization. It is not connected with our Plan.

You should contact your state's QIO in any of these situations:

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

State Quality Improvement Organizations (QIO)

CALL	**1-800-445-6941**
TTY/TDD	**1-877-486-2048** This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.
WRITE	**Qualis Health** PO Box 33400 Seattle, WA 98133
WEB SITE	www.qualishealthmedicare.org

SECTION 5 Social Security

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

Social Security Administration	
CALL	**1-800-772-1213** Calls to this number are free. Available 7:00 a.m. to 7:00 p.m., Monday through Friday. You can use our automated telephone services to get recorded information and conduct some business 24 hours a day.
TTY	**1-800-325-0778** This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free. Available 7:00 a.m. to 7:00 p.m., Monday through Friday.
WEB SITE	http://www.ssa.gov

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

Medicaid is a joint Federal and state government program that helps with medical costs for certain people with limited incomes and resources. Some people with Medicare are also eligible for Medicaid. Medicaid also has programs that can help pay for your Medicare premiums and other costs, if you qualify. To find out more about Medicaid and its programs, contact your state Medicaid agency.

State Medicaid Programs

CALL	**1-800-562-3022**
TTY/TDD	**711** This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.
WRITE	**Department of Social & Health Services Health and Recovery Services Administration Customer Service Center** P.O. Box 45505 Olympia, WA 98504-5505
WEB SITE	www.hrsa.dshs.wa.gov/

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

Medicare's "Extra Help" Program

Medicare provides "Extra Help" to pay prescription drug costs for people who have limited income and resources. Resources include your savings and stocks, but not your home or car. If you qualify, you get help paying for any Medicare drug plan's monthly premium, yearly deductible, and prescription copayments. This Extra Help also counts toward your out-of-pocket costs.

People with limited income and resources may qualify for Extra Help. Some people automatically qualify for Extra Help and don't need to apply. Medicare mails a letter to people who automatically qualify for Extra Help.

If you think you may qualify for Extra Help, call Social Security (see Section 5 of this chapter for contact information) to apply for the program. You may also be able to apply at your State Medical Assistance or Medicaid Office (see Section 6 of this chapter for contact information). After you apply, you will get a letter letting you know if you qualify for Extra Help and what you need to do next.

SECTION 8 How to contact the Railroad Retirement Board

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

Railroad Retirement Board	
CALL	**1-877-772-5772** Calls to this number are free. Available 9:00 a.m. to 3:30 p.m., Monday through Friday If you have a touch-tone telephone, recorded information and automated services are available 24 hours a day, including weekends and holidays.
TTY	**1-312-751-4701** This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are **not** free.
WEB SITE	http://www.rrb.gov

CHAPTER 3: Medical Benefits Chart (what is covered and what you pay)

SECTION 1 Understanding your out-of-pocket costs for covered services

This chapter focuses on your covered services and what you pay for your medical benefits. It includes a Medical Benefits Chart that lists your covered services and how much you will pay for each covered service as a member of our Plan. Later in this chapter, you can find information about medical services that are not covered. It also gives details about exclusions on certain services.

Chapter 3
Section 1.1

What types of out-of-pocket costs do you pay for your covered services?

To understand the payment information we give you in this chapter, you need to know about the types of out-of-pocket costs you may pay for your covered services.

- A "**copayment**" means that you pay a fixed amount each time you receive a medical service. You pay a copayment at the time you get the medical service.
- "**Coinsurance**" means that you pay a percent of the total cost of a medical service. You pay a coinsurance at the time you get the medical service.

Some people qualify for programs to help them pay their out-of-pocket costs for Medicare. If you are enrolled in these programs, you may still have to pay the Medicaid copayment, depending on the rules in your state.

Chapter 3
Section 1.2

What is the maximum amount you will pay for certain covered medical services?

Your in-network out-of-pocket maximum is the maximum amount that you pay during the calendar year for covered Part A (Hospital Insurance) and Part B (Medical Insurance) services received from in-network providers. (The amount you or your Plan Sponsor pays for your plan premium, if applicable, does not count toward your out-of-pocket maximum.) Once you have reached your out-of-pocket maximum for covered services from in-network providers, you will not have any out-of-pocket costs for the remainder of the year when you see our network providers. (You or your Plan Sponsor will have to continue to pay your plan premium, if applicable, and the Medicare Part B premium.). For the plan year specified inside the front cover of this Evidence of Coverage, your benefit plan has a $2,000 out-of-pocket maximum limit for the following covered services:

Questions? *Call our Customer Service Department listed in Chapter 2.*

PHYSICIAN SERVICES
Primary Care Physician Office Visit
(includes Non-MD office visits)
Specialist Office Visit

INPATIENT SERVICES
Inpatient Hospital Care
Inpatient Mental Health in a Psychiatric Hospital
Skilled Nursing Facility Care
Transplants - Professional services copay in addition to facility charges

OUTPATIENT SERVICES
Outpatient Surgery - Facility Component
Outpatient Hospital Services
Outpatient Mental Health/Substance Abuse (Individual Visit)
Outpatient Mental Health/Substance Abuse (Group Visit)
Partial Hospitalization (Mental Health Day Treatment) per day
Comprehensive Outpatient Rehabilitation Facility (CORF)
Occupational Therapy
Physical Therapy and Speech/Language Therapy
Cardiac/Pulmonary Rehabilitation Services
Kidney Dialysis

MEDICARE-COVERED SPECIALIST VISITS
Chiropractic Visit (Medicare-covered)
Podiatry Visit (Medicare-covered)
Eye Exam, includes Glaucoma (Medicare-covered)
Hearing Exam (Medicare-covered)
Dental Services (Medicare-covered)
Smoking Cessation Visit (Medicare-covered)

AMBULANCE/EMERGENCY ROOM/URGENT CARE
Ambulance Services
Emergency Room (includes Worldwide Coverage)
Urgently Needed Care In-Network
Urgently Needed Care Out-of-Network (includes Worldwide Coverage)

PART B DRUGS AND BLOOD
Part B Drugs - Immunosuppressives, Oral Chemotherapy, Anti-nausea, Inhalation Solutions, Hemophilia Clotting Factors Cost share
Part B Drugs – Antigens

Part B Drugs - Outpatient Injectable Medications - Administered in a Physician's Office
Outpatient Injectable Medications - Self Administered (Covered under Part B)
Home Infusion Drugs (as covered under Part B)
Blood

DURABLE MEDICAL EQUIPMENT (DME) AND SUPPLIES
Durable Medical Equipment
Durable Medical Equipment purchased in a pharmacy
Orthotics and Prosthetics
Medical Supplies
Diabetes Monitoring Supplies

HOME HEALTHCARE AGENCY
Home Health Services

HOSPICE
Hospice (Medicare-covered)

PROCEDURES
Diagnostic Procedure/Test
Clinical Laboratory Services
Outpatient X-ray Services
Diagnostic Radiology Services
Therapeutic Radiology Service

PREVENTIVE SERVICES
Cardiovascular Screenings (Medicare-covered)
Immunizations (Flu, Pneumococcal, Hepatitis B Vaccines) - (Medicare-covered)
Pap Smears and Pelvic Exams
Prostate Cancer Screening
Colorectal Cancer Screenings
Bone Mass Measurements (Bone Density)
Mammography
Diabetes Monitoring - Self Management Training
Medical Nutrition Therapy
Physical Exam - one time "Welcome to Medicare" (includes an EKG)
Routine Physical Exam (Non Medicare-covered)

You are responsible for the copayment or coinsurance amounts for any combination of the covered services listed above until you reach your out-of-pocket maximum limit(s).

Questions? *Call our Customer Service Department listed in Chapter 2.*

After you have reached the out-of-pocket maximum limit(s) in a plan year, we will be responsible for the cost of any copayments or coinsurance amounts for the covered services listed above for the remainder of the plan year.

The covered services must be received within your Plan Sponsor's plan year for the copayments and coinsurance you pay to count towards your out-of-pocket maximum limit.

Important Note: The out-of-pocket maximum limit does not apply to all covered services described in this chapter. Only the covered services listed above apply to the out-of-pocket maximum limit. If you are not sure if a covered service applies to the out-of-pocket maximum limit, or if you want to know how much of your benefit limit you have already used, call Customer Service.

If you disenroll from our Plan and then seek reinstatement under the Plan before the end of the plan year in which you disenrolled, any amount that you accumulated toward your out-of-pocket maximum limit before you disenrolled continues to apply toward your out-of-pocket maximum limit for that plan year.

SECTION 2 Use this *Medical Benefits Chart* to find out what is covered for you and how much you will pay

Chapter 3
Section 2.1

Your medical benefits and costs as a member of the Plan

The Medical Benefits Chart on the following pages lists the services our Plan covers and what you pay for each service. The services listed in the Medical Benefits Chart are covered only when all coverage requirements are met:

- Your Medicare covered services must be provided according to the coverage guidelines established by Medicare.
- Except in the case of preventive services and screening tests, your services (including medical care, services, supplies, and equipment) **must** be medically necessary. Medically necessary means that the services are used for the diagnosis, direct care, and treatment of your medical condition and are not provided mainly for your convenience or that of your doctor.
- You receive your care from a network provider. In most cases, care you receive from an out-of-network provider will not be covered. The chapter of this Evidence of Coverage titled: *Using the Plan's coverage for your medical services* provides more information about requirements for using network providers and the situations when we will cover services from an out-of-network provider.

Questions? *Call our Customer Service Department listed in Chapter 2.*

- You have a Primary Care Physician (a PCP) who is providing and overseeing your care. In most situations, your PCP must give you approval in advance before you can see other providers in the Plan's network. This is called giving you a "referral." The chapter of this Evidence of Coverage titled: *Using the plan's coverage for your medical services* provides more information about getting a referral and the situations when you do not need a referral.

Services that are covered for you	What you must pay when you get these services
Inpatient Care	
Inpatient hospital care Covered services include: - Semi-private room (or a private room if medically necessary) - Meals including special diets - Regular nursing services - Costs of special care units (such as intensive or coronary care units) - Drugs and medications - Lab tests - X-rays and other radiology services - Necessary surgical and medical supplies - Use of appliances, such as wheelchairs - Operating and recovery room costs - Physical, occupational, and speech language therapy - Under certain conditions, the following types of transplants are covered: corneal, kidney, kidney-pancreatic, heart, liver, lung, heart/lung, bone marrow, stem cell, and intestinal/multivisceral. If you need a transplant, we will arrange to have your case reviewed by a Medicare-approved transplant center that will decide whether you are a candidate for a transplant. If you are sent outside of your community for a transplant, we will arrange or pay for appropriate lodging and transportation costs for you and a companion. - Blood - including storage and administration. Coverage of whole blood and packed red cells begins with the first pint of blood that you need. - Physician Services - Inpatient substance abuse and detoxification services	You pay a $200 copayment for each Medicare-covered hospital stay. Medicare hospital benefit periods do not apply. (See definition of benefit periods in the chapter of the Evidence of Coverage titled: *Definitions of important words.*) For inpatient hospital care, you are covered for unlimited days as long as the hospital stay is covered in accordance with Plan rules.

Services that are covered for you	What you must pay when you get these services
Inpatient mental health care	
- Covered services include mental health care services that require a hospital stay in a psychiatric hospital. - There is a 190-day lifetime limit for inpatient services in a psychiatric hospital. The 190-day limit does not apply to Mental Health services provided in a psychiatric unit of a general hospital.	You pay a $200 copayment for each Medicare-covered hospital stay, up to 190 days.
Skilled nursing facility (SNF) care	
(For a definition of "skilled nursing facility," see the chapter of the Evidence of Coverage titled: *Definitions of important words*. Skilled nursing facilities are sometimes called "SNFs.") Covered services include: - Semiprivate room (or a private room if medically necessary) - Meals, including special diets - Regular nursing services - Physical therapy, occupational therapy, and speech therapy - Drugs administered to you as part of your plan of care (This includes substances that are naturally present in the body, such as blood clotting factors.) - Blood - including storage and administration. Coverage of whole blood and packed red cells begins with the first pint of blood that you need. - Medical and surgical supplies ordinarily provided by SNFs - Laboratory tests ordinarily provided by SNFs - X-rays and other radiology services ordinarily provided by SNFs - Use of appliances such as wheelchairs ordinarily provided by SNFs	You pay a $0 copayment each day for days 1 to 20 for Medicare-covered SNF care. You pay a $50 copayment for additional Medicare-covered days, up to 100 days.

Services that are covered for you	What you must pay when you get these services
Skilled nursing facility (SNF) care *(continued)* - Physician services You are covered for up to 100 days per benefit period for inpatient services in a SNF, in accordance with Medicare guidelines. A benefit period begins on the first day you go to a Medicare-covered inpatient hospital or a skilled nursing facility. The benefit period ends when you haven't been an inpatient at any hospital or SNF for 60 days in a row. If you go to the hospital (or SNF) after one benefit period has ended, a new benefit period begins. There is no limit to the number of benefit periods you can have. A 3-day prior hospital stay is **not** required. Generally, you will get your SNF care from Plan facilities. However, under certain conditions listed below, you may be able to pay in-network cost-sharing for a facility that isn't a Plan provider, if the facility accepts our Plan's amounts for payment. - A nursing home or continuing care retirement community where you were living right before you went to the hospital (as long as it provides skilled nursing facility care). - A SNF where your spouse is living at the time you leave the hospital.	
Inpatient services covered when the hospital or SNF days aren't, or are no longer, covered Covered services include:	When your stay is no longer covered, these services will be covered as described in the following sections:

Services that are covered for you	What you must pay when you get these services
Inpatient services covered when the hospital or SNF days aren't, or are no longer, covered *(continued)*	
- Physician services	Please refer to Physician services
- Tests (like X-ray or lab tests)	Please refer to Outpatient diagnostic tests and therapeutic services and supplies.
- X-ray, radium, and isotope therapy including technician materials and services	Please refer to Outpatient diagnostic tests and therapeutic services and supplies.
- Surgical dressings, splints, casts and other devices used to reduce fractures and dislocations	Please refer to Outpatient diagnostic tests and therapeutic services and supplies.
- Prosthetics and orthotics devices (other than dental) that replace all or part of an internal body organ (including contiguous tissue), or all or part of the function of a permanently inoperative or malfunctioning internal body organ, including replacement or repairs of such devices	Please refer to Prosthetics devices, corrective appliances and related supplies.
- Leg, arm, back, and neck braces; trusses, and artificial legs, arms, and eyes including adjustments, repairs, and replacements required because of breakage, wear, loss, or a change in the patient's physical condition	Please refer to Prosthetics devices, corrective appliances and related supplies.
- Physical therapy, speech therapy, and occupational therapy	Please refer to Outpatient rehabilitation services.

Services that are covered for you	What you must pay when you get these services
Home health agency care Covered services include: - Part-time or intermittent skilled nursing and home health aide services (To be covered under the home health care benefit, your skilled nursing and home health aide services combined must total fewer than 8 hours per day and 35 hours per week) - Physical therapy, occupational therapy, and speech therapy - Medical social services - Medical equipment and supplies	You pay a $0 copayment for all home health visits provided by a network home health agency when Medicare criteria are met. Other copayments or coinsurance may apply. (Please see Durable medical equipment for applicable copayments or coinsurance.)

Services that are covered for you	What you must pay when you get these services
Hospice care	
You may receive care from any Medicare-certified hospice program. Original Medicare (rather than our Plan) will pay the hospice provider for the services you receive. Your hospice doctor can be a network provider or an out-of-network provider. You will still be a Plan member and will continue to get the rest of your care that is unrelated to your terminal condition through our Plan. However, Original Medicare will pay for all of your Part A and Part B services. Your provider will bill Original Medicare while your hospice election is in force. Covered services include: - Drugs for symptom control and pain relief, short-term respite care, and other services not otherwise covered by Original Medicare - Home care - Non-Medicare covered benefits, to which you are entitled under your Plan, such as routine vision coverage and other Plan optional supplemental benefits to which you may be entitled. - Hospice consultation services (one time only) for a terminally ill person who has not chosen hospice care. - Note: If you are not entitled to Medicare Part A coverage, the above description of hospice services does not apply to you. Neither Medicare nor the Plan will pay for hospice services.	When you enroll in a Medicare-certified hospice program, your hospice services and your Original Medicare services are paid for by Original Medicare, not the Plan. Note: If you are not entitled to Medicare Part A coverage, hospice services are not covered by the Plan or by Medicare.
Outpatient Services	
Physician services, including doctor's office visits Covered services include: - Office visits, including medical and surgical care in a physician's office or certified ambulatory surgical center	You pay a $10 copayment for each office visit with a **Primary Care Physician**. (See "Outpatient surgery, observation and medical services, or outpatient hospital services provided at

Services that are covered for you	What you must pay when you get these services
Physician services, including doctor's office visits *(continued)*	
	an outpatient facility" later in this chart for any applicable copayments or coinsurance amounts for ambulatory surgical center visits.)
- Consultation, diagnosis, and treatment by a Specialist	You pay a $20 copayment for each office visit with a **Specialist**.
- Hearing and balance exams, if your doctor orders it to see if you need medical treatment.	You pay a $20 copayment for each Medicare-covered exam.
- Telehealth office visits including consultation, diagnosis and treatment by a Specialist - Second opinion by another network provider (Specialist) prior to surgery	You pay a $20 copayment for each visit.
- Outpatient hospital services	See "Outpatient surgery, observation and medical services, or outpatient hospital services provided at an outpatient facility" later in this chart for any applicable copayments or coinsurance amounts for services obtained in an outpatient hospital setting.
- Non-routine dental care (covered services are limited to surgery of the jaw or related structures, setting fractures of the jaw or facial bones, extraction of teeth to prepare the jaw for radiation treatments of neoplastic cancer disease, or services that would be covered when provided by a doctor)	You pay a $20 copayment for each visit.

Services that are covered for you	What you must pay when you get these services
Chiropractic services	
Covered services include: - Manual manipulation of the spine to correct subluxation	You pay a 50% coinsurance for each Medicare-covered visit.
Podiatry services	
Covered services include: - Treatment of injuries and diseases of the feet (such as hammer toe or heel spurs). - Foot care for members with certain medical conditions affecting the lower limbs	You pay a $20 copayment for each Medicare-covered visit.
Eye care	
Covered services include: - Outpatient physician services for eye care. - For people who are at high risk of glaucoma, such as people with a family history of glaucoma, people with diabetes, and African-Americans who are age 50 and older: $0 copayment for each glaucoma screening once every 12 months.	You pay a $20 copayment for each Medicare-covered visit.
- One pair of eyeglasses or contact lenses after each cataract surgery that includes insertion of an intraocular lens. Corrective lenses/frames (and replacements) needed after a cataract removal without a lens implant.	Up to $75 allowance for one pair of Medicare-covered standard glasses or contact lenses after cataract surgery.
Medicare-covered smoking cessation	
Includes two counseling attempts within a 12-month period if ordered by a doctor if you are diagnosed with a smoking-related illness or are taking medicine that may be affected by tobacco. Each counseling attempt includes up to four face-to-face visits.	You pay a $0 copayment for Medicare-covered Smoking Cessation counseling.

Services that are covered for you	What you must pay when you get these services
Outpatient mental health care, including partial hospitalization services Covered services include: - Mental health services provided by a doctor, clinical psychologist, clinical social worker, clinical nurse Specialist, nurse practitioner, physician assistant, or other Medicare-qualified mental health care professional as allowed under applicable state laws.	You pay a $20 copayment for each Medicare-covered **individual** therapy session. You pay a $10 copayment for each Medicare-covered **group** therapy session.
- "Partial hospitalization" is a structured program of active treatment that is more intense than the care received in your doctor's or therapist's office and is an alternative to inpatient hospitalization.	You pay a $60 copayment each day for Medicare-covered benefits.
Outpatient substance abuse services	You pay a $20 copayment for each Medicare-covered **individual** therapy session. You pay a $10 copayment for each Medicare-covered **group** therapy session.
Outpatient surgery, observation and medical services, or outpatient hospital services provided in an outpatient facility	You pay a $100 copayment for Medicare-covered surgical, observation and medical services, or outpatient hospital services (including outpatient tests or diagnostic radiology services) performed at an outpatient hospital-based facility, outpatient hospital or ambulatory surgical center.
Ambulance services Covered ambulance services include fixed wing, rotary wing, and ground ambulance services, to the nearest appropriate facility that can provide care only if they are furnished to a member whose	You pay a $50 copayment for each one-way Medicare-covered trip.

Services that are covered for you	What you must pay when you get these services
Ambulance services *(continued)* medical condition is such that other means of transportation are contraindicated (could endanger the person's health). The member's condition must require both the ambulance transportation itself and the level of service provided in order for the billed service to be considered medically necessary. Non-emergency transportation by ambulance is appropriate if it is documented that the member's condition is such that other means of transportation are contraindicated (could endanger the person's health) and that transportation by ambulance is medically required.	
Emergency care Worldwide coverage for emergency services when you reasonably believe your health is in serious danger, which can include severe pain, a bad injury, a sudden illness, or a medical condition that is quickly getting much worse.	You pay a $50 copayment for each emergency room visit. You do not pay this amount if you are admitted to the hospital within 24 hours for the same condition. If you need inpatient care at an out-of-network hospital after your emergency condition is stabilized, you must return to a network hospital in order for your care to continue to be covered at the in-network cost-sharing, or you must have your inpatient care at the out-of-network hospital authorized by the Plan and your cost is the highest cost-sharing you would pay at a network hospital.

Services that are covered for you	What you must pay when you get these services
Urgently needed care Worldwide for 'urgently needed care' when medical care is needed right away because of an illness, injury, or condition that you did not expect or anticipate, and you are either temporarily outside our Plan's service area, or in extraordinary circumstances when network providers are temporarily unavailable or inaccessible.	You pay a $35 copayment for each visit in a network Urgent Care Center. You pay a $50 copayment for each visit in an out-of-network or an out-of-area facility. You do not pay this amount if you are admitted to the hospital within 24 hours for the same condition.
Outpatient rehabilitation services Covered services include: physical therapy (including wound therapy), occupational therapy, speech language therapy, cardiac rehabilitation services, intensive cardiac rehabilitation services, pulmonary rehabilitation services and Comprehensive Outpatient Rehabilitation Facility (CORF) services.	You pay the following: You pay a $25 copayment for each Medicare-covered physical therapy and speech-language therapy visit. You pay a $25 copayment for each Medicare-covered occupational therapy visit. You pay a $25 copayment for each Medicare-covered cardiac rehabilitative or pulmonary rehabilitative visit. You pay a $25 copayment for each Medicare-covered comprehensive outpatient rehabilitation facility (CORF) visit.
Durable medical equipment and related supplies (For a definition of "durable medical equipment," see the chapter of the Evidence of Coverage titled: *Definitions of important words.*) Covered items include, but are not limited to: wheelchairs, crutches, hospital bed, IV infusion pump, oxygen equipment, nebulizer, and walker.	You pay a 20% coinsurance for Medicare-covered benefits.

Services that are covered for you	What you must pay when you get these services
Prosthetic devices, corrective appliances and related supplies	
Devices (other than dental) that replace a body part or function. These include, but are not limited to colostomy bags and supplies directly related to colostomy care, pacemakers, braces, prosthetic shoes, artificial limbs, and breast prostheses (including a surgical brassiere after a mastectomy). Includes certain supplies related to prosthetic devices, and repair and/or replacement of prosthetic devices. Also includes some coverage following cataract removal or cataract surgery – see "Eye Care" earlier in this section for more detail.	You pay a 20% coinsurance for each Medicare-covered prosthetic or corrective appliance, including replacement or repairs of such devices.
One pair per plan year of therapeutic custom-molded shoes (including inserts provided with such shoes) and two additional pairs of inserts, or one pair of depth shoes and three pairs of inserts (not including the non-customized removable inserts provided with such shoes) for people with diabetes who have severe diabetic foot disease. Coverage includes fitting.	You pay a 20% coinsurance for each pair of Medicare-covered therapeutic shoes.
Diabetes self-monitoring, training, and supplies	
For all people who have diabetes (insulin and non-insulin users). Covered services include:	You pay the following:
- Blood glucose monitor, blood glucose test strips, lancet devices and lancets, and glucose-control solutions for checking the accuracy of test strips and monitors	You pay a 20% coinsurance for each Medicare-covered diabetes monitoring supply. For cost sharing applicable to insulin and syringes, see the Part D cost sharing later in this section.
- Self-management training is covered under certain conditions	You pay a $0 copayment for Medicare-covered benefits.

Services that are covered for you	What you must pay when you get these services
Medical nutrition therapy and Kidney disease education services	
Medical nutrition therapy for people with diabetes, renal (kidney) disease (but not on dialysis), and after a transplant when referred by your doctor. Education to teach kidney care and help members make informed decisions about their care. For people with stage IV chronic kidney disease, when referred by their doctor, we cover up to six sessions of kidney disease education services per lifetime.	You pay a $0 copayment for Medicare-covered benefits.
Outpatient diagnostic tests and therapeutic services and supplies	
Covered services include:	
- X-rays	You pay a $0 copayment for each Medicare-covered standard X-ray service.
- Radiation therapy	You pay a $25 copayment for each Medicare-covered radiation therapy service.
- Diagnostic radiology services ($0 copayment for each Abdominal Aortic Aneurysm screening)	You pay a $25 copayment for each Medicare-covered diagnostic radiology service performed in a physician's office or at a free-standing facility (such as a radiology center or medical clinic). The diagnostic radiology services require specialized equipment beyond standard X-ray equipment and must be performed by specially trained or certified personnel. Examples include, but are not limited to, specialized scans, CT, SPECT, PET, MRI, MRA, nuclear studies, sonograms, diagnostic

Services that are covered for you	What you must pay when you get these services
Outpatient diagnostic tests and therapeutic services and supplies *(continued)*	
	mammograms and interventional radiological procedures (myelogram, cystogram, angiogram, and barium studies). See "Outpatient surgery, observation and medical services, or outpatient hospital services provided at an outpatient facility" earlier in this chart for any applicable copayments or coinsurance amounts for diagnostic radiology services performed at an outpatient facility.
- Outpatient diagnostic tests ($0 copayment for each EKG screening)	You pay a $0 copayment for each Medicare-covered diagnostic test. Examples include, but are not limited to, pulmonary function tests, sleep studies and treadmill stress tests.
- Surgical supplies, such as dressings - Supplies, such as splints and casts	You pay a 20% coinsurance for each Medicare-covered medical supply.
- Laboratory tests ($0 copayment for each fasting plasma glucose test or for each HIV screening)	You pay a $0 copayment for Medicare-covered lab services.
- Blood. Coverage begins with the first pint of blood that you need. Coverage of storage and administration begins with the first pint of blood that you need.	You pay a $0 copayment for Medicare-covered services.
Preventive Care and Screening Tests	
Bone mass measurement	
For qualified individuals (generally, this means people at risk of losing bone mass or at risk of osteoporosis), the following services are covered	You pay a $0 copayment for each Medicare-covered screening.

Services that are covered for you	What you must pay when you get these services
Bone mass measurement *(continued)* every 24 months or more frequently if medically necessary: procedures to identify bone mass, detect bone loss, or determine bone quality, including a physician's interpretation of the results	
Colorectal screening The following services are covered once every 12 months: - Flexible sigmoidoscopy (or screening barium enema as an alternative) - Fecal occult blood test - Screening colonoscopy (or screening barium enema as an alternative)	You pay a $0 copayment for each screening exam. A screening colonoscopy or screening sigmoidoscopy does not include polyp removal or biopsy procedures. A colonoscopy or sigmoidoscopy that includes polyp removal or biopsy is a surgical procedure. See "Outpatient surgery, observation and medical services, or outpatient hospital services provided at an outpatient facility" earlier in this chart for any applicable copayments or coinsurance amounts for colorectal screening services performed at an outpatient facility.
HIV Screening For people who ask for an HIV screening test or who are at increased risk for HIV infection, we cover: - One screening test every 12 months For women who are pregnant, we cover: - Up to three screening tests during a pregnancy	You pay a $0 copayment for each Medicare-covered HIV screening test.

Services that are covered for you	What you must pay when you get these services
Immunizations Covered services include: - Pneumonia vaccine - Flu shots, once a year in the fall or winter - Hepatitis B vaccine if you are at high or intermediate risk of getting Hepatitis B - Other vaccines if you are at risk We also cover some vaccines under our outpatient prescription drug benefit.	You pay a $0 copayment for each Medicare-covered immunization.
Mammography screening Covered services include: - One baseline exam between the ages of 35 and 39 - One screening every 12 months for women age 40 and older	You pay a $0 copayment for each Medicare-covered screening.
Pap test, pelvic exams, and clinical breast exams Covered services include: - For all women, Pap tests, pelvic exams, and clinical breast exams are covered once every 12 months	You pay a $0 copayment for each exam.
Prostate cancer screening exams For men age 50 and older, covered services include the following - once every 12 months: - Digital rectal exam - Prostate Specific Antigen (PSA) test	You pay a $0 copayment for each Medicare-covered screening exam.
Cardiovascular disease testing Lipid profile blood tests for the detection of cardiovascular disease (or abnormalities associated with an elevated risk of cardiovascular disease) covered once every 12 months.	You pay a $0 copayment for each test.

Services that are covered for you	What you must pay when you get these services
Physical exams	
Includes measurement of height, weight and blood pressure; education, counseling and referral with respect to covered screening and preventive services. Doesn't include lab tests.	You pay a $0 copayment for a routine physical exam every 12 months.
Other Services	
Dialysis (kidney)	
Covered services include:	
- Outpatient dialysis treatments (including dialysis treatments when temporarily out of the service area, as explained in the chapter of the Evidence of Coverage titled: *Using the Plan's coverage for your medical services.*	You pay a 20% coinsurance for Medicare-covered benefits. These services will be covered as described in the following sections:
- Inpatient dialysis treatments (if you are admitted to a hospital for special care)	Please refer to Inpatient hospital care.
- Self-dialysis training (includes training for you and anyone helping you with your home dialysis treatments)	Please refer to Home health agency care.
- Home dialysis equipment and supplies	Please refer to Durable medical equipment and related supplies.
- Certain home support services (such as, when necessary, visits by trained dialysis workers to check on your home dialysis, to help in emergencies, and check your dialysis equipment and water supply)	Please refer to Home health agency care.
Medicare Part B prescription drugs	
These drugs are covered under Part B of Original Medicare. Members of our Plan receive coverage for these drugs through our Plan. Covered drugs include: - Drugs that usually aren't self-administered by the patient and are injected while you are getting physician services - Drugs you take using durable medical	You pay a 20% coinsurance for each Medicare-covered Part B drug.

Services that are covered for you	What you must pay when you get these services
Medicare Part B prescription drugs *(continued)* equipment (such as nebulizers) that was authorized by the Plan - Clotting factors you give yourself by injection if you have hemophilia - Immunosuppressive Drugs, if you were enrolled in Medicare Part A at the time of the organ transplant - Injectable osteoporosis drugs, if you are homebound, have a bone fracture that a doctor certifies was related to post-menopausal osteoporosis, and cannot self-administer the drug - Antigens - Certain oral anti-cancer drugs and anti-nausea drugs - Certain drugs for home dialysis, including heparin, the antidote for heparin when medically necessary, topical anesthetics, and erythropoisis-stimulating agents (such as Epogen®, Procrit®, Epoetin Alfa, Aranesp®, or Darbepoetin Alfa) - Intravenous Immune Globulin for the home treatment of primary immune deficiency diseases The *List of Covered Drugs (Formulary)* tells which Part D prescription drugs are covered by our Plan. The chapter of the Evidence of Coverage titled: *Using the Plan's coverage for your Part D prescription drugs* explains the Part D prescription drug benefit, including rules you must follow to have prescriptions covered. What you pay for your Part D prescription drugs through our Plan is listed in the chapter of the Evidence of Coverage	

Services that are covered for you	What you must pay when you get these services
Medicare Part B prescription drugs *(continued)* titled: *What you pay for your Part D prescription drugs.*	
Outpatient injectable medications	
(Self-administered outpatient injectable medications not covered under Part B of Original Medicare)	These medications may be covered under Medicare Part D. The *List of Covered Drugs (Formulary)* tells which Part D prescription drugs are covered by our Plan. The chapter in the *Evidence of Coverage* titled: *Using your Plan's coverage for Part D prescription drugs* explains the Part D prescription drug benefit, including rules you must follow to have prescriptions covered. What you pay for your Part D prescription drugs through our Plan is listed in the chapter of the *Evidence of Coverage* titled: *What you pay for your Part D prescription drugs*.
Additional Benefits	
Hearing services	
Routine hearing exam	You pay a $0 copayment for each routine hearing exam, limited to one exam every 12 months.
Hearing aids (Includes digital hearing aids)	
Please turn to the chapter of the Evidence of Coverage titled: *Additional benefits (not covered under Original Medicare)* for more detailed information about this hearing services benefit.	Plan pays up to $500 allowance for hearing aids every 3 years.

Services that are covered for you	What you must pay when you get these services
Vision services	
Routine eye exams (refraction)	You pay a $20 copayment for a routine eye exam, limited to one exam every 12 months.
Routine podiatry	You pay a $20 copayment for each routine visit up to 6 visits every plan year.
Fitness Program	$0 membership fee. Monthly basic membership fee for Fitness Program through network fitness centers. There is no visit or use fee when you use network service providers.
24-Hour NurseLine/treatment decision support	You may call the NurseLine, 24 hours a day, seven days a week and speak to a registered nurse (RN) about your medical concerns and questions.
Access support	You may call the NurseLine, 24 hours a day, seven days a week to help you find a quality doctor and schedule appointments.
Wellness advising	You pay $0 for this OptumHealth program designed to help you address certain particular conditions (for example weight management or fall risk issues) associated with defined medical conditions or criteria. The program provides you with access to advisors who assist you in making lifestyle behavior changes, as well as understanding risk factors associated with your health issues. The advisors provide you with either printed materials or telephonic support to achieve your goal.

Services that are covered for you	What you must pay when you get these services
Personal health management program	A program that offers guidance and support once you are diagnosed with complex and related co-morbid health conditions and also if you are not engaged in the disease and condition-specific management programs.
Advanced illness care management	A multi-dimensional program that utilizes Personal Resource Nurses and an interdisciplinary oversight team (including physical, speech, occupational and nutrition therapists, social workers, psychologists, nurses, palliative care physicians, and pharmacists) to identify, engage, assess and monitor members through all stages of disease progression, including death, loss and bereavement.

