

Charter

Evidence of Coverage

Your Medicare Health Benefits and Services as a Member of Puget Sound Health Partners

This mailing gives you the details about your Medicare health coverage from January 1 – December 31, 2009, and explains how to get the health care you need. This is an important legal document. Please keep it in a safe place. This Plan is offered by Puget Sound Health Partners, referred throughout the EOC as “we”, “us” or “our.” Partners Charter is referred to as “Plan” or “our Plan.” Our organization contracts with the Federal government. This information may be available in a different format. Please call Member Services at the number listed above if you need plan information in another format or language.

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This is Your 2009 Evidence of Coverage (EOC)

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1. Introduction

Thank you for being a member of our Plan!

This is your Evidence of Coverage, which explains how to get your Medicare health care coverage through our Plan, a coordinated care plan; you are still covered by Medicare, but you are getting your health care through our Plan.

This Evidence of Coverage, together with your enrollment form, riders including optional supplemental benefit brochures and amendments that we send to you, is our contract with you. The Evidence of Coverage explains your rights, benefits, and responsibilities as a member of our Plan and is in effect from January 1, 2009 - December 31, 2009. There is more than one plan described in this EOC. Please refer to the cover sheet you received with this information to identify which plan you are enrolled in. Our plan's contract with the Centers for Medicare & Medicaid Services (CMS) is renewed annually, and availability of coverage beyond the end of the current contract year is not guaranteed.

This Evidence of Coverage will explain to you:

- What is covered by our Plan and what isn't covered
- How to get the care you need including some rules you must follow
- What you will have to pay for your health care
- What to do if you are unhappy about something related to getting your covered services
- How to leave our Plan, and other Medicare options that are available

This Section of the EOC has important information about:

- Eligibility requirements
- The geographic service area of our Plan
- Keeping your membership record up-to-date
- Materials that you will receive from our Plan
- Paying your plan premiums
- Late enrollment penalty

Eligibility Requirements

To be a member of our Plan, you must live in our service area, be entitled to Medicare Part A, and enrolled in Medicare Part B and not have End Stage Renal Disease (ESRD), with limited exceptions, such as if you are already a member of our plan. If you currently pay a premium for Medicare Part A and/or Medicare Part B, you must continue paying your premium in order to keep your Medicare Part A and/or Medicare Part B and remain a member of this plan.

If after you enroll in our plan, you begin hospice care or you develop end-stage renal disease, you can remain a member of our plan. However, if you no longer meet the other eligibility conditions, we will have to end your membership, as described in Section 6.

The geographic service area for our Plan

The counties in our service area are listed below.

King, Pierce, Snohomish and Thurston counties

We offer coverage in several counties. However, there may be cost or other differences between the plans we offer in each county. If you move out of the county where you live into a county that is still within our service area, you must call Member Services in order to update your information. If you move into a county outside of our service area, you cannot remain a member of our plan. Please call Member Services to find out if we have a plan in your new county.

How do I keep my membership record up to date?

We have a membership record about you. Your membership record has information from your enrollment form, including your address and telephone number. It shows your specific Plan coverage, including the Primary Care Physician you chose and other information. Doctors, hospitals, and other network providers use your membership record to know what services are covered for you. Section 3 tells how we protect the privacy of your personal health information.


Please help us keep your membership record up to date by telling Member Services if there are changes to your name, address, or phone number, or if you go into a nursing home. Also, tell Member Services about any changes in other health insurance coverage you have, such as from your employer, your spouse's employer, workers' compensation, Medicaid, or liability claims such as claims from an automobile accident.

Materials that you will receive from our Plan

Plan Identification Card

While you are a member of our Plan, you must use our identification card for services covered by this plan. While you are a member of our Plan you must not use your red, white, and blue Medicare card to get covered services and/or items. Keep your red, white, and blue Medicare card in a safe place in case you need it later. If you get covered services using your red, white, and blue Medicare card instead of using our identification card while you are a plan member, the Medicare Program won't pay for these services and you may have to pay the full cost yourself.

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 PUGET SOUND HEALTH PARTNERS Member Name: First M Last Member ID: xxxxxxxxxx Effective Date: MM/DD/YYYY PCP: Phone: XXX-XXX-XXXX RXBin: 012189 RX PCN: 5040 Rx America: (24/7 for Pharmacy calls only): 1-800-591-2869 Behavioral Health: 24/7: 1-866-750-1327 A FRESH APPROACH TO BETTER HEALTH	Group ID: PODx Plan: XXXXXXXXXXXXXXXX Issuer #: 80840 Co-Pay Due at time of Service PCP: \$ Specialist: \$ ER: \$ Routine Vision: VSP Chiro/Acu: ASHN	Present this card each time you make a health care visit Benefit Question: Contact Member Services Department at: 253-779-8830 or 1-866-789-7747 or ms@OurPSHP.com . TTY users should call 1-866-264-4141. Electronic Claims: Payer ID# 42172 Emergencies: Call 911 or go to the nearest emergency care facility in event of a serious or life threatening medical emergency. Contact PSHP Member Services within 24 hours. PUGET SOUND HEALTH PARTNERS PO Box 99948 Lakewood, WA 98496 www.OurPSHP.com This card is not an authorization of services or a guarantee of payment.
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Please carry your identification card that we gave you at all times and remember to show your card when you get covered services and/or items. If your identification card is damaged, lost, or stolen, call Member Services right away and we will send you a new card.

The Provider Directory gives you a list of network providers

Every year that you are a member of our Plan, we will send you either a Provider Directory or an update to your Provider Directory, which lists our network providers. If you don't have the Provider Directory, you can get a copy from Member Services. You may ask Member Services for more information about our network providers, including their qualifications. A complete list of network providers is also available on our web site at www.OurPSHP.com.

You must use network providers for services to be covered by us at plan cost-sharing levels, except in emergencies, for urgently needed care out-of-area, or for out of the area dialysis services. See the benefits chart in Section 10 for more specific out-of-network coverage information.

This directory contains the names of providers who contract with our plan. You may pay more for services if you do not use one of these providers, except in emergencies, for certain urgently needed services, and for out-of-area dialysis services.

Your monthly plan premium

As a member of our Plan, you pay:

- 1) Your monthly Medicare Part B premium. Most people will pay the standard premium amount, which is \$96.40 in 2008. (Your Part B premium is typically deducted from your Social Security payment.) (If you receive benefits from your state Medicaid program, all or part of your Part B premium may be paid for you.)

Your monthly premium will be higher if you are single (file an individual tax return) and your yearly income is more than \$82,000, or if you are married (file a joint tax return) and your yearly income is more than \$164,000.

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If your Yearly Income is*		In 2008, you pay*
File individual tax return	File joint tax return	
\$82,000 or below	\$164,000 or below	\$96.40
\$82,001-\$102,000	\$164,001-\$204,000	\$122.20
\$102,001-\$153,000	\$204,001-\$306,000	\$160.90
\$153,001-\$205,000	\$306,001-\$410,000	\$199.70
Above \$205,000	Above \$410,000	\$238.40

*The above income and Part B premium amounts are for 2008 and will change for 2009. If you pay a Part B late-enrollment penalty, the premium amount is higher.

- 2) Your monthly Medicare Part A premium, if necessary (most people don't have to pay this premium).
- 3) Your monthly premium for our Plan.

Your monthly premium for our Plan is listed in Section 10. (If you signed up for extra benefits, also called "optional supplemental benefits", then you pay an additional premium each month for these extra benefits.) If you have any questions about your Plan premiums or the payment programs, please call Member Services.

Monthly Plan Premium Payment Options

There are two ways to pay your monthly plan premium.

Option one: Pay your monthly plan premium directly to our Plan.

You may decide to pay your monthly plan premium directly to our Plan. Premiums are due by the 3rd or 18th of each month. You may elect to receive a statement from Puget Sound Health Partners to remind you of the payment due date. Payments can be mailed to Puget Sound Health Partners PO Box 99948 Lakewood, WA 98496 or dropped off to Puget Sound Health Partners at 7502

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Lakewood Dr. W., Suite A, Lakewood, WA 98499. There will be a fee for non-sufficient funds (NSF) checks.

Instead of paying by check, you can have your monthly plan premium automatically withdrawn from your bank account, charged directly to your credit card, or charged directly to your debit card. Automatic deductions may be made monthly, quarterly or annually and are withdrawn on either the 3rd or 18th of the month. To request automatic withdrawal or an automatic charge to a bank card, please call Member Services.

Option two: You may have your monthly plan premium directly deducted from your monthly Social Security payment.

Contact Member Services for more information on how to pay your monthly plan premium this way.

Can your monthly plan premiums change during the year?

The monthly plan premium associated with this plan cannot change during the year. However, the amount you pay could change, depending on whether you become eligible for, or lose extra help for your prescription drug costs. If our monthly plan premium changes for next year, we will tell you in October and the change will take effect on January 1.

What is the Medicare Prescription Drug Plan late enrollment penalty?

If you don't join a Medicare drug plan when you are first eligible, and/or you go without creditable prescription drug coverage for a continuous period of 63 days or more, you may have to pay a late enrollment penalty when you enroll in a plan later. The Medicare drug plan will let you know what the amount is and it will be added to your monthly premium. This penalty amount changes every year, and you have to pay it as long as you have Medicare prescription drug coverage. However, if you qualified for extra help in 2006, 2007, or 2008, you may not have to pay a penalty.

If you must pay a late enrollment penalty, your penalty is calculated when you first join a Medicare drug plan. To estimate your penalty, take 1% of the national base beneficiary premium for the year you join (in 2008, the national base beneficiary premium is \$27.93. This amount may change in 2009). Multiply it by the number of full months you were eligible to join a Medicare drug plan but didn't, and then round that amount to the nearest ten cents. This is your estimated penalty amount, which is added each month to your Medicare drug plan's premium for as long as you are in that plan.

If you disagree with your late enrollment penalty, you may be eligible to have it reconsidered (reviewed). Call Member Services to find out more about the late enrollment penalty reconsideration process and how to ask for such a review.

You won't have to pay a late enrollment penalty if:

- You had creditable coverage (coverage that expects to pay, on average, at least as much as Medicare's standard prescription drug coverage)
- You had prescription drug coverage but you were not adequately informed that the coverage was not creditable (as good as Medicare's drug coverage)
- Any period of time that you didn't have creditable prescription drug coverage was less than 63 continuous days
- 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 stay in a Medicare prescription drug plan
- You received or are receiving extra help AND you enroll in a Medicare prescription drug plan by December 31, 2008, AND you stay in a Medicare prescription drug plan

What happens if you don't pay or are late with your monthly plan premiums?

If your monthly plan premiums are late, we will tell you in writing that if you don't pay your monthly plan premium by the 30th day, which includes a grace period, we will end your membership in our Plan. Our plan's grace period is thirty (30) days. If we end your membership, you will have Original Medicare Plan coverage.

Should you decide later to re-enroll in our Plan, or to enroll in another plan that we offer, you will have to pay any late monthly plan premiums that you didn't pay from your previous enrollment in our Plan.

If you signed up for extra benefits ("optional supplemental benefits"), and you don't pay the additional monthly plan premium for these extra benefits on time, we will tell you in writing that if you don't pay the monthly plan premium for these extra benefits within thirty (30) days we will end coverage for the extra benefits. If you want to terminate your extra benefits, you must notify us in advance or we will end your membership in the optional supplemental benefits.

Important Information

We will send you a Coordination of Benefits (COB) Survey so that we can know what other health and/or drug coverage you have besides our Plan. Medicare requires us to collect this information from you, so when you get the survey, please fill it out and send it back. If you have additional health and/or drug coverage, you must provide that information to our Plan. The information you provide helps us calculate how much you and others have paid for your prescription drugs. In addition, if you lose or gain additional health and/or prescription drug coverage, please call Member Services to update your membership records.

2. How You Get Care

What are “providers”?

“Providers” is the term we use for doctors, other health care professionals, hospitals, and other health care facilities that are licensed by the state and as appropriate eligible to receive payment from Medicare.

What are “network providers”?

A provider is a “network provider” when they participate in our Plan. When we say that network providers “participate in our Plan,” this means that we have arranged with them (for example, by contracting with them) to coordinate or provide covered services to members in our Plan. Network providers may also be referred to as “plan providers”.

What are “covered services”?

“Covered services” is the term we use for all the medical care, health care services, supplies, and equipment that are covered by our Plan. Covered services are listed in the Benefits Chart in Section 10.

What do you pay for “covered services”?

The amount you pay for covered services is listed in Section 10.

Providers you can use to get services covered by our Plan

While you are a member of our Plan, you must use our network providers to get your covered services except in limited cases such as emergency care, urgently needed care when our network is not available, or out of service area dialysis. We list the providers that participate with our Plan in our provider directory. If you get non-emergency care from non-plan (out-of-network) providers without prior authorization you must pay the entire cost yourself, unless the services are urgent and our network is not available, or the services are out-of-area dialysis services. If an out-of-network provider sends you a bill that you think we should pay for emergency services, please contact Member Services or send the bill to us for payment.

What should you do with your provider bills?

You should only pay the provider the cost-sharing allowed by our Plan and listed in Section 10. You should ask your provider to bill us for the rest of the fee and we will pay the provider according to our Plan’s terms and conditions of payment. If the provider asks you to pay the full amount of the bill, and have you get paid back by the Plan, tell the provider that you only have to pay the cost-sharing amount. Your identification card in our Plan will indicate how the provider can contact us

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for information on our terms and conditions of payment. If the provider wants further information on payment for covered services, please have them contact us at 1-866-789-PSHP (7747) or by mail at Puget Sound Health Partners, Attn: Claims PO Box 99948 Lakewood, WA 98496.

If you get a bill for the services, you may send the bill to us for payment. We will pay your provider for our share of the bill and will let you know if you must pay any cost-sharing. However, if you have already paid for the covered services we will reimburse you for our share of the cost.

If you have any questions about whether our plan will pay for a certain health care service, you can ask us for a written advance coverage decision before you get the service. We will let you know if our plan will pay for the service.

Choosing Your Primary Care Physician (PCP)

What is a PCP?

When you become a member of our Plan, you must choose a plan provider to be your PCP. Your PCP is a physician, nurse practitioner or physician assistant, who meets state requirements and is trained to give you medical care. Your PCP will also coordinate the rest of the covered services you get as a member of our Plan. For example, in order for you to see a network specialist you would need a “referral” from your PCP.

Your PCP will provide most of your care and will help you arrange or coordinate the rest of the covered services you get as a member of our Plan. This includes:

- Radiology services
- Laboratory tests
- Therapies
- Care from other plan providers
- Hospital admissions
- Follow-up care
- Coordinating your care includes checking or consulting with other plan providers about your care

If you need certain types of covered services or supplies, you must get approval in advance from your PCP (such as giving you a referral to a specialist). In some cases, your PCP will need to get prior authorization (prior approval) from us. Since your PCP will provide and coordinate your medical care, you should have all of your past medical records sent to your PCP’s office. Section 3 tells you how we will protect your privacy of your medical records and personal health information.

What types of providers may act as a PCP?

Plan providers specializing in internal medicine, family practice, or general practice are able to act as a PCP.

How do you choose/change a PCP if member desires or when PCP leaves plan?

You may choose from any of the PCP's in the Directory of Network Providers and Hospitals. It is recommended that you choose one that meets your specific health care needs and is easily accessible. You should visit your PCP for routine preventive care and establish a good relationship with him or her before you need serious medical attention. If there is a particular network specialist or hospital that you want to use, check first to be sure your PCP makes referrals to that specialist or uses that hospital.

You can find a list of available PCPs in our Directory of Network Providers and Hospitals, available on our web site at www.OurPSHP.com or by calling Member Services. If you need assistance in selecting a PCP, please call Member Services at 1-866-789-PSHP (7747).

You may change your PCP at any time simply by contacting Member Services. Typically this change will not be effective until the first of the following month. When you call, be sure to tell Member Services if you are seeing a specialist or getting other covered services that need your PCP's approval (such as home health services or durable medical equipment). Member Services will assist you with coordinating specialty care and other services you were receiving prior to changing your PCP. They will also check to make sure the PCP you want to switch to is accepting new patients. Member Services will change your membership record to show the name of your new PCP, and tell you when the change to your new PCP will take effect. They will also send you a new identification card that shows the name and phone number of your new PCP.

What services can you get on your own without getting a referral 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 and pneumonia vaccinations as long as you get them from a network provider.
- Emergency services, whether you get these services from network providers or out-of-network providers
- Urgently needed care that you get from out-of-network providers when you are temporarily outside the Plan's service area or when you are in the service area but, because of unusual or extraordinary circumstances, the Network providers are temporarily unavailable or inaccessible.
- Dialysis (kidney) services that you get at a Medicare certified dialysis facility when you are temporarily outside the Plan's service area. If possible, please let us know before you leave the service area where you are going to be so we can help arrange for you to have maintenance dialysis while outside the service area.

What services require prior authorization from the plan?

- Inpatient Admissions (i.e. acute hospital, skilled nursing facilities, rehabilitation facilities)
- Durable Medical Equipment (any item costing more than \$500)
- Referrals to non-participating providers and facilities
- Oncology services (i.e. radiation or chemotherapy)
- Plastic Surgery
- Physical, Occupational, Speech Therapy
- Radiology or Imaging (i.e. MRI, MRA, PET)
- Other services such as transplants, in-area dialysis, home health, sclerotherapy

What if your doctor or other provider leaves your plan?

Sometimes a 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. Member Services can assist you in finding and selecting another provider.

Getting care if you have a medical emergency or an urgent need for care

What is a “medical emergency”?

A “medical emergency” is when you believe that your health is in serious danger. A medical emergency includes 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 medical help as quickly as possible. Call 911 for help or go to the nearest emergency room, hospital, or urgent care center. You don’t need to get approval or a referral first from your doctor or other network provider.
- As soon as possible, make sure that we know about your emergency, because we need to be involved in following up on your emergency care. You or someone else should call to tell us about your emergency care, usually within 48 hours. You may call Member Services at 1-866-789-PSHP (7747).

We will talk with the doctors who are giving you emergency care to help manage and follow up on your care. When the doctors who are giving you emergency care say that your condition is stable and the medical emergency is over then you are still entitled to follow-up post stabilization care. Your follow-up post stabilization care will be covered according to Medicare guidelines. In general, if your emergency care is provided out of network we will try to arrange for network providers to take over your care as soon as your medical condition and the circumstances allow.

What is covered if you have a medical emergency?

- You may get covered emergency medical care whenever you need it, anywhere in the United States
- **Ambulance** services are covered in situations where other means of transportation in the United States would endanger your health. (See the benefits chart in Section 10 for more detailed information.)
- **Worldwide emergency** care is discussed in Section 10

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 this happens, you are still covered for the care you got to determine what was wrong, as long as you thought your health was in serious danger, as explained in “What is a ‘medical emergency’” above. However, please note that:

- If you get any extra care after the doctor says it wasn't a medical emergency, the Plan will pay its portion of the covered additional care **only if you get it from a network provider**
- We will pay our portion of the covered additional care from an out-of-network provider if you are out of our service area, as long as the additional care you get meets the definition of “urgently needed care” that is given below

What is urgently needed care?

Urgently needed care refers to a non-emergency situation when you are:

- Inside the United States
- Temporarily absent from the Plan's authorized service area
- In need of medical attention right away for an unforeseen illness, injury, or condition, and
- It isn't reasonable given the situation for you to obtain medical care through the Plan's participating provider network

Under unusual and extraordinary circumstances, care may be considered urgently needed and paid for by our Plan when the member is in the service area, but the provider network of the Plan is temporarily unavailable or inaccessible.

What is the difference between a “medical emergency” and “urgently needed care”?

The two main differences between urgently needed care and a medical emergency are in the danger to your health and your location. A “medical emergency” occurs when you reasonably believe that your health is in serious danger, whether you are in or outside of the service area. “Urgently needed

care” is when you need medical help for an unforeseen illness, injury, or condition, but your health is not in serious danger and you are generally outside of the service area.

How to get urgently needed care

If, while temporarily outside the Plan’s service area, you require urgently needed care, then you may get this care from any provider.

Note: If you have a pressing, non-emergency medical need while in the service area, you generally must obtain services from the Plan according to its procedures and requirements as outlined earlier in this section.

How to submit a paper claim for emergency or urgently needed care

When you receive emergency or urgently needed health care services from a provider who is not part of our network, you are responsible for paying your plan cost sharing amount and you should tell the provider to bill our Plan for the balance of the payment they are due. However, if you have received a bill from the provider, please send that claim to Puget Sound Health Partners Attn: Claims PO Box 99948 Lakewood, WA 98496 so we can pay the provider the amount they are owed. If you have any questions about what to pay a provider or where to send a paper claim you may call Member Services.

What is your cost for services that aren’t covered by our Plan?

Our Plan covers all of the medically-necessary services that are covered under Medicare Part A and Part B. Our Plan uses Medicare’s coverage rules to decide what services are medically necessary. You are responsible for paying the full cost of services that aren’t covered by our Plan. Other sections of this booklet describe the services that are covered under our Plan and the rules that apply to getting your care as a plan member. Our plan might not cover the costs of services that aren’t medically necessary under Medicare, even if the service is listed as covered by our Plan.

If you need a service that our Plan decides isn’t medically necessary based on Medicare’s coverage rules, you may have to pay all of the costs of the service if you didn’t ask for an advance coverage determination. However, you have the right to appeal the decision.

If you have any questions about whether our Plan will pay for a service or item, including inpatient hospital services, you have the right to have an organization determination made for the service. You may call Member Services and tell us you would like a decision on whether the service will be covered before you get the service.

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. Payments for services that exceed a benefit limit will not count toward an out-of-pocket maximum. You can call Member Services when you want to know how much of your benefit limit you have already used.

How can you participate in a clinical trial?

A “clinical trial” is a way of testing new types of medical care, like how well a new cancer drug works. A clinical trial is one of the final stages of a research process that helps doctors and researchers see if a new approach works and if it is safe.

The Original Medicare Plan pays for routine costs if you take part in a clinical trial that meets Medicare requirements (meaning it’s a “qualified” clinical trial and Medicare-approved). Routine costs include costs like room and board for a hospital stay that Medicare would pay for even if you weren’t in a trial, an operation to implant an item that is being tested, and items and services to treat side effects and complications arising from the new care. Generally, Medicare will not cover the costs of experimental care, such as the drugs or devices being tested in a clinical trial.

There are certain requirements for Medicare coverage of clinical trials. If you participate as a patient in a clinical trial that meets Medicare requirements, the Original Medicare Plan (and not our Plan) pays the clinical trial doctors and other providers for the covered services you get that are related to the clinical trial. When you are in a clinical trial, you may stay enrolled in our Plan and continue to get the rest of your care, like diagnostic services, follow-up care, and care that is unrelated to the clinical trial through our Plan. Our Plan is still responsible for coverage of certain investigational devices exemptions (IDE), called Category B IDE devices, needed by our members.

You will have to pay the same coinsurance amounts charged under Original Medicare for the services you receive when participating in a qualifying clinical trial, but you do not have to pay the Original Medicare Part A or Part B deductibles because you are enrolled in our Plan.

You don’t need to get a referral (approval in advance) from a network provider to join a clinical trial, and the clinical trial providers don’t need to be network providers. However, please be sure to **tell us before you start participation in a clinical trial** so that we can keep track of your health care services. When you tell us about starting participation in a clinical trial, we can let you know whether the clinical trial is Medicare-approved, and what services you will get from clinical trial providers instead of from our plan.

You may view or download the publication “Medicare and Clinical Trials” at www.medicare.gov under “Search Tools” select “Find a Medicare Publication.” Or, call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

How to access care in Religious Non-medical Health Care Institutions

Care in a Medicare-certified Religious Non-medical Health Care Institution (RNHCI) is covered by our Plan under certain conditions. Covered services in an RNHCI are limited to non-religious aspects of care. To be eligible for covered services in an RNHCI, you must have a medical condition that would allow you to receive inpatient hospital or skilled nursing facility care. You may get services furnished in the home, but only items and services ordinarily furnished by home health

agencies that are not RNHCIs. In addition, you must sign a legal document that says you are conscientiously opposed to the acceptance of “non-excepted” medical treatment. (“Excepted” medical treatment is medical care or treatment that you receive involuntarily or that is required under federal, state or local law. “Non-excepted” medical treatment is any other medical care or treatment.) Your stay in the RNHCI is not covered by our Plan unless you obtain authorization (approval) in advance from our Plan. See Section 10 for Inpatient Benefits.

3. Your Rights and Responsibilities as a Member of our Plan

Introduction to your rights and protections

Since you have Medicare, you have certain rights to help protect you. In this section, we explain your Medicare rights and protections as a member of our Plan and we explain what you can do if you think you are being treated unfairly or your rights are not being respected.