Services that are covered for you	What you must pay when you get these services
Disease management	You pay a $0 copayment for the following programs designed to help you best manage your particular diagnosed condition. The Congestive Heart Failure (CHF) program is designed to help you best manage your condition, educate you on your disease, prevent a reoccurrence of your CHF and recognize changes in symptoms and actively intervene to reduce unnecessary hospitalizations or emergency room visits by monitoring your condition. The Coronary Artery Disease (CAD) and Diabetes program is designed to help you best manage your condition, blood glucose levels and risk factors, reduce unnecessary emergency room visits and hospitalizations, prevent heart attacks and prevent disease progression and other illnesses related to coronary artery disease and poorly managed diabetes. The End Stage Renal Disease (ESRD) Services Program provides you with a comprehensive approach for managing your ESRD, both prior to starting dialysis, and during your dialysis treatment, as well as through transplant.

Services that are covered for you	What you must pay when you get these services
Evercare™ Solutions for Caregivers	Evercare™ Solutions for Caregivers is to support those individuals who are caregivers. Members have access to geriatric Specialists for: Care Resource Center – unlimited telephonic access to geriatric Specialists for information and research as well as identification of local care services such as meal delivery, transportation, housekeeping, etc. - Care Manager Services - up to six hours to be used for assessment to help members evaluate medical, social, financial safety and emotional needs and plan for future needs.

SECTION 3 What types of benefits are not covered by the Plan?

Chapter 3
Section 3.1

Types of benefits we do not cover

This section describes what kinds of benefits are "excluded." Excluded means that the Plan doesn't cover these benefits.

The list below describes some services and items that aren't covered by our Plan under any conditions and some that are excluded only under specific conditions.

If you get benefits that are excluded, you must pay for them yourself. We won't pay for the medical benefits listed in this section, or elsewhere in the Evidence of Coverage, and neither will Original Medicare. The only exception: If a benefit on the exclusion list is found upon appeal to be a medical benefit that we should have paid for or covered because of your specific situation. For information about appealing a decision we have made to not cover a medical service, go to the chapter titled: *What to do if you have a problem or complaint* in the Evidence of Coverage.

In addition to any exclusions or limitations described in the Medical Benefits Chart, or anywhere else in the Evidence of Coverage, **the following items and services aren't covered under Original Medicare or by our Plan:**

- Services considered not reasonable and necessary, according to the standards of Original Medicare, unless these services are listed by our Plan as covered services.
- Experimental medical and surgical procedures, equipment and medications. However, certain services may be covered by Original Medicare under a Medicare-approved Clinical Trial. See the chapter of the Evidence of Coverage titled: *Using the Plan's coverage for your medical services* in the section titled: *How are your medical services covered when you are in a "clinical research study?"* for more information on clinical research studies.
- Surgical treatment for morbid obesity, except when it is considered medically necessary and covered under Original Medicare.
- Private room in a hospital, except when it is considered medically necessary.
- Private duty nurses, except as specifically described as a covered service in the Medical Benefits Chart in this chapter.

Questions? *Call our Customer Service Department listed in Chapter 2.*

- Personal items in your room at a hospital or a skilled nursing facility, such as a telephone or a television.

- Full-time nursing care in your home.

- Custodial care or homemaker services, unless it is provided with covered skilled nursing care and/or skilled rehabilitation services. Custodial care, homemaker services, or non-skilled care, is care that helps you with activities of daily living, such as bathing or dressing, or basic household assistance, including light housekeeping or light meal preparation.

- Fees charged by your immediate relatives or members of your household.

- Meals delivered to your home.

- 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 procedures, unless needed because of an accidental injury or to improve a malformed part of the body. However, all stages of reconstruction are covered for a breast after a mastectomy, as well as for the unaffected breast to produce a symmetrical appearance.

- Routine dental care, such as cleanings, fillings or dentures, except as specifically described as a covered service in the Medical Benefits Chart in this chapter. However, non-routine dental care received at a hospital may be covered.

- Chiropractic care, other than manual manipulation of the spine consistent with Medicare coverage guidelines, and except as specifically described as a covered service in the Medical Benefits Chart in this chapter.

- Routine foot care, except for the limited coverage provided according to Medicare guidelines, and except as specifically described as a covered service in the Medical Benefits Chart in this chapter.

- Orthopedic shoes, unless the shoes are part of a leg brace and are included in the cost of the brace or the shoes are for a person with diabetic foot disease, and except as specifically described as a covered service in the Medical Benefits Chart in this chapter.

- Foot orthotics, orthopedic or therapeutic shoes, except for people with diabetic foot disease, and except as specifically described as a covered service in the Medical Benefits Chart in this chapter.

- Hearing aids and routine hearing examinations, except as specifically described as a covered service in the Medical Benefits Chart in this chapter.

- Eyeglasses, routine eye examinations, radial keratotomy, LASIK surgery, vision therapy and other low vision aids and services, except as specifically described as a covered service in the Medical Benefits Chart in this chapter.

- Prescription drugs for treatment of sexual dysfunction, including erectile dysfunction, impotence, and anorgasmy or hyporgasmy, except as specifically described as a covered service in your separate pharmacy benefit materials, if applicable to your plan.

- Reversal of sterilization procedures, sex change operations, and non-prescription contraceptive supplies.

- Acupuncture, except as specifically described as a covered service in the Medical Benefits Chart in this chapter.

- Naturopath services (uses natural or alternative treatments) except as specifically described as a covered service in the Medical Benefits Chart in this chapter.

- Services provided to veterans in Veterans Affairs (VA) facilities. However, when emergency services are received at VA hospital and the VA cost-sharing is more than the cost-sharing under our Plan. We will reimburse veterans for the difference. Members are still responsible for our cost-sharing amounts.

- Medical treatment for any services provided in a local, state or federal government facility or agency except when payment under the Plan is expressly required by federal or state law.

- All services, procedures, treatments, medications and supplies related to Workers' Compensation claims.

- Physical examinations for the purpose of maintaining or obtaining employment, licenses, insurance, court hearings, travel, dietary counseling, weight reduction programs or for premarital and pre-adoption purposes and/or other non-preventive reasons.

- Abortion, except for cases resulting in pregnancies from rape or incest or that endanger the life of the mother.

Questions? *Call our Customer Service Department listed in Chapter 2.*

- Smoking cessation products and treatments, except as covered in accordance with Medicare guidelines or as specifically described as a covered service in the Medical Benefits Chart in this chapter.

- Routine transportation, except as specifically described as a covered service in the Medical Benefits Chart in this chapter.

- Health services received as a result of war or any act of war that occurs during the member's term of Coverage under the Evidence of Coverage.

- Health services for treatment of military service related disabilities provided by the Military Health Services System (including CHAMPUS or TRICARE) under which the federal government agrees to pay for the services and supplies.

- Paramedic intercept service (advanced life support provided by an emergency service entity, such as a paramedic services unit, which do not provide ambulance transport), except when Medicare criteria are met.

- Optional, additional, or deluxe features or accessories to durable medical equipment, corrective appliances or prosthetics which are primarily for the comfort or convenience of the member, or for ambulation primarily in the community, including home and car remodeling or modification.

- Immunizations for foreign travel or employment purposes, except as covered in accordance with Medicare guidelines.

- Substance abuse detoxification and rehabilitation, except as covered in accordance with Medicare guidelines.

- Proton beam therapy for the medically appropriate treatment of prostate cancer is a covered service. Prior authorization must be obtained for all treatment in order for the proton beam therapy to be considered a covered service. Coverage for proton beam therapy for the treatment of prostate cancer is limited to a maximum of the Original Medicare allowable amount for conformal 3D photon beam therapy treatments for prostate cancer. Coverage is subject to coinsurance, including but not limited to, coinsurance for radiation therapy. Members are responsible for any amounts in excess of Original Medicare allowable amounts, and for any travel or other costs associated with obtaining proton beam therapy treatment of prostate cancer.

- If you are asking the Plan to pay its share of the costs for Medicare Part B covered drugs, you must send us your request for payment within 90 days of getting your prescription filled.

- The following services and items are excluded from coverage under the UnitedHealthcare United Resource Network transplant program:

    - Unauthorized or not prior authorized organ procurement and transplant related services.
    - Transplants performed in a non-UnitedHealthcare United Resource Network facility, unless specifically authorized by the UnitedHealthcare Medical Director.
    - Transplant services, including donor costs, when the transplant recipient is not a member.
    - Artificial or non-human organs.
    - Transportation services for any day a member is not receiving medically necessary transplant services.
    - Transportation of any potential donor for typing and matching.
    - Food and housing costs for any day a member is not receiving medically necessary transplant services.
    - Storage costs for any organ or bone marrow, unless authorized by the UnitedHealthcare Transplant Medical Director.
    - Services for which government funding or other insurance coverage is available.
    - Bone marrow transplants or stem cell transplantation, except as a treatment for an appropriate diagnosis as specifically stated in the Medicare coverage guidelines or in the Evidence of Coverage.

- Any services listed above that aren't covered will remain not covered even if received at an emergency facility. For example, non-authorized, routine conditions that do not appear to a reasonable person to be based on a medical emergency are not covered if received at an emergency facility.

We regularly review new procedures, devices and drugs to determine whether or not they are safe and efficacious for members. New procedures and technology that are safe and efficacious are eligible to become covered services. If the technology becomes a covered service, it will be subject to all other terms and conditions of the Plan, including medical necessity and any applicable member copayments, coinsurance, deductibles or other payment contributions.

In determining whether to cover a service, we use proprietary technology guidelines to review new devices, procedures and drugs, including those related to behavioral health. When clinical necessity requires a rapid determination of the safety and efficacy of a new technology or new application of an existing technology for an individual member, one of our Medical Directors makes a medical necessity determination based on individual member medical documentation, review of published scientific evidence, and, when appropriate, relevant specialty or professional opinion from an individual who has expertise in the technology.

CHAPTER 4: What you pay for your Part D prescription drugs

Questions? *Call our Customer Service Department listed in Chapter 2.*

SECTION 9. Do you have to pay the Part D "late enrollment penalty?"

Did you know there are programs to help people pay for their drugs?

There are programs to help people with limited resources pay for their drugs. The "Extra Help" program helps people with limited resources pay for their drugs.

Are you currently getting help to pay for your drugs?

If you are in a program that helps pay for your drugs, some information in the Evidence of Coverage may not apply to you. Please call Customer Service and ask for the *Low Income Subsidy information* for people who get extra help paying for drugs if we have not already sent this information to you. Phone numbers are in Chapter 2 of the Evidence of Coverage.

SECTION 1 Introduction

Chapter 4
Section 1.1

Use this chapter together with other materials that explain your drug coverage

This chapter focuses on what you pay for your Part D prescription drugs. To keep things simple, we use "drug" in this chapter to mean a Part D prescription drug. As explained in the chapter titled: *Using the Plan's coverage for your Part D prescription drugs* under *"What types of drugs are not covered by the Plan?"* some drugs are not covered under Original Medicare or are excluded by law.

To understand the payment information we give you in this chapter, you need to know the basics of what drugs are covered, where to fill your prescriptions, and what rules to follow when you get your covered drugs. Here are materials that explain these basics:

- **The Plan's *List of Covered Drugs (Formulary)*.** To keep things simple, we call this the "Drug List."
    - This Drug List includes a list of drugs that are covered for you.
    - It also shows which of the 4 tiers the drug is in and whether there are any restrictions on your coverage for the drug.

- If you need a copy of the Drug List, call Customer Service (phone numbers are in Chapter 2 of the Evidence of Coverage). You can also find the Drug List on our Web site listed in Chapter 2 of the Evidence of Coverage. The Drug List on the Web site is always the most current.

- **The chapter of the Evidence of Coverage titled: Using the Plan's coverage for your Part D prescription drugs.** This chapter gives the details about your prescription drug coverage, including rules you need to follow when you get your covered drugs. This chapter also explains which types of prescription drugs are not covered by our Plan.
- **The Plan's *Pharmacy Directory*.** In most situations you must use a network pharmacy to get your covered drugs (see the chapter in the Evidence of Coverage titled: *Using the Plan's coverage for your Part D prescription drugs* for the details). The *Pharmacy Directory* has a list of pharmacies in the Plan's network and it explains how you can use the Plan's mail order service. It also explains how you can get a long-term supply of a drug (such as filling a prescription for a three month's supply).

SECTION 2 What you pay for a drug depends on which "drug payment stage" you are in when you get the drug

Chapter 4
Section 2.1

What are Medicare's three drug payment stages?

As shown in the table below, there are three "drug payment stages" for your prescription drug coverage. How much you pay for a drug depends on which of these stages you are in at the time you get a prescription filled or refilled. Keep in mind you are always responsible for the Plan's monthly premium (if applicable) regardless of the drug payment stage.

If you get extra help paying for drugs, you will not pay the amounts shown below, please see your Low Income Subsidy information for more information about your actual drug costs.

Stage 1 **Initial Coverage Stage**	Stage 2 **Coverage Gap Stage**	Stage 3 **Catastrophic Coverage Stage**
The Plan pays its share of the cost of your drugs and you **pay your share of the cost.** You stay in this stage until your payments for the year plus the Plan's payments total $2,840. (Details are in the Section *During the Initial Coverage Stage, the Plan pays its share of your drug costs and you pay your share* later in this chapter.)	You receive a **discount on brand name drugs** and you pay only 93% of the costs of generic drugs. You stay in this stage until your "out-of-pocket costs" reach a total of $4,550. This amount and rules for counting costs toward this amount have been set by Medicare. (Details are in the Section titled: *During the Coverage Gap Stage, you receive a discount on brand name drugs and pay only 93% of the costs of generic drugs* later in this chapter.)	Once you have paid enough for your drugs to move on to this last payment stage, **the Plan will pay most of the cost** of your drugs for the rest of the year. (Details are in Section *During the Catastrophic Coverage Stage, the Plan pays most of the cost for your drugs* of this chapter.)

As shown in this summary of the three payment stages, whether you move on to the next payment stage depends on how much you and/or the Plan spends for your drugs while you are in each stage.

SECTION 3 We send you reports that tell about payments for your drugs and which payment stage you are in

Chapter 4
Section 3.1

We send you a monthly report called the "Explanation of Benefits"

We keep track of the costs of your prescription drugs and the payments you have made when you get your prescriptions filled or refilled at the pharmacy. This way, we can tell you when you have moved from one drug payment stage to the next. In particular, there are two types of costs we keep track of:

- We keep track of how much you have paid. This is called your "out-of-pocket" cost.
- We keep track of your "total drug costs." This is the amount you pay out-of-pocket or others pay on your behalf plus the amount paid by the Plan.

We will prepare a written report called the *Explanation of Benefits* (it is sometimes called the "EOB.") when you have had one or more prescriptions filled. It includes:

- **Information for that month**. This report gives the payment details about the prescriptions you have filled during the previous month. It shows the total drug costs, what the Plan paid, and what you and others on your behalf paid.

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

Chapter 4
Section 3.2

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

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

- **Show your member ID card when you get a prescription filled.** To make sure we know about the prescriptions you are filling and what you are paying, show your member ID card every time you get a prescription filled.
- **Make sure we have the information we need.** There are times you may pay for prescription drugs when we will not automatically get the information we need. To help us keep track of your out-of-pocket costs, you may give us copies of receipts for drugs that you have purchased. (If you are billed for a covered drug, you can ask our Plan to pay our share of the cost. For instructions on how to do this, go to the chapter of the

Evidence of Coverage titled: *Asking the Plan to pay its share of a bill you have received for covered services or drugs.*) Here are some types of situations when you may want to give us copies of your drug receipts to be sure we have a complete record of what you have spent for your drugs:

- When you purchase a covered drug at a network pharmacy at a special price or using a discount card that is not part of our Plan's benefit.
- When you made a copayment for drugs that are provided under a drug manufacturer patient assistance program.
- Any time you have purchased covered drugs at out-of-network pharmacies or other times you have paid the full price for a covered drug under special circumstances.

- **Send us information about the payments others have made for you.** Payments made by certain other individuals and organizations also count toward your out-of-pocket costs and help qualify you for catastrophic coverage. For example, payments made by a State Pharmaceutical Assistance Program, an AIDS drug assistance program, the Indian Health Service, and most charities count toward your out-of-pocket costs. You should keep a record of these payments and send them to us so we can track your costs.
- **Check the written report we send you.** When you receive an *Explanation of Benefits* in the mail, please look it over to be sure the information is complete and correct. If you think something is missing from the report, or you have any questions, please call us at Customer Service (phone numbers are in Chapter 2 of the Evidence of Coverage). Be sure to keep these reports. They are an important record of your drug expenses.

SECTION 4 During the Initial Coverage Stage, the Plan pays its share of your drug costs and you pay your share

Chapter 4
Section 4.1

What you pay for a drug depends on the drug and where you fill your prescription

During the Initial Coverage Stage, the Plan pays its share of the cost of your covered prescription drugs, and you pay your share. Your share of the cost will vary depending on the drug and where you fill your prescription.

The Plan has Four Tiers

Every drug on the Plan's Drug List is in one of four tiers. In general, the higher the tier number, the higher your cost will be for the drug:

Tier 1 – includes most generic prescription drugs

Tier 2 – includes many common brand-name and some higher-cost generic drugs

Tier 3 – includes non-preferred brand-name drugs and non-preferred generic drugs

Tier 4 – includes unique or very high-cost drugs

To find out which tier your drug is in, look it up in the Plan's Drug List.

Your pharmacy choices

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

- A retail pharmacy that is in our Plan's network
- A pharmacy that is not in the Plan's network
- The Plan's network mail service pharmacy

For more information about these pharmacy choices and filling your prescriptions, see the chapter in the Evidence of Coverage titled: *Using the Plan's coverage for your Part D prescription drugs* and the Plan's *Pharmacy Directory*.

Chapter 4
Section 4.2

A table that shows your costs for a covered drug

During the Initial Coverage Stage, your share of the cost of a covered drug will be either a copayment or coinsurance.

- **"Copayment"** means that you pay a fixed amount each time you fill a prescription.
- **"Coinsurance"** means that you pay a percent of the total cost of the drug each time you fill a prescription.

As shown in the table below, the amount of the copayment or coinsurance depends on which tier your drug is in and where you fill your prescription.

For some drugs, you can get a longer-term supply (also called an "extended supply") when you fill your prescription. This can be up to a 90 day supply. (For details on where and how to get a longer-term supply of a drug, see the chapter titled: Using the Plan's coverage for your Part D prescription drugs.)

The following table shows what you pay when you get a 31-day supply and a longer-term up to 90 day supply of a drug.

Your share of the cost when you get a covered Part D prescription drug from:			
	Network pharmacy (when you get a 31-day supply (or less) of a covered Part D prescription drug)	**The Plan's network mail service pharmacy** (When you get a longer-term supply up to 90 days of a covered Part D prescription drug)	**Out-of-network pharmacy** (coverage is limited to a 31-day supply of a covered Part D prescription drug in certain situations; see the chapter titled: *Using the Plan's coverage for your Part D prescription drugs* for details)
Tier 1	$4 copayment	$8 copayment	$4 copayment*
Tier 2	$28 copayment	$74 copayment	$28 copayment*
Tier 3	$58 copayment	$164 copayment	$58 copayment*
Tier 4	33% coinsurance	33% coinsurance	33% coinsurance*

*You may be responsible for paying the difference between what we would pay for a prescription filled at a network pharmacy and what the out-of-network pharmacy charged for your prescription.

If you qualify for "extra help" from Medicare to help pay for your prescription drug costs, your costs for your Medicare Part D prescription drug will be lower than the amounts listed in the chart above. If you have Medicare and Medicaid you automatically qualify for extra help. Members with the lowest income and resources are eligible for the most extra help. (Please see your *Low Income Subsidy information* for more information about your actual drug costs.)

Chapter 4
Section 4.3

You stay in the Initial Coverage Stage until your total drug costs for the year reach $2,840

You stay in the Initial Coverage Stage until the total amount for the prescription drugs you have filled and refilled reaches the **$2,840 limit for the Initial Coverage Stage**.

Your total drug cost is based on adding together what you have paid and what the Plan has paid:

- **What you have paid** for all the covered drugs you have gotten since you started with your first drug purchase of the year. (See Section 5.2 for more information about how Medicare calculates your out-of-pocket costs.) This includes:
- The total you paid as your share of the cost for your drugs during the Initial Coverage Stage.
- **What the Plan has paid** as its share of the cost for your drugs during the Initial Coverage Stage.

The *Explanation of Benefits* that we send to you will help you keep track of how much you and the Plan have spent for your drugs during the year. Many people do not reach the $2,840 limit in a year.

We will let you know if you reach this $2,840 amount. If you do reach this amount, you will leave the Initial Coverage Stage and move on to the Coverage Gap Stage.

SECTION 5 During the Coverage Gap Stage, you receive a discount on brand name drugs and pay only 93% of the costs of generic drugs

Chapter 4
Section 5.1

You stay in the Coverage Gap Stage until your out-of-pocket costs reach $4,550

Once your total out-of-pocket costs reach $4,550, you will qualify for catastrophic coverage.

When you are in the coverage gap stage, **you pay a discounted price for brand name drugs**. You continue paying the discounted price for brand name drugs and 93% of the costs of generic drugs until your yearly out-of-pocket payments reach a maximum amount that Medicare has set. In 2011, that amount is $4,550.

Questions? *Call our Customer Service Department listed in Chapter 2.*

Medicare Coverage Gap Discount Program

Beginning in 2011, the Medicare Coverage Gap Discount Program will provide manufacturer discounts on brand name drugs to Part D enrollees who have reached the coverage gap and are not already receiving "Extra Help." A 50% discount on the negotiated price (excluding the dispensing fee) will be available for those brand name drugs from manufacturers that have agreed to pay the discount.

We will automatically apply the discount when your pharmacy bills you for your prescription and your Explanation of Benefits will show any discount provided. The amount discounted by the manufacturer counts toward your out-of-pockets costs as if you had paid this amount and moves you through the coverage gap.

Medicare has rules about what counts and what does **not** count as your out-of-pocket costs. When you reach an out-of-pocket limit of $4,550, you leave the Coverage Gap Stage and move on to the Catastrophic Coverage Stage.

Chapter 4
Section 5.2

How Medicare calculates your "out-of-pocket" costs for your prescription drugs

Here are Medicare's rules that we must follow when we keep track of your out-of-pocket costs for your drugs.

These payments **are included** in your out-of-pocket costs

When you add up your out-of-pocket costs, you **can include** the payments listed below (as long as they are for Part D covered drugs and you followed the rules for drug coverage that are explained in the chapter of the Evidence of Coverage titled: *Using the Plan's coverage for your Part D prescription drugs*):

- The amount you pay for drugs when you are in any of the following drug payment stages:
  - The Initial Coverage Stage.
  - The Coverage Gap Stage.
- Any payments you made during this calendar year under another Medicare prescription drug plan before you joined our Plan.

It matters who pays:

- If you make these payments **yourself**, they are included in your out-of-pocket costs.
- These payments are also included if they are made on your behalf by **certain other individuals or organizations**. This includes payments for your drugs made by a friend or relative, by most charities, by AIDS drug assistance programs, by the Indian Health Service, or by a State Pharmaceutical Assistance Program that is qualified by Medicare. Payments made by "Extra Help" and the Medicare Coverage Gap Discount Program from Medicare are also included.

Moving on to the Catastrophic Coverage Stage:

When you (or those paying on your behalf) have spent a total of $4,550 in out-of-pocket costs within the calendar year, you will move from the Coverage Gap Stage to the Catastrophic Coverage Stage.

These payments are **not included** in your out-of-pocket costs

When you add up your out-of-pocket costs, you are **not allowed to include** any of these types of payments for prescription drugs:

- If you have a Part D premium, the amount you pay for your monthly premium.
- Drugs you buy outside the United States and its territories.
- Drugs that are not covered by our Plan.
- Drugs you get at an out-of-network pharmacy that do not meet the Plan's requirements for out-of-network coverage.
- Non-Part D drugs, including prescription drugs covered by Part A or Part B and other drugs excluded from coverage by Medicare.
- Payments you make toward prescription drugs not normally covered in a Medicare Prescription Drug Plan.
- Payments for your drugs that are made by group health plans including employer health plans.
- Payments for your drugs that are made by certain insurance plans and government-funded health programs such as TRICARE and the Veteran's Administration
- Payments for your drugs made by a third-party with a legal obligation to pay for prescription costs (for example, Worker's Compensation).

Reminder: If any other organization such as the ones listed above pays part or all of your out-of-pocket costs for drugs, you are required to tell us. Call Customer Service to let us know (phone numbers are in Chapter 2 of the Evidence of Coverage).

How can you keep track of your out-of-pocket total?

- **We will help you.** The *Explanation of Benefits* report we send to you includes the current amount of your out-of-pocket costs (Section 3 explains this report). When you reach a total of $4,550 in out-of-pocket costs for the year, this report will show you that you have left the Coverage Gap Stage and have moved on to the Catastrophic Coverage Stage.
- **Make sure we have the information we need.** Section 3 explains what you can do to help make sure that our records of what you have spent are complete and up to date.

SECTION 6 During the Catastrophic Coverage Stage, the Plan pays most of the cost for your drugs

Chapter 4
Section 6.1

Once you are in the Catastrophic Coverage Stage, you will stay in this stage for the rest of the year

You qualify for the Catastrophic Coverage Stage when your out-of-pocket costs have reached the $4,550 limit for the calendar year. Once you are in the Catastrophic Coverage Stage, you will stay in this payment stage until the end of the calendar year.

During this stage, the Plan will pay most of the cost for your drugs.

- **Your share** of the cost for a covered drug will be either coinsurance or a copayment, whichever is the *larger* amount:
  - **either** coinsurance of 5% of the cost of the drug
  - **or** $2.50 copayment for a generic drug or a drug that is treated like a generic. Or a $6.30 copayment for all other drugs.
- **Our Plan pays the rest** of the cost.

SECTION 7 Benefit limitations

Chapter 4
Section 7.1

Our Plan has benefit limitations

This part of this chapter talks about benefit limitations of our Plan.

1. Early refills for lost, stolen or destroyed drugs are not covered except during a declared "National Emergency."
2. Early refills for vacation supplies are limited to a one-time fill of up to 31 days per calendar year.
3. Medications will not be covered if prescribed by physicians or other providers who are excluded from Medicare program participation.
4. You may refill a prescription when a minimum of seventy-five (75%) of the quantity is consumed based on the days supply.

Questions? *Call our Customer Service Department listed in Chapter 2.*

SECTION 8 What you pay for vaccinations depends on how and where you get them

Chapter 4
Section 8.1

Our Plan has separate coverage for the vaccine medication itself and for the cost of giving you the vaccination shot

Our Plan includes coverage of a number of vaccines. There are two parts to our coverage of vaccinations:

- The first part of coverage is the cost of **the vaccine medication itself**. The vaccine is a prescription medication.
- The second part of coverage is for the cost of **giving you the vaccination shot**. (This is sometimes called the "administration" of the vaccine.)

What do you pay for a vaccination?

What you pay for a vaccination depends on three things:

1. **The type of vaccine** (what you are being vaccinated for).
    - Some vaccines are considered medical benefits. You can find out about your coverage of these vaccines by going to the chapter in the Evidence of Coverage titled: *Medical benefits chart (what is covered and what you pay).*
    - Other vaccines are considered Part D drugs. You can find these vaccines listed in the Plan's Drug List.
2. **Where you get the vaccine medication.**
3. **Who gives you the vaccination shot.**

What you pay at the time you get the vaccination can vary depending on the circumstances. For example:

- Sometimes when you get your vaccination shot, you will have to pay the entire cost for both the vaccine medication and for getting the vaccination shot. You can ask our Plan to pay you back for our share of the cost.
- Other times, when you get the vaccine medication or the vaccination shot, you will pay only your share of the cost.

To show how this works, here are three common ways you might get a vaccination shot. Remember you are responsible for all of the costs associated with vaccines (including their administration) during the Coverage Gap Stage of your benefit.

Situation 1: You buy the vaccine at the network pharmacy and you get your vaccination shot at the network pharmacy. (Whether you have this choice depends on where you live. Some states do not allow pharmacies to administer a vaccination.)

- You will have to pay the network pharmacy the amount of your copayment and/or coinsurance for the vaccine and the administration of the vaccine itself.

Situation 2: You get the vaccination at your doctor's office.

- When you get the vaccination, you will pay for the entire cost of the vaccine and its administration.
- You can then ask our Plan to pay our share of the cost by using the procedures that are described in the chapter of the Evidence of Coverage titled: *Asking the Plan to pay its share of a bill you have received for medical services or drugs*.
- You will be reimbursed the amount you paid less your normal copayment and/or coinsurance for the vaccine (including administration) less any difference between the amount the doctor charges and what we normally pay. (If you are in the Extra Help program, we will reimburse you for this difference.)

Situation 3: You buy the vaccine at your network pharmacy, and then take it to your doctor's office where they give you the vaccination shot.

- You will have to pay the network pharmacy the amount of your copayment and/or coinsurance for the vaccine itself.
- When your doctor gives you the vaccination shot, you will pay the entire cost for this service. You can then ask our Plan to pay our share of the cost by using the procedures described in the chapter of the Evidence of Coverage titled: *Asking the Plan to pay its share of a bill you have received for medical services or drugs*.
- You will be reimbursed the amount charged by the doctor less any cost-sharing amount that you need to pay for the vaccine less any difference between the amount the doctor charges and what we normally pay. (If you are in the Extra Help program, we will reimburse you for this difference.)

For best coverage, UnitedHealthcare recommends that you get vaccines at a network pharmacy wherever possible. If the administration fee is less than $20, all you will have to pay is your copayment or coinsurance amount. And you won't have to fill out a form to get reimbursed so getting your vaccine at a network pharmacy rather than at your doctor's office may be more convenient. If the administration fee is more than $20, you will need to pay the difference between the $20 and the administrative fee your doctor charges. Check your *Pharmacy Directory* for a list of network pharmacies.

Chapter 4
Section 8.2

You may want to call us at Customer Service before you get a vaccination

The rules for coverage of vaccinations are complicated. We are here to help. We recommend that you call us first at Customer Service whenever you are planning to get a vaccination (phone numbers are in Chapter 2 of the Evidence of Coverage).

- We can tell you about how your vaccination is covered by our Plan and explain your share of the cost.
- We can tell you how to keep your own cost down by using providers and pharmacies in our network.
- If you are not able to use a network provider and pharmacy, we can tell you what you need to do to get payment from us for our share of the cost.

SECTION 9 Do you have to pay the Part D "late enrollment penalty?"

Chapter 4
Section 9.1

What is the Part D "late enrollment penalty?"

You may pay a financial penalty if you did not enroll in a plan offering Medicare Part D drug coverage when you first became eligible for this drug coverage or you experienced a continuous period of 63 days or more when you didn't keep your prescription drug coverage. The amount of the penalty depends on how long you waited before you enrolled in drug coverage after you became eligible or how many months after 63 days you went without drug coverage.

The penalty is added to your monthly premium. (For members who must pay a late enrollment penalty, the amount of the penalty will be added to the bill we send to your Plan Sponsor.) When you first enroll in our Plan we let you know the amount of the penalty, if you have one.

Chapter 4
Section 9.2

How much is the "Part D" late enrollment penalty?

Medicare determines the amount of the penalty. Here is how it works:

- First count the number of full months that you delayed enrolling in a Medicare drug plan, after you were eligible to enroll. Or count the number of full months in which you did not have creditable prescription drug coverage, if the break in coverage was 63 days or more. The penalty is 1% for every month that you didn't have creditable coverage. For our example, let's say it is 14 months without coverage, which will be 14%.
- Then Medicare determines the amount of the average monthly premium for Medicare drug plans in the nation from the previous year. For 2011, this average premium amount was $32.34. This amount may change for 2012.
- You multiply together the two numbers to get your monthly penalty and round it to the nearest 10 cents. In the example here it would be 14% times $32.34, which equals $4.5276, which rounds to $4.53. This amount would be added to your Plan Sponsor's monthly premium for your late enrollment penalty.

There are three important things to note about this monthly premium penalty:

- First, **the penalty may change each year,** because the average monthly premium can change each year. If the national average premium (as determined by Medicare) increases, your penalty will increase.
- Second, **you will continue to pay a penalty** every month for as long as you are enrolled in a plan that has Medicare Part D drug benefits.
- Third, if you are under 65 and currently receiving Medicare benefits, the late enrollment penalty will reset when you turn 65. After age 65, your late enrollment penalty will be based only on the months that you don't have coverage after your initial enrollment into Medicare.

If you are eligible for Medicare and you are under age 65, any late enrollment penalty you are paying will be eliminated when you attain age 65. After age 65, your late enrollment penalty is based only on the months you do not have coverage after you Age 65 Initial Enrollment Period.

Chapter 4
Section 9.3

In some situations, you can enroll late and not have to pay the penalty

Even if you have delayed enrolling in a plan offering Medicare Part D coverage when you were first eligible, sometimes you do not have to pay the late enrollment penalty.

You will not have to pay a premium penalty for late enrollment if you are in any of these situations:

- You already have prescription drug coverage at least as good as Medicare's standard drug coverage. Medicare calls this "**creditable drug coverage.**" Creditable coverage could include drug coverage from a former employer or union, TRICARE, or the Department of Veterans Affairs. Speak with your insurer or your human resources department to find out if your current drug coverage is as least as good as Medicare's.
- If you were without creditable coverage, you can avoid paying the late enrollment penalty if you were without it for less than 63 days in a row.
- If you didn't receive enough information to know whether or not your previous drug coverage was creditable.
- You lived in an area affected by Hurricane Katrina at the time of the hurricane (August 2005), **and** you signed up for a Medicare prescription drug plan by December 31, 2006, **and** you have stayed in a Medicare prescription drug plan.
- You are receiving "Extra Help" from Medicare.

Chapter 4
Section 9.4

What can you do if you disagree about your late enrollment penalty?

If you disagree about your late enrollment penalty, you can ask us to review the decision about your late enrollment penalty. Call Customer Service at the number listed in Chapter 2 of the Evidence of Coverage to find out more about how to do this.

CHAPTER 5: Using the Plan's coverage for your medical services

SECTION 1 Things to know about getting your medical care coverage as a member of our Plan

This chapter provides information you need to know about using our Plan to get your medical care coverage. It gives definitions of terms and explains the rules you will need to follow to get the medical treatments, services, and other medical care that are covered by the Plan.

For the details on what medical care is covered by our Plan and how much you pay as your share of the cost when you get this care, use the benefits chart in the chapter of the Evidence of Coverage titled: *Medical benefits chart (what is covered and what you pay).*

Chapter 5
Section 1.1

What are "network providers" and "covered services?"