Your right to be treated with dignity, respect and fairness

You have the right to be treated with dignity, respect, and fairness at all times. Our Plan must obey laws that protect you from discrimination or unfair treatment. We don’t discriminate based on a person’s race, disability, religion, sex, sexual orientation, health, ethnicity, creed, age, or national origin. If you need help with communication, such as help from a language interpreter, please call Member Services. Member Services can also help if you need to file a complaint about access (such as wheel chair access). You may also call the Office for Civil Rights at 1-800-368-1019 or TTY/TDD 1-800-537-7697, or your local Office for Civil Rights.

Your right to the privacy of your medical records and personal health information

There are federal and state laws that protect the privacy of your medical records and personal health information. We protect your personal health information under these laws. Any personal information that you give us when you enroll in this plan is protected. We will make sure that unauthorized people don’t see or change your records. Generally, we must get written permission from you (or from someone you have given legal power to make decisions for you) before we can give your health information to anyone who isn’t providing your care or paying for your care. There are exceptions allowed or required by law, such as release of health information to government agencies that are checking on quality of care.

The laws that protect your privacy give you rights related to getting information and controlling how your health information is used. We are required to provide you with a notice that tells about these rights and explains how we protect the privacy of your health information. You have the right to look at medical records held at the Plan, and to get a copy of your records (there may be a fee charged 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 review your request and figure out whether the changes are appropriate). You have the right to know how your health information has been given out and used for non-routine purposes. If you have questions or concerns about privacy of your personal information and medical records, please call Member Services.

Your right to see network providers, get covered services within a reasonable period of time

As explained in this booklet, you will get most or all of your care from network providers, that is, from doctors and other health providers who are part of our Plan. You have the right to choose a network provider (we will tell you which doctors are accepting new patients). You have the right to go to a women's health specialist in our Plan (such as a gynecologist) without a referral. You have the right to timely access to your providers and to see specialists when care from a specialist is needed. "Timely access" means that you can get appointments and services within a reasonable amount of time.

Your right to know your treatment options and participate in decisions about your health care

You have the right to get full information from your providers when you go for medical care, and the right to participate fully in decisions about your health care. Your providers must explain things in a way that you can understand. Your rights include knowing 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. 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, and be given the choice of refusing experimental treatments.

You have the right to receive a detailed explanation from us if you believe that a provider has denied care that you believe you were entitled to receive or care you believe you should continue to receive. In these cases, you must request an initial decision called an organization determination. Organization determinations are discussed in Section 5.

You have the right to refuse treatment. This includes the right to leave a hospital or other medical facility, even if your doctor advises you not to leave. This includes the right to stop taking your medication. If you refuse treatment, you accept responsibility for what happens as a result of your refusing treatment.

Your right to use advance directives (such as a living will or a power of attorney)

You have the right to ask someone such as a family member or friend to help you with decisions about your health care. Sometimes, people become unable to make health care decisions for themselves due to accidents or serious illness. If you want to, you can use a special form to give someone the legal authority to make decisions for you if you ever become unable to make decisions

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for yourself. You also have the right to 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 have an advance directive, you can get a form from your lawyer, from a social worker, from some office supply stores, or by contacting Member Services. You can sometimes get advance directive forms from organizations that give people information about Medicare. 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. It is important to sign this form and keep a copy at home. 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.

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. 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 Washington State Department of Health and Social Services at 1-800-562-6078.

Your right to get information about our Plan

You have the right to get information from us about our Plan. This includes information about our financial condition, and how our Plan compares to other health plans. To get any of this information, call Member Services.

Your right to get information in other formats

You have the right to get your questions answered. Our plan must have individuals and translation services available to answer questions from non-English speaking beneficiaries, and must provide information about our benefits that is accessible and appropriate for persons eligible for Medicare because of disability. If you have difficulty obtaining information from your plan based on language or a disability, call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

Your right to get information about our network providers

You have the right to get information from us about our network providers and their qualifications and how we pay our doctors. To get this information, call Member Services.

Your right to get information about your Part C medical care or services and costs

You have the right to an explanation from us about any Part C medical care or service not covered by our Plan. We must tell you in writing why we will not pay for or approve Part C medical care or service, and how you can file an appeal to ask us to change this decision. See Section 5 for more information about filing an appeal. You also have the right to this explanation even if you obtain the Part C medical care or service from a provider not affiliated with our organization.

Your right to make complaints

You have the right to make a complaint if you have concerns or problems related to your coverage or care. See Section 4 and Section 5 for more information about complaints. If you make a complaint, we must treat you fairly (i.e., not retaliate against you) because you made a complaint. You have the right to get a summary of information about the appeals and grievances that members have filed against our Plan in the past. To get this information, call Member Services.

How to get more information about your rights

If you have questions or concerns about your rights and protections, you can

1. Call Member Services at the number on the cover of this booklet
2. Get free help and information from your State Health Insurance Assistance Program (SHIP). Contact information for your SHIP is in Section 8 of this booklet.
3. Visit www.medicare.gov to view or download the publication “Your Medicare Rights & Protections”
4. Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048

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

If you think you have been treated unfairly or your rights have not been respected, you may call Member Services or:

- If you think you have been treated unfairly due to your race, color, national origin, disability, age, or religion, you can call the Office for Civil Rights at 1-800-368-1019 or TTY/TDD 1-800-537-7697, or call your local Office for Civil Rights
- If you have any other kind of concern or problem related to your Medicare rights and protections described in this section, you can also get help from your SHIP

Your responsibilities as a member of our Plan include:

- Getting familiar with your coverage and the rules you must follow to get care as a member. You can use this booklet to learn about your coverage, what you have to pay, and the rules you need to follow. Call Member Services if you have questions.
- Using all of your insurance coverage. If you have additional health insurance coverage besides our Plan, it is important that you use your other coverage in combination with your coverage as a member of our Plan to pay your health care expenses. This is called “coordination of benefits” because it involves coordinating all of the health benefits that are available to you.
- **You are required to tell our Plan if you have additional health insurance Call Member Services**
- Notifying providers when seeking care (unless it is an emergency) that you are enrolled in our Plan and you must present your plan identification card to the provider
- Giving your doctor and other providers the information they need to care for you, and following the treatment plans and instructions that you and your doctors agree upon. Be sure to ask your doctors and other providers if you have any questions and have them explain your treatment in a way you can understand.
- Acting in a way that supports the care given to other patients and helps the smooth running of your doctor’s office, hospitals, and other offices
- Paying your plan premiums and coinsurance or co-payment for your covered services. You must pay for services that aren’t covered
- Notifying us if you move. If you move within our service area, we need to keep your membership record up-to-date. If you move outside of our plan service area, you cannot remain a member of our plan, but we can let you know if we have a plan in that area
- Letting us know if you have any questions, concerns, problems, or suggestions. If you do, please call Member Services.

4. How to File a Grievance

What is a Grievance?

A grievance is any complaint, other than one that involves a request for an initial determination or an appeal as described in Section 5 of this manual.

Grievances do not involve problems related to approving or paying for Part C medical care or services, problems about having to leave the hospital too soon, and problems about having Skilled Nursing Facility (SNF), Home Health Agency (HHA), or Comprehensive Outpatient Rehabilitation Facility (CORF) services ending too soon.

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If we will not pay for or give you the Part C medical care or services you want, you believe that you are being released from the hospital or SNF too soon, or your HHA or CORF services are ending too soon, you must follow the rules outlined in Section 5.

What types of problems might lead to your filing a grievance?

- Problems with the service you receive from Member Services
- If you feel that you are being encouraged to leave (disenroll from) the Plan
- If you disagree with our decision not to give you a “fast” decision or a “fast” appeal. We discuss these fast decisions and appeals in Section 5
- We don’t give you a decision within the required time frame
- We don’t give you required notices
- You believe our notices and other written materials are hard to understand
- Problems with the quality of the medical care or services you receive, including quality of care during a hospital stay
- Problems with how long you have to wait on the phone, in the waiting room, or in the exam room
- Problems getting appointments when you need them, or waiting too long for them
- Rude behavior by doctors, nurses, receptionists, or other staff
- Cleanliness or condition of doctor’s offices, clinics, or hospitals

If you have one of these types of problems and want to make a complaint, it is called “filing a grievance.”

Who may file a grievance

You or someone you name may file a grievance. The person you name would be your “representative.” You may name a relative, friend, lawyer, advocate, doctor, or anyone else to act for you. Other persons may already be authorized by the Court or in accordance with State law to act for you. If you want someone to act for you who is not already authorized by the Court or under State law, then you and that person must sign and date a statement that gives the person legal permission to be your representative. To learn how to name your representative, you may call Member Services.

Filing a grievance with our Plan

If you have a complaint, you or your representative may call the phone number for **Part C Grievances** (for complaints about Part C medical care or services) in Section 8. We will try to resolve your complaint over the phone. If you ask for a written response, file a written grievance, or your complaint is related to quality of care, we will respond in writing to you. **If we cannot resolve your complaint over the phone, we have a formal procedure to review your complaints. We call this** our grievance process.

The grievance must be submitted within 60 days of the event or incident. Your complaint will be forwarded to the Grievance and Appeal Coordinator (GAC) for review. For written grievances the GAC will send you a letter acknowledging receipt of your grievance. 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.

Fast Grievances

In certain cases, you have the right to ask for a “fast grievance,” meaning we will answer your grievance within 24 hours. We discuss situations where you may request a fast grievance in Section 5.

For quality of care problems, you may also complain to the QIO

You may complain about the quality of care received under Medicare, including care during a hospital stay. You may complain to us using the grievance process, to the Quality Improvement Organization (QIO), or both. If you file with the QIO, we must help the QIO resolve the complaint. See Section 8 for more information about the QIO and for the name and phone number of the QIO in your state.

5. Complaints and Appeals about your Part C Medical Care and Service(s)

Introduction

This section explains how you ask for coverage of your Part C medical care or service(s) or payments in different situations. This section also explains how to make complaints when you think you are being asked to leave the hospital too soon, or you think your skilled nursing facility (SNF), home health (HHA) or comprehensive outpatient rehabilitation facility (CORF) services are ending too soon. These types of requests and complaints are discussed below in Part 1, Part 2, or Part 3.

Other complaints that do not involve the types of requests or complaints discussed below in Part 1, Part 2, or Part 3 are considered **grievances**. You would file a grievance if you have any type of problem with us or one of our network providers that does not relate to coverage for Part C medical care or services. For more information about grievances, see Section 4.

Part 1. Requests for Part C medical care or services or payments.

Part 2. Complaints if you think you are asked to leave the hospital too soon.

Part 3. Complaints if you think your skilled nursing facility (SNF), home health (HHA) or comprehensive outpatient rehabilitation facility (CORF) services are ending too soon.

PART 1. Requests for medical care or services or payment

This part explains what you can do if you have problems getting the Part C medical care or service you request, or payment (including the amount you paid) for a Part C medical care or service you already received.

If you have problems getting the Part C medical care or services you need, or payment for a Part C service you already received, you must request an initial determination with the plan.

Initial Determinations

The initial determination we make is the starting point for dealing with requests you may have about covering a Part C medical care or service you need, or paying for a Part C medical care or service you already received. Initial decisions about Part C medical care or services are called "**organization determinations.**" With this decision, we explain whether we will provide the Part C medical care or service you are requesting, or pay for the Part C medical care or service you already received.

The following are examples of requests for initial determinations:

- You are not getting Part C medical care or services you want, and you believe that this care is covered by the Plan
- We will not approve the medical treatment your doctor or other medical provider wants to give you, and you believe that this treatment is covered by the Plan
- You are being told that a medical treatment or service you have been getting will be reduced or stopped, and you believe that this could harm your health
- You have received Part C medical care or services that you believe should be covered by the Plan, but we have refused to pay for this care

Who may ask for an initial determination?

You, your prescribing physician, or someone you name may ask us for an initial determination. The person you name would be your "appointed representative." You may name a relative, friend, advocate, doctor, or anyone else to act for you. Other persons may already be authorized under State law to act for you. If you want someone to act for you who is not already authorized under State law, then you and that person must sign and date a statement that gives the person legal permission to be your appointed representative. If you are requesting Part C medical care or services, this statement must be sent to us at the address or fax number listed under "**Part C Organization Determinations**" in Section 8. To learn how to name your appointed representative, you may call Member Services.

You also have the right to have a lawyer 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.

Asking for a "standard" or "fast" initial determination

A decision about whether we will give you, or pay for, the Part C medical care or service you are requesting can be a "standard" decision that is made within the standard time frame, or it can be a "fast" decision that is made more quickly. A fast decision is also called an "expedited" decision.

Asking for a standard decision

To ask for a standard decision for a Part C medical care or service you, your doctor, or your representative should fax, or write us at the numbers or address listed under **Part C Organization Determinations** (for appeals about Part C medical care or services) in Section 8.