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

- **"Providers"** are doctors and other health care professionals that the state licenses to provide medical services and care. The term "providers" also includes hospitals and other health care facilities.
- **"Network providers"** are the doctors and other health care professionals, medical groups, hospitals, and other health care facilities that have an agreement with us to accept payment in full. We have arranged for these providers to deliver covered services to members in our Plan. The providers in our network generally bill us directly for care they give you. When you see a network provider, you usually pay only your share of the cost for their services.
- **"Covered services"** include all the medical care, health care services, supplies, and equipment that are covered by our Plan. Your covered services for medical care are listed in the benefits chart in the chapter of the Evidence of Coverage titled: *Medical benefits chart (what is covered and what you pay).*

Chapter 5
Section 1.2

Basic rules for getting your medical care that is covered by the Plan

The Plan will generally cover your medical care as long as:

- **The care you receive is included in the Plan's Medical Benefits Chart** (this chart is in the chapter of the Evidence of Coverage titled: *Medical benefits chart (what is covered and what you pay).*
- **The care you receive is considered medically necessary**. It needs to be accepted treatment for your medical condition.
- **You have a Primary Care Physician (a PCP) who is providing and overseeing your care**. As a member of our Plan, you must choose a PCP (for more information about this, see Section 2.1 in this chapter).
  - In most situations, your PCP must give you approval in advance before you can use other providers in the Plan's network, such as Specialists, hospitals, skilled nursing facilities, or home health care agencies. This is called giving you a "referral." For more information about this, see Section 2.2 of this chapter.
  - Referrals from your PCP are not required for emergency care or urgently needed care. There are also some other kinds of care you can get without having approval in advance from your PCP (for more information about this, see Section 2.3 of this chapter).
- **You generally must receive your care from a network provider** (for more information about this, see Section 2 in this chapter). In most cases, care you receive from an out-of-network provider (a provider who is not part of our Plan's network) will not be covered. Here are two exceptions:
  - The Plan covers emergency care or urgently needed care that you get from an out-of-network provider. For more information about this, and to see what emergency or urgently needed care means, see Section 3 in this chapter.
  - If you need medical care that Medicare 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. In this situation, you will pay the same as you would pay if you got the care from a network provider. If this situation occurs please contact Customer Service to let us know in advance of getting care from an out-of-network provider.

SECTION 2 Using network providers to get your medical care

Chapter 5
Section 2.1

You must choose a Primary Care Physician (PCP) to provide and arrange for your medical care

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

What is a PCP?

A Primary Care Physician (PCP) is a network physician who is selected by you to provide or coordinate your covered services.

What types of providers may act as a PCP?

PCPs are generally physicians specializing in Internal Medicine, Family Practice or General Practice.

What is the role of my PCP?

Your relationship with your PCP is an important one because your PCP is responsible for your routine health care needs, for the coordination of all covered services provided to you, for maintaining a central medical record for you, and for ensuring continuity of care. If you need an appointment with a network Specialist or other network provider who is not your PCP, you must obtain a referral from your PCP.

How do you choose your PCP?

You must select a PCP from the *Provider Directory* at the time of your enrollment.

Because your access to network Specialists and hospitals is based upon your PCP selection, if there are specific hospitals, physicians or other providers that you want to use, be sure to find out if a PCP refers to those providers, as part of your selection process.

For a copy of the most recent *Provider Directory*, or for help in selecting a PCP, call Customer Service or visit the Web site listed in Chapter 2 of the Evidence of Coverage for the most up-to-date information about our network providers.

If you do not select a PCP at the time of enrollment, we will pick one for you. You may change your PCP at any time. See "Changing your PCP" below.

Changing your PCP

You may change your PCP for any reason, at any time. Also, it's possible that your PCP might leave our Plan's network of providers and you would have to find a new PCP in our Plan.

If you want to change your PCP, call Customer Service. If the PCP is accepting additional Plan members, the change will become effective on the first day of the following month. You will receive a new member ID card that shows this change.

Chapter 5
Section 2.2

What kinds of medical care can you get without getting approval in advance from your PCP?

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

- Routine women's health care, which include breast exams, mammograms (X-rays of the breast), Pap tests, and pelvic exams as long as you get them from a network provider.
- Flu shots.
- Emergency services from network providers or from out-of-network providers.
- Urgently needed care from from in-network providers or from out-of-network providers when network providers are temporarily unavailable or, e.g., when you are temporarily outside of the Plan's service area.
- Kidney dialysis services that you get at a Medicare-certified dialysis facility when you are temporarily outside the Plan's service area.

Chapter 5
Section 2.3

How to get care from Specialists and other network providers

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

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

Even though your PCP is trained to handle the majority of common health care needs, there may be a time when he or she feels you need more specialized treatment. In that case, you may receive a referral to a network Specialist. When you select a PCP it is important to remember this may limit you to a network of Specialists who are with your PCP's contracted medical group/IPA or network.

If the network Specialist wants you to come back for more care, please make sure those services will be covered services, by checking first with your PCP to make sure that your referral will extend to the additional care.

Neither the Plan nor Medicare will pay for services, supplies, treatments, surgeries, and/or drug therapies for which a referral is required, but was not obtained from your PCP or us, except for emergency services, urgently needed services, out-of-area dialysis and post-stabilization care services, or when you have a prior authorization and/or a referral to an out-of-network provider.

Please refer to the *Provider Directory* for a listing of Plan Specialists available through your network or you may view this information online at the Web site listed in Chapter 2 of the Evidence of Coverage.

When you select a PCP it is important to remember that your PCP will choose the network Specialist to whom you will be referred based upon his or her referring practices and hospital affiliation. The presence of a particular network Specialist in this directory does not mean that your PCP will refer you to that provider.

What if a Specialist or another network provider leaves our Plan?

Sometimes a Specialist, clinic, hospital or other network provider you are using might leave the Plan. If this happens, you will have to switch to another provider who is part of our Plan. We will attempt to notify you as soon as possible if you are using a network provider who is leaving our Plan. We will also give you information on how to find another provider. You may call Customer Service at the number listed in Chapter 2 of the Evidence of Coverage and they will assist you in finding and selecting another provider.

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

Chapter 5
Section 3.1

Getting care if you have a medical emergency

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

When you have a "medical emergency," you believe that your health is in serious danger. A medical emergency can include severe pain, a bad injury, a sudden illness, or a medical condition that is quickly getting much worse.

If you have a medical emergency:

- **Get help as quickly as possible**. Call 911 for help or go to the nearest emergency room, hospital, or urgent care center. Call for an ambulance if you need it. You do *not* need to get approval or a referral first from your PCP.
- **As soon as possible, make sure that our Plan has been told about your emergency**. We need to follow up on your emergency care. You or someone else should call to tell us about your emergency care, usually within 48 hours by calling the Customer Service number located on the back of your member ID card. You can also find the Customer Service number in Chapter 2 of the Evidence of Coverage.

What is covered if you have a medical emergency?

You are covered for emergency medical care anywhere in the world. Our Plan covers ambulance services in situations where getting to the emergency room in any other way could endanger your health. For more information, see the Medical Benefits Chart in the chapter of the Evidence of Coverage titled: *Medical benefits chart (what is covered and what you pay)*.

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

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

Questions? *Call our Customer Service Department listed in Chapter 2.*

What if it wasn't a medical emergency?

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

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

- You go to a network provider to get the additional care.
- **or** the additional care you get is considered "urgently needed care" and you follow the rules for getting this urgent care (for more information about this, see Section 3.2 below).

Chapter 5
Section 3.2

Getting care if you have an urgent need for care

What is "urgently needed care?"

"Urgently needed care" is a non-emergency situation when:

- You need medical care right away because of an illness, injury, or condition that you did not expect or anticipate, but your health is not in serious danger.
- Because of the situation, it isn't reasonable for you to obtain medical care from a network provider.

What if you are in the Plan's service area when you have an urgent need for care?

Whenever possible, you must use our network providers when you are in the Plan's service area and you have an urgent need for care. (For more information about the Plan's service area, see the section titled: *Here is the geographic service area for our Plan* in Chapter 1 of this Evidence of Coverage).

In most situations, if you are in the Plan's service area, we will cover urgently needed care **only** if you get this care from a network provider and follow the other rules described earlier in this chapter. If the circumstances are unusual or extraordinary, and network providers are temporarily unavailable or inaccessible, our Plan will cover urgently needed care that you get from an out-of-network provider.

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

Suppose that you are temporarily outside our Plan's service area. If you have an urgent need for care, you probably will not be able to find or get to one of the providers in our Plan's network. In this situation (when you are outside the service area and cannot get care from a network provider), our Plan will cover urgently needed care that you get from any provider.

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

Chapter 5 **Section 4.1**

You can ask the Plan to pay our share of the cost of your covered services

Sometimes when you get medical care, you may need to pay the full cost right away. Other times, you may find that you have paid more than you expected under the coverage rules of the Plan. In either case, you will want our Plan to pay our share of the costs by reimbursing you for payments you have already made.

There may also be times when you get a bill from a provider for the full cost of medical care you have received. In many cases, you should send this bill to us so that we can pay our share of the costs for your covered medical services.

If you have paid more than your share for covered services, or if you have received a bill for the full cost of covered medical services, go to the chapter in the Evidence of Coverage titled: *Asking the Plan to pay its share of a bill you have received for covered services or drugs* for information about what to do.

Chapter 5 **Section 4.2**

If services are not covered by our Plan, you must pay the full cost

Our Plan covers all medical services that are medically necessary, are covered under Medicare, and are obtained consistent with Plan rules. You are responsible for paying the full cost of services that aren't covered by our Plan, either because they are not Plan covered services, or plan rules were not followed.

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

The chapter of the Evidence of Coverage titled: *What to do if you have a problem or complaint (coverage decisions, appeals, complaints)* has more information about what to do if you want a coverage decision from us or want to appeal a decision we have already made. You may also call Customer Service at the number listed in Chapter 2 of the Evidence of Coverage to get more information about how to do this.

For covered services that have a benefit limitation, you pay the full cost of any services you get after you have used up your benefit for that type of covered service. For example, if your Plan covers one routine physical exam per year and you receive that routine physical but choose to have a second routine physical within the same year, you pay the full cost of the second routine physical. If your Plan has an out-of-pocket maximum, any amounts that you pay for a service after you have reached the benefit limitation do not count toward your annual out-of-pocket maximum. (See the chapter of the Evidence of Coverage titled: *Medical benefits chart (what is covered and what you pay)* to see if your benefit Plan has an out-of-pocket maximum.) You can call Customer Service at the number listed in Chapter 2 of the Evidence of Coverage when you want to know how much of your benefit limit you have already used.

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

Chapter 5
Section 5.1

What is a "clinical research study?"

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

Not all clinical research studies are open to members of our Plan. Note: If you are not entitled to Medicare Part A coverage, neither Medicare nor the Plan will cover the Part A related costs of your participation in a research study. (Medicare Part A generally covers services furnished by institutional providers such as hospitals, skilled nursing facilities or home health agencies. Medicare first needs to approve the research study.) If you participate in a study that Medicare has not approved, **you will be responsible for paying all costs for your participation in the study**.

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

If you participate in a Medicare-approved study, Original Medicare pays most of the costs for the covered services you receive as part of the study. When you are in a clinical research study, you may stay enrolled in our Plan and continue to get the rest of your care (the care that is not related to the study) through our Plan. Note: If you are not entitled to Medicare Part A coverage, neither Medicare nor the Plan will pay the Part A related costs related to a Medicare-covered clinical research study.

If you want to participate in a Medicare-approved clinical research study, you do **not** need to get approval from our Plan or your PCP. The providers that deliver your care as part of the clinical research study do **not** need to be part of our Plan's network of providers.

Although you do not need to get our Plan's permission to be in a clinical research study, **you do need to tell us before you start participating in a clinical research study**. Here is why you need to tell us:

1. We can let you know whether the clinical research study is Medicare-approved.
2. We can tell you what services you will get from clinical research study providers instead of from our Plan.
3. We can keep track of the health care services that you receive as part of the study.

If you plan on participating in a clinical research study, contact Customer Service at the phone number listed in Chapter 2 of the Evidence of Coverage.

Chapter 5
Section 5.2

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

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

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

Note: If you are not entitled to Medicare Part A coverage, neither Medicare nor the Plan will pay the Part A related costs related to a Medicare-covered clinical research study.

Original Medicare pays most of the cost of the covered services you receive as part of the study. After Medicare has paid its share of the cost for these services, our plan will also pay for part of the costs. We will pay the difference between the cost-sharing in Original Medicare and your cost-sharing as a member of our plan. This means your costs for the services you receive as part of the study will not be higher than they would be if you received these services outside of a clinical research study.

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

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

Do you want to know more?

To find out what your coinsurance would be if you joined a Medicare-approved clinical research study, please call Customer Service (phone numbers are located in Chapter 2 of the Evidence of Coverage).

You can get more information about joining a clinical research study by reading the publication "Medicare and Clinical Research Studies" on the Medicare Web site http://www.medicare.gov. You can also call **1-800-MEDICARE (1-800-633-4227)** 24 hours a day, 7 days a week. TTY users should call **1-877-486-2048**.

Questions? *Call our Customer Service Department listed in Chapter 2.*

SECTION 6 Rules for getting care in a religious non-medical health care institution

Chapter 5
Section 6.1

What is a religious non-medical health care institution?

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

Chapter 5
Section 6.2

What care from a religious non-medical health care institution is covered by our Plan?

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

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

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

- The facility providing the care must be certified by Medicare.
- Our Plan's coverage of services you receive is limited to **non-religious** aspects of care.
- If you get services from this institution that are provided to you in your home, our Plan will cover these services only if your condition would ordinarily meet the conditions for coverage of services given by home health agencies that are not religious non-medical health care institutions.

- If you get services from this institution that are provided to you in a facility, the following conditions apply
  - You must have a medical condition that would allow you to receive covered services for inpatient hospital care or skilled nursing facility care.
  - **and** you must get approval in advance from our Plan before you are admitted to the facility or your stay will not be covered.

The coverage limits are described under *Inpatient hospital care* in the benefits chart in the chapter of the Evidence of Coverage titled: *Medical benefits chart (what is covered and what you pay).*

CHAPTER 6: Using the Plan's coverage for your Part D prescription drugs

Questions? *Call our Customer Service Department listed in Chapter 2.*

Did you know there are programs to help people pay for their drugs?

There are programs to help people with limited resources pay for their drugs. The "Extra Help" program helps people with limited resources pay for their drugs.

Are you currently getting help to pay for your drugs?

If you are in a program that helps pay for your drugs, some information in the Evidence of Coverage may not apply to you. Please call Customer Service and ask for the *Low Income Subsidy information* for people who get extra help paying for drugs if we have not already sent this information to you. Phone numbers are in Chapter 2 of the Evidence of Coverage.

SECTION 1 Introduction

Chapter 6
Section 1.1

This chapter describes your coverage for Part D drugs

This chapter explains rules for using your coverage for Part D drugs. There is also a chapter in the Evidence of Coverage that shows what you pay for Part D drugs (the chapter titled: *What you pay for your Part D prescription drugs*).

In addition to your coverage for Part D drugs, we also cover some drugs under the Plan's medical benefits:

- The Plan covers **drugs you are given during covered stays in the hospital or in a skilled nursing facility**. The chapter in the Evidence of Coverage titled: *Medical benefits chart* (*what is covered and what you pay*), explains the benefits and costs for drugs during a covered hospital or skilled nursing facility stay.
- Medicare Part B also provides benefits for some **drugs**. Part B drugs include certain chemotherapy drugs, certain drug injections you are given during an office visit, and drugs you are given at a dialysis facility. The chapter in the Evidence of Coverage titled: *Medical benefits chart (what is covered and what you pay),* explains your benefits and costs for Part B drugs.

The two types of drugs described above are covered by the Plan's medical benefits. The rest of your prescription drugs are covered under the Plan's Part D benefits. **This chapter explains rules for using your coverage for Part D drugs**. The chapter in the Evidence of Coverage titled: *What you pay for your Part D prescription drugs* shows what you pay for Part D drugs.

Chapter 6
Section 1.2

Basic rules for the Plan's Part D drug coverage

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

- You must use a network pharmacy to fill your prescription. (See the Section *Fill your prescriptions at a network pharmacy* in Section 2.1 of this Chapter.)
- Your drug must be on the Plan's *List of Covered Drugs (Formulary)* (we call it the "Drug List" for short). (See the Section *Your drugs need to be on the Plan's Drug list* later in this Chapter.)
- Your drug must be considered medically necessary, meaning reasonable and necessary for treatment of your illness or injury. It also needs to be an accepted treatment for your medical condition.

SECTION 2 Fill your prescription at a network pharmacy or through the Plan's mail order service

Chapter 6
Section 2.1

To have your prescription covered, use a network pharmacy

In most cases, your prescriptions are covered **only** if they are filled at the Plan's network pharmacies.

A network pharmacy is a pharmacy that has a contract with the Plan to provide your covered prescription drugs. The term "covered drugs" means all of the Part D prescription drugs that are covered by the Plan.

Chapter 6
Section 2.2

Finding network pharmacies

How do you find a network pharmacy in your area?

You can look in your *Pharmacy Directory*, visit our Web site or call Customer Service (Web site and phone numbers are in Chapter 2 of the Evidence of Coverage). Choose whatever is easiest for you.

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

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

If the pharmacy you have been using leaves the Plan's network, you will have to find a new pharmacy that is in the network. To find another network pharmacy in your area, you can get help from Customer Service (phone numbers are in Chapter 2 of the Evidence of Coverage) or use the *Pharmacy Directory*.

What if you need a specialty pharmacy?

Sometimes prescriptions must be filled at a specialty pharmacy. Specialty pharmacies include:

- Pharmacies that supply drugs for home infusion therapy.
- Pharmacies that supply drugs for residents of a long-term-care facility. Usually, a long-term care facility (such as a nursing home) has its own pharmacy. Residents may get prescription drugs through the facility's pharmacy as long as it is part of our network. If your long-term care pharmacy is not in our network, please contact Customer Service.
- Pharmacies that serve the Indian Health Service / Tribal / Urban Indian Health Program. Except in emergencies, only Native Americans or Alaska Natives have access to these pharmacies in our network.
- Pharmacies that dispense certain drugs that are restricted by the FDA to certain locations, require extraordinary handling, provider coordination, or education on its use. (Note: This scenario should happen rarely.)
- To locate a specialty pharmacy, look in your *Pharmacy Directory* or call Customer Service.

Questions? *Call our Customer Service Department listed in Chapter 2.*

Chapter 6
Section 2.3

Using the Plan's mail-order services

Our Plan's mail-order service requires you to order **up to a 90-day supply.**

To get order forms and information about filling your prescriptions by mail you may contact our network mail service pharmacy, Prescription Solutions. Prescription Solutions can be reached at **1-877-889-6358,** or for the hearing impaired, (TTY) **1-866-394-7218,** 24 hours a day, 7 days a week. If you use a mail-order pharmacy not in the Plan's network, your prescription will not be covered.

Usually a mail-order pharmacy order will get to you in no more than 7 days. However, sometimes your mail order may be delayed. If your mail order is delayed, please follow these steps:

If your prescription is on file at your local network pharmacy, go to your network pharmacy to fill the prescription. If your delayed prescription is not on file at your local network pharmacy, then please ask your doctor to call in a new prescription to your pharmacist. Or, your pharmacist can call the doctor's office for you to request the prescription. Your pharmacist can call the Pharmacy help desk at **1-877-889-6510** if he/she has any problems, questions, concerns, or needs a claim override for a delayed prescription.

Chapter 6
Section 2.4

How can you get a long-term supply of drugs?

When you get a long-term supply of drugs, your cost sharing may be lower. The Plan offers two ways to get a long-term supply of drugs on our Plan's Drug List.

1. **Some retail pharmacies** in our network allow you to get a long-term supply of drugs. Some of these retail pharmacies may agree to accept the mail-order cost-sharing amount for a long-term supply of drugs. Other retail pharmacies may not agree to accept the mail-order cost-sharing amounts for an extended supply of drugs. In this case you will be responsible for the difference in price. Your *Pharmacy Directory* lists which pharmacies in our network can give you a long-term supply of drugs. You can also call Customer Service for more information.
2. You can use the Plan's network **mail-order services**. Our Plan's mail-order service requires you to order up to a 90-day supply. See the section above for more information about using our mail-order services.

Questions? *Call our Customer Service Department listed in Chapter 2.*

Chapter 6
Section 2.5

When can you use a pharmacy that is not in the Plan's network?

Your prescription might be covered in certain situations

We have network pharmacies outside of our service area where you can get your prescriptions filled as a member of our Plan. If you go to a pharmacy that is not part of our Plan's network, that pharmacy is considered an out-of-network pharmacy.

Generally, we cover drugs filled at an out-of-network pharmacy *only* when you are not able to use a network pharmacy. Here are the circumstances when we would cover prescriptions filled at an out-of-network pharmacy:

- **Prescriptions for a Medical Emergency**

  We will cover prescriptions that are filled at an out-of-network pharmacy if the prescriptions are related to care for a medical emergency or urgently needed care, are included in our Drug List without restrictions, and are not excluded from Medicare Part D coverage.

- **Coverage when traveling or out of the service area**

  If you take a prescription drug on a regular basis and you are going on a trip, be sure to check your supply of the drug before you leave. When possible, take along all the medication you will need. You may be able to order your prescription drugs ahead of time through our network mail service pharmacy or through our other network pharmacies.

  If you are traveling within the United States and become ill or run out of or lose your prescription drugs, we will cover prescriptions that are filled at an out-of-network pharmacy if you follow all other coverage rules.

  - If you are unable to obtain a covered drug in a timely manner within the service area because a network pharmacy is not within reasonable driving distance that provides 24-hour service.
  - If you are trying to fill a prescription drug not regularly stocked at an accessible network retail or mail-order pharmacy (including high cost and unique drugs).
  - If you need a prescription while a patient in an emergency department, provider based clinic, outpatient surgery, or other outpatient setting.

In these situations, **please check first with Customer Service** to see if there is a network pharmacy nearby.

How do you ask for reimbursement from the Plan?

If you must use an out-of-network pharmacy, you will generally have to pay the full cost (rather than paying your normal share of the cost) when you fill your prescription. You can ask us to reimburse you for our share of the cost. (The chapter in the Evidence of Coverage titled: *Asking the Plan to pay its share of a bill you have received for covered services or drugs*, in the section titled: *How and where to send us your request for payment* explains how to ask the Plan to pay you back.)

SECTION 3 Your drugs need to be on the Plan's Drug List

Chapter 6
Section 3.1

The Drug List includes a list of the Part D drugs that are covered

The Plan has a Drug List.

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

The drugs on the Drug List are only those covered under Medicare Part D (earlier in this chapter, Section 1.1 explains about Part D drugs).

We will generally cover a drug on the Plan's Drug List as long as you follow the other coverage rules explained in this chapter and the drug is medically necessary, meaning reasonable and necessary for treatment of your illness or injury. It also needs to be an accepted treatment for your medical condition.

The Drug List includes both brand-name and generic drugs

A generic drug is a prescription drug that has the same active ingredients as the brand-name drug. It works just as well as the brand-name drug, but it costs less. There are generic drug substitutes available for many brand-name drugs.

What is not on the Drug List?

The Plan does not cover all prescription drugs.

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

Questions? *Call our Customer Service Department listed in Chapter 2.*

Chapter 6
Section 3.2

There are 4 Tiers for drugs on the Drug List

Every drug on the Plan's Drug List is in one of 4 tiers.

In general, the higher the tier number, the higher your cost for the drug:

Tier 1 – includes most generic prescription drugs

Tier 2 – includes many common brand-name and some higher-cost generic drugs

Tier 3 – includes non-preferred brand-name drugs and non-preferred generic drugs

Tier 4 – includes unique or very high-cost drugs

To find out which tier your drug is in, look it up in the Plan's Drug List.

The amount you pay for drugs in each tier is shown in the chapter in the Evidence of Coverage titled: *What you pay for your Part D prescription drugs.*

Chapter 6
Section 3.3

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

You have three ways to find out:

1. Check the most recent Drug List we sent you in the mail.
2. Visit the Plan's Web site listed under Customer Service in Chapter 2 of the Evidence of Coverage. The Drug List on the Web site is always the most current.
3. Call Customer Service to find out if a particular drug is on the Plan's Drug List or to ask for a copy of the list. Phone numbers for Customer Service are in Chapter 2 of the Evidence of Coverage.

SECTION 4 There are restrictions on coverage for some drugs

Chapter 6
Section 4.1

Why do some drugs have restrictions?

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

In general, our rules encourage you to get a drug that works for your medical condition and is safe. Whenever a safe, lower-cost drug will work medically just as well as a higher-cost drug, the Plan's rules are designed to encourage you and your doctor to use that lower-cost option. We also need to comply with Medicare's rules and regulations for drug coverage and cost sharing.

Chapter 6
Section 4.2

What kinds of restrictions?

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

Using generic drugs whenever you can

A "generic" drug works the same as a brand-name drug, but usually costs less. **When a generic version of a brand-name drug is available, our network pharmacies must provide you the generic version**. However, if your doctor has told us the medical reason that the generic drug will not work for you, then we will cover the brand-name drug. (Your share of the cost may be greater for the brand-name drug than for the generic drug.)

Getting Plan approval in advance

For certain drugs, you or your doctor need to get approval from the Plan before we will agree to cover the drug for you. This is called "**prior authorization**." Sometimes Plan approval is required so we can be sure that your drug is covered by Medicare rules. Sometimes the requirement for getting approval in advance helps guide appropriate use of certain drugs. If you do not get this approval, your drug might not be covered by the Plan.

Trying a different drug first

This requirement encourages you to try safer or more effective drugs before the Plan covers another drug. For example, if Drug A and Drug B treat the same medical condition, the Plan may require you to try Drug A first. If Drug A does not work for you, the Plan will then cover Drug B. This requirement to try a different drug first is called "**Step Therapy**."

Quantity limits

For certain drugs, we limit the amount of the drug that you can have. For example, the Plan might limit how many refills you can get, or how much of a drug you can get each time you fill your prescription. For example, if it is normally considered safe to take only one pill per day for a certain drug, we may limit coverage for your prescription to no more than one pill per day.

Chapter 6
Section 4.3

Do any of these restrictions apply to your drugs?

The Plan's Drug List includes information about the restrictions described above. To find out if any of these restrictions apply to a drug you take or want to take, check the Drug List. For the most up-to-date information, call Customer Service (phone numbers are in Chapter 2 of the Evidence of Coverage) or check our Web site listed under Customer Service in Chapter 2 of the Evidence of Coverage.

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

Chapter 6
Section 5.1

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

Suppose there is a prescription drug you are currently taking, or one that you and your doctor think you should be taking. We hope that your drug coverage will work well for you, but it's possible that you might have a problem. For example:

- **What if the drug you want to take is not covered by the Plan?** For example, the drug might not be covered at all. Or maybe a generic version of the drug is covered but the brand-name version you want to take is not covered.

- **What if the drug is covered, but there are extra rules or restrictions on coverage for that drug?** As explained in Section 4 earlier in this chapter, some of the drugs covered by the Plan have extra rules to restrict their use. For example, you might be required to try a different drug first, to see if it will work, before the drug you want to take will be covered for you. Or there might be limits on what amount of the drug (number of pills, etc.) is covered during a particular time period.
- **What if the drug is covered, but it is in a tier that makes your cost sharing more expensive than you think it should be?** The Plan puts each covered drug into one of 4 different tiers. How much you pay for your prescription depends in part on which tier your drug is in.

There are things you can do if your drug is not covered in the way that you'd like it to be covered. Your options depend on what type of problem you have:

- If your drug is not on the Drug List or if your drug is restricted, go to Section 5.2 below to learn what you can do.
- If your drug is in a tier that makes your cost more expensive than you think it should be, go to Section 5.3 to learn what you can do.

Chapter 6
Section 5.2

What can you do if your drug is not on the Drug List or if the drug is restricted in some way?

If your drug is not on the Drug List or is restricted, here are things you can do:

- You may be able to get a temporary supply of the drug (only members in certain situations can get a temporary supply).
- You can change to another drug.
- You can request an exception and ask the Plan to cover the drug in the way you would like it to be covered.

You may be able to get a temporary supply

Under certain circumstances, the Plan can offer a temporary supply of a drug to you when your drug is no longer on the Drug List or when it is restricted in some way. Doing this gives you time to talk with your doctor about the change in coverage and figure out what to do.

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

1. The change to your drug coverage must be one of the following types of changes:

- The drug you have been taking is **no longer on the Plan's Drug List**.

Questions? *Call our Customer Service Department listed in Chapter 2.*

- **or** the drug you have been taking is **now restricted in some way** (Section 4 earlier in this chapter explains about restrictions).

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

- **For those members who were in the Plan last year and aren't in a long term care facility:**

  We will cover a temporary supply of your drug **one time only during the first 90 days of the plan year**. This temporary supply will be for a maximum of a 31-day supply, or less if your prescription is written for fewer days. The prescription must be filled at a network pharmacy.

- **For those members who are new to the Plan and aren't in a long-term care facility:**

  We will cover a temporary supply of your drug **one time only during the first 90 days of your membership** in the Plan. This temporary supply will be for a maximum of a 31-day supply, or less if your prescription is written for fewer days.

- **For those who are new members, and are residents in a long-term-care facility:**

  We will cover a temporary supply of your drug **during the first 90 days of your membership** in the Plan. The first supply will be for a maximum of a 31-day supply, or less if your prescription is written for fewer days. If needed, we will cover additional refills during your first 90 days in the Plan.

- **For those who have been a member of the Plan for more than 90 days and are a resident of a long-term care facility and need a supply right away:**

- We will cover one 31-day supply, or less if your prescription is written for fewer days. This is in addition to the above **long-term-care** transition supply.

- For those current members with level of care changes:

There may be unplanned transitions such as hospital discharges or level of care changes that occur after the first 90 days that you are enrolled as a member in our Plan. If you are prescribed a drug that is not included in our Drug List or your ability to get your drugs is limited, you are required to use the Plan's exception process. You may request a one-time emergency supply of up to 31 days to allow you time to discuss alternative treatment with your doctor or to pursue a formulary exception.

To ask for a temporary supply, call Customer Service at the phone numbers listed in Chapter 2 of the Evidence of Coverage.

During the time when you are getting a temporary supply of a drug, you should talk with your doctor to decide what to do when your temporary supply runs out. Perhaps there is a different drug covered by the Plan that might work just as well for you. Or you and your doctor can ask the Plan to make an exception for you and cover the drug in the way you would like it to be covered. The sections below tell you more about these options.

You can change to another drug

Start by talking with your doctor. Perhaps there is a different drug covered by the Plan that might work just as well for you. You can call Customer Service to ask for a list of covered drugs that treat the same medical condition. This list can help your doctor to find a covered drug that might work for you.

You can file an exception

You and your doctor can ask the Plan to make an exception for you and cover the drug in the way you would like it to be covered. If your doctor or other prescriber says that you have medical reasons that justify asking us for an exception, your prescriber can help you request an exception to the rule.

For example, you can ask the Plan to cover a drug even though it is not on the Plan's Drug List. Or you can ask the Plan to make an exception and cover the drug without restrictions.

If you are a current member and a drug you are taking will be removed from the Drug List or restricted in some way for next year, we will allow you to request a formulary exception in advance for next year. We will tell you about any change in the coverage for your drug for the following year. You can then ask us to make an exception and cover the drug in the way you would like it to be covered for the following year. We will give you an answer to your request for an exception before the change takes effect.

If you and your doctor or other prescriber want to ask for an exception, the Chapter in the Evidence of Coverage titled: *What to do if you have a problem or complaint (coverage decisions, appeals, complaints)*, in the section titled: *Your Part D prescription drugs: How to ask for a coverage decision or make an appeal* describes what to do. It explains the procedures and deadlines that have been set by Medicare to make sure your request is handled promptly and fairly.

Chapter 6
Section 5.3

What can you do if your drug is in a tier you think is too high?

If your drug is in a tier you think is too high, here are things you can do:

You can change to another drug

Start by talking with your doctor. Perhaps there is a different drug in a lower tier that might work just as well for you. You can call Customer Service to ask for a list of covered drugs that treat the same medical condition. This list can help your doctor to find a covered drug that might work for you.

You can file an exception

You and your doctor can ask the Plan to make an exception in the tier for the drug so that you pay less for the drug. If your doctor or other provider says that you have medical reasons that justify asking us for an exception, your doctor can help you request an exception to the rule.

If you and your doctor want to ask for an exception, the chapter in the Evidence of Coverage titled: *What to do if you have a problem or complaint (coverage decisions, appeals, complaints)*, in the section titled: *Your Part D prescription drugs: How to ask for a coverage decision or make an appeal* describes what to do. It explains the procedures and deadlines that have been set by Medicare to make sure your request is handled promptly and fairly.

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

Chapter 6
Section 6.1

The Drug List can change during the year

Most of the changes in drug coverage happen at the beginning of each plan year. However, during the year, the Plan might make many kinds of changes to the Drug List. For example, the Plan might:

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

Questions? *Call our Customer Service Department listed in Chapter 2.*

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

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

Chapter 6
Section 6.2

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

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

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

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

Do changes to your drug coverage affect you right away?

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

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

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

In some cases, you will be affected by the coverage change before the next plan year. **If a brand-name drug you are taking is replaced by a new generic drug**, the Plan must give you at least 60 days' notice or give you a 60-day refill of your brand-name drug at a network pharmacy.

Questions? *Call our Customer Service Department listed in Chapter 2.*

- During this 60-day period, you should be working with your doctor to switch to the generic or to a different drug that we cover.
- Or you and your doctor or other prescriber can ask the Plan to make an exception and continue to cover the brand-name drug for you. For information on how to ask for an exception, see the chapter of the Evidence of Coverage titled: *What to do if you have a problem or complaint (coverage decisions, appeals, complaints).*
- Again if a drug is **suddenly recalled** because it's been found to be unsafe or for other reasons, the Plan will immediately remove the drug from the Drug List. We will let you know of this change right away.

Your doctor will also know about this change, and can work with you to find another drug for your condition.

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

Chapter 6
Section 7.1

Types of drugs we do not cover

This section explains what kinds of prescription drugs are "excluded." Excluded means that the Plan doesn't cover these types of drugs because the law doesn't allow any Medicare drug plan to cover them.

If you get drugs that are excluded, you must pay for them yourself. We won't pay for the drugs that are listed in this section. The only exception: If the requested drug is found upon appeal to be a drug that is not excluded under Part D and we should have paid for or covered the drug because of your specific situation. (For information about appealing a decision we have made to not cover a drug, see the chapter in the Evidence of Coverage titled: *What to do if you have a problem or complaint (coverage decisions, appeals, complaints).)*

Here are three general rules about drugs that Medicare drug plans will not cover under Part D:

1. Our Plan's Part D drug coverage cannot cover a drug that would be covered under Medicare Part A or Part B.
2. Our Plan cannot cover a drug purchased outside the United States and its territories.

3. "Off-label use" is any use of the drug other than those indicated on a drug's label as approved by the Food and Drug Administration.

   Generally, coverage for "off-label use" is allowed only when the use is supported by certain reference books. These reference books are the American Hospital Formulary Service Drug Information, the DRUGDEX Information System, and the USPDI or its successor. If the use is not supported by any of these reference books, then our Plan cannot cover its "off-label use."

Also, by law, the categories of drugs listed below are not covered by Medicare drug plans;

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

Please note: Your Plan Sponsor **may** have elected to offer some of the drugs listed above to you as an additional benefit. If so, you will receive additional information about the drugs they have chosen to offer to you separately, in your Plan materials.

If you receive extra help paying for your drugs, your state Medicaid program may cover some prescription drugs not normally covered in a Medicare drug plan. Please contact your state Medicaid program to determine what drug coverage may be available to you.

SECTION 8 Show your member ID card when you fill a prescription

Chapter 6
Section 8.1

Show your member ID card

To fill your prescription, show your member ID card at the network pharmacy you choose. When you show your member ID card, the network pharmacy will automatically bill the Plan for *our* share of your covered prescription drug cost. You will need to pay the pharmacy *your* share of the cost when you pick up your prescription.

If you have Medicare and Medicaid, make sure to present your member ID card and your State Medicaid card when filling prescriptions to ensure correct billing.

Chapter 6
Section 8.2

What if you don't have your member ID card with you?

If you don't have your member ID card with you when you fill your prescription, ask the pharmacy to call the Plan to get the necessary information.

If the pharmacy is not able to get the necessary information, **you may have to pay the full cost of the prescription when you pick it up**. (You can then **ask us to reimburse you** for our share. See the Chapter in the Evidence of Coverage titled: *Asking the Plan to pay its share of a bill you have received for covered services or drugs*, in the section titled: *How and where to send us your request for payment* for information about how to ask the Plan for reimbursement.)

SECTION 9 Part D drug coverage in special situations

Chapter 6
Section 9.1

What if you're in a hospital or a skilled nursing facility for a stay that is covered by the Plan?

If you are admitted to a hospital or to a skilled nursing facility for a stay covered by the Plan, we will generally cover the cost of your prescription drugs during your stay. Once you leave the hospital or skilled nursing facility, the Plan will cover your drugs as long as the drugs meet all of our rules for coverage. See the previous parts of this chapter that tell about the rules for getting drug coverage. The chapter in the Evidence of Coverage titled: *What you pay for your Part D prescription drugs* gives more information about drug coverage and what you pay.

Questions? *Call our Customer Service Department listed in Chapter 2.*

Please Note: When you enter, live in, or leave a skilled nursing facility, you are entitled to a special enrollment period. During this time period, you can leave this Plan and join a new Medicare Advantage plan or Original Medicare. (The chapter in the Evidence of Coverage titled: *Ending your membership in the Plan*, explains how you can leave our Plan and join a different Medicare plan.)

Chapter 6
Section 9.2

What if you're a resident in a long-term care facility?

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

Check your *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, please contact Customer Service.

What if you're a resident in a long-term care facility and become a new member of the Plan?

If you need a drug that is not on our Drug List or is restricted in some way, the Plan will cover a **temporary supply** of your drug during the first 90 days of your membership. The first supply will be for a maximum of a 31-day supply, or less if your prescription is written for fewer days. If needed, we will cover additional refills during your first 90 days in the Plan.

If you have been a member of the Plan for more than 90 days and need a drug that is not on our Drug List or if the Plan has any restriction on the drug's coverage, we will cover one 31-day supply, or less if your prescription is written for fewer days.

During the time when you are getting a temporary supply of a drug, you should talk with your doctor to decide what to do when your temporary supply runs out. Perhaps there is a different drug covered by the Plan that might work just as well for you. Or you and your doctor can ask the Plan to make an exception for you and cover the drug in the way you would like it to be covered. If you and your doctor want to ask for an exception, the chapter in the Evidence of Coverage titled: *What to do if you have a problem or complaint (coverage decisions, appeals, complaints)*, in Section 6, titled: Y*our Part D prescription drugs: How to ask for a coverage decision or make an appeal* explains what to do.

Chapter 6
Section 9.3

Special note about 'creditable coverage'

Special note about 'creditable coverage:'

Each year your Plan Sponsor should send you a notice by November 15 that confirms if your prescription drug coverage for the next calendar year is "**creditable**," and the choices you have for drug coverage.

If the coverage from the group plan is "**creditable**," it means that it has drug coverage that pays, on average, at least as much as Medicare's standard drug coverage.

Keep these notices about creditable coverage, because you may need them later, if you ever decide to change plans. If you enroll in a Medicare plan that includes Part D drug coverage, you may need these notices to show that you have maintained creditable coverage so that you do not have to pay a late enrollment penalty. If you didn't get a notice about creditable coverage from your Plan Sponsor, you can get a copy from your former employer or retiree plan's benefits administrator or your former employer or union. See the chapter in the Evidence of Coverage titled: *What you pay for your Part D prescription drugs*, in the section titled: *In some situations, you can enroll late and not have to pay the penalty* for more information.

SECTION 10 Programs on drug safety and managing medications

Chapter 6
Section 10.1

Programs to help members use drugs safely

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

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

- Possible medication errors.
- Drugs that may not be necessary because you are taking another drug to treat the same medical condition.
- Drugs that may not be safe or appropriate because of your age or gender.
- Certain combinations of drugs that could harm you if taken at the same time.

Questions? *Call our Customer Service Department listed in Chapter 2.*

- Prescriptions written for drugs that have ingredients you are allergic to.
- Possible errors in the amount (dosage) of a drug you are taking.

If we see a possible problem in your use of medications, we will work with your doctor to correct the problem.

Chapter 6
Section 10.2

Programs to help members manage their medications

We have programs that can help our members with special situations. For example, some members have several complex medical conditions or they may need to take many drugs at the same time, or they could have very high drug costs.

These programs are voluntary and free to members. A team of pharmacists and doctors developed the programs for us. The programs can help make sure that our members are using the drugs that work best to treat their medical conditions and help us identify possible medication errors.

If we have a program that fits your needs, we will automatically enroll you in the program and send you information. If you decide not to participate, please notify us and we will withdraw your participation in the program.

CHAPTER 7: Asking the Plan to pay its share of a bill you have received for covered services or drugs

SECTION 1 Situations in which you should ask our Plan to pay our share of the cost of your covered services or drugs

Chapter 7
Section 1.1

If you pay our Plan's share of the cost of your covered services or drugs or if you receive a bill, you can ask us for payment

Sometimes when you get medical care or a prescription drug, you may need to pay the full cost right away. Other times, you may find that you have paid more than you expected under the coverage rules of the Plan. In either case, you can ask our Plan to pay you back (paying you back is often called "reimbursing" you). It is your right to be paid back by our Plan whenever you've paid more than your share of the cost for medical services or drugs that are covered by our Plan.

There may also be times when you get a bill from a provider for the full cost of medical care you have received. In many cases, you should send this bill to us instead of paying it. We will look at the bill and decide whether the services should be covered. If we decide they should be covered, we will pay the provider directly.

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

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

   When you've received emergency or urgently needed care from a provider who is not part of our network, you are only responsible for paying your share of the cost, not for the entire cost. You should ask the provider to bill the Plan for our share of the cost.

   - If you paid the entire amount yourself at the time you received the care, you need to ask us to pay you back for our share of the cost. Send us the bill, along with documentation of any payments you have made.
   - At times you may get a bill from the provider asking for payment that you think you do not owe. Send us this bill, along with documentation of any payments you have already made.
     - If the provider is owed anything, we will pay the provider directly.
   - If you have already paid more than your share of the cost of the service, we will determine how much you owed and pay you back for our share of the cost.

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

Network providers should always bill the Plan directly, and ask you only for your share of the cost. But sometimes they make mistakes, and ask you to pay more than your share.

- Whenever you get a bill from a network provider that you think is more than you should pay, send us the bill. We will contact the provider directly and resolve the billing problem.
- If you have already paid a bill to a network provider, but you feel that you paid too much, send us the bill along with documentation of any payment you have made and ask us to pay you back the difference between the amount you paid and the amount you owed under the Plan.

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

If you go to an out-of-network pharmacy and try to use your member ID card to fill a prescription, the pharmacy may not be able to submit the claim directly to us. When that happens, you will have to pay the full cost of your prescription.

- Save your receipt and send a copy to us when you ask us to pay you back for our share of the cost.

4. When you pay the full cost for a prescription because you don't have your member ID card with you

If you do not have your member ID card with you, you can ask the pharmacy to call the Plan or to look up your Plan enrollment information. However, if the pharmacy cannot get the enrollment information they need right away, you may need to pay the full cost of the prescription yourself.

- Save your receipt and send a copy to us when you ask us to pay you back for our share of the cost.

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

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

- For example, the drug may not be on the Plan's Drug List; or it could have a requirement or restriction that you didn't know about or don't think should apply to you. If you decide to get the drug immediately, you may need to pay the full cost for it.
- Save your receipt and send a copy to us when you ask us to pay you back. In some situations, we may need to get more information from your doctor in order to pay you back for our share of the cost.

All of the examples above are types of coverage decisions. This means that if we deny your request for payment, you can appeal our decision. See the chapter titled: *(What to do if you have a problem or complaint (coverage decisions, appeals, complaints))* for information about how to make an appeal.

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

Chapter 7
Section 2.1

How and where to send us your request for payment

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

To make sure you are giving us all the information we need to make a decision, you can fill out our claim form to make your request for payment.

- You don't have to use the form, but it's helpful for our plan to process the information faster.
- Either download a copy of the form from our Web site or call Customer Service and ask for the form. The Web site and phone numbers for Customer Service are located in Chapter 2 of the Evidence of Coverage.

Mail your request for payment together with any bills or receipts to us. See Chapter 2 for the address.

Please be sure to contact Customer Service if you have any questions. If you don't know what you owe, or you receive bills and you don't know what to do about those bills, we can help. You can also call if you want to give us more information about a request for payment you have already sent to us.

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

Chapter 7
Section 3.1

We check to see whether we should cover the service or drug and how much we owe

When we receive your request for payment, we will let you know if we need any additional information from you. Otherwise, we will consider your request and decide whether to pay it and how much we owe.

- If we decide that the medical care or drug is covered and you followed all the rules for getting the care or drug, we will pay for our share of the cost. If you have already paid for the service or drug, we will mail your reimbursement of our share of the cost to you. If you have not paid for the service or drug yet, we will mail the payment directly to the provider. (The chapter of the Evidence of Coverage titled: *Using the Plan's coverage for your medical services* explains the rules you need to follow for getting your medical services.) The chapter of the Evidence of Coverage titled: *Using the Plan's coverage for your Part D prescription drugs* explains the rules you need to follow for getting your Part D prescription drugs.)
- If we decide that the medical care or drug is *not* covered, or you did *not* follow all the rules, we will not pay for our share of the cost. Instead, we will send you a letter that explains the reasons why we are not sending the payment you have requested, and what your rights are to appeal that decision.

Chapter 7
Section 3.2

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

If you think we have made a mistake in turning down your request for payment, you can make an appeal. If you make an appeal, it means you are asking us to change the decision we made when we turned down your request for payment.

For the details on how to make this appeal, go to the chapter in the Evidence of Coverage titled: *What to do if you have a problem or complaint (coverage decisions, appeals, complaints).* The appeals process is a legal process with detailed procedures and important deadlines. If making an appeal is new to you, you will find it helpful to start by reading Section 4 of the chapter titled: *What to do if you have a problem or complaint (coverage decisions, appeals, complaints).* Section 4 is an introductory section that explains the process for coverage decisions and appeals and gives definitions of terms such as "appeal." Then after you have read Section 4, you can go to the section in the chapter that describes what to do for your situation:

Questions? *Call our Customer Service Department listed in Chapter 2.*

- If you want to make an appeal about getting paid back for a medical service, go to Section 5.5 in Chapter 9.
- If you want to make an appeal about getting paid back for a drug, go to Section 6.1 in Chapter 9.

SECTION 4 Other situations in which you should save your receipts and send them to the Plan

Chapter 7
Section 4.1

In some cases, you should send your receipts to the Plan to help us track your out-of-pocket drug costs

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

Here is a situation when you should send us receipts to let us know about payments you have made for your drugs:

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

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

- Save your receipt and send a copy to us so that we can have your out-of-pocket expenses count toward qualifying you for the Catastrophic Coverage Stage.
- **Please note:** Because you are getting your drug through the patient assistance program and not through the Plan's benefits, the Plan will not pay for any share of these drug costs. But sending the receipt allows us to calculate your out-of-pocket costs correctly and may help you qualify for the Catastrophic Coverage Stage more quickly.

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

CHAPTER 8: Your rights and responsibilities

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

SECTION 2. You have some responsibilities as a member of the Plan

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

Chapter 8
Section 1.1

You have a right to receive information about the organization, its services, its practitioners and providers and member rights and responsibilities. We must provide information in a way that works for you (in languages other than English that are spoken in the Plan service area, in large print, or other alternate formats, etc.).

To get information from us in a way that works for you, please call Customer Service (phone numbers are in Chapter 2 of the Evidence of Coverage).

Our Plan has people and translation services available to answer questions from non-English speaking members. We can also give you information in large print or other alternate formats if you need it. If you are eligible for Medicare because of disability, we are required to give you information about the Plan's benefits that is accessible and appropriate for you.

If you have any trouble getting information from our Plan because of problems related to language or disability, please call Medicare at **1-800-MEDICARE (1-800-633-4227)**, 24 hours a day, 7 days a week and tell them that you want to file a complaint. TTY users call **1-877-486-2048.**

Chapter 8
Section 1.2

You have a right to be treated with respect and recognition of your dignity and right to privacy. We must treat you with fairness and respect at all times.

Our Plan must obey laws that protect you from discrimination or unfair treatment. **We do not discriminate** based on a person's race, disability, religion, sex, health, ethnicity, creed (beliefs), age, or national origin.

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

If you have a disability and need help with access to care, please call Customer Service (phone numbers are in Chapter 2 of the Evidence of Coverage). If you have a complaint, such as a problem with wheelchair access, Customer Service can help.

Chapter 8
Section 1.3

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

As a member of our Plan, you have the right to choose a Primary Care Physician (PCP) in the Plan's network to provide and arrange for your covered services (the chapter of the Evidence of Coverage titled: *Using the Plan's coverage for your medical services* explains more about this). Call Customer Service to learn which doctors are accepting new patients (phone numbers are in Chapter 2 of the Evidence of Coverage). You also have the right to go to a women's health Specialist (such as a gynecologist) without a referral.

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

If you think that you are not getting your medical care or Part D drugs within a reasonable amount of time, the chapter of the Evidence of Coverage titled: *What to do if you have a problem or complaint (coverage decisions, appeals, complaints)* explains what you can do.

Chapter 8
Section 1.4

We must protect the privacy of your personal health information

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

- Your "personal health information" includes the personal information you gave us when you enrolled in this Plan as well as your medical records and other medical and health information.
- The laws that protect your privacy give you rights related to getting information and controlling how your health information is used. We give you a written notice, called a "Notice of Privacy Practices," that tells about these rights and explains how we protect the privacy of your health information.

How do we protect the privacy of your health information?

- We make sure that unauthorized people don't see or change your records.
- In most situations, if we give your health information to anyone who isn't providing your care or paying for your care, **we are required to get written permission from you first.** Written permission can be given by you or by someone you have given legal power to make decisions for you.

Questions? *Call our Customer Service Department listed in Chapter 2.*

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

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

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

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

If you have questions or concerns about the privacy of your personal health information, please call Customer Service (phone numbers are in Chapter 2 of the Evidence of Coverage).

Chapter 8
Section 1.5

We must give you information about the Plan, its network of providers, and your covered services

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

If you want any of the following kinds of information, please call Customer Service (phone numbers are in Chapter 2 of the Evidence of Coverage):

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

- **Information about our network providers including our network pharmacies.**
  - For example, you have the right to get information from us about the qualifications of the providers and pharmacies in our network and how we pay the providers in our network.
  - For a list of the providers in the Plan's network, see the *Provider Directory*.
  - For a list of the pharmacies in the Plan's network, see the *Pharmacy Directory*.
  - For more detailed information about our network providers or pharmacies, you can call Customer Service (phone numbers are in Chapter 2 of the Evidence of Coverage) or visit our Web site (also listed in Chapter 2 of the Evidence of Coverage).
- **Information about your coverage and rules you must follow in using your coverage.**
  - In the Evidence of Coverage, in the chapters titled: *Using the Plan's coverage for your medical services* and *Medical benefits chart (what is covered and what you pay)*, we explain what medical services are covered for you, any restrictions to your coverage, and what rules you must follow to get your covered medical services.
  - To get the details on your Part D prescription drug coverage, see the chapters titled: *Using the Plan's coverage for your Part D prescription drugs* and *What you pay for your Part D prescription drugs* of the Evidence of Coverage plus the Plan's Drug List. These chapters, together with the formulary tell you what drugs are covered and explain the rules you must follow and the restrictions to your coverage for certain drugs.
  - If you have questions about the rules or restrictions, please call Customer Service (phone numbers are in Chapter 2 of the Evidence of Coverage).
- **Information about why something is not covered and what you can do about it.**
  - If a medical service or Part D drug is not covered for you, or if your coverage is restricted in some way, you can ask us for a written explanation. You have the right to this explanation even if you received the medical service or drug from an out-of-network provider or pharmacy.
  - If you are not happy or if you disagree with a decision we make about what medical care or Part D drug is covered for you, you have the right to ask us to change the decision. For details on what to do if something is not covered for you in the way you think it should be covered, see the chapter titled: *What to do if you have a problem or complaint (coverage decisions, appeals,*

complaints) of the Evidence of Coverage. It gives you the details about how to ask the Plan for a decision about your coverage and how to make an appeal if you want us to change our decision. (This chapter also explains about how to make a complaint about quality of care, waiting times, and other concerns.)

- If you want to ask our Plan to pay our share of a bill you have received for medical care or a Part D prescription drug, see the chapter titled: *Asking the Plan to pay its share of a bill you have received for covered services or drugs*.

Chapter 8
Section 1.6

You have a right to participate with practitioners in making decisions about your health care. We must support your right to make decisions about your care and a candid discussion of appropriate or medically necessary treatment options for your conditions, regardless of cost or benefit coverage.

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

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

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

- **To know about all of your choices.** This means that you have the right to be told about all of the treatment options that are recommended for your condition, no matter what they cost or whether they are covered by our Plan. It also includes being told about programs our Plan offers to help members manage their medications and use drugs safely.
- **To know about the risks.** You have the right to be told about any risks involved in your care. You must be told in advance if any proposed medical care or treatment is part of a research experiment. You always have the choice to refuse any experimental treatments.
- **The right to say "no."** You have the right to refuse any recommended treatment. This includes the right to leave a hospital or other medical facility, even if your doctor advises you not to leave. You also have the right to stop taking your medication. Of course, if you refuse treatment or stop taking medication, you accept full responsibility for what happens to your body as a result.

- **To receive an explanation if you are denied care.** You have the right to receive an explanation from us if a provider has denied care that you believe you should receive. To receive this explanation, you will need to ask us for a coverage decision. The chapter titled: *What to do if you have a problem or complaint (coverage decisions, appeals, complaints)* of the Evidence of Coverage explains how to ask the Plan for a coverage decision.

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

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

- Fill out a written form to give **someone the legal authority to make medical decisions for you** if you ever become unable to make decisions for yourself.
- **Give your doctors written instructions** about how you want them to handle your medical care if you become unable to make decisions for yourself.

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

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

- **Get the form.** If you want to have an advance directive, you can get a form from your lawyer, from a social worker, or from some office supply stores. You can sometimes get advance directive forms from organizations that give people information about Medicare.
- **Fill it out and sign it.** Regardless of where you get this form, keep in mind that it is a legal document. You should consider having a lawyer help you prepare it.
- **Give copies to appropriate people.** You should give a copy of the form to your doctor and to the person you name on the form as the one to make decisions for you if you can't. You may want to give copies to close friends or family members as well. Be sure to keep a copy at home.

If you know ahead of time that you are going to be hospitalized, and you have signed an advance directive, **take a copy with you to the hospital.**

- If you are admitted to the hospital, they will ask you whether you have signed an advance directive form and whether you have it with you.

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

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

What if your instructions are not followed?

If you have signed an advance directive, and you believe that a doctor or hospital hasn't followed the instructions in it, you may file a complaint with the appropriate state-specific agency, for example, your State Department of Health.

Chapter 8
Section 1.7

You have a right to voice complaints or appeals about the organization or the care it provides. You have the right to make complaints and to ask us to reconsider decisions we have made.

If you have any problems or concerns about your covered services or care, the chapter titled: *What to do if you have a problem or complaint (coverage decisions, appeals, complaints)* of the Evidence of Coverage explains what you can do. It gives the details about how to deal with all types of problems and complaints.

As explained in the chapter of the Evidence of Coverage titled: *What to do if you have a problem or complaint (coverage decisions, appeals, complaints)*, what you need to do to follow up on a problem or concern depends on the situation. You might need to ask our Plan to make a coverage decision for you, make an appeal to us to change a coverage decision, or make a complaint. Whatever you do – ask for a coverage decision, make an appeal, or make a complaint – **we are required to treat you fairly.**

You have the right to get a summary of information about the appeals and complaints that other members have filed against our Plan in the past. To get this information, please call Customer Service (phone numbers are in Chapter 2 of the Evidence of Coverage).

Chapter 8
Section 1.8

What can you do if you think you are being treated unfairly or your rights are not being respected?

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

If you think you have been treated unfairly or your rights have not been respected due to your race, disability, religion, sex, health, ethnicity, creed (beliefs), age, or national origin, you should call the **Department of Health and Human Services, Office for Civil Rights** at **1-800-368-1019** or **TTY/TDD 1-800-537-7697**, or call your local Office for Civil Rights.

Is it about something else?

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

- You can **call Customer Service** (phone numbers are in Chapter 2 of the Evidence of Coverage).
- You can **call the State Health Insurance Assistance Program**. For details about this organization and how to contact it, turn to Chapter 2 of the Evidence of Coverage and look for Section 3.

Chapter 8
Section 1.9

You have a right to make recommendations regarding the organization's member rights and responsibilities policy. How to get more information about your rights.

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

- You can **call Customer Service** (phone numbers are in Chapter 2, of the Evidence of Coverage).
- You can **call the State Health Insurance Assistance Program**. For details about this organization and how to contact it, turn to Chapter 2 of the Evidence of Coverage and look for Section 3.
- You can contact **Medicare**.
  - You can visit http://www.medicare.gov to read or download the publication "Your Medicare Rights & Protections."
  - Or, you can call **1-800-MEDICARE (1-800-633-4227)** 24 hours a day, 7 days a week. TTY users should call **1-877-486-2048**.

Questions? *Call our Customer Service Department listed in Chapter 2.*

SECTION 2 You have some responsibilities as a member of the Plan

Chapter 8
Section 2.1

What are your responsibilities?

Things you need to do as a member of the Plan are listed below. If you have any questions, please call Customer Service (phone numbers are in Chapter 2 of the Evidence of Coverage). We're here to help.

- **Get familiar with your covered services and the rules you must follow to get these covered services.** Use the Evidence of Coverage to learn what is covered for you and the rules you need to follow to get your covered services.
  - In the Evidence of Coverage, in the chapters titled: *Using the Plan's coverage for your medical services and Medical benefits chart (what is covered and what you pay)* give the details about your medical services, including what is covered, what is not covered, rules to follow, and what you pay.
  - In the Evidence of Coverage, the chapters titled: *Using the Plan's coverage for your Part D prescription drugs and What you pay for your Part D prescription drugs* give the details about your coverage for Part D prescription drugs.
- **If you have any other health insurance coverage or prescription drug coverage besides our Plan, you are required to tell us.** Please call Customer Service to let us know.
  - We are required to follow rules set by Medicare to make sure that you are using all of your coverage in combination when you get your covered services from our Plan. This is called "**coordination of benefits**" because it involves coordinating the health and drug benefits you get from our Plan with any other health and drug benefits available to you. We'll help you with it.
- **Tell your doctor and other health care providers that you are enrolled in our Plan.** Show your member ID card whenever you get your medical care or Part D prescription drugs.

- **Help your doctors and other providers help you by giving them information, asking questions, and following through on your care.**
  - To help your doctors and other health providers give you the best care, learn as much as you are able to about your health problems and give them the information they need about you and your health. Follow the treatment plans and instructions that you and your doctors agree upon.
  - If you have any questions, be sure to ask. Your doctors and other health care providers are supposed to explain things in a way you can understand. If you ask a question and you don't understand the answer you are given, ask again.
- **Be considerate.** We expect all our members to respect the rights of other patients. We also expect you to act in a way that helps the smooth running of your doctor's office, hospitals, and other offices.
- Supply information (to the extent possible) that the organization and its practitioners and providers need in order to provide care.
- Follow plans and instructions for care that you have agreed to with your practitioner.
- Understand your health problems and participate in developing mutually agreed-upon treatment goals, to the degree possible.
- **Pay what you owe.** As a Plan member, you are responsible for these payments:
  - If you have a Plan premium, you must pay your Plan premiums to continue being a member of our Plan.
  - For some of your medical services or drugs covered by the Plan, you must pay your share of the cost when you get the service or drugs. This will be a copayment (a fixed amount) or coinsurance (a percentage of the total cost). The chapter titled: *Medical benefits chart (what is covered and what you pay)* of the Evidence of Coverage lists what you must pay for your medical services. The chapter titled: *What you pay for your Part D prescription drugs* shows what you must pay for your Part D prescription drugs.
  - If you get any medical services or drugs that are not covered by our Plan or by other insurance you may have, you must pay the full cost.
- **Tell us if you move.** If you are going to move, it's important to tell us right away. Call Customer Service (phone numbers are in Chapter 2 of the Evidence of Coverage).

  - **If you move outside of our Plan service area, you cannot remain a member of our Plan.** (Chapter 1 describes our service area.) We can help you figure out whether you are moving outside our service area. If you are leaving our service area, we can let you know if we have a plan in your new area.
  - **If you move within our service area, we still need to know** so we can keep your membership record up to date and know how to contact you.
- **Call Customer Service for help if you have questions or concerns.** We also welcome any suggestions you may have for improving our Plan.
  - Phone numbers and calling hours for Customer Service are in Chapter 2 of the Evidence of Coverage.

For more information on how to reach us, including our mailing address, please see Chapter 2 of the Evidence of Coverage

Chapter 9. What to do if you have a problem or complaint (coverage decisions, appeals, complaints)

Questions? *Call our Customer Service Department listed in Chapter 2.*

Questions? *Call our Customer Service Department listed in Chapter 2.*

SECTION 1 Introduction

Chapter 9
Section 1.1

What to do if you have a problem or concern

Please call us first

Your health and satisfaction are important to us. When you have a problem or concern, we hope you'll try an informal approach first: Please call Customer Service (phone numbers are located in Chapter 2 of the Evidence of Coverage). We will work with you to try to find a satisfactory solution to your problem.

You have rights as a member of our Plan and as someone who is getting Medicare. We pledge to honor your rights, to take your problems and concerns seriously, and to treat you with respect.

Two formal processes for dealing with problems

Sometimes you might need a formal process for dealing with a problem you are having as a member of our Plan.

This chapter explains two types of formal processes for handling problems and concerns:

- For some types of problems, you need to use the **process for coverage decisions and making appeals**.
- For other types of problems you need to use the **process for making complaints**.

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

Which one do you use? That depends on the type of problem you are having. The guide in Section 3 of this chapter will help you identify the right process to use.

Chapter 9
Section 1.2

What about the legal terms?

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

Questions? *Call our Customer Service Department listed in Chapter 2.*

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

However, it can be helpful – and sometimes quite important – for you to know the correct legal terms for the situation you are in. Knowing which terms to use will help you communicate more clearly and accurately when you are dealing with your problem and get the right help or information for your situation. To help you know which terms to use, we include legal terms when we give the details for handling specific types of situations.

SECTION 2 You can get help from government organizations that are not connected with us

Chapter 9
Section 2.1

Where to get more information and personalized assistance

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

Get help from an independent government organization

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

The services of SHIP counselors are free. You will find phone numbers in Chapter 2, Section 3 of the Evidence of Coverage.

You can also get help and information from Medicare

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

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

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

Chapter 9
Section 3.1

Should you use the process for coverage decisions and appeals? Or should you use the process for making complaints?

If you have a problem or concern and you want to do something about it, you don't need to read this whole chapter. You just need to find and read the parts of this chapter that apply to your situation. The guide that follows will help.

To figure out which part of this chapter explains what to do for your problem or concern, **START HERE**

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

Yes

Go on to the next section of this chapter, **Section 4: "A guide to the basics of coverage decisions and making appeals."**

No

Skip ahead to **Section 10** at the end of this chapter: **"How to make a complaint about quality of care, waiting times, customer service or other concerns."**

SECTION 4 A guide to the basics of coverage decisions and appeals

Chapter 9
Section 4.1

Asking for coverage decisions and making appeals: the big picture

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

Asking for coverage decisions

A coverage decision is a decision we make about your benefits and coverage or about the amount we will pay for your medical services or drugs. We make a coverage decision for you whenever you go to a doctor for medical care. You can also contact the Plan and ask for a coverage decision. For example, if you want to know if we will cover a medical service before you receive it, you can ask us to make a coverage decision for you.

We are making a coverage decision for you whenever we decide what is covered for you and how much we pay:

- Usually, there is no problem. We decide the service or drug is covered and pay our share of the cost.
- But in some cases we might decide the service or drug is not covered or is no longer covered by Medicare for you. If you disagree with this coverage decision, you can make an appeal.

Making an appeal

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

When you make an appeal, we review the coverage decision we have made to check to see if we were following all of the rules properly. When we have completed the review we give you our decision.

If we say no to all or part of your Level 1 Appeal, you can go on to a Level 2 Appeal. The Level 2 Appeal is conducted by an independent organization that is not connected to our Plan. If you are not satisfied with the decision at the Level 2 Appeal, you may be able to continue through several more levels of appeal.

Questions? *Call our Customer Service Department listed in Chapter 2.*

Chapter 9
Section 4.2

How to get help when you are asking for a coverage decision or making an appeal

Would you like some help? Here are resources you may wish to use if you decide to ask for any kind of coverage decision or appeal a decision:

- **You can call us at Customer Service** (phone numbers are located in Chapter 2 of the Evidence of Coverage).
- **To get free help from an independent organization** that is not connected with our Plan, contact your State Health Insurance Assistance Program (see Chapter 2, Section 3 of the Evidence of Coverage).
- **Your doctor or other provider can make a request for you.** Your doctor or other provider can request a coverage decision or a Level 1 Appeal on your behalf. To request any appeal after Level 1, your doctor or other provider must be appointed as your representative.
- **You can ask someone to act on your behalf**. If you want to, you can name another person to act for you as your "representative" to ask for a coverage decision or make an appeal.
  - There may be someone who is already legally authorized to act as your representative under State law.
  - If you want a friend, relative, your doctor or other provider, or other person to be your representative, call Customer Service and ask for the form to give that person permission to act on your behalf. The form must be signed by you and by the person who you would like to act on your behalf. You must give our Plan a copy of the signed form.
- **You also have the right to hire a lawyer to act for you**. You may contact your own lawyer, or get the name of a lawyer from your local bar association or other referral service. There are also groups that will give you free legal services if you qualify. However, **you are not required to hire a lawyer** to ask for any kind of coverage decision or appeal a decision.

Chapter 9
Section 4.3

Which section of this chapter gives the details for your situation?

There are four different types of situations that involve coverage decisions and appeals. Since each situation has different rules and deadlines, we give the details for each one in a separate section in this chapter:

Section 5 of this chapter	**Section 6** of this chapter	**Section 7** of this chapter	**Section 8** of this chapter
"Your medical care: How to ask for a coverage decision or make an appeal"	"Your Part D prescription drugs: How to ask for a coverage decision or make an appeal"	"How to ask us to cover a longer hospital stay if you think you are being asked to leave the hospital too soon"	"How to ask us to keep covering certain medical services if you think your coverage is ending too soon" (*Applies to these services only*: home health care, skilled nursing facility care, and Comprehensive Outpatient Rehabilitation Facility (CORF) services)

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

SECTION 5 Your medical care: How to ask for a coverage decision or make an appeal

Have you read Section 4 of this chapter *(A guide to "the basics" of coverage decisions and appeals)*? If not, you may want to read it before you start this section.

Chapter 9
Section 5.1

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 our share of the cost of your care

This section is about your benefits for medical care and services but does not cover Part D drugs, please see Section 6 for Part D drug appeals. These are the benefits described in the chapter of the Evidence of Coverage titled: *Medical benefits chart (what is covered and what you pay)*. To keep things simple, we generally refer to "medical care coverage" or "medical care" in the rest of this section, instead of repeating "medical care or treatment or services" every time.

This section explains what you can do if you are in any of the five following situations:

1. You are not getting certain medical care you want, and you believe that this care is covered by our Plan.
2. Our Plan will not approve the medical care your doctor or other medical provider wants to give you, and you believe that this care is covered by the Plan.
3. You have received medical care or services that you believe should be covered by the Plan, but we have said we will not pay for this care.
4. You have received and paid for medical care or services that you believe should be covered by the Plan, and you want to ask our Plan to reimburse you for this care.
5. You are being told that coverage for certain medical care you have been getting will be reduced or stopped, and you believe that reducing or stopping this care could harm your health.
   - **NOTE: If the coverage that will be stopped is for hospital care, home health care, skilled nursing facility care, or Comprehensive Outpatient Rehabilitation Facility (CORF) services**, you need to read a separate section of this chapter because special rules apply to these types of care. Here's what to read in those situations:

- Section 7 of this chapter: *How to ask us to cover a longer hospital stay if you think you are being asked to leave the hospital too soon.*
- Section 8 of this chapter: *How to ask us to keep covering certain medical services if you think your coverage is ending too soon.* This section is about three services only: home health care, skilled nursing facility care, and Comprehensive Outpatient Rehabilitation Facility (CORF) services.

– For **all other** situations that involve being told that medical care you have been getting will be stopped, use this section (Section 5) as your guide for what to do.

Which of these situations are you in?

Do you want to find out whether our Plan will cover the medical care or services you want?	Has our Plan already told you that we will **not** cover or pay for a medical service in the way that you want it to be covered or paid for?	Do you want to ask our Plan to pay you back for medical care or services you have already received and paid for?
You need to ask our Plan to make a coverage decision for you. Go on to the next section of this chapter, **Section 5.2.**	You can make an **appeal**. (This means you are asking us to reconsider.) Skip ahead to **Section 5.3** of this chapter.	You can send us the bill. Skip ahead to **Section 5.5** of this chapter.