Asking for a fast decision

You may ask for a fast decision **only** if you or your doctor believe that waiting for a standard decision could seriously harm your health or your ability to function. (Fast decisions apply only to requests for benefits that you have not yet received. You cannot get a fast decision if you are asking us to pay you back for a benefit that you already received.)

If you are requesting a Part C medical care or service that you have not yet received, you, your doctor, or your representative may ask us to give you a fast decision by calling, faxing, or writing us at the numbers or address listed under **Part C Organization Determinations** (for appeals about Part C medical care or services) in Section 8.

Be sure to ask for a "fast," or "expedited" review. If your doctor asks for a fast decision for you, or supports you in asking for one, and the doctor indicates that waiting for a standard decision could seriously harm your health or your ability to function, we will automatically give you a fast decision.

If you ask for a fast decision without support from a doctor, we will decide if your health requires 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 informing you that if you get a doctor's support for a fast review, we will automatically give you a fast decision. The letter will also tell you how to file a "fast grievance." You have the right to file a fast grievance if you disagree with our decision to deny your request for a fast review (for more information about fast grievances, see Section 4). If we deny your request for a fast initial determination, we will give you a standard decision.

What happens when you request an initial determination?

- For a decision about payment for Part C medical care or services you already received

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If we do not need more information to make a decision, we have up to 30 days to make a decision after we receive your request, although a small number of decisions may take longer. However, if we need more information in order to make a decision, we have up to 60 days from the date of the receipt of your request to make a decision. You will be told in writing when we make a decision.

If you have not received an answer from us within 60 days of your request, you have the right to appeal

- For a standard decision about Part C medical care or services you have not yet received

We have 14 days to make a decision after we receive your request. However, we can take up to 14 more days if you ask for additional time, or if we need more information (such as medical records) that may benefit you. If we take additional days, we will notify you in writing. If you believe that we should not take additional days, you can make a specific type of complaint called a “fast grievance”. For more information about fast grievances, see Section 4.

If you have not received an answer from us within 14 days of your request (or by the end of any extended time period), you have the right to appeal.

- For a fast decision about Part C medical care or services you have not yet received

If you receive a “fast” decision, we will give you our decision about your requested medical care or services within 72 hours after we receive the request. 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 more time to prepare for this review. If we take additional days, we will notify you in writing. If you believe that we should not take any extra days, you can file a fast grievance. We will call you as soon as we make the decision.

If we do not tell you about our decision within 72 hours (or by the end of any extended time period), you have the right to appeal. If we deny your request for a fast decision, you may file a "fast grievance." For more information about fast grievances, see Section 4.

What happens if we decide completely in your favor?

- For a decision about payment for Part C medical care or services you already received

Generally, we must send payment no later than 30 days after we receive your request, although a small number of decisions may take up to 60 days. If we need more information in order to make a decision, we have up to 60 days from the date of the receipt of your request to make payment.

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- For a standard decision about Part C medical care or services you have not yet received

We must authorize or provide your requested care within 14 days of receiving your request. If we extended the time needed to make our decision, we will authorize or provide your medical care before the extended time period expires.

- For a fast decision about Part C medical care or services you have not yet received

We must authorize or provide your requested care within 72 hours of receiving your request. If we extended the time needed to make our decision, we will authorize or provide your medical care before the extended time period expires.

What happens if we decide against you?

If we decide against you, we will send you a written decision explaining why we denied your request. If an initial determination does not give you all that you requested, you have the right to appeal the decision. (See **Appeal Level 1**.)

Appeal Level 1: Appeal to the Plan

You may ask us to review our initial determination, even if only part of our decision is not what you requested. An appeal to the plan about Part C medical care or services is also called a plan "**reconsideration**." When we receive your request to review the initial determination, we give the request to people at our organization who were not involved in making the initial determination. This helps ensure that we will give your request a fresh look.

Who may file your appeal of the initial determination?

If you are appealing an initial decision about Part C medical care or services, the rules about who may file an appeal are the same as the rules about who may ask for an organization determination. Follow the instructions under "Who may ask for an initial determination?" However, providers who do not have a contract with the Plan may also appeal a payment decision as long as the provider signs a "waiver of payment" statement saying it will not ask you to pay for the Part C medical care or service under review, regardless of the outcome of the appeal.

How soon must you file your appeal?

You must file the appeal request within 60 calendar days from the date included on the notice of our initial determination. We may give you more time if you have a good reason for missing the deadline.

How to file your appeal

1. Asking for a standard appeal

To ask for a standard appeal about a Part C medical care or service a signed, written appeal request must be sent to the address listed under **Part C Appeals** (for appeals about medical care or services) in Section 8.

You may also ask for a standard appeal by calling us at the phone number shown under **Part C Appeals** (for appeals about Part C medical care or services) in Section 8.

2. Asking for a fast appeal

If you are appealing a decision we made about giving you a Part C medical care or service that you have not received yet, you and/or your doctor will need to decide if you need a fast appeal. The rules about asking for a fast appeal are the same as the rules about asking for a fast initial determination. You, your doctor, or your representative may ask us for a fast appeal by calling, faxing, or writing us at the numbers or address listed under **Part C Appeals** (for appeals about Part C medical care or services) in Section 8.

Be sure to ask for a "fast" or "expedited" review. Remember, if your doctor provides a written or oral supporting statement explaining that you need the fast appeal, we will automatically give you a fast appeal. If you ask for a fast decision without support from a doctor, we will decide if your health requires 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 informing you that if you get a doctor's support for a fast review, we will automatically give you a fast decision. The letter will also tell you how to file a "fast grievance." You have the right to file a fast grievance if you disagree with our decision to deny your request for a fast review (for more information about fast grievances, see Section 4). If we deny your request for a fast appeal, we will give you a standard appeal.

Getting information to support your appeal

We must gather all the information we need to make a decision about your appeal. If we need your assistance in gathering this information, we will contact you or your representative. You have the right to obtain and include additional information as part of your appeal. For example, you may already have documents related to your request, or you may want to get your doctor's records or opinion to help support your request. You may need to give the doctor a written request to get information.

You may give us your additional information to support your appeal by calling, faxing, or writing us at the numbers or address listed under **Part C Appeals** (for appeals about Part C medical care or services) in Section 8.

You may also deliver additional information in person to the address listed under **Part C Appeals** (for appeals about Part C medical care or services) in Section 8.

You also have the right to ask us for a copy of information regarding your appeal. You may call or write us at the phone number or address listed under **Part C Appeals** (for appeals about Part C medical care or services) in Section 8.

How soon must we decide on your appeal?

- For a decision about payment for Part C medical care or services you already received

After we receive your appeal request, we have 60 days to decide. If we do not decide within 60 days, your appeal automatically goes to Appeal Level 2.

- For a standard decision about Part C medical care or services you have not yet received

After we receive your appeal, we have 30 days to decide, but will decide sooner if your health condition requires. However, if you ask for more time, or if we find that helpful information is missing, we can take up to 14 more days to make our decision. If we do not tell you our decision within 30 days (or by the end of the extended time period), your request will automatically go to Appeal Level 2.

- For a fast decision about Part C medical care or services you have not yet received

After we receive your appeal, we have 72 hours to decide, but will decide sooner if your health condition requires. However, if you ask for more time, or if we find that helpful information is missing, we can take up to 14 more days to make our decision. If we do not decide within 72 hours (or by the end of the extended time period), your request will automatically go to Appeal Level 2.

What happens if we decide completely in your favor?

- For a decision about payment for Part C medical care or services you already received

We must pay within 60 days of receiving your appeal request.

- For a standard decision about Part C medical care or services you have not yet received

We must authorize or provide your requested care within 30 days of receiving your appeal request. If we extended the time needed to decide your appeal, we will authorize or provide your requested care before the extended time period expires.

- For a fast decision about Part C medical care or services you have not yet received

We must authorize or provide your requested care within 72 hours of receiving your appeal request. If we extended the time needed to decide your appeal, we will authorize or provide your requested care before the extended time period expires.

Appeal Level 2: Independent Review Entity (IRE)

At the second level of appeal, your appeal is reviewed by an outside, Independent Review Entity (IRE) that has a contract with the Centers for Medicare & Medicaid Services (CMS), the government agency that runs the Medicare program. The IRE has no connection to us. You have the right to ask us for a copy of your case file that we sent to this entity.

How to file your appeal

If you asked for Part C medical care or services, or payment for Part C medical care or services, and we did not rule completely in your favor at Appeal Level 1, your appeal is automatically sent to the IRE.

How soon must the IRE decide?

The IRE has the same amount of time to make its decision as the plan had at **Appeal Level 1**.

If the IRE decides completely in your favor:

The IRE will tell you in writing about its decision and the reasons for it.

- For a decision about payment for Part C medical care or services you already received

We must pay within 30 days after we receive notice reversing our decision.

- For a standard decision about Part C medical care or services you have not yet received

We must authorize your requested Part C medical care or service within 72 hours, or provide it to you within 14 days after we receive notice reversing our decision.

- For a fast decision about Part C medical care or services

We must authorize or provide your requested Part C medical care or services within 72 hours after we receive notice reversing our decision.

Appeal Level 3: Administrative Law Judge (ALJ)

If the IRE does not rule completely in your favor, you or your representative may ask for a review by an Administrative Law Judge (ALJ) if the dollar value of the Part C medical care or service you asked for meets the minimum requirement provided in the IRE's decision. During the ALJ review, you may present evidence, review the record (by either receiving a copy of the file or accessing the file in person when feasible), and be represented by counsel.

How to file your appeal

The request must be filed with an ALJ within 60 calendar days of the date you were notified of the decision made by the IRE (Appeal Level 2). The ALJ may give you more time if you have a good reason for missing the deadline. The decision you receive from the IRE will tell you how to file this appeal, including who can file it.

The ALJ will not review your appeal if the dollar value of the requested Part C medical care or service does not meet the minimum requirement specified in the IRE's decision. If the dollar value is less than the minimum requirement, you may not appeal any further.

How soon will the Judge make a decision?

The ALJ will hear your case, weigh all of the evidence, and make a decision as soon as possible.

If the Judge decides in your favor:

See the section “**Favorable Decisions by the ALJ, MAC, or a Federal Court Judge**” below for information about what we must do if our decision denying what you asked for is reversed by an ALJ.

Appeal Level 4: Medicare Appeals Council (MAC)

If the ALJ does not rule completely in your favor, you or your representative may ask for a review by the Medicare Appeals Council (MAC).

How to file your appeal

The request must be filed with the MAC within 60 calendar days of the date you were notified of the decision made by the ALJ (Appeal Level 3). The MAC may give you more time if you have a good reason for missing the deadline. The decision you receive from the ALJ will tell you how to file this appeal, including who can file it.

How soon will the Council make a decision?

The MAC will first decide whether to review your case (it does not review every case it receives). If the MAC reviews your case, it will make a decision as soon as possible. If it decides not to review your case, you may request a review by a Federal Court Judge (see Appeal Level 5). The MAC will issue a written notice explaining any decision it makes. The notice will tell you how to request a review by a Federal Court Judge.

If the Council decides in your favor:

See the section “**Favorable Decisions by the ALJ, MAC, or a Federal Court Judge**” below for information about what we must do if our decision denying what you asked for is reversed by the MAC.

Appeal Level 5: Federal Court

You have the right to continue your appeal by asking a Federal Court Judge to review your case if the amount involved meets the minimum requirement specified in the Medicare Appeals Council's decision, you received a decision from the Medicare Appeals Council (Appeal Level 4), and:

- The decision is not completely favorable to you, or
- The decision tells you that the MAC decided not to review your appeal request.

How to file your appeal

In order to request judicial review of your case, you must file a civil action in a United States district court within 60 calendar days after the date you were notified of the decision made by the Medicare Appeals Council (Appeal Level 4). The letter you get from the Medicare Appeals Council will tell you how to request this review, including who can file the appeal.

Your appeal request will not be reviewed by a Federal Court if the dollar value of the requested Part C medical care or service does not meet the minimum requirement specified in the MAC's decision.

How soon will the Judge make a decision?

The Federal Court Judge will first decide whether to review your case. If it reviews your case, a decision will be made according to the rules established by the Federal judiciary.

If the Judge decides in your favor:

See the section “**Favorable Decisions by the ALJ, MAC, or a Federal Court Judge**” below for information about what we must do if our decision denying what you asked for is reversed by a Federal Court Judge.

If the Judge decides against you:

You may have further appeal rights in the Federal Courts. Please refer to the Judge's decision for further information about your appeal rights.