Chapter 9
Section 5.2

Step-by-Step: How to ask for a coverage decision

(how to ask our Plan to authorize or provide the medical care coverage you want)

LEGAL TERMS A coverage decision is often called an "**initial determination**" or "initial decision." When a coverage decision involves your medical care, the initial determination is called an "**organization determination.**"

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

LEGAL TERMS A "fast decision" is called an "**expedited decision.**"

How to request coverage for the medical care you want

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

Generally we use the standard deadlines for giving you our decision

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

- **However, we can take up to 14 more days** if you ask for more time, or if we need information (such as medical records) that may benefit you. If we decide to take extra days to make the decision, we will tell you in writing.
- If you believe we should **not** take extra days, you can file a "fast complaint" about our decision to take extra days. When you file a fast complaint, we will give you an answer to your complaint within 24 hours. (The process for making a complaint is different from the process for coverage decisions and appeals. For more information about the process for making complaints, including fast complaints, see Section 10 of this chapter.)

If your health requires it, ask us to give you a "**fast decision.**"

- **A fast decision means we will answer within 72 hours**.
  - **However, we can take up to 14 more days** if we find that some information is missing that may benefit you, or if you need time to get information to us for the review. If we decide to take extra days, we will tell you in writing.
  - If you believe we should **not** take extra days, you can file a "fast complaint" about our decision to take extra days. (For more information about the process for making complaints, including fast complaints, see Section 10 of this chapter.) We will call you as soon as we make the decision.
- **To get a fast decision, you must meet two requirements:**
  1. You can get a fast decision only if you are asking for coverage for medical care **you have not yet received**. (You cannot get a fast decision if your request is about payment for medical care you have already received.)
  2. You can get a fast decision **only** if using the standard deadlines could **cause serious harm to your health or hurt your ability to function**.
- **If your doctor informs us that your health requires a "fast decision," we will automatically agree to give you a fast decision.**
- If you ask for a fast decision on your own, without your doctor's support, our Plan will decide whether your health requires that we give you a fast decision.
  - If we decide that your medical condition does not meet the requirements for a fast decision, we will send you a letter that says so (and we will use the standard deadlines instead).
  - This letter will tell you that if your doctor asks for the fast decision, we will automatically give a fast decision.
  - The letter will also tell how you can file a "fast complaint" about our decision to give you a standard decision instead of the fast decision you requested. (For more information about the process for making complaints, including fast complaints, see Section 10 of this chapter.)

Step 2: Our Plan considers your request for medical care coverage and we give you our answer.

Deadlines for a "**fast**" coverage decision

- Generally, for a fast decision, we will give you our answer **within 72 hours**.
  - As explained earlier in this section, we can take up to 14 more days under certain circumstances. If we decide to take extra days to make the decision, we will tell you in writing. If we take extra days, it is called "an extended time period."
  - If we do not give you our answer within 72 hours (or if there is an extended time period, by the end of that period), you have the right to appeal. Section 5.3 of this chapter explains how to make an appeal.
- **If our answer is yes to part or all of what you requested**, we must authorize or provide the medical care coverage we have agreed to provide within 72 hours after we received your request. If we extended the time needed to make our decision, we will provide the coverage by the end of that extended period.
- **If our answer is no to part or all of what you requested**, we will send you a written statement that explains why we said no.

Deadlines for a "**standard**" coverage decision

- Generally, for a standard decision, we will give you our answer **within 14 days of receiving your request.**
  - We can take up to 14 more days ("an extended time period") under certain circumstances. If we decide to take extra days to make the decision, we will tell you in writing.
  - If we do not give you our answer within 14 days (or if there is an extended time period, by the end of that period), you have the right to appeal. Section 5.3 of this chapter explains how to make an appeal.
- **If our answer is yes to part or all of what you requested**, we must authorize or provide the coverage we have agreed to provide within 14 days after we received your request. If we extended the time needed to make our decision, we will provide the coverage by the end of that extended period.
- **If our answer is no to part or all of what you requested**, we will send you a written statement that explains why we said no.

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

- If our Plan says no, you have the right to ask us to reconsider – and perhaps change – this decision by making an appeal. Making an appeal means making another try to get the medical care coverage you want.
- If you decide to make an appeal, it means you are going on to Level 1 of the appeals process (see Section 5.3 below).

Chapter 9
Section 5.3

Step-by-Step: How to make a Level 1 Appeal
(how to ask for a review of a medical care coverage decision made by our Plan)

LEGAL TERMS	When you start the appeal process by making an appeal, it is called the "first level of appeal" or a "Level 1 Appeal." An appeal to the Plan about a medical care coverage decision is called a plan "**reconsideration.**"

Step 1: You contact our Plan and make your appeal. If your health requires a quick response, you must ask for a "**fast appeal**."

What to do

- **To start an appeal you, your representative, or in some cases your doctor must contact our Plan**. For details on how to reach us for any purpose related to your appeal, go to Chapter 2, and look for the section called, *How to contact us when you are making an appeal or complaint about your medical care.*
- **If you are asking for a standard appeal, make your standard appeal in writing by submitting a signed request.**
- **If you are asking for a fast appeal, make your appeal in writing or you may call us** at the phone number shown in Chapter 2, in the section called, *How to contact us when you are making an appeal or complaint about your medical care*.
- **You must make your appeal request within 60 days** from the date on the written notice we sent to tell you our answer to your request for a coverage decision. If you miss this deadline and have a good reason for missing it, we may give you more time to make your appeal.

Questions? *Call our Customer Service Department listed in Chapter 2.*

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

If your health requires it, ask for a "fast appeal" (you can make an oral request).

LEGAL TERMS	A "fast appeal" is also called an "**expedited appeal.**"

- If you are appealing a decision our Plan made about coverage for care you have not yet received, you and/or your doctor will need to decide if you need a "fast appeal."
- The requirements and procedures for getting a "fast appeal" are the same as those for getting a "fast decision." To ask for a fast appeal, follow the instructions for asking for a fast decision. (These instructions are given earlier in this section.)
- If your doctor informs us that your health requires a "fast appeal," we will automatically agree to give you a fast appeal.

Step 2: Our Plan considers your appeal and we give you our answer.

- When our Plan is reviewing your appeal, we take another careful look at all of the information about your request for coverage of medical care. We check to see if we were following all the rules when we said no to your request.
- We will gather more information if we need it. We may contact you or your doctor to get more information.

Deadlines for a "**fast**" appeal

- When we are using the fast deadlines, we must give you our answer **within 72 hours after we receive your appeal**. We will give you our answer sooner if your health requires us to do so.
  - However, if you ask for more time, or if we need to gather more information that may benefit you, we **can take up to 14 more days**. If we decide to take extra days to make the decision, we will tell you in writing.
  - If we do not give you an answer within 72 hours (or by the end of the extended time period if we took extra days), we are required to

automatically send your request on to Level 2 of the appeals process, where it will be reviewed by an independent organization. Later in this section, we tell you about this organization and explain what happens at Level 2 of the appeals process.

- **If our answer is yes to part or all of what you requested**, we must authorize or provide the coverage we have agreed to provide within 72 hours after we receive your appeal.
- **If our answer is no to part or all of what you requested**, we will send you a written denial notice informing you that we have automatically sent your appeal to the Independent Review Organization for a Level 2 Appeal.

Deadlines for a "**standard**" appeal

- If we are using the standard deadlines, we must give you our answer **within 30 days** after we receive your appeal if your appeal is about coverage for services you have not yet received. We will give you our decision sooner if your health condition requires us to.
  - However, if you ask for more time, or if we need to gather more information that may benefit you, **we can take up to 14 more days**.
  - If we do not give you an answer by the deadline above (or by the end of the extended time period if we took extra days), we are required to send your request on to Level 2 of the appeals process, where it will be reviewed by an independent outside organization. Later in this section, we tell about this review organization and explain what happens at Level 2 of the appeals process.
- **If our answer is yes to part or all of what you requested**, we must authorize or provide the coverage we have agreed to provide within 30 days after we receive your appeal.
- **If our answer is no to part or all of what you requested**, we will send you a written denial notice informing you that we have automatically sent your appeal to the Independent Review Organization for a Level 2 Appeal.

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

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

Chapter 9
Section 5.4

Step-by-Step: How to make a Level 2 Appeal

If our Plan says no to your Level 1 Appeal, your case will **automatically** be sent on to the next level of the appeals process. During the Level 2 Appeal, the **Independent Review Organization** reviews the decision our Plan made when we said no to your first appeal. This organization decides whether the decision we made should be changed.

LEGAL TERMS	The formal name for the "Independent Review Organization" is the "**Independent Review Entity.**" It is sometimes called the "**IRE.**"

Step 1: The Independent Review Organization reviews your appeal.

- **The Independent Review Organization is an outside, independent organization that is hired by Medicare**. This organization is not connected with our Plan and it is not a government agency. This organization is a company chosen by Medicare to handle the job of being the Independent Review Organization. Medicare oversees its work.
- We will send the information about your appeal to this organization. This information is called your "case file." **You have the right to ask us for a copy of your case file**.
- You have a right to give the Independent Review Organization additional information to support your appeal.
- Reviewers at the Independent Review Organization will take a careful look at all of the information related to your appeal.

If you had a "**fast**" appeal at Level 1, you will also have a "**fast**" appeal at Level 2

- If you had a fast appeal to our Plan at Level 1, you will automatically receive a fast appeal at Level 2. The review organization must give you an answer to your Level 2 Appeal **within 72 hours** of when it receives your appeal.
- However, if the Independent Review Organization needs to gather more information that may benefit you, **it can take up to 14 more days**.

If you had a "**standard**" appeal at Level 1, you will also have a "**standard**" appeal at Level 2

- If you made a standard appeal to our Plan at Level 1, you will automatically receive a standard appeal at Level 2. The review organization must give you an answer to your Level 2 Appeal **within 30 days** of when it receives your appeal.

Questions? *Call our Customer Service Department listed in Chapter 2.*

- However, if the Independent Review Organization needs to gather more information that may benefit you, **it can take up to 14 more days**.

Step 2: The Independent Review Organization gives you their answer.

The Independent Review Organization will tell you its decision in writing and explain the reasons for it.

- **If the review organization says yes to part or all of what you requested**, we must authorize the medical care coverage within 72 hours or provide the service within 14 days after we receive the decision from the review organization.
- **If this organization says no to part or all of your appeal**, it means they agree with our Plan that your request (or part of your request) for coverage for medical care should not be approved. (This is called "upholding the decision." It is also called "turning down your appeal.")
  - The notice you get from the Independent Review Organization will tell you in writing if your case meets the requirements for continuing with the appeals process. For example, to continue and make another appeal at Level 3, the dollar value of the medical care coverage you are requesting must meet a certain minimum. If the dollar value of the coverage you are requesting is too low, you cannot make another appeal, which means that the decision at Level 2 is final.

Step 3: If your case meets the requirements, you choose whether you want to take your appeal further.

- There are three additional levels in the appeals process after Level 2 (for a total of five levels of appeal).
- If your Level 2 Appeal is turned down and you meet the requirements to continue with the appeals process, you must decide whether you want to go on to Level 3 and make a third appeal. The details on how to do this are in the written notice you got after your Level 2 Appeal.
- The Level 3 Appeal is handled by an administrative law judge. Section 9 in this chapter tells more about Levels 3, 4, and 5 of the appeals process.

Chapter 9
Section 5.5

What if you are asking our Plan to pay you for our share of a bill you have received for medical care?

If you want to ask our Plan for payment for medical care, start by reading the chapter of the Evidence of Coverage titled: *Asking the Plan to pay its share of a bill you have received for covered services or drugs*. It describes the situations in which you may need to ask for reimbursement or to pay a bill you have received from a provider. It also explains how to send us the paperwork that asks us for payment.

Asking for reimbursement is asking for a coverage decision from our Plan

If you send us the paperwork that asks for reimbursement, you are asking us to make a coverage decision (for more information about coverage decisions, see Section 4.1 of this chapter). To make this coverage decision, we will check to see if the medical care you paid for is a covered service (see the chapter of the Evidence of Coverage titled: *Medical benefits chart (what is covered and what you pay)*). We will also check to see if you followed all the rules for using your coverage for medical care (these rules are given in the chapter of the Evidence of Coverage titled: *Using the Plan's coverage for your medical services).*

We will say yes or no to your request

- If the medical care you paid for is covered and you followed all the rules, we will send you the payment for our share of the cost of your medical care within 60 days after we receive your request. Or, if you haven't paid for the services, we will send the payment directly to the provider. When we send the payment, it's the same as saying **yes** to your request for a coverage decision.)
- If the medical care is **not** covered, or you did **not** follow all the rules, we will not send payment. Instead, we will send you a letter that says we will not pay for the services and the reasons why. (When we turn down your request for payment, it's the same as saying **no** to your request for a coverage decision.)

What if you ask for payment and we say that we will not pay?

If you do not agree with our decision to turn you down, **you can make an appeal**. If you make an appeal, it means you are asking us to change the coverage decision we made when we turned down your request for payment.

To make this appeal, follow the process for appeals that we describe in part 5.3 of this section. Go to this part for step-by-step instructions. When you are following these instructions, please note:

- If you make an appeal for reimbursement we must give you our answer within 60 days after we receive your appeal. (If you are asking us to pay you back for medical care you have already received and paid for yourself, you are not allowed to ask for a fast appeal.)
- If the Independent Review Organization reverses our decision to deny payment, we must send the payment you have requested to you or to the provider within 30 days. If the answer to your appeal is yes at any stage of the appeals process after Level 2, we must send the payment you requested to you or to the provider within 60 days.

SECTION 6 Your Part D prescription drugs: How to ask for a coverage decision or make an appeal

Have you read Section 4 of this chapter *(A guide to "the basics" of coverage decisions and appeals)*? If not, you may want to read it before you start this section.

Chapter 9
Section 6.1

This section explains what to do if you have problems getting a Part D drug or you want us to pay you back for a Part D drug

Your benefits as a member of our Plan include coverage for many outpatient prescription drugs. Medicare calls these outpatient prescription drugs "Part D drugs." You can get these drugs as long as they are included in our Plan's Drug List and they are medically necessary for you, as determined by your primary care doctor or other provider.

- **This section is about your Part D drugs only.** To keep things simple, we generally say "drug" in the rest of this section, instead of repeating "covered outpatient prescription drug" or "Part D drug" every time.
- For details about what we mean by Part D drugs, the Drug List, rules and restrictions on coverage, and cost information, see the chapters of the Evidence of Coverage titled: *Using our Plan's coverage for your Part D prescription drugs and What you pay for your Part D prescription drugs.*

Part D coverage decisions and appeals

As discussed in Section 4 of this chapter, a coverage decision is a decision we make about your benefits and coverage or about the amount we will pay for your drugs.

LEGAL TERMS	A coverage decision is often called an "**initial determination**" or "initial decision." When the coverage decision is about your Part D drugs, the initial determination is called a "**coverage determination.**"

Here are examples of coverage decisions you ask us to make about your Part D drugs:

- You ask us to make an exception, including:
  - Asking us to cover a Part D drug that is not on the Plan's Drug List
  - Asking us to waive a restriction on the Plan's coverage for a drug (such as limits on the amount of the drug you can get)
  - Asking to pay a lower cost-sharing amount for a covered non-preferred drug
- You ask us whether a drug is covered for you and whether you satisfy any applicable coverage rules. (For example, when your drug is on the Plan's Drug List but we require you to get approval from us before we will cover it for you.)
- You ask us to pay for a prescription drug you already bought. This is a request for a coverage decision about payment.

If you disagree with a coverage decision we have made, you can appeal our decision.

This section explains both how to ask for coverage decisions and how to request an appeal. Use this guide to help you determine which part has information for your situation:

Which of these situations are you in?

Request a Coverage Decision:			***Make an Appeal:***
Do you want to ask us to make an exception to the rules or restrictions on our Plan's coverage of a drug?	Do you want to ask us to cover a drug for you? (For example, if we cover the drug but we require you to get approval from us first.)	Do you want to ask us to pay you back for a drug you have already received and paid for?	Has our Plan already told you that we will <u>not</u> cover or pay for a drug in the way that you want it to be covered or paid for?
You can ask us to make an exception. (This is a type of coverage decision.) Start with **Section 6.2** of this chapter.	You can ask us for a coverage decision. Skip ahead to **Section 6.4** of this chapter.	You can ask us to pay you back. (This is a type of coverage decision.) Skip ahead to **Section 6.4** of this chapter.	You can make an appeal. (This means you are asking us to reconsider.) Skip ahead to **Section 6.5** of this chapter.

Chapter 9
Section 6.2

What is an exception?

If a drug is not covered in the way you would like it to be covered, you can ask the Plan to make an "exception." An exception is a type of coverage decision. Similar to other types of coverage decisions, if we turn down your request for an exception, you can appeal our decision.

When you ask for an exception, your doctor or other prescriber will need to explain the medical reasons why you need the exception approved. We will then consider your request. Here are examples of exceptions that you or your doctor or other prescriber can ask us to make:

1. Covering a Part D drug for you that is not on our Plan's Drug List.

LEGAL TERMS	Asking for coverage of a drug that is not on the Drug List is sometimes called asking for a "**formulary exception.**"

- If we agree to make an exception and cover a drug that is not on the Drug List, you will need to pay the cost-sharing amount that applies to Tier 3 drugs. You cannot ask for an exception to the copayment or co-insurance amount we require you to pay for the drug.
- You cannot ask for coverage of any "excluded drugs" or other non-Part D drugs which Medicare does not cover. (For more information about excluded drugs, see the chapter of the Evidence of Coverage titled: *Using our Plan's coverage for your Part D prescription drugs.*)

2. Removing a restriction on the Plan's coverage for a covered drug. There are extra rules or restrictions that apply to certain drugs on the Plan's Drug List (for more information, go to the chapter of the Evidence of Coverage titled: *Using our Plan's coverage for your Part D prescription drugs*, and look for Section 5).

LEGAL TERMS	Asking for removal of a restriction on coverage for a drug is sometimes called asking for a "**formulary exception.**"

- The extra rules and restrictions on coverage for certain drugs include:
  - **Being required to use the generic version** of a drug instead of the brand-name drug.

- **Getting Plan approval in advance** before we will agree to cover the drug for you. (This is sometimes called "prior authorization.")
- **Being required to try a different drug first** before we will agree to cover the drug you are asking for. (This is sometimes called "step therapy.")
- **Quantity limits**. For some drugs, there are restrictions on the amount of the drug you can have.

– If our Plan agrees to make an exception and waive a restriction for you, you can ask for an exception to the copayment or co-insurance amount we require you to pay for the drug.

3. **Changing coverage of a drug to a lower cost-sharing tier.** Every drug on the Plan's Drug List is in one of four cost-sharing tiers. In general, the lower the cost-sharing tier number, the less you will pay as your share of the cost of the drug.

LEGAL TERMS Asking to pay a lower preferred price for a covered non-preferred drug is sometimes called asking for a "**tiering exception.**"

– If your drug is in Tier 3 you can ask us to cover it at the cost-sharing amount that applies to drugs in Tier 2. This would lower your share of the cost for the drug.

– You cannot ask us to change the cost-sharing tier for any drug in Tier 4 (Specialty Drugs).

Chapter 9
Section 6.3

Important things to know about asking for exceptions

Your doctor must tell us the medical reasons

Your doctor or other prescriber must give us a written statement that explains the medical reasons for requesting an exception. For a faster decision, include this medical information from your doctor or other prescriber when you ask for the exception.

Typically, our Drug List includes more than one drug for treating a particular condition. These different possibilities are called "alternative" drugs. If an alternative drug would be just as effective as the drug you are requesting and would not cause more side effects or other health problems, we will generally **not** approve your request for an exception.

Our Plan can say yes or no to your request

- If we approve your request for an exception, our approval usually is valid until the end of the plan year. This is true as long as your doctor continues to prescribe the drug for you and that drug continues to be safe and effective for treating your condition.
- If we say no to your request for an exception, you can ask for a review of our decision by making an appeal. Section 6.5 explains how to make an appeal if we say no.

The next section provides details for how to ask for a coverage decision, including an exception.

Chapter 9
Section 6.4

Step-by-Step: How to ask for a coverage decision, including an exception

Step 1: You ask our Plan to make a coverage decision about the drug(s) or payment you need. If your health requires a quick response, you must ask us to make a "fast decision." You cannot ask for a fast decision if you are asking us to pay you back for a drug you already bought.

What to do

- **Request the type of coverage decision you want**. Start by calling or writing our Plan to make your request. You, your representative, or your doctor (or other prescriber) can do this. For the details, go to Chapter 2, and look for the section called, *How to contact us when you are asking for a coverage decision about your Part D prescription drugs.* Or if you are asking us to pay you back for a drug, go to the section of Chapter 2 called, *Where to send a request that asks us to pay for our share of the cost for medical care or a drug you have received.*
- **You or your doctor or someone else who is acting on your behalf** can ask for a coverage decision. Section 4 of this chapter explains how you can give written permission to someone else to act as your representative. You can also have a lawyer act on your behalf.
- **If you want to ask our Plan to pay you back for a drug**, start by reading the chapter of the Evidence of Coverage titled: *Asking the Plan to pay its share of a bill you have received for covered services or drugs.* It describes the situations in which you may need to ask for reimbursement. It also explains how to send us the paperwork that asks us to pay you back for our share of the cost of a drug you have paid for.

- **If you are requesting an exception, provide the "doctor's statement."** Your doctor or other prescriber must give us the medical reasons for the drug exception you are requesting. (We call this the "doctor's statement.") Your doctor or other prescriber can fax or mail the statement to our Plan. Or your doctor or other prescriber can tell us on the phone and follow up by faxing or mailing the signed statement. See Sections 6.2 and 6.3 for more information about exception requests.

If your health requires it, ask us to give you a "**fast decision.**"

LEGAL TERMS	A "fast decision" is called an "**expedited decision.**"

- When we give you our decision, we will use the "standard" deadlines unless we have agreed to use the "fast" deadlines. A standard decision means we will give you an answer within 72 hours after we receive your doctor's statement. A fast decision means we will answer within 24 hours.
- **To get a fast decision, you must meet two requirements:**
  1. You can get a fast decision only if you are asking for a **drug you have not yet received**. (You cannot get a fast decision if you are asking us to pay you back for a drug you are already bought.)
  2. You can get a fast decision **only** if using the standard deadlines could **cause serious harm to your health or hurt your ability to function.**
- **If your doctor or other prescriber informs us that your health requires a "fast decision," we will automatically agree to give you a fast decision.**
- If you ask for a fast decision on your own (without your doctor's or other prescriber's support), our Plan will decide whether your health requires that we give you a fast decision.
  - If we decide that your medical condition does not meet the requirements for a fast decision, we will send you a letter that says so (and we will use the standard deadlines instead).
  - This letter will tell you that if your doctor or other prescriber asks for the fast decision, we will automatically give a fast decision.

- The letter will also tell how you can file a complaint about our decision to give you a standard decision instead of the fast decision you requested. It explains how to file a "fast" complaint, which means you would get our answer to your complaint within 24 hours. (The process for making a complaint is different from the process for coverage decisions and appeals. For more information about the process for making complaints, see Section 10 of this chapter.)

Step 2: Our Plan considers your request and we give you our answer.

Deadlines for a "**fast**" coverage decision

- If we are using the fast deadlines, we must give you our answer **within 24 hours.**
  - Generally, this means within 24 hours after we receive your request. If you are requesting an exception, we will give you our answer within 24 hours after we receive your doctor's statement supporting your request. We will give you our answer sooner if your health requires us to.
  - If we do not meet this deadline, we are required to send your request on to Level 2 of the appeals process, where it will be reviewed by an independent outside organization. Later in this section, we tell about this review organization and explain what happens at Appeal Level 2.
- **If our answer is yes to part or all of what you requested**, we must provide the coverage we have agreed to provide within 24 hours after we receive your request or doctor's statement supporting your request.
- **If our answer is no to part or all of what you requested**, we will send you a written statement that explains why we said no.

Deadlines for a "**standard**" coverage decision about a drug you have not yet received

- If we are using the standard deadlines, we must give you our answer **within 72 hours**.
  - Generally, this means within 72 hours after we receive your request. If you are requesting an exception, we will give you our answer within 72 hours after we receive your doctor's statement supporting your request. We will give you our answer sooner if your health requires us to.
  - If we do not meet this deadline, we are required to send your request on to Level 2 of the appeals process, where it will be reviewed by an independent organization. Later in this section, we tell about this review organization and explain what happens at Appeal Level 2.

- **If our answer is yes to part or all of what you requested**
  - If we approve your request for coverage, we must **provide the coverage** we have agreed to provide **within 72 hours** after we receive your request or doctor's statement supporting your request.
- **If our answer is no to part or all of what you requested**, we will send you a written statement that explains why we said no.

Deadlines for a **"standard"** coverage decision about a payment for a drug you have already purchased

- We must give you our answer **within 14 days** after we receive your request.
  - If we do not meet this deadline, we are required to send your request on to Level 2 of the appeals process, where it will be reviewed by an independent organization. Later in this section, we will explain this review organization and explain what happens at Appeal Level 2.
- **If our answer is yes to part or all of what you requested,** we are also required to make payment to you **within 14 days** after we receive your request.
- **If our answer is no to part or all of what you requested,** we will send you a written statement that explains why we said no.

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

If our Plan says no, you have the right to request an appeal. Requesting an appeal means asking us to reconsider – and possibly change – the decision we made.

Chapter 9
Section 6.5

Step-by-Step: How to make a Level 1 Appeal
(how to ask for a review of a coverage decision made by our Plan)

LEGAL TERMS	When you start the appeals process by making an appeal, it is called the "first level of appeal" or a "Level 1 Appeal." An appeal to the Plan about a Part D drug coverage decision is called a plan "**redetermination.**"

Step 1: You contact our Plan and make your Level 1 Appeal. If your health requires a quick response, you must ask for a "**fast appeal**."

What to do

- **To start your appeal, you (or your representative or your doctor or other prescriber) must contact our Plan.**
  - For details on how to reach us by phone, fax, or mail for any purpose related to your appeal, go to Chapter 2, and look for the section called, *How to contact us when you are making an appeal or a complaint about your Part D prescription drugs.*
- **If you are asking for a standard appeal, make your appeal in writing by submitting a signed request.**
- **If you are asking for a fast appeal, make your appeal in writing or you may call us** at the phone number shown in Chapter 2, in the section called, *How to contact us when you are making an appeal or a complaint about your Part D prescription drugs.*
- **You must make your appeal request within 60 days** from the date on the written notice we sent to tell you our answer to your request for a coverage decision. If you miss this deadline and have a good reason for missing it, we may give you more time to make your appeal.
- **You can ask for a copy of the information in your appeal and add more information.**
  - You have the right to ask us for a copy of the information regarding your appeal.
  - If you wish, you and your doctor or other prescriber may give us additional information to support your appeal.

If your health requires it, ask for a "**fast appeal.**"

LEGAL TERMS	A "fast appeal" is also called an "**expedited appeal.**"

- If you are appealing a decision our Plan made about a drug you have not yet received, you and your doctor or other prescriber will need to decide if you need a "fast appeal."
- The requirements for getting a "fast appeal" are the same as those for getting a "fast decision" in Section 6.4 of this chapter.

Step 2: Our Plan considers your appeal and we give you our answer.

- When our Plan is reviewing your appeal, we take another careful look at all of the information about your coverage request. We check to see if we were following all the rules when we said no to your request. We may contact you or your doctor or other prescriber to get more information.

Deadlines for a "**fast**" appeal

- If we are using the fast deadlines, we must give you our answer **within 72 hours after we receive your appeal**. We will give you our answer sooner if your health requires it.
  - If we do not give you an answer within 72 hours, we are required to send your request on to Level 2 of the appeals process, where it will be reviewed by an Independent Review Organization. Later in this section, we tell about this review organization and explain what happens at Level 2 of the appeals process.
- **If our answer is yes to part or all of what you requested**, we must provide the coverage we have agreed to provide within 72 hours after we receive your appeal.
- **If our answer is no to part or all of what you requested**, we will send you a written statement that explains why we said no and how to appeal our decision.

Deadlines for a "**standard**" appeal

- If we are using the standard deadlines, we must give you our answer **within 7 days** after we receive your appeal. We will give you our decision sooner if you have not received the drug yet and your health condition requires us to do so.
  - If we do not give you a decision within 7 days, we are required to send your request on to Level 2 of the appeals process, where it will be reviewed by an Independent Review Organization. Later in this section, we tell about this review organization and explain what happens at Level 2 of the appeals process.
- **If our answer is yes to part or all of what you requested –**
  - If we approve a request for coverage, we must **provide the coverage** we have agreed to provide as quickly as your health requires, but **no later than 7 days** after we receive your appeal.
  - If we approve a request to pay you back for a drug you already bought, we are required to **send payment to you within 30 days** after we receive your appeal request.

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

Step 3: If we say no to your appeal, you decide if you want to continue with the appeals process and make another appeal.

- If our Plan says no to your appeal, you then choose whether to accept this decision or continue by making another appeal.
- If you decide to make another appeal, it means your appeal is going on to Level 2 of the appeals process.

Chapter 9
Section 6.6

Step-by-Step: How to make a Level 2 Appeal

If our Plan says no to your appeal, you then choose whether to accept this decision or continue by making another appeal. If you decide to go on to a Level 2 Appeal, the **Independent Review Organization** reviews the decision our Plan made when we said no to your first appeal. This organization decides whether the decision we made should be changed.

LEGAL TERMS	The formal name for the "Independent Review Organization" is the "**Independent Review Entity.**" It is sometimes called the "**IRE.**"

Step 1: To make a Level 2 Appeal, you must contact the Independent Review Organization and ask for a review of your case.

- If our Plan says no to your Level 1 Appeal, the written notice we send you will include **instructions on how to make a Level 2 Appeal** with the Independent Review Organization. These instructions will tell who can make this Level 2 Appeal, what deadlines you must follow, and how to reach the review organization.
- When you make an appeal to the Independent Review Organization, we will send the information we have about your appeal to this organization. This information is called your "case file." **You have the right to ask us for a copy of your case file**.
- You have a right to give the Independent Review Organization additional information to support your appeal.

Step 2: The Independent Review Organization does a review of your appeal and gives you an answer.

- **The Independent Review Organization is an outside, independent organization that is hired by Medicare**. This organization is not connected with our Plan and it is not a government agency. This organization is a company chosen by Medicare to review our decisions about your Part D benefits with our Plan.
- Reviewers at the Independent Review Organization will take a careful look at all of the information related to your appeal. The organization will tell you its decision in writing and explain the reasons for it.

Deadlines for "**fast**" appeal at Level 2

- If your health requires it, ask the Independent Review Organization for a "fast appeal."
- If the review organization agrees to give you a "fast appeal," the review organization must give you an answer to your Level 2 Appeal **within 72 hours** after it receives your appeal request.
- **If the Independent Review Organization says yes to part or all of what you requested**, we must provide the drug coverage that was approved by the review organization **within 24 hours** after we receive the decision from the review organization.

Deadlines for "**standard**" appeal at Level 2

- If you have a standard appeal at Level 2, the review organization must give you an answer to your Level 2 Appeal **within 7 days** after it receives your appeal.
- **If the Independent Review Organization says yes to part or all of what you requested –**
  - If the Independent Review Organization approves a request for coverage, we must **provide the drug coverage** that was approved by the review organization **within 72 hours** after we receive the decision from the review organization.
  - If the Independent Review Organization approves a request to pay you back for a drug you already bought, we are required to **send payment to you within 30 days** after we receive the decision from the review organization.

What if the review organization says no to your appeal?

If this organization says no to your appeal, it means the organization agrees with our decision not to approve your request. (This is called "upholding the decision." It is also called "turning down your appeal.")

To continue and make another appeal at Level 3, the dollar value of the drug coverage you are requesting must meet a minimum amount. If the dollar value of the coverage you are requesting is too low, you cannot make another appeal and the decision at Level 2 is final. The notice you get from the Independent Review Organization will tell you if the dollar value of the coverage you are requesting is high enough to continue with the appeals process.

Step 3: If the dollar value of the coverage you are requesting meets the requirement, you choose whether you want to take your appeal further.

- There are three additional levels in the appeals process after Level 2 (for a total of five levels of appeal).
- If your Level 2 Appeal is turned down and you meet the requirements to continue with the appeals process, you must decide whether you want to go on to Level 3 and make a third appeal. If you decide to make a third appeal, the details on how to do this are in the written notice you got after your second appeal.
- The Level 3 Appeal is handled by an administrative law judge. Section 9 in this chapter explains more about Levels 3, 4, and 5 of the appeals process.

SECTION 7 How to ask us to cover a longer hospital stay if you think you are being asked to leave the hospital too soon

When you are admitted to a hospital, you have the right to get all of your covered hospital services that are necessary to diagnose and treat your illness or injury. For more information about the Plan's coverage for your hospital care, including any limitations on this coverage, see the chapter of the Evidence of Coverage titled: *Medical benefits chart (what is covered and what you pay).*

During your hospital stay, your doctor and the hospital staff will be working with you to prepare for the day when you will leave the hospital. They will also help arrange for care you may need after you leave.

- The day you leave the hospital is called your "**discharge date**." Our Plan's coverage of your hospital stay ends on this date.
- When your discharge date has been decided, your doctor or the hospital staff will let you know.

Questions? *Call our Customer Service Department listed in Chapter 2.*

– If you think you are being asked to leave the hospital too soon, you can ask for a longer hospital stay and your request will be considered. This section explains how to ask.

Chapter 9
Section 7.1

During your hospital stay, you will get a written notice from Medicare that explains your rights

During your hospital stay, you will be given a written notice called *An Important Message from Medicare about Your Rights.* Everyone with Medicare gets a copy of this notice whenever they are admitted to a hospital. Someone at the hospital is supposed to give it to you within two days after you are admitted.

1. **Read this notice carefully and ask questions if you don't understand it.** It explains your rights as a hospital patient, including:
   - Your right to receive Medicare-covered services during and after your hospital stay, as ordered by your doctor. This includes the right to know what these services are, who will pay for them, and where you can get them.
   - Your right to be involved in any decisions about your hospital stay, and know who will pay for it.
   - Where to report any concerns you have about quality of your hospital care.
   - What to do if you think you are being discharged from the hospital too soon.

LEGAL TERMS	The written notice from Medicare explains how you can "**make an appeal.**" Making an appeal is a formal, legal way to ask for a delay in your discharge date so that your hospital care will be covered for a longer time. (Section 7.2 explains how to make this appeal.)

2. **You must sign the written notice to show that you received it and understand your rights.**
   - You or someone who is acting on your behalf must sign the notice. (Section 4 of this chapter explains how you can give written permission to someone else to act as your representative.)
   - Signing the notice shows **only** that you have received the information about your rights. The notice does not give your discharge date (your doctor or hospital staff will tell you your discharge date). Signing the notice **does not mean** you are agreeing on a discharge date.

3. **Keep your copy** of the signed notice so you will have the information about making an appeal (or reporting a concern about quality of care) handy if you need it.
   - If you sign the notice more than 2 days before the day you leave the hospital, you will get another copy before you are scheduled to be discharged.
   - To look at a copy of this notice in advance, you can call Customer Service or **1-800-MEDICARE (1-800-633-4227 or TTY 1-877-486-2048)**, 24 hours a day, 7 days a week. You can also see it online at http://www.cms.hhs.gov.

Chapter 9
Section 7.2

Step-by-Step: How to make a Level 1 Appeal to change your hospital discharge date

If you want to ask for your hospital services to be covered by our Plan for a longer time, you will need to use the appeals process to make this request. Before you start, understand what you need to do and what the deadlines are.

- **Follow the process.** Each step in the first two levels of the appeals process is explained below.
- **Meet the deadlines.** The deadlines are important. Be sure that you understand and follow the deadlines that apply to things you must do.
- **Ask for help if you need it.** If you have questions or need help at any time, please call Customer Service (phone numbers are located in Chapter 2 of the Evidence of Coverage). Or call your State Health Insurance Assistance Program, a government organization that provides personalized assistance (see Chapter 2, Section 3 of the Evidence of Coverage).

During a Level 1 Appeal, the Quality Improvement Organization reviews your appeal. It checks to see if your planned discharge date is medically appropriate for you.

LEGAL TERMS	When you start the appeal process by making an appeal, it is called the "first level of appeal" or a "Level 1 Appeal."

Step 1: Contact the Quality Improvement Organization in your state and ask for a "fast review" of your hospital discharge. You must act quickly.

LEGAL TERMS	A "fast review" is also called an "**immediate review**" or an "**expedited review.**"

What is the Quality Improvement Organization?

- This organization is a group of doctors and other health care professionals who are paid by the Federal government. These experts are not part of our Plan. This organization is paid by Medicare to check on and help improve the quality of care for people with Medicare. This includes reviewing hospital discharge dates for people with Medicare.

How can you contact this organization?

- The written notice you received (*An Important Message from Medicare*) informs you how to reach this organization. (Or find the name, address, and phone number of the Quality Improvement Organization for your state in Chapter 2, Section 4, of the Evidence of Coverage.)

Act quickly:

- To make your appeal, you must contact the Quality Improvement Organization **before** you leave the hospital and **no later than your planned discharge date**. (Your "planned discharge date" is the date that has been set for you to leave the hospital.)
  - If you meet this deadline, you are allowed to stay in the hospital **after** your discharge date **without paying for it** while you wait to get the decision on your appeal from the Quality Improvement Organization.
  - If you do **not** meet this deadline, and you decide to stay in the hospital after your planned discharge date, **you may have to pay all of the costs** for hospital care you receive after your planned discharge date.
- If you miss the deadline for contacting the Quality Improvement Organization about your appeal, you can make your appeal directly to our Plan instead. For details about this other way to make your appeal, see Section 8.5 of this chapter.

Ask for a "**fast review**:"

- You must ask the Quality Improvement Organization for a "**fast review**" of your discharge. Asking for a "fast review" means you are asking for the organization to use the "fast" deadlines for an appeal instead of using the standard deadlines.

LEGAL TERMS	A "fast review" is also called an "**immediate review**" or an "**expedited review.**"

Step 2: The Quality Improvement Organization conducts an independent review of your case.

What happens during this review?

- Health professionals at the Quality Improvement Organization (we will call them "the reviewers" for short) will ask you (or your representative) why you believe coverage for the services should continue. You don't have to prepare anything in writing, but you may do so if you wish.
- The reviewers will also look at your medical information, talk with your doctor, and review information that the hospital and our Plan has given to them.
- By noon of the day after the reviewers informed our Plan of your appeal, you will also get a written notice that gives your planned discharge date and explains the reasons why your doctor, the hospital, and our Plan think it is right (medically appropriate) for you to be discharged on that date.

LEGAL TERMS	This written explanation is called the "**Detailed Notice of Discharge.**" You can get a sample of this notice by calling Customer Service or **1-800-MEDICARE (1-800-633-4227)**, 24 hours a day, 7 days a week. TTY users should call **1-877-486-2048**. Or you can get see a sample notice online at http://www.cms.hhs.gov/BNI/

Step 3: Within one full day after it has all the needed information, the Quality Improvement Organization will give you its answer to your appeal.

What happens if the answer is yes?

- If the review organization says **yes** to your appeal, **our Plan must keep providing your covered hospital services for as long as these services are medically necessary.**
- You will have to keep paying your share of the costs (such as deductibles or copayments, if these apply). In addition, there may be limitations on your covered hospital services. See the chapter of the Evidence of Coverage titled: *Medical benefits chart (what is covered and what you pay).*

What happens if the answer is no?

- If the review organization says ***no*** to your appeal, they are saying that your planned discharge date is medically appropriate. (Saying **no** to your appeal is also called **turning down** your appeal.) If this happens, **our Plan's coverage for your hospital services will end** at noon on the day **after** the Quality Improvement Organization gives you its answer to your appeal.

– If the review organization says **no** to your appeal and you decide to stay in the hospital, then **you may have to pay the full cost** of hospital care you receive after noon on the day after the Quality Improvement Organization gives you its answer to your appeal.

Step 4: If the answer to your Level 1 Appeal is no, you decide if you want to make another appeal.

– If the Quality Improvement Organization has turned down your appeal, **and** you stay in the hospital after your planned discharge date, then you can make another appeal. Making another appeal means you are going on to "Level 2" of the appeals process.

Chapter 9
Section 7.3

Step-by-Step: How to make a Level 2 Appeal to change your hospital discharge date

If the Quality Improvement Organization has turned down your appeal, **and** you stay in the hospital after your planned discharge date, then you can make a Level 2 Appeal. During a Level 2 Appeal, you ask the Quality Improvement Organization to take another look at the decision they made on your first appeal.

Here are the steps for Level 2 of the appeal process:

Step 1: You contact the Quality Improvement Organization again and ask for another review.

– You must ask for this review **within 60 days** after the day when the Quality Improvement Organization said **no** to your Level 1 Appeal. You can ask for this review only if you stayed in the hospital after the date that your coverage for the care ended.

Step 2: The Quality Improvement Organization does a second review of your situation.

– Reviewers at the Quality Improvement Organization will take another careful look at all of the information related to your appeal.

Step 3: Within 14 days, the Quality Improvement Organization reviewers will decide on your appeal and tell you their decision.

If the review organization says yes:

– **Our Plan must reimburse you** for our share of the costs of hospital care you have received since noon on the day after the date your first appeal was turned down by the Quality Improvement Organization. **Our Plan must continue**

providing coverage for your hospital care for as long as it is medically necessary.

- You must continue to pay your share of the costs and coverage limitations may apply.

If the review organization says no:

- It means they agree with the decision they made to your Level 1 Appeal and will not change it. This is called "upholding the decision." It is also called "turning down your appeal."
- The notice you get will tell you in writing what you can do if you wish to continue with the review process. It will give you the details about how to go on to the next level of appeal, which is handled by a judge.

Step 4: If the answer is no, you will need to decide whether you want to take your appeal further by going on to Level 3.

- There are three additional levels in the appeals process after Level 2 (for a total of five levels of appeal). If the review organization turns down your Level 2 Appeal, you can choose whether to accept that decision or whether to go on to Level 3 and make another appeal. At Level 3, your appeal is reviewed by a judge.
- Section 9 in this chapter explains more about Levels 3, 4, and 5 of the appeals process.

Chapter 9
Section 7.4

What if you miss the deadline for making your Level 1 Appeal?

You can appeal to our Plan instead

As explained above in Section 7.2, you must act quickly to contact the Quality Improvement Organization to start your first appeal of your hospital discharge. ("Quickly" means before you leave the hospital and no later than your planned discharge date.) If you miss the deadline for contacting this organization, there is another way to make your appeal.

If you use this other way of making your appeal, **the first two levels of appeal are different**.

Step-by-Step: How to make a Level 1 *Alternate* Appeal

If you miss the deadline for contacting the Quality Improvement Organization, you can make an appeal to our Plan, asking for a "fast review." A fast review is an appeal that uses the fast deadlines instead of the standard deadlines.

LEGAL TERMS	A "fast" review (or "fast appeal") is also called an "**expedited**" **review** (or "**expedited appeal**").

Step 1: Contact our Plan and ask for a "fast review."

- For details on how to contact our Plan, go to Chapter 2, and look for the section called, *How to contact us when you are making an appeal or complaint about your medical care.*
- **Be sure to ask for a "fast review."** This means you are asking us to give you an answer using the "fast" deadlines rather than the "standard" deadlines.

Step 2: Our Plan does a "fast" review of your planned discharge date, checking to see if it was medically appropriate.

- During this review, our Plan takes a look at all of the information about your hospital stay. We check to see if your planned discharge date was medically appropriate. We will check to see if the decision about when you should leave the hospital was fair and followed all the rules.
- In this situation, we will use the "fast" deadlines rather than the standard deadlines for giving you the answer to this review.

Step 3: Our Plan gives you our decision within 72 hours after you ask for a "fast review" ("fast appeal").

- **If our Plan says yes to your fast appeal**, it means we have agreed with you that you still need to be in the hospital after the discharge date, and will keep providing your covered services for as long as it is medically necessary. It also means that we have agreed to reimburse you for our share of the costs of care you have received since the date when we said your coverage would end. (You must pay your share of the costs and there may be coverage limitations that apply.)
- **If our Plan says no to your fast appeal**, we are saying that your planned discharge date was medically appropriate. Our coverage for your hospital services ends as of the day we said coverage would end.
- If you stayed in the hospital **after** your planned discharge date, then **you may have to pay the full cost** of hospital care you received after the planned discharge date. You will be responsible for the cost of care starting from noon on the day after our Plan says no to your appeal.

Step 4: If our Plan says *no* to your fast appeal, your case will automatically be sent on to the next level of the appeals process.

- To make sure we were following all the rules when we said no to your fast appeal, **our Plan is required to send your appeal to the "Independent Review Organization."** When we do this, it means that you are **automatically** going on to Level 2 of the appeals process.

Step-by-Step: How to make a Level 2 *Alternate* Appeal

If our Plan says no to your Level 1 Appeal, your case will **automatically** be sent on to the next level of the appeals process. During the Level 2 Appeal, the **Independent Review Organization** reviews the decision our Plan made when we said no to your "fast appeal." This organization decides whether the decision we made should be changed.

LEGAL TERMS	The formal name for the "Independent Review Organization" is the "**Independent Review Entity.**" It is sometimes called the "**IRE.**"

Step 1: We will automatically forward your case to the Independent Review Organization.

- We are required to send the information for your Level 2 Appeal to the Independent Review Organization within 24 hours of when we tell you that we are saying no to your first appeal. (If you think we are not meeting this deadline or other deadlines, you can make a complaint. The complaint process is different from the appeal process. Section 10 of this chapter explains how to make a complaint.)

Step 2: The Independent Review Organization does a "fast review" of your appeal. The reviewers give you an answer within 72 hours.

- **The Independent Review Organization is an outside, independent organization that is hired by Medicare**. This organization is not connected with our Plan and it is not a government agency. This organization is a company chosen by Medicare to handle the job of being the Independent Review Organization. Medicare oversees its work.

- Reviewers at the Independent Review Organization will take a careful look at all of the information related to your appeal of your hospital discharge.
- **If this organization says yes to your appeal**, then our Plan must reimburse you (pay you back) for our share of the costs of hospital care you have received since the date of your planned discharge. We must also continue the Plan's coverage of your hospital services for as long as it is medically necessary. You must continue to pay your share of the costs. If there are coverage limitations, these could limit how much we would reimburse or how long we would continue to cover your services.
- **If this organization says no to your appeal**, it means they agree with our Plan that your planned hospital discharge date was medically appropriate. (This is called "upholding the decision." It is also called "turning down your appeal.")
    - The notice you get from the Independent Review Organization will tell you in writing what you can do if you wish to continue with the review process. It will give you the details about how to go on to a Level 3 Appeal, which is handled by a judge.

Step 3: If the Independent Review Organization turns down your appeal, you choose whether you want to take your appeal further.

- There are three additional levels in the appeals process after Level 2 (for a total of five levels of appeal). If reviewers say no to your Level 2 Appeal, you decide whether to accept their decision or go on to Level 3 and make a third appeal.
- Section 9 in this chapter explains more about Levels 3, 4, and 5 of the appeals process.

SECTION 8 How to ask us to keep covering certain medical services if you think your coverage is ending too soon

Chapter 9
Section 8.1

This section is about three services only:
Home health care, skilled nursing facility care, and Comprehensive Outpatient Rehabilitation Facility (CORF) services

This section is about the following types of care **only**:

- **Home health care services** you are getting.
- **Skilled nursing care** you are getting as a patient in a skilled nursing facility. (To learn about requirements for being considered a "skilled nursing facility," see the chapter of the Evidence of Coverage titled: *Definitions of important words*.)

– **Rehabilitation care** you are getting as an outpatient at a Medicare-approved Outpatient Rehabilitation Facility. Usually, this means you are getting treatment for an illness or accident, or you are recovering from a major operation. (For more information about this type of facility, see the chapter of the Evidence of Coverage titled: *Definitions of important words.*)

When you are getting any of these types of care, you have the right to keep getting your covered services for that type of care for as long as the care is needed to diagnose and treat your illness or injury. For more information on your covered services, including your share of the cost and any limitations to coverage that may apply, see the chapter of the Evidence of Coverage titled: *Medical benefits chart (what is covered and what you pay).*

When our Plan decides it is time to stop covering any of the three types of care for you, we are required to tell you in advance. When your coverage for that care ends, **our Plan will stop paying its share of the cost for your care**.

If you think we are ending the coverage of your care too soon, **you can appeal our decision**. This section explains how to ask.

Chapter 9
Section 8.2

We will tell you in advance when your coverage will be ending

1. **You receive a notice in writing.** At least two days before our Plan is going to stop covering your care, the agency or facility that is providing your care will give you a notice. The written notice includes the date when our Plan will stop covering the care for you.

LEGAL TERMS	In this written notice, we are telling you about a "**coverage decision**" we have made about when to stop covering your care. (For more information about coverage decisions, see Section 4 in this chapter.)

The written notice also explains what you can do if you want to ask our Plan to change this decision about when to end your care, and keep covering it for a longer period of time.

LEGAL TERMS	In telling what you can do, the written notice is telling how you can "**make an appeal.**" Making an appeal is a formal, legal way to ask our Plan to change the coverage decision we have made about when to stop your care. (Section 8.3 of this chapter explains how you can make an appeal.)

LEGAL TERMS	The written notice is called the "**Notice of Medicare Non-Coverage.**" To get a sample copy, call Customer Service or **1-800-MEDICARE (1-800-633-4227)**, 24 hours a day, 7 days a week. (TTY users should call **1-877-486-2048**.) Or see a copy online at http://www.cms.hhs.gov/BNI/

2. **You must sign the written notice to show that you received it.**
   - You or someone who is acting on your behalf must sign the notice. (Section 4 explains how you can give written permission to someone else to act as your representative.)
   - Signing the notice shows **only** that you have received the information about when your coverage will stop. **Signing it does not mean you agree** with the Plan that it's time to stop getting the care.

Chapter 9
Section 8.3

Step-by-Step: How to make a Level 1 Appeal to have our Plan cover your care for a longer time

If you want to ask us to cover your care for a longer period of time, you will need to use the appeals process to make this request. Before you start, understand what you need to do and what the deadlines are.

- **Follow the process.** Each step in the first two levels of the appeals process is explained below.
- **Meet the deadlines.** The deadlines are important. Be sure that you understand and follow the deadlines that apply to things you must do. There are also deadlines our Plan must follow. (If you think we are not meeting our deadlines, you can file a complaint. Section 10 of this chapter explains how to file a complaint.)
- **Ask for help if you need it.** If you have questions or need help at any time, please call Customer Service (phone numbers are located in Chapter 2 of the Evidence of Coverage). Or call your State Health Insurance Assistance Program, a government organization that provides personalized assistance (see Chapter 2, Section 3 of the Evidence of Coverage).

During a Level 1 Appeal, the Quality Improvement Organization reviews your appeal and decides whether to change the decision made by our Plan.

LEGAL TERMS	When you start the appeal process by making an appeal, it is called the "**first level of appeal**" or "**Level 1 Appeal.**"

Step 1: Make your Level 1 Appeal: contact the Quality Improvement Organization in your state and ask for a review. You must act quickly.

What is the Quality Improvement Organization?

- This organization is a group of doctors and other health care experts who are paid by the Federal government. These experts are not part of our Plan. They check on the quality of care received by people with Medicare and review Plan decisions about when it's time to stop covering certain kinds of medical care.

How can you contact this organization?

- The written notice you received explains how to reach this organization. (Or find the name, address, and phone number of the Quality Improvement Organization for your state in Chapter 2, Section 4, of the Evidence of Coverage.)

What should you ask for?

- Ask this organization to do an independent review of whether it is medically appropriate for our Plan to end coverage for your medical services.

Your deadline for contacting this organization.

- You must contact the Quality Improvement Organization to start your appeal **no later than noon of the day after you receive the written notice telling you when we will stop covering your care**.
- If you miss the deadline for contacting the Quality Improvement Organization about your appeal, you can make your appeal directly to our Plan instead. For details about this other way to make your appeal, see Section 8.5.

Step 2: The Quality Improvement Organization conducts an independent review of your case.

What happens during this review?

- Health professionals at the Quality Improvement Organization (we will call them "the reviewers" for short) will ask you (or your representative) why you believe coverage for the services should continue. You don't have to prepare anything in writing, but you may do so if you wish.
- The review organization will also look at your medical information, talk with your doctor, and review information that our Plan has given to them.
- The review organization will inform us of their decision on your appeal. By the end of that day, you will also get a written notice from us that gives our reasons for wanting to end coverage for your services.

LEGAL TERMS	This notice explanation is called the "**Detailed Explanation of Non-Coverage.**"

Step 3: Within one full day after they have all the information they need, the reviewers will tell you their decision.

What happens if the reviewers say yes to your appeal?

- If the reviewers say *yes* to your appeal, then **our Plan must keep providing your covered services for as long as it is medically necessary**.
- You will have to keep paying your share of the costs (such as deductibles or copayments, if these apply). In addition, there may be limitations on your covered services. See the chapter of the Evidence of Coverage titled: *Medical benefits chart (what is covered and what you pay).*

What happens if the reviewers say no to your appeal?

- If the reviewers say **no** to your appeal, then **your coverage will end on the date we have told you**. Our Plan will stop paying its share of the costs of this care.
- If you decide to keep getting the home health care, or skilled nursing facility care, or Comprehensive Outpatient Rehabilitation Facility (CORF) services **after** this date when your coverage ends, then **you will have to pay the full cost** of this care yourself.

Step 4: If the answer to your Level 1 Appeal is no, you decide if you want to make another appeal.

- This first appeal you make is "Level 1" of the appeals process. If reviewers say **no** to your Level 1 Appeal – **and** you choose to continue getting care after your coverage for the care has ended – then you can make another appeal.
- Making another appeal means you are going on to "Level 2" of the appeals process.

Chapter 9
Section 8.4

Step-by-Step: How to make a Level 2 Appeal to have our Plan cover your care for a longer time

If the Quality Improvement Organization has turned down your appeal **and** you choose to continue getting care after your coverage for the care has ended, then you can make a Level 2 Appeal. During a Level 2 Appeal, you ask the Quality Improvement Organization to take another look at the decision they made on your first appeal.

Here are the steps for Level 2 of the appeal process:

Step 1: You contact the Quality Improvement Organization again and ask for another review.

- You must ask for this review **within 60 days** after the day when the Quality Improvement Organization said **no** to your Level 1 Appeal. You can ask for this review only if you continued getting care after the date that your coverage for the care ended.

Step 2: The Quality Improvement Organization does a second review of your situation.

- Reviewers at the Quality Improvement Organization will take another careful look at all of the information related to your appeal.

Step 3: Within 14 days, the Quality Improvement Organization reviewers will decide on your appeal and tell you their decision.

What happens if the review organization says yes to your appeal?

- **Our Plan must reimburse you** for our share of the costs of care you have received since the date when we said your coverage would end. **Our Plan must continue providing coverage** for the care for as long as it is medically necessary.
- You must continue to pay your share of the costs and there may be coverage limitations that apply.

What happens if the review organization says no?

- It means they agree with the decision they made to your Level 1 Appeal and will not change it. (This is called "upholding the decision." It is also called "turning down your appeal.")
- The notice you get will tell you in writing what you can do if you wish to continue with the review process. It will give you the details about how to go on to the next level of appeal, which is handled by a judge.

Step 4: If the answer is no, you will need to decide whether you want to take your appeal further.

- There are three additional levels of appeal after Level 2, for a total of five levels of appeal. If reviewers turn down your Level 2 Appeal, you can choose whether to accept that decision or whether to go on to Level 3 and make another appeal. At Level 3, your appeal is reviewed by a judge.
- Section 9 in this chapter explains more about Levels 3, 4, and 5 of the appeals process.

Questions? *Call our Customer Service Department listed in Chapter 2.*

Chapter 9
Section 8.5

What if you miss the deadline for making your Level 1 Appeal?

You can appeal to our Plan instead

As explained in Section 8.3, you must act quickly to contact the Quality Improvement Organization to start your first appeal (within a day or two, at the most). If you miss the deadline for contacting this organization, there is another way to make your appeal. If you use this other way of making your appeal, **the first two levels of appeal are different.**

Step-by-Step: How to make a Level 1 *Alternate* Appeal

If you miss the deadline for contacting the Quality Improvement Organization, you can make an appeal to our Plan, asking for a "fast review." A fast review is an appeal that uses the fast deadlines instead of the standard deadlines.

Here are the steps for a Level 1 Alternate Appeal:

LEGAL TERMS	A "fast" review (or "fast appeal") is also called an **"expedited" review** (or "**expedited appeal**").

Step 1: Contact our Plan and ask for a "fast review."

- For details on how to contact our Plan, go to Chapter 2, and look for the section called, *How to contact us when you are making an appeal or complaint about your medical care*.
- **Be sure to ask for a "fast review."** This means you are asking us to give you an answer using the "fast" deadlines rather than the "standard" deadlines.

Step 2: Our Plan does a "fast" review of the decision we made about when to stop coverage for your services.

- During this review, our Plan takes another look at all of the information about your case. We check to see if we were following all the rules when we set the date for ending the Plan's coverage for services you were receiving.
- We will use the "fast" deadlines rather than the standard deadlines for giving you the answer to this review. (Usually, if you make an appeal to our Plan and ask for a "fast review," we are allowed to decide whether to agree to your request and give you a "fast review." But in this situation, the rules require us to give you a fast response if you ask for it.)

Step 3: Our Plan gives you our decision within 72 hours after you ask for a "fast review" ("fast appeal").

- **If our Plan says yes to your fast appeal**, it means we have agreed with you that you need services longer, and will keep providing your covered services for as long as it is medically necessary. It also means that we have agreed to reimburse you for our share of the costs of care you have received since the date when we said your coverage would end. (You must pay your share of the costs and there may be coverage limitations that apply.)
- **If our Plan says no to your fast appeal**, then your coverage will end on the date we have told you and our Plan will not pay after this date. Our Plan will stop paying its share of the costs of this care.
- If you continued to get home health care, or skilled nursing facility care, or Comprehensive Outpatient Rehabilitation Facility (CORF) services **after** the date when we said your coverage would end, then **you will have to pay the full cost** of this care yourself.

Step 4: If our Plan says no to your fast appeal, your case will automatically go on to the next level of the appeals process.

- To make sure we were following all the rules when we said no to your fast appeal, **our Plan is required to send your appeal to the "Independent Review Organization."** When we do this, it means that you are **automatically** going on to Level 2 of the appeals process.

Step-by-Step: How to make a Level 2 *Alternate* Appeal

If our Plan says no to your Level 1 Appeal, your case will **automatically** be sent on to the next level of the appeals process. During the Level 2 Appeal, the **Independent Review Organization** reviews the decision our Plan made when we said no to your "fast appeal." This organization decides whether the decision we made should be changed.

LEGAL TERMS	The formal name for the "Independent Review Organization" is the "**Independent Review Entity.**" It is sometimes called the "**IRE.**"

Step 1: We will automatically forward your case to the Independent Review Organization.

- We are required to send the information for your Level 2 Appeal to the Independent Review Organization within 24 hours of when we tell you that we are saying no to your first appeal. (If you think we are not meeting this deadline or other deadlines, you can make a complaint. The complaint process is different from the appeal process. Section 10 of this chapter explains how to make a complaint.)

Questions? *Call our Customer Service Department listed in Chapter 2.*

Step 2: The Independent Review Organization does a "fast review" of your appeal. The reviewers give you an answer within 72 hours.

- **The Independent Review Organization is an outside, independent organization that is hired by Medicare**. This organization is not connected with our Plan and it is not a government agency. This organization is a company chosen by Medicare to handle the job of being the Independent Review Organization. Medicare oversees its work.
- Reviewers at the Independent Review Organization will take a careful look at all of the information related to your appeal.
- **If this organization says *yes* to your appeal**, then our Plan must reimburse you (pay you back) for our share of the costs of care you have received since the date when we said your coverage would end. We must also continue to cover the care for as long as it is medically necessary. You must continue to pay your share of the costs. If there are coverage limitations, these could limit how much we would reimburse or how long we would continue to cover your services.
- **If this organization says *no* to your appeal**, it means they agree with the decision our Plan made to your first appeal and will not change it. (This is called "upholding the decision." It is also called "turning down your appeal.")
  - The notice you get from the Independent Review Organization will tell you in writing what you can do if you wish to continue with the review process. It will give you the details about how to go on to a Level 3 Appeal.

Step 3: If the Independent Review Organization turns down your appeal, you choose whether you want to take your appeal further.

- There are three additional levels of appeal after Level 2, for a total of five levels of appeal. If reviewers say no to your Level 2 Appeal, you can choose whether to accept that decision or whether to go on to Level 3 and make another appeal. At Level 3, your appeal is reviewed by a judge.
- Section 9 in this chapter explains more about Levels 3, 4, and 5 of the appeals process.

SECTION 9 Taking your appeal to Level 3 and beyond

Chapter 9
Section 9.1

Levels of Appeal 3, 4, and 5 for Medical Service Appeals

This section may be appropriate for you if you have made a Level 1 Appeal and a Level 2 Appeal, and both of your appeals have been turned down.

Questions? *Call our Customer Service Department listed in Chapter 2.*

If the dollar value of the item or medical service you have appealed meets certain minimum levels, you may be able to go on to additional levels of appeal. If the dollar value is less than the minimum level, you cannot appeal any further. If the dollar value is high enough, the written response you receive to your Level 2 Appeal will explain who to contact and what to do to ask for a Level 3 Appeal.

For most situations that involve appeals, the last three levels of appeal work in much the same way. Here is who handles the review of your appeal at each of these levels.

Level 3 Appeal	**A judge who works for the Federal government** will review your appeal and give you an answer. This judge is called an "Administrative Law Judge."

- **If the answer is yes, the appeals process *may* or *may not* be over** - We will decide whether to appeal this decision to Level 4. Unlike a decision at Level 2 (Independent Review Organization), we have the right to appeal a Level 3 decision that is favorable to you.
  - If we decide **not** to appeal the decision, we must authorize or provide you with the service within 60 days after receiving the judge's decision.
  - If we decide to appeal the decision, we will send you a copy of the Level 4 Appeal request with any accompanying documents. We may wait for the Level 4 Appeal decision before authorizing or providing the service in dispute.
- **If the answer is no, the appeals process may or may not be over.**
  - If you decide to accept this decision that turns down your appeal, the appeals process is over.
  - If you do not want to accept the decision, you can continue to the next level of the review process. If the administrative law judge says no to your appeal, the notice you get will tell you what to do next if you choose to continue with your appeal.

Level 4 Appeal	The **Medicare Appeals Council** will review your appeal and give you an answer. The Medicare Appeals Council works for the Federal government.

- **If the answer is yes, or if the Medicare Appeals Council denies our request to review a favorable Level 3 Appeal decision, the appeals process may or may not be over** - We will decide whether to appeal this decision to Level 5. Unlike a decision at Level 2 (Independent Review Organization), we have the right to appeal a Level 4 decision that is favorable to you.
  - If we decide **not** to appeal the decision, we must authorize or provide you with the service within 60 days after receiving the Medicare Appeals Council's decision.
  - If we decide to appeal the decision, we will let you know in writing.
- **If the answer is no or if the Medicare Appeals Council denies the review request, the appeals process may or may not be over**.
  - If you decide to accept this decision that turns down your appeal, the appeals process is over.
  - If you do not want to accept the decision, you might be able to continue to the next level of the review process. It depends on your situation. If the Medicare Appeals Council says no to your appeal, the notice you get will tell you whether the rules allow you to go on to a Level 5 Appeal. If the rules allow you to go on, the written notice will also tell you who to contact and what to do next if you choose to continue with your appeal.

Level 5 Appeal	A judge at the **Federal District Court** will review your appeal. This is the last stage of the appeals process.

- This is the last step of the administrative appeals process.

Chapter 9
Section 9.2

Levels of Appeal 3, 4, and 5 for Part D Drug Appeals

This section may be appropriate for you if you have made a Level 1 Appeal and a Level 2 Appeal, and both of your appeals have been turned down.

If the dollar value of the drug you have appealed meets certain minimum levels, you may be able to go on to additional levels of appeal. If the dollar value is less than the minimum level, you cannot appeal any further. If the dollar value is high enough, the written response you receive to your Level 2 Appeal will explain who to contact and what to do to ask for a Level 3 Appeal.

For most situations that involve appeals, the last three levels of appeal work in much the same way. Here is who handles the review of your appeal at each of these levels.

Level 3 Appeal	**A judge who works for the Federal government** will review your appeal and give you an answer. This judge is called an "Administrative Law Judge."

- **If the answer is yes, the appeals process is over**. What you asked for in the appeal has been approved.
- **If the answer is no, the appeals process may or may not be over**.
  - If you decide to accept this decision that turns down your appeal, the appeals process is over.
  - If you do not want to accept the decision, you can continue to the next level of the review process. If the administrative judge says no to your appeal, the notice you get will tell you what to do next if you choose to continue with your appeal.

Level 4 Appeal	The **Medicare Appeals Council** will review your appeal and give you an answer. The Medicare Appeals Council works for the Federal government.

- **If the answer is yes, the appeals process is over**. What you asked for in the appeal has been approved.
- **If the answer is no, the appeals process may or may not be over.**
  - If you decide to accept this decision that turns down your appeal, the appeals process is over.
  - If you do not want to accept the decision, you might be able to continue to the next level of the review process. It depends on your situation. Whenever the reviewer says no to your appeal, the notice you get will tell you whether the rules allow you to go on to another level of appeal. If the rules allow you to go on, the written notice will also tell you who to contact and what to do next if you choose to continue with your appeal.

Level 5 Appeal	A judge at the **Federal District Court** will review your appeal. This is the last stage of the appeals process.

- This is the last step of the administrative appeals process.

SECTION 10 How to make a complaint about quality of care, waiting times, customer service, or other concerns

If your problem is about decisions related to benefits, coverage, or payment, then this section is **not for you**. Instead, you need to use the process for coverage decisions and appeals. Go to Section 4 of this chapter.

Chapter 9
Section 10.1

What kinds of problems are handled by the complaint process?

This section explains how to use the process for making complaints. The complaint process is used for certain types of problems **only**. This includes problems related to quality of care, waiting times, and the customer service you receive. Here are examples of the kinds of problems handled by the complaint process.

If you have any of these kinds of problems, you can "make a complaint"

Quality of your medical care

- Are you unhappy with the quality of the care you have received (including care in the hospital)?

Respecting your privacy

- Do you believe that someone did not respect your right to privacy or shared information about you that you feel should be confidential?

Disrespect, poor customer service, or other negative behaviors

- Has someone been rude or disrespectful to you?
- Are you unhappy with how our Customer Service has dealt with you?
- Do you feel you are being encouraged to leave our Plan (disenroll from our Plan)?

Waiting times

- Are you having trouble getting an appointment, or waiting too long to get it?
- Have you been kept waiting too long by doctors, pharmacists, or other health professionals? Or by Customer Service or other staff at our Plan?
- Examples include waiting too long on the phone, in the waiting room, in the exam room, or when getting a prescription.

Cleanliness

- Are you unhappy with the cleanliness or condition of a clinic, hospital, or doctor's office?

Information you get from our Plan

- Do you believe we have not given you a notice that we are required to give?
- Do you think written information we have given you is hard to understand?

The next page has more examples of possible reasons for making a complaint

Possible complaints (continued)

These types of complaints are all related to the timeliness of our actions related to coverage decisions and appeals

The process of asking for a coverage decision and making appeals is explained in sections 4-9 of this chapter. If you are asking for a decision or making an appeal, you use that process, not the complaint process.

However, if you have already asked for a coverage decision or made an appeal, and you think that our Plan is not responding quickly enough, you can also make a complaint about our slowness. Here are examples:

- If you have asked us to give you a "fast response" for a coverage decision or appeal, and we have said we will not, you can make a complaint.
- If you believe our Plan is not meeting the deadlines for giving you a coverage decision or an answer to an appeal you have made, you can make a complaint.
- When a coverage decision we made is reviewed and our Plan is told that we must cover or reimburse you for certain medical services or drugs, there are deadlines that apply. If you think we are not meeting these deadlines, you can make a complaint.
- When our Plan does not give you a decision on time, we are required to forward your case to the Independent Review Organization. If we do not do that within the required deadline, you can make a complaint.

Chapter 9
Section 10.2

The formal name for "making a complaint" is "filing a grievance"

LEGAL TERMS	– What this section calls a "**complaint**" is also called a "**grievance**." – Another term for "**making a complaint**" is "**filing a grievance**." – Another way to say "**using the process for complaints**" is "**using the process for filing a grievance**."

Chapter 9
Section 10.3

Step-by-Step: Making a complaint

Step 1: Contact us promptly – either by phone or in writing.

Usually, calling Customer Service is the first step. If there is anything else you need to do, Customer Service will let you know. The phone numbers and hours of operation for Customer Service are located in Chapter 2 of the Evidence of Coverage.