Favorable Decisions by the ALJ, MAC, or a Federal Court Judge

This section explains what we must do if our initial decision denying what you asked for is reversed by the ALJ, MAC, or a Federal Court Judge.

- For a decision about Part C medical care or services, we must pay for, authorize, or provide the medical care or service you have asked for within 60 days of the date we receive the decision.

PART 2. Complaints (appeals) if you think you are being discharged from the hospital too soon

When you are admitted to the hospital, you have the right to get all the hospital care covered by the Plan that is necessary to diagnose and treat your illness or injury. The day you leave the hospital (your discharge date) is based on when your stay in the hospital is no longer medically necessary. This part explains what to do if you believe that you are being discharged too soon.

Information you should receive during your hospital stay

Within two days of admission as an inpatient or during pre-admission, someone at the hospital must give you a notice called the Important Message from Medicare (call Member Services or 1-800-MEDICARE (1-800-633-4227) to get a sample notice or see it online at <http://www.cms.hhs.gov/BNI>). This notice explains:

- Your right to get all medically necessary hospital services paid for by the Plan (except for any applicable co-payments or deductibles).
- Your right to be involved in any decisions that the hospital, your doctor, or anyone else makes about your hospital services and who will pay for them.
- Your right to get services you need after you leave the hospital.
- Your right to appeal a discharge decision and have your hospital services paid for by us during the appeal (except for any applicable co-payments or deductibles).

You (or your representative) will be asked to sign the Important Message from Medicare to show that you received and understood this notice. **Signing the notice does not mean that you agree that the coverage for your services should end – only that you received and understand the notice.** If the hospital gives you the Important Message from Medicare more than 2 days before your discharge day, it must give you a copy of your signed Important Message from Medicare before you are scheduled to be discharged.

Review of your hospital discharge by the Quality Improvement Organization

You have the right to request a review of your discharge. You may ask a Quality Improvement Organization to review whether you are being discharged too soon.

What is the “Quality Improvement Organization”?

“QIO” stands for Quality Improvement Organization. The QIO is a group of doctors and other health care experts paid by the federal government to check on and help improve the care given to Medicare patients. They are not part of the Plan or the hospital. There is one QIO in each state. QIOs have different names, depending on which state they are in. The doctors and other health experts in the QIO review certain types of complaints made by Medicare patients. These include complaints from Medicare patients who think their hospital stay is ending too soon.

Getting the QIO to review your hospital discharge

You must quickly contact the QIO. The Important Message from Medicare gives the name and telephone number of the QIO and tells you what you must do.

- You must ask the QIO for a **“fast review”** of your discharge. This “fast review” is also called an “immediate review.”
- You must request a review from the QIO no later than the day you are scheduled to be discharged from the hospital. **If you meet this deadline, you may stay in the hospital after your discharge date without paying for it while you wait to get the decision from the QIO.**
- The QIO will look at your medical information provided to the QIO by us and the hospital
- During this process you will get a notice, called the Detailed Notice of Discharge, giving the reasons why we believe that your discharge date is medically appropriate. Call Member Services or 1-800-MEDICARE (1-800-633-4227 - TTY users should call 1-877-486-2048) to get a sample notice or see it online at <http://www.cms.hhs.gov/BNI/>.
- The QIO will decide, within one day after receiving the medical information it needs, whether it is medically appropriate for you to be discharged on the date that has been set for you.

What happens if the QIO decides in your favor?

We will continue to cover your hospital stay (except for any applicable co-payments or deductibles) for as long as it is medically necessary and you have not exceeded our Plan coverage limitations as described in Section 10.

What happens if the QIO agrees with the discharge?

You will not be responsible for paying the hospital charges until noon of the day after the QIO gives you its decision. However, you could be financially liable for any inpatient hospital services provided after noon of the day after the QIO gives you its decision. You may leave the hospital on or before that time and avoid any possible financial liability.

If you remain in the hospital, you may still ask the QIO to review its first decision if you make the request within 60 days of receiving the QIO’s first denial of your request. However, you could be

financially liable for any inpatient hospital services provided after noon of the day after the QIO gave you its first decision.

What happens if you appeal the QIO decision?

The QIO has 14 days to decide whether to uphold its original decision or agree that you should continue to receive inpatient care. If the QIO agrees that your care should continue, we must pay for or reimburse you for any care you have received since the discharge date on the Important Message from Medicare, and provide you with inpatient care (except for any applicable co-payments or deductibles) for as long as it is medically necessary and you have not exceeded our Plan coverage limitations as described in Section 10.

If the QIO upholds its original decision, you may be able to appeal its decision to an Administrative Law Judge (ALJ). Please see Appeal Level 3 in Part 1 of this section for guidance on the ALJ appeal. If the ALJ upholds the decision, you may also be able to ask for a review by the Medicare Appeals Council (MAC) or a Federal court. If any of these decision makers agree that your stay should continue, we must pay for or reimburse you for any care you have received since the discharge date, and provide you with inpatient care (except for any applicable co-payments or deductibles) for as long as it is medically necessary and you have not exceeded our Plan coverage limitations as described in Section 10.

What if you do not ask the QIO for a review by the deadline?

If you do not ask the QIO for a fast review of your discharge by the deadline, you may ask us for a “fast appeal” of your discharge, which is discussed in Part 1 of this section. If you ask us for a fast appeal of your discharge and you stay in the hospital past your discharge date, you may have to pay for the hospital care you receive past your discharge date. Whether you have to pay or not depends on the decision we make.

- If we decide, based on the fast appeal, that you need to stay in the hospital, we will continue to cover your hospital care (except for any applicable co-payments or deductibles) for as long as it is medically necessary and you have not exceeded our Plan coverage limitations as described in Section 10.
- If we decide that you should not have stayed in the hospital beyond your discharge date, we will not cover any hospital care you received after the discharge date.

If we uphold our original decision, we will forward our decision and case file to the Independent Review Entity (IRE) within 24 hours. Please see Appeal Level 2 in Part 1 of this section for guidance on the IRE appeal. If the IRE upholds our decision, you may also be able to ask for a review by an ALJ, MAC, or a Federal court. If any of these decision makers agree that your stay should continue, we must pay for or reimburse you for any care you have received since the discharge date on the notice you got from your provider, and provide you with any services you asked for (except for any applicable co-payments or deductibles) for as long as it is medically necessary and you have not exceeded our Plan coverage limitations as described in Section 10.

PART 3. Complaints (appeals) if you think coverage for your skilled nursing facility, home health agency, or comprehensive outpatient rehabilitation facility services, is ending too soon

When you are a patient in a Skilled Nursing Facility (SNF), Home Health Agency (HHA), or Comprehensive Outpatient Rehabilitation Facility (CORF), you have the right to get all the SNF, HHA or CORF care covered by the Plan that is necessary to diagnose and treat your illness or injury. The day we end coverage for your SNF, HHA or CORF services is based on when these services are no longer medically necessary. This part explains what to do if you believe that coverage for your services is ending too soon.

Information you will receive during your SNF, HHA or CORF stay

Your provider will give you written notice called the Notice of Medicare Non-Coverage at least 2 days before coverage for your services ends (call Member Services or 1-800-MEDICARE (1-800-633-4227) to get a sample notice or see it online at <http://www.cms.hhs.gov/BNI/>). You (or your representative) will be asked to sign and date this notice to show that you received it. **Signing the notice does not mean that you agree that coverage for your services should end – only that you received and understood the notice.**

Getting QIO review of our decision to end coverage

You have the right to appeal our decision to end coverage for your services. As explained in the notice you get from your provider, you may ask the Quality Improvement Organization (the “QIO”) to do an independent review of whether it is medically appropriate to end coverage for your services.

How soon do you have to ask for QIO review?

You must quickly contact the QIO. The written notice you got from your provider gives the name and telephone number of your QIO and tells you what you must do.

- If you get the notice 2 days before your coverage ends, you must contact the QIO no later than noon of the day after you get the notice.
- If you get the notice more than 2 days before your coverage ends, you must make your request no later than noon of the day before the date that your Medicare coverage ends.

What will happen during the QIO’s review?

The QIO will ask 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 QIO will also look at your medical information, talk to your doctor, and review information that we have given to the QIO. During this process, you will get a notice called the Detailed Explanation of Non-Coverage giving the reasons why we believe coverage for your services should end. Call Member Services or 1-800-MEDICARE

(1-800-633-4227 - TTY users should call 1-877-486-2048) to get a sample notice or see it online at <http://www.cms.hhs.gov/BNI/>).

The QIO will make a decision within one full day after it receives all the information it needs.

What happens if the QIO decides in your favor?

We will continue to cover your SNF, HHA or CORF services (except for any applicable co-payments or deductibles) for as long as it is medically necessary and you have not exceeded our Plan coverage limitations as described in Section 10.

What happens if the QIO agrees that your coverage should end?

You will not be responsible for paying for any SNF, HHA, or CORF services provided before the termination date on the notice you get from your provider. You may stop getting services on or before the date given on the notice and avoid any possible financial liability. If you continue receiving services, you may still ask the QIO to review its first decision if you make the request within 60 days of receiving the QIO's first denial of your request.

What happens if you appeal the QIO decision?

The QIO has 14 days to decide whether to uphold its original decision or agree that you should continue to receive services. If the QIO agrees that your services should continue, we must pay for or reimburse you for any care you have received since the termination date on the notice you got from your provider, and provide you with any services you asked for (except for any applicable co-payments or deductibles) for as long as it is medically necessary and you have not exceeded our Plan coverage limitations as described in Section 10.

If the QIO upholds its original decision, you may be able to appeal its decision to an Administrative Law Judge (ALJ). Please see Appeal Level 3 in Part 1 of this section for guidance on the ALJ appeal. If the ALJ upholds our decision, you may also be able to ask for a review by the Medicare Appeals Council (MAC) or a Federal Court. If either the MAC or Federal Court agrees that your stay should continue, we must pay for or reimburse you for any care you have received since the termination date on the notice you got from your provider, and provide you with any services you asked for (except for any applicable co-payments or deductibles) for as long as it is medically necessary and you have not exceeded our Plan coverage limitations as described in Section 10.

What if you do not ask the QIO for a review by the deadline?

If you do not ask the QIO for a review by the deadline, you may ask us for a fast appeal, which is discussed in Part 1 of this section.

If you ask us for a fast appeal of your coverage ending and you continue getting services from the SNF, HHA, or CORF, you may have to pay for the care you get after your termination date. Whether you have to pay or not depends on the decision we make.

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- If we decide, based on the fast appeal, that coverage for your services should continue, we will continue to cover your SNF, HHA, or CORF services (except for any applicable co-payments or deductibles) for as long as it is medically necessary and you have not exceeded our Plan coverage limitations as described in Section 10.
- If we decide that you should not have continued getting services, we will not cover any services you received after the termination date.

If we uphold our original decision, we will forward our decision and case file to the Independent Review Entity (IRE) within 24 hours. Please see Appeal Level 2 in Part 1 of this section for guidance on the IRE appeal. If the IRE upholds our decision, you may also be able to ask for a review by an ALJ, MAC, or a Federal court. If any of these decision makers agree that your stay should continue, we must pay for or reimburse you for any care you have received since the discharge date on the notice you got from your provider, and provide you with any services you asked for (except for any applicable co-payments or deductibles) for as long as it is medically necessary and you have not exceeded our Plan coverage limitations as described in Section 10.

6. Ending your Membership

Ending your membership in our 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 also limited situations where we are required to end your membership. For example, if you move permanently out of our geographic service area.

Voluntarily ending your membership

There are only certain times during the year when you may voluntarily end your membership in our Plan. The key time to make changes is the Medicare fall open enrollment period (also known as the “Annual Election Period”), which occurs every year from November 15 through December 31. This is the time to review your health care and drug coverage for the following year and make changes to your Medicare health or prescription drug coverage. Any changes you make during this time will be effective January 1. Certain individuals, such as those with Medicaid, those who get extra help, or who move, can make changes at other times. For more information on when you can make changes see the enrollment period table later in this section.

If you want to end your membership in our plan during this time, this is what you need to do:

- **If you are planning on enrolling in a new Medicare Advantage plan:** Simply join the new plan. You will be disenrolled from our plan when your new plan’s coverage begins on January 1.
- **If you are planning on switching to the Original Medicare Plan and joining a Medicare Prescription drug plan:** Simply join the new Medicare Prescription drug plan. You will be disenrolled automatically from our plan when your new coverage begins on January 1.
- **If you are planning on switching to the Original Medicare Plan without a Medicare Prescription drug plan:** Contact Member Services for information on how

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to request disenrollment. You may also call 1-800-MEDICARE (1-800-633-4227) to request disenrollment from our plan. TTY users should call 1-877-486-2048. Your enrollment in Original Medicare will be effective January 1.