If you do not wish to call (or you called and were not satisfied), you can put your complaint in writing and send it to us. If you do this, it means that we will use our formal procedure for answering grievances. Here's how it works:

The complaint must be submitted within 60 days of the event or incident. The address for filing complaints is located in Chapter 2 under *How to contact us when you are making an appeal or complaint about your medical care*, or for Part D complaints, *How to contact us when you are making an appeal or a complaint about your Part D prescription drugs*. We must address your grievance as quickly as your case requires based on your health status, but no later than 30 days after receiving your complaint. We may extend the time frame by up to 14 days if you ask for the extension, or if we justify a need for additional information and the delay is in your best interest. If we deny your grievance in whole or in part, our written decision will explain why we denied it, and will tell you about any dispute resolution options you may have.

Whether you call or write, you should contact Customer Service right away. The complaint must be made within 60 days after you had the problem you want to complain about.

If you are making a complaint because we denied your request for a "fast response" to a coverage decision or appeal, we will automatically give you a "fast" complaint. If you have a "fast" complaint, it means we will give you an answer within 24 hours.

Questions? *Call our Customer Service Department listed in Chapter 2.*

LEGAL TERMS	What this section calls a "**fast complaint**" is also called a "**fast grievance.**"

Step 2: We look into your complaint and give you our answer.

If possible, we will answer you right away. If you call us with a complaint, we may be able to give you an answer on the same phone call. If your health condition requires us to answer quickly, we will do that.

Most complaints are answered in 30 days, but we may take up to 44 days. If we need more information and the delay is in your best interest or if you ask for more time, we can take up to 14 more days (44 days total) to answer your complaint.

If we do not agree with some or all of your complaint or don't take responsibility for the problem you are complaining about, we will let you know. Our response will include our reasons for this answer. We must respond whether we agree with the complaint or not.

Chapter 9
Section 10.4

You can also make complaints about quality of care to the Quality Improvement Organization (QIO)

You can make your complaint about the quality of care you received to our Plan by using the step-by-step process outlined above.

When your complaint is about **quality of care,** you also have two extra options:

You can make your complaint to the Quality Improvement Organization. If you prefer, you can make your complaint about the quality of care you received directly to this organization (**without** making the complaint to our Plan). To find the name, address, and phone number of the Quality Improvement Organization in your state, look in Chapter 2, Section 4, of the Evidence of Coverage. If you make a complaint to this organization, we will work together with them to resolve your complaint.

Or you can make your complaint to both at the same time. If you wish, you can make your complaint about quality of care to our Plan and also to the Quality Improvement Organization.

CHAPTER 10: Ending your membership in the Plan

SECTION 1 Introduction

Chapter 10
Section 1.1

This chapter focuses on ending your membership in our Plan

Ending your membership in the Plan may be **voluntary** (your own choice) or **involuntary** (not your own choice):

- You might leave our Plan because you have decided that you **want** to leave.
  - There are only certain times during the year, or certain situations, when you may voluntarily end your membership in the Plan. Section 2 explains **when** you can end your membership in the Plan.
  - The process for voluntarily ending your membership varies depending on what type of new coverage you are choosing. Section 3 explains **how** to end your membership in each situation.
- There are also limited situations where you do not choose to leave, but we are required to end your membership. Section 5 explains situations when we must end your membership.

If you are leaving our Plan, you must continue to get your medical care and prescription drugs through our Plan until your membership ends.

In the event you choose to end your membership in our Plan, re-enrollment may not be permitted, or you may have to wait until your Plan Sponsor's next Open Enrollment Period. You should consult with your Plan Sponsor regarding the availability of other employer-sponsored coverage prior to ending your Plan membership outside of your Plan Sponsor's Open Enrollment Period. It is important to understand your Plan Sponsor's eligibility policies, and the possible impact to your retiree health care coverage options and other retirement benefits before submitting your request to end your membership in our Plan.

SECTION 2 When can you end your membership in our Plan?

Because you are enrolled in our Plan through your Plan Sponsor, some of the information below does not apply to you because you are allowed to make plan changes at times designated by your Plan Sponsor (See Section 1). However, if you ever choose to discontinue your employer-sponsored health care coverage, the following information (the rest of this section, and Sections 2.1, 2.2 and 2.3) will apply to you.

Questions? *Call our Customer Service Department listed in Chapter 2.*

You may end your membership in our Plan only during certain times of the year, known as enrollment periods. All members have the opportunity to leave the Plan during the Annual Enrollment Period and during the Medicare Advantage Annual Disenrollment Period. In certain situations, you may also be eligible to leave the Plan at other times of the year.

Chapter 10
Section 2.1

You can end your membership during the Annual Enrollment Period

You can end your membership during the **Annual Enrollment Period** (also known as the "Annual Coordinated Election Period"). This is the time when you should review your health and drug coverage and make a decision about your coverage for the upcoming year.

- **When is the Annual Enrollment Period?** This happens from November 15 to December 31 in 2010.
- **What type of plan can you switch to during the Annual Enrollment Period?** During this time, you can review your health coverage and your prescription drug coverage. You can choose to keep your current coverage or make changes to your coverage for the upcoming year. If you decide to change to a new plan, you can choose any of the following types of plans:
  - Another Medicare Advantage plan. (You can choose a plan that covers prescription drugs or one that does not cover prescription drugs.)
  - Original Medicare **with** a separate Medicare prescription drug plan
  - **or** Original Medicare **without** a separate Medicare prescription drug plan.

    Note: If you disenroll from a Medicare prescription drug plan and go without creditable prescription drug coverage, you may need to pay a late enrollment penalty if you join a Medicare drug plan later. ("Creditable" coverage means the coverage is at least as good as Medicare's standard prescription drug coverage.)
- **When will your membership end?** Your membership will end when your new plan's coverage begins on January 1.

Chapter 10
Section 2.2

You can end your membership during the Medicare Advantage Annual Disenrollment Period, but your choices are more limited

You have the opportunity to make **one** change to your health coverage during the **Medicare Advantage Annual Disenrollment Period**.

- **When is the Medicare Advantage Annual Disenrollment Period?** This happens every year from January 1 to February 14.
- **What type of plan can you switch to during the Medicare Annual Disenrollment Period?** During this time, you can cancel your Medicare Advantage enrollment and switch to Original Medicare. If you choose to switch to Original Medicare, you may also choose a separate Medicare prescription drug plan at the same time.
- **When will your membership end?** Your membership will end on the first day of the month after we get your request to switch to Original Medicare. If you also choose to enroll in a Medicare prescription drug plan, your membership in the drug plan will begin at the same time.

Chapter 10
Section 2.3

In certain situations, you can end your membership during a Special Enrollment Period

In certain situations, members of our Plan may be eligible to end their membership at other times of the year. This is known as a **Special Enrollment Period**.

- **Who is eligible for a Special Enrollment Period?** If any of the following situations apply to you, you are eligible to end your membership during a Special Enrollment Period. These are just examples, for the full list you can contact the Plan, call **1-800-MEDICARE (1-800-633-4227)**, 24 hours a day, 7 days a week. TTY users should call **1-877-486-2048**, or visit the Medicare Web site at http://www.medicare.gov:
  - Usually when you have moved.
  - If you have Medicaid.
  - If you are eligible for Extra Help with paying for your Medicare prescriptions.
  - If you live in a facility, such as a nursing home.
  - You lose eligibility for employer sponsored benefits.

Questions? *Call our Customer Service Department listed in Chapter 2.*

- **When are Special Enrollment Periods?** The enrollment periods vary depending on your situation.
- **What can you do?** If you are eligible to end your membership because of a special situation, you can choose to change both your Medicare health coverage and prescription drug coverage. This means you can choose any of the following types of plans:
  - Another Medicare Advantage plan. (You can choose a plan that covers prescription drugs or one that does not cover prescription drugs.)
  - Original Medicare **with** a separate Medicare prescription drug plan.
  - **or** Original Medicare ***without*** a separate Medicare prescription drug plan.
- **Note:** If you disenroll from a Medicare prescription drug plan and go without creditable prescription drug coverage, you may need to pay a late enrollment penalty if you join a Medicare drug plan later. ("Creditable" coverage means the coverage is at least as good as Medicare's standard prescription drug coverage.)
- **When will your membership end?** Your membership will usually end on the first day of the month after we receive your request to change your Plan.

Chapter 10
Section 2.4

Where can you get more information about when you can end your membership?

If you have any questions or would like more information on when you can end your membership:

- Call your Plan Sponsor.
- You can call Customer Service (phone numbers are in Chapter 2 of the Evidence of Coverage)
- You can find the information in the "Medicare & You 2011" handbook.
  - Everyone with Medicare receives a copy of "Medicare & You" each fall. Those new to Medicare receive it within a month after first signing up.
  - You can also download a copy from the Medicare Web site http://www.medicare.gov. Or, you can order a printed copy by calling Medicare at the number below.
- You can contact Medicare at **1-800-MEDICARE (1-800-633-4227)** 24 hours a day, 7 days a week. TTY users should call **1-877-486-2048**.

SECTION 3 How do you end your membership in our Plan?

Chapter 10
Section 3.1

Usually you end your membership by enrolling in another plan

Usually, to end your membership in our Plan, you simply enroll in another health plan during your Plan Sponsor's Open Enrollment Period, or one of the enrollment periods (see Section 2 for information about the enrollment periods). One exception is when you want to switch from our Plan to Original Medicare **without** a Medicare prescription drug plan. In this situation, you must contact our Plan Customer Service and ask to be disenrolled from our Plan.

The table below explains how you should end your membership in our Plan.

If you would like to switch from our Plan to:	This is what you should do:
– Another Medicare Advantage plan	– Enroll in the new Medicare Advantage plan. You will automatically be disenrolled from **our Plan** when your new plan's coverage begins.

If you would like to switch from our Plan to:	This is what you should do:
– Original Medicare **with** a separate Medicare prescription drug plan.	– Enroll in the new Medicare prescription drug plan. You will automatically be disenrolled from **our Plan** when your new plan's coverage begins.
– Original Medicare **without** a separate Medicare prescription drug plan	– **Contact Customer Service and ask to be disenrolled from the Plan (phone numbers are in Chapter 2 of the Evidence of Coverage). We will provide instructions on how to submit your request in writing.** – You can also contact Medicare, at **1-800-MEDICARE (1-800-633-4227)**, 24 hours a day, 7 days a week, and ask to be disenrolled. TTY users should call **1-877-486-2048**. – You will be disenrolled from our Plan when your coverage in Original Medicare begins.

SECTION 4 Until your membership ends, you must keep getting your medical services and prescription drugs through our Plan

Chapter 10
Section 4.1

Until your membership ends, you are still a member of our Plan

If you leave our Plan it may take time before your membership ends and your new Medicare coverage goes into effect. (See Section 2 for information on when your new coverage begins.) During this time, you must continue to get your medical care and prescription drugs through our Plan.

- **You should continue to use our network pharmacies to get your prescriptions filled until your membership in our Plan ends.** Usually, your prescription drugs are only covered if they are filled at a network pharmacy including through our mail-order pharmacy services.
- **If you are hospitalized on the day that your membership ends, your hospital stay will usually be covered by our Plan until you are discharged** (even if you are discharged after your new health coverage begins).

SECTION 5 We must end your membership in the Plan in certain situations

Chapter 10
Section 5.1

When must we end your membership in the Plan?

We must end your membership in the Plan if any of the following happen:

- If you do not stay continuously enrolled in Medicare Part A and Part B.
- If you move out of our service area for more than six months.
  - If you move or take a long trip, you need to call Customer Service to find out if the place you are moving or traveling to is in our Plan's area.
- If you become incarcerated
- If you lie about or withhold information about other insurance you have that provides prescription drug coverage.

- If you intentionally give us incorrect information when you are enrolling in our Plan and that information affects your eligibility for our Plan.
- If you continuously behave in a way that is disruptive and makes it difficult for us to provide medical care for you and other members of our Plan.
  - We cannot make you leave our Plan for this reason unless we get permission from Medicare first.
- If you let someone else use your member ID card to get medical care.
  - If we end your membership because of this reason, Medicare may have your case investigated by the Inspector General.
- If your Plan Sponsor is responsible for paying any portion of your Plan premium on your behalf and it does not pay the Plan premium according to its contract with us.
  - We must notify you in writing 30 days before we end your membership. Note that you will most likely be eligible for a Special Enrollment Period if this occurs. (See Section 2.3 of this chapter)

Where can you get more information?

If you have questions or would like more information on when we can end your membership:

- You can call **Customer Service** for more information (phone numbers are in Chapter 2 of the Evidence of Coverage).

Chapter 10
Section 5.2

We cannot ask you to leave our Plan for any reason related to your health

What should you do if this happens?

If you feel that you are being asked to leave our Plan because of a health-related reason, you should call Medicare at **1-800-MEDICARE (1-800-633-4227)**. TTY users should call **1-877-486-2048**. You may call 24 hours a day, 7 days a week.

Chapter 10
Section 5.3

You have the 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 make a complaint about our decision to end your membership. You can also look in the chapter of the Evidence of Coverage titled: *What to do if you have a problem or complaint (coverage decisions, appeals, complaints)* in the section titled: *How to make complaints about quality of care, waiting times, customer service, or other concerns*, for information about how to make a complaint.

CHAPTER 11: Legal notices

SECTION 1 Notice about governing law

Many laws apply to the Evidence of Coverage and some additional provisions may apply because they are required by law. This may affect your rights and responsibilities even if the laws are not included or explained in the Evidence of Coverage. The principal law that applies to the Evidence of Coverage is Title XVIII of the Social Security Act and the regulations created under the Social Security Act by the Centers for Medicare & Medicaid Services, or CMS. In addition, other Federal laws may apply and, under certain circumstances, the laws of the state you live in.

SECTION 2 Notice about nondiscrimination

We don't discriminate based on a person's race, disability, religion, sex, health, ethnicity, creed, age, or national origin. All organizations that provide Medicare Advantage plans, like our Plan, must obey Federal laws against discrimination, including Title VI of the Civil Rights Act of 1964, the Rehabilitation Act of 1973, the Age Discrimination Act of 1975, the Americans with Disabilities Act, all other laws that apply to organizations that get Federal funding, and any other laws and rules that apply for any other reason.

SECTION 3 Health Plan Notices

Chapter 11
Section 3.1

Medical Information Privacy Notice

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.

Effective January 1, 2011

We[1] are required by law to protect the privacy of your health information. We are also required to send you this notice, which explains how we may use information about you

[1] This Medical Information Notice of Privacy Practices applies to the following health plans that are affiliated with UnitedHealth Group: All Savers Insurance Company; All Savers Life Insurance Company of California; American Medical Security Life Insurance Company; AmeriChoice of Connecticut, Inc.;

and when we can give out or "disclose" that information to others. You also have rights regarding your health information that are described in this notice. We are required by law to abide by the terms of this notice.

The terms "information" or "health information" in this notice include any information we maintain that reasonably can be used to identify you and that relates to your physical or mental health condition, the provision of health care to you, or the payment for such health care.

AmeriChoice of Georgia, Inc.; AmeriChoice of New Jersey, Inc.; AmeriChoice of Pennsylvania, Inc.; Arizona Physicians IPA, Inc.; Dental Benefit Providers of California, Inc.; Dental Benefit Providers of Illinois, Inc.; Evercare of Arizona, Inc.; Evercare of New Mexico, Inc.; Evercare of Texas, LLC; Golden Rule Insurance Company; Great Lakes Health Plan, Inc.; Health Plan of Nevada, Inc.; MAMSI Life and Health Insurance Company; MD - Individual Practice Assocation, Inc.; Midwest Security Life Insurance Company; National Pacific Dental, Inc.; Neighborhood Health Partnership, Inc.; Nevada Pacific Dental; Optimum Choice, Inc.; Oxford Health Insurance, Inc.; Oxford Health Plans (CT), Inc.; Oxford Health Plans (NJ), Inc.; Oxford Health Plans (NY), Inc.; PacifiCare Dental; PacifiCare Dental of Colorado, Inc.; PacifiCare Life and Health Insurance Company; PacifiCare Life Assurance Company; PacifiCare of Arizona, Inc.; PacifiCare of California; PacifiCare of Colorado, Inc.; PacifiCare of Nevada, Inc.; PacifiCare of Oklahoma, Inc.; PacifiCare of Oregon, Inc.; PacifiCare of Texas, Inc.; PacifiCare of Washington, Inc.; Sierra Health & Life Insurance Co., Inc.; U.S. Behavioral Health Plan, California; Unimerica Insurance Company; Unimerica Life Insurance Company of New York; Unison Family Health Plan of Pennsylvania, Inc.; Unison Health Plan of Delaware, Inc.; Unison Health Plan of Ohio, Inc.; Unison Health Plan of Pennsylvania, Inc.; Unison Health Plan of South Carolina, Inc.; Unison Health Plan of Tennessee, Inc.; Unison Health Plan of the Capital Area, Inc.; United Behavioral Health; UnitedHealthcare Insurance Company; UnitedHealthcare Insurance Company of Illinois; UnitedHealthcare Insurance Company of New York; UnitedHealthcare Insurance Company of the River Valley; UnitedHealthcare Insurance Company of Ohio; UnitedHealthcare of Alabama, Inc.; UnitedHealthcare of Arizona, Inc.; UnitedHealthcare of Arkansas, Inc.; UnitedHealthcare of Colorado, Inc.; UnitedHealthcare of Florida, Inc.; United HealthCare of Georgia, Inc.; UnitedHealthcare of Illinois, Inc.; UnitedHealthcare of Kentucky, Ltd.; United HealthCare of Louisiana, Inc.; UnitedHealthcare of Mid-Atlantic, Inc.; UnitedHealthcare of the Midlands, Inc.; UnitedHealthcare of the Midwest, Inc.; United HealthCare of Mississippi, Inc.; UnitedHealthcare of New England, Inc.; UnitedHealthcare of New York, Inc.; UnitedHealthcare of North Carolina, Inc.; UnitedHealthcare of Ohio, Inc.; UnitedHealthcare of Tennessee, Inc.; UnitedHealthcare of Texas, Inc.; United HealthCare of Utah, Inc.; UnitedHealthcare of Wisconsin, Inc.; UnitedHealthcare Plan of the River Valley, Inc.

We have the right to change our privacy practices and the terms of this notice. If we make a material change to our privacy practices, we will provide to you a revised notice by direct mail or electronically as permitted by applicable law. In all cases, we will post the revised notice on our Web site (You can find our Web site and contact information in Chapter 2 of the Evidence of Coverage). We reserve the right to make any revised or changed notice effective for information we already have and for information that we receive in the future.

How We Use or Disclose Information

We must use and disclose your health information to provide that information:

- To you or someone who has the legal right to act for you (your personal representative) in order to administer your rights as described in this notice; and
- To the Secretary of the Department of Health and Human Services, if necessary, to make sure your privacy is protected.

We have the right to use and disclose health information for your treatment, to pay for your health care and to operate our business. For example, we may use or disclose your health information:

- **For Payment** of premiums due us, to determine your coverage, and to process claims for health care services you receive, including for subrogation or coordination of other benefits you may have. For example, we may tell a doctor whether you are eligible for coverage and what percentage of the bill may be covered.
- **For Treatment**. We may use or disclose health information to aid in your treatment or the coordination of your care. For example, we may disclose information to your physicians or hospitals to help them provide medical care to you.
- **For Health Care Operations**. We may use or disclose health information as necessary to operate and manage our business activities related to providing and managing your health care coverage. For example, we might talk to your physician to suggest a disease management or wellness program that could help improve your health or we may analyze data to determine how we can improve our services.
- **To Provide You Information on Health Related Programs or Products** such as alternative medical treatments and programs or about health-related products and services, subject to limits imposed by law.
- **For Plan Sponsors**. If your coverage is through an employer sponsored group health plan, we may share summary health information and enrollment and disenrollment information with the Plan Sponsor. In addition, we may share other health information with the Plan Sponsor for plan administration if the Plan Sponsor agrees to special restrictions on its use and disclosure of the information in accordance with federal law.

- **For Reminders**. We may use or disclose health information to send you reminders about your benefits or care, such as appointment reminders with providers who provide medical care to you.

We may use or disclose your health information for the following purposes under limited circumstances:

- **As Required by Law**. We may disclose information when required to do so by law.
- **To Persons Involved With Your Care**. We may use or disclose your health information to a person involved in your care or who helps pay for your care, such as a family member, when you are incapacitated or in an emergency, or when you agree or fail to object when given the opportunity. If you are unavailable or unable to object, we will use our best judgment to decide if the disclosure is in your best interests.
- **For Public Health Activities** such as reporting or preventing disease outbreaks.
- **For Reporting Victims of Abuse, Neglect or Domestic Violence** to government authorities that are authorized by law to receive such information, including a social service or protective service agency.
- **For Health Oversight Activities** to a health oversight agency for activities authorized by law, such as licensure, governmental audits and fraud and abuse investigations.
- **For Judicial or Administrative Proceedings** such as in response to a court order, search warrant or subpoena.
- **For Law Enforcement Purposes**. We may disclose your health information to a law enforcement official for purposes such as providing limited information to locate a missing person or report a crime.
- **To Avoid a Serious Threat to Health or Safety** to you, another person, or the public, by, for example, disclosing information to public health agencies or law enforcement authorities, or in the event of an emergency or natural disaster.
- **For Specialized Government Functions** such as military and veteran activities, national security and intelligence activities, and the protective services for the President and others.
- **For Workers' Compensation** as authorized by, or to the extent necessary to comply with, state workers compensation laws that govern job-related injuries or illness.
- **For Research Purposes** such as research related to the evaluation of certain treatments or the prevention of disease or disability, if the research study meets privacy law requirements.

- **To Provide Information Regarding Decedents**. We may disclose information to a coroner or medical examiner to identify a deceased person, determine a cause of death, or as authorized by law. We may also disclose information to funeral directors as necessary to carry out their duties.
- **For Organ Procurement Purposes**. We may use or disclose information to entities that handle procurement, banking or transplantation of organs, eyes or tissue to facilitate donation and transplantation.
- **To Correctional Institutions or Law Enforcement Officials** if you are an inmate of a correctional institution or under the custody of a law enforcement official, but only if necessary (1) for the institution to provide you with health care; (2) to protect your health and safety or the health and safety of others; or (3) for the safety and security of the correctional institution.
- **To Business Associates** that perform functions on our behalf or provide us with services if the information is necessary for such functions or services. Our business associates are required, under contract with us, to protect the privacy of your information and are not allowed to use or disclose any information other than as specified in our contract.
- **For Data Breach Notification Purposes**. We may use your contact information to provide legally-required notices of unauthorized acquisition, access, or disclosure of your health information. We may send notice directly to you or provide notice to the sponsor of your Plan through which you receive coverage.
- **Additional Restrictions on Use and Disclosure**. Certain federal and state laws may require special privacy protections that restrict the use and disclosure of certain health information, including highly confidential information about you. "Highly confidential information" may include confidential information under Federal laws governing alcohol and drug abuse information and genetic information as well as state laws that often protect the following types of information:

    1. HIV/AIDS
    2. Mental health
    3. Genetic tests
    4. Alcohol and drug abuse
    5. Sexually transmitted diseases and reproductive health information
    6. Child or adult abuse or neglect, including sexual assault

If a use or disclosure of health information described above in this notice is prohibited or materially limited by other laws that apply to us, it is our intent to meet the requirements of the more stringent law. Attached to this notice is a Summary of Federal and State Laws on Use and Disclosure of Certain Types of Medical Information.

Except for uses and disclosures described and limited as set forth in this notice, we will use and disclose your health information only with a written authorization from you. Once you give us authorization to release your health information, we cannot guarantee that the person to whom the information is provided will not disclose the information. You may take back or "revoke" your written authorization at anytime in writing, except if we have already acted based on your authorization. To find out where to mail your written authorization and how to revoke an authorization, contact the phone number listed on the back of your member ID card.

What Are Your Rights

The following are your rights with respect to your health information:

- **You have the right to ask to restrict** uses or disclosures of your information for treatment, payment, or health care operations. You also have the right to ask to restrict disclosures to family members or to others who are involved in your health care or payment for your health care. We may also have policies on dependent access that authorize your dependents to request certain restrictions. **Please note that while we will try to honor your request and will permit requests consistent with our policies, we are not required to agree to any restriction.**
- **You have the right to ask to receive confidential communications** of information in a different manner or at a different place (for example, by sending information to a P.O. Box instead of your home address). We will accommodate reasonable requests where a disclosure of all or part of your health information otherwise could endanger you. We will accept verbal requests to receive confidential communications, but requests to modify or cancel a previous confidential communication request must be made in writing. Mail your request to the address listed below.
- **You have the right to see and obtain a copy** of health information that may be used to make decisions about you such as claims and case or medical management records. You also may in some cases receive a summary of this health information. You must make a written request to inspect and copy your health information. Mail your request to the address listed below. In certain limited circumstances, we may deny your request to inspect and copy your health information. We may charge a reasonable fee for any copies. If we deny your request, you have the right to have the denial reviewed. If we maintain an electronic health record containing your health information, when and if we are required by law, you will have the right to request that we send a copy of your health information in an electronic format to you or to a third party that you identify. We may charge a reasonable fee for sending the electronic copy of your health information.
- **You have the right to ask to amend** information we maintain about you if you believe the health information about you is wrong or incomplete. Your request must be in writing and provide the reasons for the requested amendment. Mail your request to the address listed below. If we deny your request, you may have a statement of your disagreement added to your health information.

Questions? *Call our Customer Service Department listed in Chapter 2.*

- **You have the right to receive an accounting** of certain disclosures of your information made by us during the six years prior to your request. This accounting will not include disclosures of information made: (i) prior to April 14, 2003; (ii) for treatment, payment, and health care operations purposes; (iii) to you or pursuant to your authorization; (iv) to correctional institutions or law enforcement officials; and (v) other disclosures for which federal law does not require us to provide an accounting.
- **You have the right to a paper copy of this notice**. You may ask for a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice. You may also obtain a copy of this notice at our Web site (You can find our Web site and contact information in Chapter 2 of the Evidence of Coverage).

Exercising Your Rights

- **Contacting your Health Plan.** If you have any questions about this notice or want to exercise any of your rights, please **call the phone number on the back of your member ID card** or you may contact the UnitedHealth Group Customer Call Center at **1-866-633-2446.**
- **Submitting a Written Request.** Mail to us your written requests for modifying or cancelling a confidential communication, for copies of your records, or for amendments to your record, at the following address:

  UnitedHealth Group
  PSMG Privacy Office
  MN006-W800
  P.O. Box 1459
  Minneapolis, MN 55440

- **Filing a Complaint.** If you believe your privacy rights have been violated, you may file a complaint with us at the address listed above.

You may also notify the Secretary of the U.S. Department of Health and Human Services of your complaint. We will not take any action against you for filing a complaint.

Chapter 11
Section 3.2

Financial Information Privacy Notice

THIS NOTICE DESCRIBES HOW FINANCIAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Effective January 1, 2011

We[2] are committed to maintaining the confidentiality of your personal financial information. For the purposes of this notice, "personal financial information" means information, other than health information, about a member or an applicant for health care coverage that identifies the individual, is not generally publicly available and is collected from the individual or is obtained in connection with providing health care coverage to the individual.

Information We Collect

We collect personal financial information about you from the following sources:

- Information we receive from you on applications or other forms, such as name, address, age and social security number; and
- Information about your transactions with us, our affiliates or others, such as premium payment history.

[2] For purposes of this Financial Information Privacy Notice, "we" or "us" refers to the entities listed in footnote 1, beginning on the first page of the Health Plan Notices of Privacy Practices, plus the following UnitedHealthcare affiliates: ACN Group IPA of New York, Inc.; ACN Group, Inc.; AmeriChoice Health Services, Inc.; DBP Services of New York IPA, Inc.; DCG Resource Options, LLC; Dental Benefit Providers, Inc.; Disability Consulting Group, LLC; HealthAllies, Inc.; MAMSI Insurance Resources, LLC; Managed Physical Network, Inc.; Mid Atlantic Medical Services, LLC; OneNet PPO, LLC; OptumHealth Bank, Inc.; Oxford Benefit Management, Inc.; Oxford Health Plans LLC; PacifiCare Health Plan Administrators, Inc.; PacificDental Benefits, Inc.; ProcessWorks, Inc.; Spectera of New York, IPA, Inc.; UMR, Inc.; Unison Administrative Services, LLC; United Behavioral Health of New York I.P.A., Inc.; United HealthCare Services, Inc.; UnitedHealth Advisors, LLC; United Healthcare Service LLC; UnitedHealthcare Services Company of the River Valley, Inc.; UnitedHealthOne Agency, Inc. This Financial Information Privacy Notice only applies where required by law. Specifically, it does not apply to (1) health care insurance products offered in Nevada by Health Plan of Nevada, Inc. and Sierra Health and Life Insurance Company, Inc.; or (2) other UnitedHealth Group health plans in states that provide exceptions for HIPAA covered entities or health insurance products.

Disclosure of Information

We do not disclose personal financial information about our members or former members to any third party, except as required or permitted by law.

In the course of our general business practices, we may disclose personal financial information about you or others without your permission to our corporate affiliates to provide them with information about your transactions, such as your premium payment history.

Confidentiality and Security

We restrict access to personal financial information about you to our employees and service providers who are involved in administering your health care coverage and providing services to you. We maintain physical, electronic and procedural safeguards in compliance with federal standards to guard your personal financial information. We conduct regular audits to guarantee appropriate and secure handling and processing of our members' information.

Your Right to Access and Correct Personal Information

If you reside in certain States[3], you may have a right to request access to the personal financial information that we record about you. Your right includes the right to know the source of the information and the identity of the persons, institutions, or types of institutions to whom we have disclosed such information within 2 years prior to your request. Your right includes the right to view such information and copy it in person, or request that a copy of it be sent to you by mail (for which we may charge you a reasonable fee to cover our costs). Your right also includes the right to request corrections, amendments or deletions of any information in our possession. The procedures that you must follow to request access to or an amendment of your information are as follows:

To obtain access to your information: Submit a request in writing that includes your name, address, social security number, telephone number, and the recorded information to which you would like access. State in the request whether you would like access in person or a copy of the information sent to you by mail. Upon receipt of your request, we will contact you within 30 business days to arrange providing you with access in person or the copies that you have requested.

To correct, amend, or delete any of your information: Submit a request in writing that includes your name, address, social security number, telephone number, the specific information in dispute, and the identity of the document or record that contains the disputed information. Upon receipt of your request, we will contact you within 30 business days to notify you either that we have made the correction, amendment or deletion, or that we refuse to do so and the reasons for the refusal, which you will have an opportunity to challenge.

[3] California and Massachusetts.

Send written requests to access, correct, amend or delete information to:

United Healthcare
Customer Service – Privacy Unit
PO Box 740815
Atlanta, GA 30374-0815

Chapter 11
Section 3.3

UnitedHealth Group Health Plan Notice of Privacy Practices: Federal and State Amendments

UNITEDHEALTH GROUP
HEALTH PLAN NOTICE OF PRIVACY PRACTICES:
FEDERAL AND STATE AMENDMENTS

Revised: January 1, 2011

The first part of this Notice, which provides our privacy practices for Medical Information, describes how we may use and disclose your health information under federal privacy rules. There are other laws that may limit our rights to use and disclose your health information beyond what we are allowed to do under the federal privacy rules. The purpose of the charts below is to:

1. show the categories of health information that are subject to these more restrictive laws; and
2. give you a general summary of when we can use and disclose your health information **without your consent.**

If your written consent is required under the more restrictive laws, the consent must meet the particular rules of the applicable federal or state law.

Summary of Federal Laws

Alcohol & Drug Abuse Information
We are allowed to use and disclose alcohol and drug abuse information that is protected by federal law only (1) in certain limited circumstances, and/or disclose only (2) to specific recipients.
Genetic Information
We are not allowed to use genetic information for underwriting purposes.

Summary of State Laws

General Health Information	
We are allowed to disclose general health information only (1) under certain limited circumstances, and /or (2) to specific recipients.	CA, NE, RI, VT, WA, WI
HMOs must give members an opportunity to approve or refuse disclosures, subject to certain exceptions.	KY
You may be able to restrict certain electronic disclosures of such health information.	NV
We are not allowed to use health information for certain purposes.	CA, NH
Prescriptions	
We are allowed to disclose prescription-related information only (1) under certain limited circumstances, and /or (2) to specific recipients.	ID, NV
Communicable Diseases	
We are allowed to disclose communicable disease information only (1) under certain limited circumstances, and /or (2) to specific recipients.	AZ, IN, MI, OK
You may be able to restrict certain electronic disclosures of such health information.	NV
Sexually Transmitted Diseases and Reproductive Health	
We are allowed to disclose sexually transmitted disease and/or reproductive health information only (1) under certain limited circumstances and/or (2) to specific recipients.	MT, NJ, WA
You may be able to restrict certain electronic disclosures of such health information.	NV
Alcohol and Drug Abuse	
We are allowed to use and disclose alcohol and drug abuse information (1) under certain limited circumstances, and/or disclose only (2) to specific recipients.	CT, HI, KY, IL, IN, IA, LA, MD, MA, NH, NV, WA, WI

Summary of State Laws

Disclosures of alcohol and drug abuse information may be restricted by the individual who is the subject of the information.	WA
Genetic Information	
We are not allowed to disclose genetic information without your written consent.	CA, CO, HI, IL, KY, NY, TN
We are allowed to disclose genetic information only (1) under certain limited circumstances and/or (2) to specific recipients.	GA, IA, MD, MA, MO, NV, NH, NM, RI, SC, TX, UT, VT
Restrictions apply to (1) the use, and/or (2) the retention of genetic information.	FL, GA, IA, LA, MD, OH, SC, SD, UT, VT
HIV / AIDS	
We are allowed to disclose HIV/AIDS-related information only (1) under certain limited circumstances and/or (2) to specific recipients.	AZ, AR, CA, CT, DE, FL, HI, IL, IN, MI, MT, NY, NC, PA, PR, RI, TX, VT, WV
Certain restrictions apply to oral disclosures of HIV/AIDS-related information.	CT
You may be able to restrict certain electronic disclosures of such health information.	NV
Mental Health	
We are allowed to disclose mental health information only (1) under certain limited circumstances and/or (2) to specific recipients.	CA, CT, DC, HI, IL, IN, KY, MA, MI, PR, WA, WI
Disclosures may be restricted by the individual who is the subject of the information.	WA
Certain restrictions apply to oral disclosures of mental health information.	CT
Certain restrictions apply to the use of mental health information.	ME
Child or Adult Abuse	
We are allowed to use and disclose child and/or adult abuse information only (1) under certain limited circumstances, and/or disclose only (2) to specific recipients.	AL, CO, IL, LA, NE, NJ, NM, RI, TN, TX, UT, WI
You may be able to restrict certain electronic disclosures of such health information.	NV

Chapter 11
Section 3.4

2011 Member Fraud & Abuse Communication

How you can fight healthcare fraud

Our company is committed to preventing fraud, waste, and abuse in Medicare benefit programs and we're asking for your help. If you identify a potential case of fraud, please report it to us immediately.