Enrollment Period	When?	Effective Date
<p>Fall Open Enrollment (Annual Election Period)</p> <p>Time to review health and drug coverage and make changes.</p>	<p>Every year from November 15 to December 31</p>	<p>January 1</p>
<p>Medicare Advantage (MA) Open Enrollment</p> <p>MA-eligible beneficiaries can make one change to their health plan coverage. However, you cannot use this period to add, drop, or change your Medicare prescription drug coverage.</p> <p>Examples:</p> <p>If you are in a MA plan that does not have Medicare prescription drug coverage, you can switch to another Medicare Advantage plan that does not offer drug coverage or go to Original Medicare</p> <p>If you are in Original Medicare Plan and have a Medicare prescription drug plan, you can join a Medicare Advantage Plan that offers Medicare drug coverage</p> <p>If you are in an MA plan that offers Medicare drug coverage, you can leave and join Original Medicare Plan and a Medicare prescription drug plan</p>	<p>Every year from January 1 to March 31</p>	<p>First day of next month after plan receives your enrollment request</p>

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Special Enrollment Periods for limited special exceptions, such as: <ul style="list-style-type: none">• You have a change in residence• You have Medicaid• You are eligible for extra help with Medicare prescriptions• You live in an institution (such as a nursing home)	Determined by exception.	Generally, first day of next month after plan receives your enrollment request
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For more information about the options available to you during these enrollment periods, contact Medicare at 1-800-MEDICARE (1-800-633-4227.) TTY users should call 1-877-486-2048. Additional information can also be found in the “*Medicare & You*” handbook. This handbook is mailed to everyone with Medicare each fall. You may view or download a copy from www.medicare.gov - under “Search Tools,” select “Find a Medicare Publication.”

Until your membership ends, you must keep getting your Medicare services through our Plan

If you leave our Plan, it may take some time for your membership to end and your new way of getting Medicare to take effect (we discuss when the change takes effect earlier in this section). While you are waiting for your membership to end, you are still a member and must continue to get your care as usual through our Plan. If you happen to be hospitalized on the day your membership ends, generally you will be covered by our Plan until you are discharged. Call Member Services for more information and to help us coordinate with your new plan.

We cannot ask you to leave the Plan because of your health

We cannot ask you to leave your health plan for any health-related reasons. If you ever feel that you are being encouraged or asked to leave our Plan because of your health, you should call 1-800-MEDICARE (1-800-633-4227), which is the national Medicare help line. TTY users should call 1-877-486-2048. You may call 24 hours a day, 7 days a week.

Involuntarily ending your membership

If any of the following situations occur, we will end your membership in our Plan.

- If you do not stay continuously enrolled in Medicare A and B
- If you move out of the service area or are away from the service area for more than 6 months you cannot remain a member of our Plan. And we must end your membership

(“disenroll” you)”. If you plan to move or take a long trip, please call Member Services to find out if the place you are moving to or traveling to is in our Plan’s service area.

- If you intentionally give us incorrect information on your enrollment request that would affect your eligibility to enroll in our Plan
- If you behave in a way that is disruptive, to the extent that you continued enrollment seriously impairs our ability to arrange or provide medical care for you or for others who are members of our Plan. We cannot make you leave our Plan for this reason unless we get permission first from Medicare.
- If you let someone else use your plan identification card to get medical care. If you are disenrolled for this reason, CMS may refer your case to the Inspector General for additional investigation.
- If you do not pay the Plan premiums, we will tell you in writing that you have a 30-day grace period during which you may pay the Plan premiums before your membership ends

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 will tell you our reasons in writing and explain how you may file a complaint against us if you want to.

7. Definitions of Important Words Used in the EOC

Appeal – An appeal is a special kind of complaint you make if you disagree with a decision to deny a request for health care services or payment for services you already received. You may also make a complaint 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 an item/service you think you should be able to receive. Section 5 explains appeals, including the process involved in making an appeal.

Benefit period – For the Original Medicare Plan, a benefit period is used to determine coverage for inpatient stays in hospitals and skilled nursing facilities. 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. For our Plan, there is no limit to the number of days covered for each benefit period for inpatient hospital admissions. However, we adhere to the Medicare benefit for Skilled Nursing facilities.

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.

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Centers for Medicare & Medicaid Services (CMS) – The Federal agency that runs the Medicare program. Section 8 explains how to contact CMS.

Cost-sharing – Cost-sharing refers to amounts that a member has to pay when services are received. It includes any combination of the following three types of payments: (1) any deductible amount a plan may impose before services are covered; (2) any fixed “co-payment” amounts that a plan may require be paid when specific services are received; or (3) any “coinsurance” amount that must be paid as a percentage of the total amount paid for a service.

Covered services – The general term we use in this EOC to mean all of the health care services and supplies that are covered by our Plan.

Creditable Prescription Drug Coverage – Coverage (for example, from an employer or union) that is at least as good as Medicare’s prescription drug coverage.

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.

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). Section 6 discusses disenrollment.

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) and Disclosure Information – This document, along with your enrollment form and any other attachments, riders, or other optional coverage selected, which explains your coverage, what we must do, your rights, and what you have to do as a member of our Plan.

Grievance – A type of complaint you make about us or one of our network providers, including a complaint concerning the quality of your care. This type of complaint does not involve coverage or payment disputes. See Section 4 for more information about grievances.

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

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Section 10 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 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. TTY users should call 1-877-486-2048)

Inpatient Care – Health care that you get when you are admitted to a hospital.

Medically Necessary – 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. A 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 plan in the same service area. A Medicare Advantage Plan can be an HMO, PPO, 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 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 the Original Medicare Plan coverage. Medigap policies only work with the Original Medicare Plan. (A Medicare Advantage plan is not a Medigap policy.)

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Member (member of our Plan, or “plan member”) – A person with Medicare who is eligible to get covered services, who has enrolled in our Plan and whose enrollment has been confirmed by the Centers for Medicare & Medicaid Services (CMS).

Member Services – A department within our Plan responsible for answering your questions about your membership, benefits, grievances, and appeals. See Section 8 for information about how to contact Member Services.

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 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 MA services or payment that you believe you should receive.

Original Medicare Plan – (“Traditional Medicare” or “Fee-for-service” Medicare) The Original Medicare Plan is the way many people get their health care coverage. It is the national pay-per-visit program that lets you go to 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. Using out-of-network providers or facilities is explained in this EOC in Section 2.

Part C – see “Medicare Advantage (MA) Plan”

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. Section 2 tells more about PCPs.

Preferred Provider Organization Plan – A Preferred Provider Organization plan is an MA plan that has a network of contracted providers that have agreed to treat plan members for a specified

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payment amount. A PPO plan must cover all plan benefits whether they are received from network or out-of-network providers. Member cost-sharing may be higher when plan benefits are received from out-of-network providers.

Prior Authorization – Approval in advance to get services. In an HMO with a referral model, some in-network services are covered only if your doctor or other network provider gets “prior authorization” from our Plan. Covered services that need prior authorization are marked in the Benefits Chart in Section 10.

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 Section 8 for information about how to contact the QIO in your state and Section 5 for information about making complaints to the QIO.

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.

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.

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.

Urgently Needed Care – Section 2 explains about “urgently needed” services. These are different from emergency services.

8. Helpful Phone Numbers and Resources

Contact Information for our Plan Member Services

If you have any questions or concerns, please call or write to our Plan Member Services. We will be happy to help you.

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- CALL** (253) 779-8830 or
1-866-789-PSHP (7747) Calls to this number are free.
Sunday, Monday, Tuesday, Wednesday, Thursday, Friday, Saturday
8 a.m. – 8 p.m. Pacific Standard Time.
- TTY/TDD** 1-866-264-4141 Calls to this number are free.
Sunday, Monday, Tuesday, Wednesday, Thursday, Friday, Saturday
8 a.m. – 8 p.m. Pacific Standard Time.
This number requires special telephone equipment.
- FAX** (253) 779-8829 or (253) 284-5693
- WRITE** Puget Sound Health Partners
PO Box 99948
Lakewood, WA 98496
- VISIT** Puget Sound Health Partners
7502 Lakewood Dr. W., Suite A
Lakewood, WA 98499
- WEBSITE** www.OurPSHP.com

Contact Information for Grievances, Organizations Determinations, Coverage Determinations and Appeals

- CALL** (253) 779-8830 or
1-866-789-PSHP (7747) Calls to this number are free.
Sunday, Monday, Tuesday, Wednesday, Thursday, Friday, Saturday
8 a.m. – 8 p.m. Pacific Standard Time.
- TTY/TDD** 1-866-264-4141 Calls to this number are free.
Sunday, Monday, Tuesday, Wednesday, Thursday, Friday, Saturday
8 a.m. – 8 p.m. Pacific Standard Time.
This number requires special telephone equipment.
- FAX** (253) 779-8829 or (253) 284-5693
- WRITE** Puget Sound Health Partners
PO Box 99948
Lakewood, WA 98496
- VISIT** Puget Sound Health Partners
7502 Lakewood Dr. W., Suite A
Lakewood, WA 98499
- WEBSITE** www.OurPSHP.com

Other important contacts

Below is a list of other important contacts. For the most up-to-date contact information, check your *Medicare & You* Handbook, visit www.medicare.gov and choose “Find Helpful Phone Numbers and Resources,” or call 1-800-Medicare (1-800-633-4227). TTY users should call 1-877-486-2048.

Qualis Health/Quality Improvement Organization

“QIO” stands for Quality Improvement Organization. The QIO is a group of doctors and health professionals in your state that reviews medical care and handles certain types of complaints from patients with Medicare, and is paid by the federal government to check on and help improve the care given to Medicare patients. There is a QIO in each state. QIOs have different names, depending on which state they are in. The doctors and other health experts in the QIO review certain types of complaints made by Medicare patients. These include complaints about quality of care and appeals filed by Medicare patients who think the coverage for their hospital, skilled nursing facility, home health agency, or comprehensive outpatient rehabilitation stay is ending too soon. See Sections 4 and 5 for more information about complaints, appeals and grievances.

You may contact Qualis Health toll free at 1-877-290-4346 or write to:

Qualis Health
PO Box 33400
Seattle, WA 98133-0400

How to contact the Medicare program

Medicare is the Federal health insurance program for people 65 years of age or older, some people under age 65 with certain disabilities, and people with End-Stage Renal Disease (generally those with permanent kidney failure who need dialysis or a kidney transplant). Our organization contracts with the federal government.

- Call 1-800-MEDICARE (1-800-633-4227) to ask questions or get free information booklets from Medicare 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048. Customer service representatives are available 24 hours a day, including weekends.
- Visit www.medicare.gov for information. This is the official government website for Medicare. This website gives you up-to-date information about Medicare and nursing homes and other current Medicare issues. It includes booklets you can print directly from your computer. It has tools to help you compare Medicare Advantage Plans and Medicare Prescription Drug Plans in your area. You can also search under “Search Tools” for Medicare contacts in your state. Select “Helpful 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 website using its computer.

Medicaid

Medicaid is a state government program that helps with medical costs for some people with limited incomes and resources. Some people with Medicare are also eligible for Medicaid. Medicaid 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:

Washington State Department of Social & Health Services
Customer Service Center
PO Box 45505
Olympia, WA 98504-5505

Social Security

Social Security programs include retirement benefits, disability benefits, family benefits, survivors' benefits, and benefits for the aged and blind. You may call Social Security at 1-800-772-1213. TTY users should call 1-800-325-0778. You may also visit www.ssa.gov on the Web.

Railroad Retirement Board

If you get benefits from the Railroad Retirement Board, you may call your local Railroad Retirement Board office or 1-800-808-0772. TTY users should call 312-751-4701. You may also visit www.rrb.gov on the Web.

Employer (or "Group") Coverage

If you get, or your spouse gets, benefits from your current or former employer or union, or from your spouse's current or former employer or union, call the employer/union benefits administrator or Member Services if you have any questions about your employer/union benefits, plan premiums, or the open enrollment season. Important Note: You (or your spouse's) employer/union benefits may change, or you (or your spouse) may lose the benefits, if you enroll in Medicare Part D. Call your employer/union benefits administrator or Member Services to find out whether the benefits will change or be terminated if you or your spouse enrolls in Part D.9. Legal Notices

9. Legal Notices

Notice about governing law

Many laws apply to this Evidence of Coverage and some additional provisions may apply because they are required by law. This may affect your rights and responsibilities even if the laws are not included or explained in this document. The principal law that applies to this document is Title XVIII of the Social Security Act and the regulations created under the Social Security Act by the

2009 Evidence of Coverage

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.

Notice about nondiscrimination

We don't discriminate based on a person's race, disability, religion, sex, sexual orientation, 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.

Third Party Liability

If you are injured through the actions of a third party and are entitled to recovery from the third party or as a result of your injury for medical expenses, you are obligated to reimburse Puget Sound Health Partners for the reasonable value of the medical services received as a result of your injury. Puget Sound Health Partners will coordinate benefits when you are entitled to worker's compensation, automobile medical, no-fault or liability insurance policy, or an employer group health plan.

If automobile medical, no-fault or liability insurance is available to you, then benefits under that plan must be used first. Puget Sound Health Partners will pay only as secondary payer of benefits regardless of whether or not a claim is made to the primary payer.

Payment of funds may be made directly between insurance and other providers of benefits. If benefits are provided in the form of service rather than cash payments, the reasonable cash value of each service rendered should be deemed both an allowable expense and a benefit paid.

None of the rules as to coordination of benefits will serve as a barrier to you receiving covered services from Puget Sound Health Partners providers. In the case of injuries caused by an act or omission of a third party, and complications incident to that act, Puget Sound Health Partners will arrange for the provision of covered services and other benefits. You must notify Puget Sound Health Partners when there is a possibility that a third party may be liable for the injuries. Puget Sound Health Partners will have a first-party lien against any such accident-related settlement, even if the settlement does not specifically include payment for medical costs. Upon settlement, Puget Sound Health Partners will be reimbursed at the prevailing rates for the cost of services and benefits provided as a result of the injury. In the event the third party does not satisfy Puget Sound Health Partners lien by direct payment, you agree to reimburse Puget Sound Health Partners any amounts it has paid in connection with treatment of the injury or any complications, but not to exceed the amount of the recovery.

If you incur health care expenses for treatment of the illness or injury after receiving a recovery, we will exclude benefits for otherwise covered expenses until the total amount of health care expenses incurred after coverage exceeds the net recovery amount.

You must agree to cooperate in protecting the interests of Puget Sound Health Partners under this provision and to execute and deliver to Puget Sound Health Partners, or its nominee, any and all assignments or other documents that may be necessary or proper to fully and completely carry out and protect the rights of Puget Sound Health Partners or its nominee.

10. How Much You Pay for Your Part C Medical Benefits

Your Monthly Premium for Our Plan

Your monthly premium for our Plan is:

Plan Name	Partners Charter
Service Area	King, Pierce, Snohomish and Thurston Counties
Premium	\$0

If you signed up for extra benefits, also called “optional supplemental benefits”, then you pay an additional premium each month for these extra benefits. If you have any questions about your Plan premiums or the payment programs, please call Member Services.

If you get your benefits from your current or former employer, or from your spouse’s current or former employer, call the employer’s benefits administrator for information about your Plan premium.

You can find more information about paying your plan premium in Section 1.

How Much You Pay for Part C Medical Benefits

This section has a Benefits Chart that gives a list of your covered services and tells what you must pay for each covered service. These are the benefits and coverage you get as a member of our Plan. Later in this section under “General Exclusions” you can find information about services that are not covered. It also tells about limitations on certain services. You may find additional information about Optional Supplemental dental benefits in the document titled “Schedule of Covered Services and Co-payments”.

What do you pay for covered services?

- Co-payments or coinsurance are the amounts you pay for covered services.
- A **“co-payment”** is a payment you make for your share of the cost of certain covered services you receive. A co-payment is a set amount per service. You pay it when you get the service.
- **“Coinsurance”** is a payment you make for your share of the cost of certain covered services you receive. Coinsurance is a percentage of the cost of the service. You pay your coinsurance when you get the service. Coinsurance is calculated as a percentage of the allowed amount for a specific service.
- Depending on your Medicaid benefit, you may not have to pay out-of-pocket costs for premiums, co-payments and coinsurances. These costs may be covered by Medicaid, as long as you qualify for Medicaid benefits and the provider accepts Medicaid. The only exception is that you are responsible for your covered health care services coinsurance or co-payments your Medicaid co-payments, if applicable.

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

There is a limit to how much you have to pay out-of-pocket for covered health care services each year. Our plan out-of-pocket applies to all covered Part C services. The out-of-pocket maximum for the Partners Charter is \$2,750 per year.

Benefits Chart

The benefits chart on the following pages lists the services our Plan covers and what you pay for each service. The benefits chart lists information for more than one of our Plans. The name of the plan you are in is listed on the front page of this packet. If you aren't sure which plan you are in or if you have any questions, call Member Services. The covered services listed in the Benefits Chart in this section are covered only when all requirements listed below are met:

- Services must be provided according to the Medicare coverage guidelines established by the Medicare Program
- The medical care, services, supplies, and equipment that are listed as covered services must be medically necessary. Certain preventive care and screening tests are also covered.
- Some of the covered services listed in the Benefits Chart are covered only if your doctor or other network provider gets “prior authorization” (approval in advance) from our Plan. Covered services that need prior authorization are marked in the Benefits Chart by an asterisk

See Section 2 for information on requirements for using network providers.

Benefits chart – your covered services

What you must pay when you get these covered services

Inpatient Services

Inpatient hospital care *

For more information about inpatient hospital care, see Section 2.

No limit to the number of consecutive days covered by the Plan each benefit period.

Except in an emergency your doctor must tell the Plan that you are going to be admitted to the hospital.

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 up to a daily limit of \$500 and not to exceed \$10,000 per year.
- Blood – including storage and administration. Coverage of whole blood, packed red cells and other

In-Network:

For Medicare-covered hospital stays:

Days 1 – 10: \$250 co-payment per day for each admission

Days 11 – 90: \$0 co-payment per day for each admission

For additional hospital days:

Days 91 – 100: \$250 co-payment per day for each admission

Days 101 and beyond: \$0 co-payment per day for each admission

If you get inpatient care at a non-plan hospital after your emergency condition is stabilized, your cost is the highest cost-sharing you would pay at a plan hospital.

Benefits chart – your covered services

What you must pay when you get these covered services

components of blood begin with the first pint of blood used. Physician Services

Inpatient mental health care *

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

You get up to 190-days in a Psychiatric Hospital in a lifetime. The 190-day limit does not apply to Mental Health services provided in a psychiatric unit of a general hospital.

Except in an emergency, your doctor must tell the Plan that you are going to be admitted to the hospital.

In-Network:

For hospital stays:

Days 1 – 10: \$250 co-payment per day for each admission
Days 11 – 90: \$0 co-payment per day for each admission

Plan covers 60 lifetime reserve days.
Cost per lifetime reserve day:

Days 1 – 10: \$250 co-payment per day for each admission

Days 11 – 60: \$0 co-payment per day for each admission

Skilled nursing facility (SNF) care *

For more information about skilled nursing facility care, see Section 2.

100 days covered for each benefit period. No prior hospital stay is required.

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, packed red cells and other

In Network:

For SNF Stays:

Days 1 – 100: \$150 co-payment per day for each admission

Benefits chart – your covered services

What you must pay when you get these covered services

components of blood begin with the first pint of blood used. Medical and surgical supplies ordinarily provided by SNFs

- Laboratory tests ordinarily provided by SNFs
- X-rays and other radiology services ordinarily provided by SNFs
- Use of appliances such as wheelchairs ordinarily provided by SNFs
- Physician services

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 are not, or are no longer, covered \$0 co-payment

Services are subject to same prior authorization requirements as services provided in non-SNF or hospital settings.

Covered services include:

- Physician services
- Tests (like X-ray or lab tests)
- X-ray, radium, and isotope therapy including technician materials and services
- Surgical dressings, splints, casts and other devices used to reduce fractures and dislocations
- 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

Benefits chart – your covered services

What you must pay when you get these covered services

- 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
- Physical therapy, speech therapy, and occupational therapy

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 less than eight hours per day and 35 or fewer hours per week)
- Physical therapy, occupational therapy, and speech therapy
- Medical social services
- Medical equipment and supplies

In-Network:

\$0 co-payment for Medicare-covered home health visits.

Hospice care

You may receive care from any Medicare-certified hospice program. The Original Medicare Plan (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. Covered services include:

- Drugs for symptom control and pain relief, short-term respite care, and other services not otherwise covered by the Original Medicare Plan
- Home care
Our Plan covers hospice consultation services (one time only) for a terminally ill person who hasn't elected the hospice benefit.

When you enroll in a Medicare-certified Hospice program, your hospice services are paid for by the Original Medicare Plan, not your Medicare Advantage plan.

Benefits chart – your covered services

What you must pay when you get these covered services

Outpatient Services

Physician services, including doctor office visits

Covered services include:

- Office visits, including medical and surgical care in a physician’s office or certified ambulatory surgical center
- Consultation, diagnosis, and treatment by a specialist
- Hearing and balance exams, if your doctor orders it to see if you need medical treatment.
- Telehealth office visits including consultation, diagnosis and treatment by a specialist
- Second opinion by another network provider prior to surgery
- Outpatient hospital services
- 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)

In-Network:

\$10 co-payment for each PCP office visit for Medicare-covered benefits.

\$30 co-payment for each visit to see a specialist for Medicare-covered benefits.

See “Physical Exams” for more information.

Chiropractic services

Covered services include:

- Manual manipulation of the spine to correct subluxation
- Up to 20 visits per year for medically necessary routine chiropractic care (20 visit limit includes any combination of routine chiropractic care or acupuncture)

In-Network:

\$25 co-payment for each Medicare-covered service.

\$25 co-payment for each medically necessary routine chiropractic visit

Benefits chart – your covered services

What you must pay when you get these covered services

Podiatry services

Covered services include:

- Treatment of injuries and diseases of the feet (such as hammer toe or heel spurs).
- Routine foot care for members with certain medical conditions affecting the lower limbs.

In-Network:

\$30 co-payment for each visit for Medicare-covered benefits.

\$10 co-payment for each visit for diabetic foot care

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. “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.

In-Network:

\$30 co-payment for each Medicare-covered individual or group therapy visit.

Outpatient substance abuse services

In-Network:

\$30 co-payment for each Medicare-covered individual or group therapy visit.

Outpatient surgery (including services provided at ambulatory surgical centers)

In-Network:

\$200 co-payment for each outpatient surgery or procedure in an outpatient hospital, ambulatory surgery center, or endoscopy center.

\$30 co-payment for outpatient clinic services including infusion clinic, dialysis, pain clinic, wound clinic, chemotherapy administration (excluding chemotherapy drugs)

Benefits chart – your covered services

What you must pay when you get these covered services

Ambulance services

Covered ambulance services include fixed wing, rotary wing, and ground ambulance services, to the nearest appropriate facility that can provide care only if they are furnished to a member whose medical condition is such that other means of transportation 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.

\$150 co-payment for each one-way Medicare-covered ambulance benefit.

If you are admitted to the hospital, you pay \$0 co-payment for the Medicare-covered ambulance benefit.

Emergency care

For more information, see Section 2.

You may go to any emergency room worldwide if you reasonably believe you need emergency care.

\$50 co-payment for Medicare-covered emergency room visits.

\$50 co-payment for emergency room services worldwide.

If you are admitted to the hospital within 24 hours for the same condition, you pay \$0 co-payment for the emergency room visit.

If you need inpatient care at a non-plan hospital after your emergency condition is stabilized, you must have your inpatient care at the non-plan hospital authorized by the plan and your cost is the cost-sharing you would pay at a plan hospital.

Benefits chart – your covered services

What you must pay when you get these covered services

Urgently needed care

For more information, see Section 2. This coverage is within the United States.

\$30 co-payment for Medicare-covered urgent care visits.

If you are admitted to a hospital within 24 hours for the same condition, you pay \$0 co-payment for the urgent care visit.

Outpatient rehabilitation services *

Covered services include: physical therapy, occupational therapy, speech language therapy, and cardiac rehabilitative therapy

In-Network:

\$0 co-payment for visits 1-5 for Medicare-covered occupational therapy, physical therapy, speech language therapy and cardiac rehabilitative therapy visits.

\$30 co-payment for additional visits.

Durable medical equipment and related supplies *

Covered items include: wheelchairs, crutches, hospital bed, IV infusion pump, oxygen equipment, nebulizer, and walker. (See definition of “durable medical equipment” in Section 7.)

In-Network:

20% of the cost for Medicare-covered items.