Here are some examples of potential Medicare fraud cases:

- A health care provider – such as a physician, pharmacy, or medical device company – bills for services you never got,
- A supplier bills for equipment different from what you got
- Someone uses another person's Medicare card to get medical care, prescriptions, supplies or equipment
- Someone bills for home medical equipment after it has been returned.
- A company offers a Medicare drug or health plan that hasn't been approved by Medicare.
- A company uses false information to mislead you into joining a Medicare drug or health plan.

To report a potential case of fraud in a Medicare benefit program, call United HealthCare Insurance Company's dedicated fraud hotline at **1-877-637-5595**, 24 hours a day, 7 days a week. TTY/TDD users may call **1-877-730-4203.**

This hotline allows you to report cases anonymously and confidentially. We will make every effort to maintain your confidentiality. However, if law enforcement needs to get involved, we may not be able to guarantee your confidentiality. Please know that our organization will not take any action against you for reporting a potential fraud case in good faith.

You may also report potential prescription drug program fraud cases to the Medicare program directly at **1-877-7SafeRx (1-877-772-3379)**. For potential medical or non-prescription fraud cases, you may report to the Medicare program directly at **1-800-MEDICARE (1-800-633-4227)**. The Medicare fax number is **1-717-975-4442** and the Web site is http://www.medicare.gov.

For more information, request the guide titled "Protecting Medicare and You from Fraud" by calling **1-800-MEDICARE (1-800-633-4227)**. TTY/TDD users should call **1-877-486-2048**. A customer service representative can answer your questions 24 hours a day, 7 days a week.

SECTION 4 Member liability

Note: This section only applies to you if you are required by your plan rules to obtain a referral before seeing non-network providers. Please see the chapter entitled *Using the Plan's coverage for your medical services* to see if your plan requires referrals to non-network providers.

You will be liable if you receive services from non-network providers without authorization or a referral.

In the event we fail to reimburse provider's charges for covered services, you will not be liable for any sums owed by us.

Neither the plan nor Medicare will pay for services received from a non-network provider without a referral except for the following eligible expenses:

- Emergency services
- Urgently needed services
- Out-of-area and routine travel dialysis (must be received in a Medicare Certified Dialysis Facility within the United States)
- Post-stabilization services

If you enter into a private contract with a non-network provider neither the Plan nor Medicare will pay for those services.

SECTION 5 Medicare-covered services must meet requirement of reasonable and necessary

Medicare-covered services must meet requirement of reasonable and necessary

In determining coverage, services must meet the reasonable and necessary requirements under Medicare in order to be covered under your plan, unless otherwise listed as a covered service. A service is "reasonable and necessary" if the service is:

- Safe and effective;
- Not experimental or investigational; and

- Appropriate, including the duration and frequency that is considered appropriate for the service, in terms of whether it is:

    1. Furnished in accordance with accepted standards of medical practice for the diagnosis or treatment of the patient's condition or to improve the function of a malformed body member;
    2. Furnished in a setting appropriate to the patient's medical needs and condition;
    3. Ordered and furnished by qualified personnel;
    4. One that meets, but does not exceed, the patient's medical need; and
    5. At least as beneficial as an existing and available medically appropriate alternative.

SECTION 6 Third party liability and subrogation

If you suffer an injury or illness for which any third party is liable or responsible due to any negligent or intentional act or omission causing illness or injury to you, you must promptly notify us of the injury or illness. We will send you a statement of the amounts we paid for services provided in connection with the injury or illness. If you recover any sums from any third party, we shall be reimbursed out of any such recovery from any third party for the payments we made on your behalf, subject to the limitations in the following paragraphs.

- *Our payments are less than the recovery amount*. If our payments are less than the total recovery amount from any third party (the "recovery amount"), then our reimbursement is computed as follows:
    - *First*: Determine the ratio of the procurement costs to the recovery amount (the term "procurement costs" means the attorney fees and expenses incurred in obtaining a settlement or judgment).
    - *Second*: Apply the ratio calculated above to our payment. The result is our share of procurement costs.
    - *Third*: Subtract our share of procurement costs from our payments. The remainder is our reimbursement amount.
- *Our payments equal or exceed the recovery amount*. If our payments equal or exceed the recovery amount, our reimbursement amount is the total recovery amount minus the total procurement costs.

- *We incur procurement costs because of opposition to our reimbursement*. If we must bring suit against the party that received the recovery amount because that party opposes our reimbursement, our reimbursement amount is the lower of the following:
    - our payments made on your behalf for services; or
    - the recovery amount, minus the party's total procurement cost.

Subject to the limitations stated above, you agree to grant us an assignment of, and a claim and a lien against, any amounts recovered through settlement, judgment or verdict. You may be required by us and you agree to execute documents and to provide information necessary to establish the assignment, claim, or lien to ascertain our right to reimbursement.

SECTION 7 Non duplication of benefits with automobile, accident or liability coverage

If you are receiving benefits as a result of other automobile, accident or liability coverage, we will not duplicate those benefits. It is your responsibility to take whatever action is necessary to receive payment under automobile, accident, or liability coverage when such payments may reasonably be expected, and to notify us of such coverage when available. If we happen to duplicate benefits to which you are entitled under other automobile, accident or liability coverage, we may seek reimbursement of the reasonable value of those benefits from you, your insurance carrier, or your health care provider to the extent permitted under State and/or federal law. We will provide benefits over and above your other automobile, accident or liability coverage, if the cost of your health care services exceeds such coverage. **You are required to cooperate with us in obtaining payment from your automobile, accident or liability coverage carrier. Your failure to do so may result in termination of your plan membership.**

SECTION 8 Acts beyond our control

If, due to a natural disaster, war, riot, civil insurrection, complete or partial destruction of a facility, ordinance, law or decree of any government or quasi-governmental agency, labor dispute (when said dispute is not within our control), or any other emergency or similar event not within the control of us, network providers may become unavailable to arrange or provide health services pursuant to this Evidence of Coverage and Disclosure Information, then we shall attempt to arrange for covered services insofar as practical and according to our best judgment. Neither we nor any network provider shall have any liability or obligation for delay or failure to provide or arrange for covered services if such delay is the result of any of the circumstances described above.

SECTION 9 Contracting medical providers and network hospitals are independent contractors

The relationships between us and our network providers and network hospitals are independent contractor relationships. None of the network providers or network hospitals or their physicians or employees are employees or agents of UnitedHealthcare. An agent would be anyone authorized to act on our behalf. Neither we nor any employee of UnitedHealthcare is an employee or agent of the network providers or network hospitals.

SECTION 10 Our contracting arrangements

In order to obtain quality service in an efficient manner, we pay providers using various payment methods, including capitation, per diem, incentive and discounted Fee-for-Service arrangements. Capitation means paying an agreed upon dollar amount per month for each member assigned to the provider. Per diem means paying a fixed dollar amount per day for all services rendered, such as inpatient hospital and skilled nursing facility stays. Incentive means a payment that is based on appropriate medical management by the provider. Discounted Fee-for-Service means paying an agreed upon fee schedule which is a reduction from their usual and customary charges.

You are entitled to ask if we have special financial arrangements with the network providers that may affect the use of referrals and other services that you might need. To obtain this information, call Customer Service and request information about the network provider's payment arrangements.

SECTION 11 How our network providers are compensated

The following is a brief description of how we pay our network providers:

We typically contract with individual physicians and medical groups, often referred to as Independent Practitioner Associations ("IPAs"), to provide medical services and with hospitals to provide services to members. The contracting medical groups/IPAs in turn, employ or contract with individual physicians.

Most of the individual physicians are paid on a Fee-for-Service arrangement. In addition, some physicians receive an agreed-upon monthly payment from us to provide services to members. The monthly payment may be either a fixed dollar amount for each member, or a

percentage of the monthly plan premium received by us. The monthly payment typically covers professional services directly provided by individual physicians and may also cover certain referral services.

Most of the contracted medical groups/IPAs receive an agreed upon monthly payment from us to provide services to members. The monthly payment may be either a fixed dollar amount for each member or a percentage of the monthly plan premium received by us. The monthly payment typically covers professional services directly provided by the contracted medical group/IPA, and may also cover certain referral services. Some of our network hospitals receive similar monthly payments in return for arranging hospital services for members. Other hospitals are paid on a discounted Fee-for-Service or fixed charge per day of hospitalization.

Each year, we and the contracted medical group/IPA agree on a budget for the cost of services covered under the program for all plan members treated by the contracted medical group/IPA. At the end of the year, the actual cost of services for the year is compared to the agreed-upon budget. If the actual cost of services is less than the agreed-upon budget, the contracted medical group/IPA shares in the savings. The network hospital and the contracted medical group/IPA typically participate in programs for hospital services similar to that described above.

Stop-loss insurance protects the contracted medical groups/IPAs and network hospitals from large financial losses and helps the providers with resources to cover necessary treatment. We provide stop-loss protection to the contracted medical groups/IPAs and network hospitals that receive capitation payments. If any capitated providers do not obtain stop-loss protection from us, they must obtain stop-loss insurance from an insurance carrier acceptable to us. You may obtain additional information on compensation arrangements by contacting Customer Service or your contracted medical group/IPA, however, specific compensation terms and rates are confidential and will not be disclosed.

SECTION 12 Technology assessment

We regularly review new procedures, devices and drugs to determine whether or not they are safe and efficacious for Members. New procedures and technology that are safe and efficacious are eligible to become Covered Services. If the technology becomes a Covered Service, it will be subject to all other terms and conditions of the plan, including medical necessity and any applicable Member Copayments, Coinsurance, deductibles or other payment contributions.

In determining whether to cover a service, we use proprietary technology guidelines to review new devices, procedures and drugs, including those related to behavioral health. When clinical necessity requires a rapid determination of the safety and efficacy of a new technology or new application of an existing technology for an individual Member, one of our

Medical Directors makes a medical necessity determination based on individual Member medical documentation, review of published scientific evidence, and, when appropriate, relevant specialty or professional opinion from an individual who has expertise in the technology.

SECTION 13 Member statements

In the absence of fraud, all statements made by you will be deemed representations and not warranties. No such representation will void coverage or reduce covered services under this Evidence of Coverage or be used in defense of a legal action unless it is contained in a written application.

SECTION 14 Information upon request

As a plan member, you have the right to request information on the following:

- General coverage and comparative plan information
- Utilization control procedures
- Quality improvement programs
- Statistical data on grievances and appeals
- The financial condition of UnitedHealthcare

SECTION 15 Internal protection of information within UnitedHealth Group

UnitedHealth Group collects and maintains oral, written and electronic information to administer our business and to provide products, services and information of importance to our enrollees. We provide physical, electronic and procedural security safeguards in the handling and maintenance of our enrollees' information to protect against risks such as loss, destruction or misuse. We conduct regular audits to guarantee appropriate and secure handling and processing of our enrollees' information.

CHAPTER 12: Definitions of important words

Appeal – An appeal is something you do if you disagree with a decision to deny a request for health care services and/or prescription drugs or payment for services and/or prescription drugs you already received. You may also make an appeal if you disagree with a decision to stop services that you are receiving. For example, you may ask for an appeal if our Plan doesn't pay for a drug, item or service you think you should be able to receive. The chapter titled: *What to do if you have a problem or complaint (coverage decisions, appeals, complaints)* explains appeals, including the process involved in making an appeal.

Benefit Period – For Original Medicare, a benefit period is used to determine coverage for inpatient stays in hospitals and skilled nursing facilities (SNF). A benefit period begins on the first day you go to a Medicare-covered inpatient hospital or a skilled nursing facility. The benefit period ends when you haven't been an inpatient at any hospital or SNF for 60 days in a row. If you go to the hospital or SNF after one benefit period has ended, a new benefit period begins. There is no limit to the number of benefit periods you can have.

The type of care that is covered depends on whether you are considered an **inpatient** for hospital and SNF stays. You must be admitted to the hospital as an inpatient, not just under observation. You are an inpatient in a SNF only if your care in the SNF meets certain standards for skilled level of care. Specifically, in order to be an inpatient in a SNF, you must need daily skilled-nursing or skilled-rehabilitation care, or both.

Please refer to the Medical Benefits Chart in Chapter 3 for information regarding the Plan's benefit periods for inpatient services.

Brand-Name Drug – A prescription drug that is manufactured and sold by the pharmaceutical company that originally researched and developed the drug. Brand name drugs have the same active-ingredient formula as the generic version of the drug. However, generic drugs are manufactured and sold by other drug manufacturers and are generally not available until after the patent on the brand name drug has expired.

Catastrophic Coverage Stage – The stage in the Part D Drug Benefit where you pay a low copayment or coinsurance for your drugs after you or other qualified parties on your behalf have spent $4,550 in covered drugs during the covered year.

Centers for Medicare & Medicaid Services (CMS) – The Federal agency that runs Medicare. Chapter 2 explains how to contact CMS.

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

Coinsurance – The percentage of the cost that a member has to pay for Covered Services. Coinsurance for in-network services is based upon contractually negotiated rates (when available for the specific covered service to which the coinsurance applies) or Medicare Allowable Cost, depending on our contractual arrangements for the service.

Comprehensive Outpatient Rehabilitation Facility (CORF) – A facility that mainly provides rehabilitation services after an illness or injury, and provides a variety of services including physician's services, physical therapy, social or psychological services, and outpatient rehabilitation.

Co-Payment, Copayment, Copay – A cost-sharing arrangement in which the health plan member pays a specified flat amount for a specific service (such as $10 for an office visit or $5 for each prescription drug). Copay amounts can vary widely from plan to plan. A copay normally does not vary with the cost of the service and is usually a flat sum amount such as $10 for every prescription or doctor visit, unlike coinsurance that is based on a percentage of the cost.

Cost-sharing – Cost-sharing refers to amounts that a member has to pay when drugs and/or services are received. It includes any combination of the following three types of payments: (1) any deductible amount a plan may impose before drugs or services are covered; (2) any fixed "copayment" amounts that a plan may require be paid when specific drugs or services are received; or (3) any "coinsurance" amount that must be paid as a percentage of the total amount paid for a drug or service.

Coverage Determination – A decision about whether a medical service or drug prescribed for you is covered by the Plan and the amount, if any, you are required to pay for the services or prescription. In general, if you bring your prescription to a pharmacy and the pharmacy tells you the prescription isn't covered under your Plan, that isn't a coverage determination. You need to call or write to your Plan to ask for a formal decision about the coverage if you disagree.

Covered Drugs – The term we use to mean all of the prescription drugs covered by our Plan.

Covered Services – The general term we use in the Evidence of Coverage to mean all of the health care services and supplies that are covered by our Plan.

Creditable Prescription Drug Coverage – Prescription drug coverage (for example, from an employer or union) that is expected to cover, on average, at least as much as Medicare's standard prescription drug coverage. People who have this kind of coverage when they become eligible for Medicare can generally keep that coverage without paying a penalty, if they decide to enroll in Medicare prescription drug coverage later.

Custodial Care – Care for personal needs rather than medically necessary needs. Custodial care is care that can be provided by people who don't have professional skills or training. This care includes help with walking, dressing, bathing, eating, preparation of special diets, and taking medication. Medicare does not cover custodial care unless it is provided as other care you are getting in addition to daily skilled nursing care and/or skilled rehabilitation services.

Customer Service – A department within our Plan responsible for answering your questions about your membership, benefits, grievances, and appeals. See Chapter 2 for information about how to contact Customer Service.

Deductible – The amount you must pay before our Plan begins to pay its share of your covered medical services or drugs. Not all of our plans have a deductible.

Disenroll or **Disenrollment** – The process of ending your membership in our Plan. Disenrollment may be voluntary (your own choice) or involuntary (not your own choice).

Durable Medical Equipment – Certain medical equipment that is ordered by your doctor for use in the home. Examples are walkers, wheelchairs, or hospital beds.

Emergency Care – Covered services that are: 1) rendered by a provider qualified to furnish emergency services; and 2) needed to evaluate or stabilize an emergency medical condition.

Evidence of Coverage (EOC) – This document, along with your enrollment form and any other attachments, riders, or other optional coverage selected, which explains your coverage, what we must do, your rights, and what you have to do as a member of our Plan.

Exception – A type of coverage determination that, if approved, allows you to get a drug that is not on your Plan Sponsor's Drug List (a formulary exception), or get a non-preferred drug at the preferred cost-sharing level (a tiering exception). You may also request an exception if your Plan Sponsor requires you to try another drug before receiving the drug you are requesting, or the Plan limits the quantity or dosage of the drug you are requesting (a formulary exception).

Generic Drug – A prescription drug that is approved by the Food and Drug Administration (FDA) as having the same active ingredient(s) as the brand-name drug. Generally, generic drugs cost less than brand-name drugs.

Grievance – A type of complaint you make about us or one of our network providers or pharmacies, including a complaint concerning the quality of your care. This type of complaint does not involve coverage or payment disputes.

Home Health Aide – A home health aide provides services that don't need the skills of a licensed nurse or therapist, such as help with personal care (e.g., bathing, using the toilet, dressing, or carrying out the prescribed exercises). Home health aides do not have a nursing license or provide therapy.

Home Health Care – Skilled nursing care and certain other health care services that you get in your home for the treatment of an illness or injury. Covered services are listed in the Benefits Chart in the chapter of the Evidence of Coverage titled: *Medical benefits chart (what is covered and what you pay)* under the heading "Home health care." If you need home health care services, our Plan will cover these services for you provided the Medicare coverage requirements are met. Home health care can include services from a **home health aide** if the services are part of the home health plan of care for your illness or injury. They aren't covered unless you are also getting a covered skilled service. Home health services don't include the services of housekeepers, food service arrangements, or full-time nursing care at home.

Hospice Care – A special way of caring for people who are terminally ill and providing counseling for their families. Hospice care is physical care and counseling that is given by a team of people who are part of a Medicare-certified public agency or private company. Depending on the situation, this care may be given in the home, a hospice facility, a hospital, or a nursing home. Care from a hospice is meant to help patients in the last months of life by giving comfort and relief from pain. The focus is on care, not cure. For more information on hospice care visit http://www.medicare.gov and under "Search Tools" choose "Find a Medicare Publication" to view or download the publication "Medicare Hospice Benefits." Or, call **1-800-MEDICARE (1-800-633-4227)**, 24 hours, 7 days a week. **TTY** users should call **1-877-486-2048**. Note: If you are not entitled to Medicare Part A coverage, hospice services are not covered by Medicare or the Plan.

Initial Coverage Limit – The maximum limit of coverage under the initial coverage stage.

Initial Coverage Stage – This is the stage before your total drug expenses have reached $ 2,840, including amounts you've paid and what our Plan has paid on your behalf.

Late Enrollment Penalty – An amount added to your monthly premium for Medicare drug coverage if you go without creditable coverage (coverage that expects to pay, on average, at least as much as standard Medicare prescription drug coverage) for a continuous period of 63 days or more. You pay this higher amount as long as you have a Medicare drug plan. There are some exceptions.

List of Covered Drugs (Formulary, or Drug List) – A list of covered drugs provided by the Plan. The drugs on this list are selected by the Plan with the help of doctors and pharmacists. The list includes both brand-name and generic drugs.

Low Income Subsidy/Extra Help – A Medicare program to help people with limited income and resources pay Medicare prescription drug program costs, such as premiums, deductibles, and coinsurance.

Medical Emergency – When you have a "medical emergency," you believe that your health is in serious danger. A medical emergency can include severe pain, a bad injury, a sudden illness, or a medical condition that is quickly getting much worse.

Medically Necessary – Drugs, services, or supplies that are proper and needed for the diagnosis or treatment of your medical condition; are used for the diagnosis, direct care, and treatment of your medical condition; meet the standards of good medical practice in the local community; and are not mainly for your convenience or that of your doctor.

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).

Medicare Advantage (MA) Plan – Sometimes called Medicare Part C. A plan offered by a private company that contracts with Medicare to provide you with all your Medicare Part A (Hospital) and Part B (Medical) benefits. An MA plan offers a specific set of health benefits at the same premium and level of cost-sharing to all people with Medicare who live in the service area covered by the plan. Medicare Advantage Organizations can offer one or more Medicare Advantage plans in the same service area. A Medicare Advantage plan can be an HMO, PPO, POS, a Private Fee-for-Service (PFFS) plan, or a Medicare Medical Savings Account (MSA) plan. In most cases, Medicare Advantage Plans also offer Medicare Part D (prescription drug coverage). These plans are called **Medicare Advantage Plans with Prescription Drug Coverage**. Everyone who has Medicare Part A and Part B is eligible to join any Medicare health plan that is offered in their area, except people with End-Stage Renal Disease (unless certain exceptions apply).

Medicare Allowable Cost – The maximum price of a service for reimbursement purposes under Original Medicare.

Medicare Coverage Gap Discount Program – A program that provides discounts on most covered Part D brand name drugs to Part D enrollees who have reached the Coverage Gap Stage and who are not already receiving "Extra Help." Discounts are based on agreements between the Federal government and certain drug manufacturers. For this reason, most, but not all, brand name drugs are discounted.

Medicare Prescription Drug Coverage (Medicare Part D) – Insurance to help pay for outpatient prescription drugs, vaccines, biologicals, and some supplies not covered by Medicare Part A or Part B.

"Medigap" (Medicare Supplement Insurance) Policy – Medicare supplement insurance sold by private insurance companies to fill "gaps" in Original Medicare. Medigap policies only work with Original Medicare. (A Medicare Advantage plan is not a Medigap policy.)

Member (member of our Plan, or "plan member") – A person with Medicare who is eligible to get covered services, who has enrolled in our Plan and whose enrollment has been confirmed by the Centers for Medicare & Medicaid Services (CMS).

Network Mail Service Pharmacy – Our Plan's mail-service pharmacy that generally offers a longer-term supply of Medicare Part D covered drugs to members of our Plan.

Network Pharmacy – A network pharmacy is a pharmacy where members of our Plan can get their prescription drug benefits. We call them "network pharmacies" because they contract with our Plan. In most cases, your prescriptions are covered only if they are filled at one of our network pharmacies.

Network Provider – "Provider" is the general term we use for doctors, other health care professionals, hospitals, and other health care facilities that are licensed or certified by Medicare and by the State to provide health care services. We call them "**network providers**" when they have an agreement with our Plan to accept our payment as payment in full, and in some cases to coordinate as well as provide covered services to members of our Plan. Our Plan pays network providers based on the agreements it has with the providers or if the providers agree to provide you with Plan-covered services. Network providers may also be referred to as "Plan providers."

Optional Supplemental Benefits – Non-Medicare-covered benefits that can be purchased (depending upon your benefit plan) for an additional premium and are not included in your package of benefits. If you choose to have optional supplemental benefits, you may have to pay an additional premium. You must voluntarily elect optional supplemental benefits in order to get them.

Organization Determination – The Medicare Advantage organization has made an organization determination when it, or one of its providers, makes a decision about whether services are covered or how much you have to pay for covered services.

Original Medicare – ("Traditional Medicare" or "Fee-for-service" Medicare) Original Medicare is offered by the government, and not a private health plan such as Medicare Advantage plans and prescription drug plans. Under Original Medicare, Medicare services are covered by paying doctors, hospitals and other health care providers payment amounts established by Congress. You can see any doctor, hospital, or other health care provider that accepts Medicare. You must pay the deductible. Medicare pays its share of the Medicare-approved amount, and you pay your share. Original Medicare has two parts: Part A (Hospital Insurance) and Part B (Medical Insurance) and is available everywhere in the United States.

Out-of-Network Provider or Out-of-Network Facility – A provider or facility with which we have not arranged to coordinate or provide covered services to members of our Plan. Out-of-network providers are providers that are not employed, owned, or operated by our Plan or are not under contract to deliver covered services to you.

Out-of-Network Pharmacy – A pharmacy that doesn't have a contract with our Plan to coordinate or provide covered drugs to members of our Plan. As explained in the Evidence of Coverage, most drugs you get from out-of-network pharmacies are not covered by our Plan unless certain conditions apply.

Out-of-Pocket Maximum – The maximum amount that you pay out-of-pocket during the calendar year, usually at the time services are received, for covered Part A (Hospital Insurance) and Part B (Medical Insurance) services. Plan premiums and Medicare Part A and Part B premiums do not count toward the out-of-pocket maximum.

Part C – See "Medicare Advantage (MA) Plan."

Part D – The voluntary Medicare Prescription Drug Benefit Program. (For ease of reference, we will refer to the prescription drug benefit program as Part D.)

Part D Drugs – Drugs that can be covered under Part D. We may or may not offer all Part D drugs. (See your Drug List for a specific list of covered drugs.) Certain categories of drugs were specifically excluded by Congress from being covered as Part D drugs.

Plan Sponsor – Your former employer, union group or trust administrator.

Plan Year – The period of time your Plan Sponsor has contracted with us to provide covered services and covered drugs to you through the Plan. Your Plan Sponsor's plan year is listed inside the front cover of the Evidence of Coverage.

Primary Care Physician (PCP) – A health care professional you select to coordinate your health care. Your PCP is responsible for providing or authorizing covered services while you are a Plan member. The chapter in the Evidence of Coverage titled: *Using the Plan's coverage for your medical services* explains more about PCPs.

Providers – Doctors and other health care professionals that the state licenses to provide medical services and care. The term "providers" also includes hospitals and other health care facilities.

Prior Authorization – Approval in advance to get services and/or certain drugs. Some drugs are covered only if your doctor or other network provider gets "prior authorization" from us. Covered drugs that need prior authorization are marked in the Drug List.

Quality Improvement Organization (QIO) – Groups of practicing doctors and other health care experts that are paid by the Federal government to check and improve the care given to Medicare patients. They must review your complaints about the quality of care given by Medicare Providers. See Chapter 2 for information about how to contact the QIO in your state and the chapter of the Evidence of Coverage titled: *What to do if you have a problem or complaint (coverage decisions, appeals, complaints)* for information about making complaints to the QIO.

Quantity Limits – A management tool that is designed to limit the use of selected drugs for quality, safety, or utilization reasons. Limits may be on the amount of the drug that we cover per prescription or for a defined period of time.

Referral – A formal recommendation by your PCP for you to receive care from a Specialist or network provider.

Rehabilitation Services – These services include physical therapy, speech and language therapy, and occupational therapy.

Service Area – "Service area" is the geographic area approved by the Centers for Medicare & Medicaid Services (CMS) within which an eligible individual may enroll in a certain plan, and in the case of network plans, where a network must be available to provide services.

Skilled Nursing Facility (SNF) Care – A level of care in a SNF ordered by a doctor that must be given or supervised by licensed health care professionals. It may be skilled nursing care, or skilled rehabilitation services, or both. Skilled nursing care includes services that require the skills of a licensed nurse to perform or supervise. Skilled rehabilitation services are physical therapy, speech therapy, and occupational therapy. Physical therapy includes exercise to improve the movement and strength of an area of the body, and training on how to use special equipment, such as how to use a walker or get in and out of a wheelchair. Speech therapy includes exercise to regain and strengthen speech and/or swallowing skills. Occupational therapy helps you learn how to perform usual daily activities, such as eating and dressing by yourself.

Step Therapy – A utilization tool that requires you to first try another drug to treat your medical condition before we will cover the drug your physician may have initially prescribed.

Supplemental Security Income (SSI) – A monthly benefit paid by the Social Security Administration to people with limited income and resources who are disabled, blind, or age 65 and older. SSI benefits are not the same as Social Security benefits.

Tiers – Every drug on the Drug List is in one of 4 Tiers. In general, the higher the Tier number, the higher your cost for the drug.

Urgently Needed Care – Urgently needed care is a non-emergency situation when you need medical care right away because of an illness, injury, or condition that you did not expect or anticipate, but your health is not in serious danger. Because of the situation, it isn't reasonable for you to obtain medical care from a network provider.

CHAPTER 13 Additional benefits (not covered under Original Medicare)

Introduction

Your health and well-being are important to us, which is why we've developed the additional benefits detailed in this chapter: Vision Care and Hearing Benefits. The benefits described on the following pages are designed to help you stay healthy and provide well-rounded health coverage. Please read this chapter carefully, and reference it later if need be, to help you know what services are covered under your Plan. If you ever have questions about what is covered, how to make a claim or about any other issue, please call Customer Service (phone numbers for Customer Service are listed in Chapter 2 of the Evidence of Coverage). We are always happy to provide answers to any questions you may have. We're here to serve you.

The information in this chapter describes the non-Medicare covered vision exam, and the non-Medicare covered hearing exam and hearing aids that are Covered Health Services when you follow the Coverage Rules in the Evidence of Coverage. These services are in addition to Medicare-covered benefits outlined in the Evidence of Coverage. The provisions of this chapter are incorporated into and made a part of your Evidence of Coverage. The Covered Health Services described in this chapter are not covered when you are in the service area of an Affiliated Organization, as defined in the Passport Program Section of your Evidence of Coverage, if applicable. Copayments or coinsurance for these Covered Health Services do not apply toward the Annual Out-of-Pocket Maximum (if applicable to your Plan) described in Chapter 3 of the Evidence of Coverage titled: *Medical benefits chart (what is covered and what you pay).*

How to Use These Programs

Access Your Benefits

Each additional benefit detailed here has a directory of contracted service providers that furnish Covered Health Services. To start using your additional benefit:

— Select a contracted provider* from the *Provider Directory* or call Customer Service for help in determining a contracted provider (phone numbers for Customer Service are listed in Chapter 2 of the Evidence of Coverage).

Vision Service Providers

You will receive your in-network routine vision care through a contracted vision provider. Please reference your vision directory for a list of network and/or contracted vision providers.

- Call your selected provider's office to schedule the services you need.
- Pay the appropriate copayment or coinsurance at the time of your service, if applicable.
- When you go to the provider's office for services, you may be asked to show your member ID card.

*The vision directory is subject to change. Please call our Customer Service Department at the phone number listed in Chapter 2 of the Evidence of Coverage if you need help finding a provider or need an updated list of providers.

Hearing Service Providers

Your health plan contracted hearing service provider, EPIC Hearing Healthcare, can help get you started. You can contact Epic Hearing Healthcare **1-866-956-5400, (TTY: 711)**, 6 a.m. to 6 p.m. PST, Monday through Friday so they can help to locate a provider in your area. Or, you can visit www.epichearing.com. Please call Customer Service if you have any questions about your hearing services. The phone numbers and hours of operation for Customer Service are located in Chapter 2 of the Evidence of Coverage.

Further details on the benefits available as part of your additional benefits (if applicable) are detailed in the section titled: *Covered Services*.

Submit a Claim or Request Reimbursement

When you obtain services, the service provider normally submits a claim on your behalf. If the service provider is unwilling to do so, you can request reimbursement from us. To receive reimbursement, please take the following steps:

- Obtain a copy of your itemized receipt(s) from the provider.
- Make sure the itemized receipt includes the following:
  - The service provider's name, address and phone number
  - Your name
  - The date the service was completed
  - The amount you paid (or "paid in full" if the total amount has been paid)
- Mail the itemized receipt(s) to:
  UnitedHealthcare
  Claims Department
  P.O. Box 489
  Cypress, CA 90630

We should receive an itemized receipt from you or the provider within ninety (90) days after the date of service, or as soon thereafter as reasonably possible.

We will process your reimbursement based on your benefits. Upon completion of the reimbursement process, an Explanation of Benefits (EOB) will be sent to your mailing address.

Limitation of Liability

We will not reduce or deny a Claim for failure to furnish such proof within the time required, provided a Claim is furnished as soon as reasonably possible. Except in the absence of legal capacity, we will not accept a Claim more than one (1) year from the date of service.

Covered Services

Vision Benefit

The following services are covered under your vision benefit:

Routine Eye Exam (refraction)

- A complete vision exam every 12 months, through a contracted vision service provider
- No authorization needed

Please see Chapter 3 of the Evidence of Coverage titled: *Medical benefits chart (what is covered and what you pay)* for any copayment or coinsurance that may be due at the time of your exam.

Hearing Benefits

The following services are covered under your additional hearing benefit:

Routine Hearing Exam

- You can receive a complete hearing exam, every 12 months, through a contracted hearing service provider
- No authorization needed

Please see the chapter of the Evidence of Coverage titled: *Medical benefits chart (what is covered and what you pay)* for any copayment or coinsurance that may be due at the time of your exam.

Hearing Aid Benefits

Hearing aid units are medical devices that fit in or near the ear. The hearing aid benefit includes the purchase, fitting and professional maintenance or repair as required by the manufacturer of the device, of the most basic hearing aid(s) that will compensate for the loss of function

When purchasing hearing aids, you will receive:

- A 3-year warranty.
- In-office servicing of the instrument(s) for one year.

You are covered up to a specific amount toward the cost of purchase, fitting and repair of hearing aid unit(s) through a contracted hearing service provider. Please see the chapter of the Evidence of Coverage titled: *Medical benefits chart (what is covered and what you pay)* for the specific amount of your benefit as well as how often you can purchase hearing aids.

Limitations and Exclusions

Please note the following limitations and exclusions apply to all additional benefits. Certain services and items are not covered by your additional benefits, including these general ones:

- Government treatment for any services provided in a local, state or federal government facility or agency except when payment under the Plan is expressly required by federal or state law
- Any treatment or services caused by or arising out of the course of employment or covered under any public liability insurance, including, but not limited to, Worker's Compensation programs.

The limitations and exclusions below apply to your additional vision benefit:

- Orthoptics or vision training and any associated supplemental testing.
- LASIK, surgeries or other laser procedures for refractive error.
- Any eye examination required by an employer as a condition of employment.

The limitations and exclusions below apply to your additional hearing aid benefit:

Covered expenses related to hearing aids are limited to Plan Usual and Customary (U&C) charge of a basic hearing aid to provide functional improvement. Certain hearing aid items and services are not covered. Items and services that are not covered include, but are not limited to, the following:

- Replacement of a hearing aid that is lost, broken or stolen if occurrence exceeds covered rate of occurrence
- Repair of the hearing aid and related services
- Surgically implanted hearing devices
- An eyeglass-type hearing aid or additional charges for a hearing aid designed specifically for cosmetic purposes
- Services or supplies rendered to a member after cessation of coverage, except, if a hearing aid is ordered while coverage is in force and such hearing aid is delivered within 60 days after the date of cessation, the hearing aid will be considered a covered hearing aid expense
- Services or supplies that are not necessary according to professionally accepted standards of practice

This list is subject to change. Please call our Customer Service Department at the phone number listed in Chapter 2 of the Evidence of Coverage if you are not certain which medical group/IPA you currently belong to, or need an updated list of providers.

Questions?

Not a member yet? Call Customer Service toll-free:
1-800-610-2660 TTY **711**
8 a.m. to 8 p.m. local time, 7 days a week

Already a member? Call Customer Service toll-free:
1-888-867-5548 TTY **711**
8 a.m. to 8 p.m. local time, 7 days a week

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