Prosthetic devices and related supplies * –

(other than dental) that replace a body part or function. These include colostomy bags and supplies directly related to colostomy care, pacemakers, braces, prosthetic shoes, artificial limbs, and breast prostheses (including a surgical brassiere after a mastectomy). Includes certain supplies related to prosthetic devices, and repair and/or replacement of prosthetic devices. Also includes some coverage following cataract removal or cataract surgery – see “Vision Care” later in this section for more detail.

In-Network:

20% of the cost for Medicare-covered items.

Benefits chart – your covered services

What you must pay when you get these covered services

Diabetes self-monitoring, training and supplies – for all people who have diabetes (insulin and non-insulin users). Covered services include:

- Blood glucose monitor, blood glucose test strips, lancet devices and lancets, and glucose-control solutions for checking the accuracy of test strips and monitors
- One pair per calendar year of therapeutic shoes for people with diabetes who have severe diabetic foot disease, including fitting of shoes or inserts
- Self-management training is covered under certain conditions
- For persons at risk of diabetes: Fasting plasma glucose tests on an annual basis.

In-Network:

\$0 co-payment for diabetes self-monitoring training.

\$0 co-payment for diabetes supplies.

Medical nutrition therapy – for people with diabetes, renal (kidney) disease (but not on dialysis), and after a transplant when referred by your doctor.

\$10 co-payment

Outpatient diagnostic tests and therapeutic services and supplies

Covered services include:

- X-rays
- Radiation therapy *
- Surgical supplies, such as dressings
- Supplies, such as splints and casts
- Laboratory tests
- Blood - Coverage of whole blood, packed red cells and other components of blood begin with the first pint of blood used.
- Other outpatient diagnostic tests *

In-Network:

\$0 co-payment for Medicare-covered:

- Lab services
- Diagnostic procedures and tests
- X-rays
- Surgical supplies
- Blood
- Radiation therapy*

\$100 co-payment for the following diagnostic radiology services:

- CT Scans
- PET Scans *
- Nuclear Medicine
- MRI/MRA *

Benefits chart – your covered services

What you must pay when you get these covered services

Vision 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: glaucoma screening once per year
- 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.
- One annual routine eye exam

In-Network:

\$30 co-payment for each Medicare covered eye exam.

\$0 co-payment for each Medicare-covered pair of eyeglasses or contact lenses after each cataract surgery up to the Medicare allowable.

\$30 co-payment for one annual routine eye exam.

Preventive Care and Screening Tests

Abdominal Aortic Aneurysm Screening

A one-time screening ultrasound for people at risk.

\$0 co-payment

Bone-mass measurements

For qualified individuals (generally, this means people at risk of losing bone mass or at risk of osteoporosis), the following services are covered every 2 years 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.

\$0 co-payment for Medicare-covered Bone-mass measurement.

Colorectal screening

For people 50 and older, the following are covered:

- Flexible sigmoidoscopy (or screening barium enema as an alternative) every 48 months
- Fecal occult blood test, every 12 months

For people at high risk of colorectal cancer, we cover:

- Screening colonoscopy (or screening barium enema as an alternative) every 24 months

\$0 co-payment for Medicare-covered colorectal screenings.

Benefits chart – your covered services

What you must pay when you get these covered services

For people not at high risk of colorectal cancer, we cover:

- Screening colonoscopy every 10 years, but not within 48 months of a screening sigmoidoscopy

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 (i.e. Zostavax) under our outpatient (Part D) prescription drug benefit.

\$0 co-payment for Flu, Pneumonia and Hepatitis B vaccines.

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
- 1 additional screening mammogram every year.

\$0 co-payment for screening mammograms

Pap tests, pelvic exams, and clinical breast exam

Covered services include:

- For all women, Pap tests, pelvic exams, and clinical breast exams are covered once every 24 months
- If you are at high risk of cervical cancer or have had an abnormal Pap test and are of childbearing age: one Pap test every 12 months
- Up to one additional screening pap smear and pelvic exam per year

\$0 co-payment for screening pap smears and pelvic exams

Benefits chart – your covered services

What you must pay when you get these covered services

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

\$0 co-payment for Medicare-covered prostate cancer screening

Cardiovascular disease testing

Blood tests for the detection of cardiovascular disease (or abnormalities associated with an elevated risk of cardiovascular disease) annually.

\$0 co-payment

Physical exams

Limited to 1 physical exam every year.

In-Network:

\$10 co-payment for routine physical exams

Other Services

Dialysis (Kidney) *

Covered services include:

- Outpatient dialysis treatments (including dialysis treatments when temporarily out of the service area, as explained in Section 2)
- Inpatient dialysis treatments (if you are admitted to a hospital for special care)
- Self-dialysis training (includes training for you and anyone helping you with your home dialysis treatments)
- Home dialysis equipment and supplies
- Certain home support services (such as, when necessary, visits by trained dialysis workers to check on your home dialysis, to help in emergencies, and check your dialysis equipment and water supply)

\$30 co-payment for in and out of area dialysis.

\$10 co-payment for nutritional therapy for renal disease.

Benefits chart – your covered services

What you must pay when you get these covered services

Medicare Part B Prescription Drugs *

These drugs are covered under Part B of the Original Medicare Plan. 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 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 your organ transplant
- Injectable osteoporosis drugs, if you are homebound, have a bone fracture that a doctor certifies was related to post-menopausal osteoporosis, and cannot self-administer the drug
- Antigens
- Certain oral anti-cancer drugs and anti-nausea drugs
- Certain drugs for home dialysis, including heparin, the antidote for heparin when medically necessary, topical anesthetics, and erythropoiesis-stimulating agents (such as Epogen, Procrit, Epoetin Alfa, Aranesp, or Darbepoetin Alfa)
- Intravenous Immune Globulin for the home treatment of primary immune deficiency diseases

10% of the cost of Part B covered drugs.

10% of the cost of Part B covered chemotherapy drugs.

Section 2 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 later in this section.

Additional Benefits

Hearing Services

- Diagnostic hearing exams
- One routine hearing exams per year

\$0 co-payment for diagnostic hearing exams provided by a Newport Audiology provider.

\$30 co-payment for diagnostic

Benefits chart – your covered services

What you must pay when you get these covered services

hearing exams provided by a network provider.

\$0 co-payment for a routine hearing exam provided by a Newport Audiology provider.

\$30 co-payment for a routine hearing exam provided by a network provider.

Vision care

Covered services include:
One annual routine eye exam

In-Network:

\$30 co-payment for up to one routine eye exam per year

Routine Transportation

Covered services include:
Up to 20, one-way trips per year to plan approved locations

\$0 co-payment

Acupuncture & Routine Chiropractic

Covered services include:
Plan covers up to 20 combined visits per year for medically necessary acupuncture and/or routine chiropractic care

\$25 co-payment per medically necessary visit

Optional Supplemental Package #1 – SmartSmile Dental Plan: You pay \$17.50 monthly premium in addition to your monthly plan premium and the monthly Medicare Part B Premium. Services must be provided by a Dental Health Services Participating Provider. See Schedule of Covered Services and Co-payments for additional detail.

Diagnostic & Preventive Services

- Office Visit
- Cleanings (up to 2 per year)
- Fluoride Treatments
- Oral Exams

\$10 co-payment per office visit
\$20 co-payment for adult cleanings
\$5 co-payment for fluoride

Benefits chart – your covered services

What you must pay when you get
these covered services

<ul style="list-style-type: none"> • X-Rays (once every 3 years) 	<p>treatments (topical application) \$5 co-payment for comprehensive oral exams \$25 co-payment for x-rays (complete series)</p>
Restorative Services	\$15 to \$400 co-payment for covered restorative services
Endodontics	\$35 to \$590 co-payment for covered endodontic services
Periodontics	\$42 to \$590 co-payment for covered periodontal services

Optional Supplemental Package #2 – Super SmartSmile Dental Plan: You pay \$21.95 monthly premium in addition to your monthly plan premium and the monthly Medicare Part B premium. Services must be provided by a Dental Health Services Participating Provider. See Schedule of Covered Services and Co-payments for additional detail.

<p>Diagnostic & Preventive Services</p> <ul style="list-style-type: none"> • Office Visit • Cleanings (up to 2 per year) • Fluoride Treatments • Oral Exams • X-Rays (once every 3 years) 	<p>\$7 co-payment per office visit \$12 co-payment for adult cleanings \$5 co-payment for fluoride treatments (topical application) \$5 co-payment for comprehensive oral exams \$20 co-payment for x-rays (complete series)</p>
Restorative Services	\$15 to \$400 co-payment for covered restorative services
Endodontics	\$30 to \$650 co-payment for covered endodontic services
Periodontics	\$40 to \$500 co-payment for covered periodontal services

General Exclusions

Introduction

The purpose of this part of Section 10 is to tell you about medical care and services, items, and drugs that aren't covered ("are excluded") or are limited by our Plan. The list below tells about these exclusions and limitations. The list describes services, items, and drugs that aren't covered under any conditions, and some services that are covered only under specific conditions. (The Benefits Chart earlier also explains about some restrictions or limitations that apply to certain services).

If you get services, items that are not covered, you must pay for them yourself

We won't pay for the exclusions that are listed in this section (or elsewhere in this EOC), and neither will the Original Medicare Plan, unless they are found upon appeal to be that we should have paid or covered (appeals are discussed in Section 5).

What services are not covered or are limited by our Plan?

In addition to any exclusions or limitations described in the Benefits Chart, or anywhere else in this EOC or the Schedule of Covered Services and Co-payments for Optional Supplemental Dental Benefits, **the following items and services aren't covered under the Original Medicare Plan or by our plan:**

1. Services that are not reasonable and necessary, according to the standards of the Original Medicare Plan, unless these services are otherwise listed by our Plan as a covered service
2. Experimental or investigational medical and surgical procedures, equipment and medications, unless covered by the Original Medicare Plan or unless, for certain services, the procedures are covered under an approved clinical trial. The Centers for Medicare and Medicaid Services (CMS) will continue to pay through Original Medicare for clinical trial items and services covered under the September 2000 National Coverage Determination that are provided to plan members. Experimental procedures and items are those items and procedures determined by our Plan and the Original Medicare Plan to not be generally accepted by the medical community.
3. Surgical treatment of morbid obesity unless medically necessary and covered under the Original Medicare plan
4. Private room in a hospital, unless medically necessary
5. Private duty nurses
6. Personal convenience items, such as a telephone or television in your room at a hospital or skilled nursing facility
7. Nursing care on a full-time basis in your home
8. Custodial care unless it is provided in conjunction with covered skilled nursing care and/or skilled rehabilitation services. This includes care that helps people with activities of daily living

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like walking, getting in and out of bed, bathing, dressing, eating and using the bathroom, preparation of special diets, and supervision of medication that is usually self-administered.

9. Homemaker services
10. Charges imposed by immediate relatives or members of your household
11. Meals delivered to your home
12. Elective or voluntary enhancement procedures, services, supplies and medications including but not limited to: Weight loss, hair growth, sexual performance, athletic performance, cosmetic purposes, anti-aging and mental performance unless medically necessary
13. Cosmetic surgery or procedures, unless needed because of accidental injury or to improve the function of a malformed part of the body. All stages of reconstruction are covered for a breast after a mastectomy, as well as for the unaffected breast to produce a symmetrical appearance.
14. Routine dental care (such as cleanings, fillings, or dentures) or other dental services. However, non-routine dental services received at a hospital may be covered. And routine dental care is available under Optional Supplemental Benefit Plans.
15. Chiropractic care is generally not covered under the Plan, (with the exception of manual manipulation of the spine,) and is limited according to Medicare guidelines
16. Routine foot care is generally not covered under the Plan and is limited according to Medicare guidelines
17. Orthopedic shoes unless they are part of a leg brace and are included in the cost of the brace. Exception: Therapeutic shoes are covered for people with diabetic foot disease
18. Supportive devices for the feet. Exception: Orthopedic or therapeutic shoes are covered for people with diabetic foot disease
19. Hearing aids
20. Eyeglasses (except after cataract surgery) and beyond \$100 allowance every two years, radial keratotomy, refractive keratoplasty, LASIK surgery, vision therapy and other low vision aids and services
21. Self-administered prescription medication for the treatment of sexual dysfunction, including erectile dysfunction, impotence, and anorgasmia or hyporgasmia, except as specified in the formulary
22. Reversal of sterilization procedures, sex change operations, and non-prescription contraceptive supplies and devices
23. Naturopath services
24. Services provided to veterans in Veterans Affairs (VA) facilities. However, in the case of emergency services received at a VA hospital, if the VA cost-sharing is more than the cost-sharing required under our Plan, we will reimburse veterans for the difference. Members are still responsible for our Plan cost-sharing amount.
25. Any of the 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.

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