BlueCross BlueShield of Georgia

SHBP State Health Benefit Plan

Blue Cross and Blue Shield of Georgia

Medicare Preferred (PPO) Standard with Senior Rx Plus

EVIDENCE OF COVERAGE

This booklet is your Evidence of Coverage (EOC). For questions regarding your coverage please call Customer Service, Monday through Friday, from 8 a.m. to 8 p.m. ET, at 1-855-322-7062. TTY/TDD users can call 711.

Y0071_14_17573_I_010 07/08/2013

State Health Benefit Plan of Georgia
Medicare Part B Only

H9947 805

Multi-language Interpreter Services

English: We have free interpreter services to answer any questions you may have about our health or drug plan. To get an interpreter, just call us at 1-855-322-7062 Someone who speaks English/Language can help you. This is a free service.

Spanish: Tenemos servicios de intérprete sin costo alguno para responder cualquier pregunta que pueda tener sobre nuestro plan de salud o medicamentos. Para hablar con un intérprete, por favor llame al 1-855-322-7062. Alguien que hable español le podrá ayudar. Este es un servicio gratuito.

Chinese Mandarin: 我们提供免费的翻译服务，帮助您解答关于健康或药物保险的任何疑问。如果您需要此翻译服务，请致电 1-855-322-7062。我们的中文工作人员很乐意帮助您。这是一项免费服务。

Chinese Cantonese: 您對我們的健康或藥物保險可能存有疑問，為此我們提供免費的翻譯服務。如需翻譯服務，請致電 1-855-322-7062。我們講中文的人員將樂意為您提供幫助。這是一項免費服務。

Tagalog: Mayroon kaming libreng serbisyo sa pagsasaling-wika upang masagot ang anumang mga katanungan ninyo hinggil sa aming planong pangkalusugan o panggamot. Upang makakuha ng tagasaling-wika, tawagan lamang kami sa 1-855-322-7062. Maaari kayong tulungan ng isang nakakapagsalita ng Tagalog. Ito ay libreng serbisyo.

French: Nous proposons des services gratuits d'interprétation pour répondre à toutes vos questions relatives à notre régime de santé ou d'assurance-médicaments. Pour accéder au service d'interprétation, il vous suffit de nous appeler au 1-855-322-7062. Un interlocuteur parlant Français pourra vous aider. Ce service est gratuit.

Vietnamese: Chúng tôi có dịch vụ thông dịch miễn phí để trả lời các câu hỏi về chương sức khỏe và chương trình thuốc men. Nếu quí vị cần thông dịch viên xin gọi 1-855-322-7062 sẽ có nhân viên nói tiếng Việt giúp đỡ quí vị. Đây là dịch vụ miễn phí .

German: Unser kostenloser Dolmetscherservice beantwortet Ihren Fragen zu unserem Gesundheits- und Arzneimittelplan. Unsere Dolmetscher erreichen Sie unter 1-855-322-7062 Man wird Ihnen dort auf Deutsch weiterhelfen. Dieser Service ist kostenlos.

Korean: 당사는 의료 보험 또는 약품 보험에 관한 질문에 답해 드리고자 무료 통역 서비스를 제공하고 있습니다. 통역 서비스를 이용하려면 전화 1-855-322-7062 번으로 문의해 주십시오. 한국어를 하는 담당자가 도와 드릴 것입니다. 이 서비스는 무료로 운영됩니다.

Russian: Если у вас возникнут вопросы относительно страхового или медикаментного плана, вы можете воспользоваться нашими бесплатными услугами переводчиков. Чтобы воспользоваться услугами переводчика, позвоните нам по телефону 1-855-322-7062. Вам окажет помощь сотрудник, который говорит по-русски. Данная услуга бесплатная.

Arabic: إننا نقدم خدمات المترجم الفوري المجانية للإجابة عن أي أسئلة تتعلق بالصحة أو جدول الأدوية لدينا. للحصول على مترجم فوري، ليس عليك سوى الاتصال بنا على 1-855-322-7062. سيقوم شخص ما يتحدث العربية بمساعدتك. هذه خدمة مجانية.

Italian: È disponibile un servizio di interpretariato gratuito per rispondere a eventuali domande sul nostro piano sanitario e farmaceutico. Per un interprete, contattare il numero 1-855-322-7062. Un nostro incaricato che parla Italianovi fornirà l'assistenza necessaria. È un servizio gratuito.

Portugués: Dispomos de serviços de interpretação gratuitos para responder a qualquer questão que tenha acerca do nosso plano de saúde ou de medicação. Para obter um intérprete, contacte-nos através do número 1-855-322-7062. Irá encontrar alguém que fale o idioma Português para o ajudar. Este serviço é gratuito.

French Creole: Nou genyen sèvis entèprèt gratis pou reponn tout kesyon ou ta genyen konsènan plan medikal oswa dwòg nou an. Pou jwenn yon entèprèt, jis rele nou nan 1-855-322-7062. Yon moun ki pale Kreyòl kapab ede w. Sa a se yon sèvis ki gratis.

Polish: Umożliwiamy bezpłatne skorzystanie z usług tłumacza ustnego, który pomoże w uzyskaniu odpowiedzi na temat planu zdrowotnego lub dawkowania leków. Aby skorzystać z pomocy tłumacza znającego język polski, należy zadzwonić pod numer 1-855-322-7062. Ta usługa jest bezpłatna.

Hindi: हमारे स्वास्थ्य या दवा की योजना के बारे में आपके किसी भी प्रश्न के जवाब देने के लिए हमारे पास मुफ्त दुभाषिया सेवाएँ उपलब्ध हैं. एक दुभाषिया प्राप्त करने के लिए, बस हमें 1-855-322-7062 पर फोन करें. कोई व्यक्ति जो हिन्दी बोलता है आपकी मदद कर सकता है. यह एक मुफ्त सेवा है.

Japanese: 当社の健康 健康保険と薬品 処方薬プランに関するご質問にお答えするために、無料の通訳サービスがありますございます。通訳をご用命になるには、1-855-322-7062 にお電話ください。日本語を話す人 者 が支援いたします。これは無料のサービスです。

EVIDENCE OF COVERAGE

January 1, 2014 – December 31, 2014

Your Group Sponsored Medicare Health Benefits and Services and Prescription Drug Coverage as a Member of Medicare Preferred (PPO) with Senior Rx Plus

This booklet gives you the details about your Medicare health and prescription drug coverage and non-Medicare supplemental drug coverage from **January 1, 2014 – December 31, 2014**. It explains how to get the coverage for health care services and prescription drugs you need. **This is an important legal document. Please keep it in a safe place.**

For help or information, please call Customer Service or go to your plan website.

1-855-322-7062 (Calls to these numbers are free.)
711 for TTY/TDD users
Website: www.bcbsga.com/shbp

Hours of Operation:
8 a.m. to 8 p.m. ET
Monday through Friday

This plan, Medicare Preferred (PPO) with Senior Rx Plus, is offered by Blue Cross and Blue Shield of Georgia, Inc. (When this Evidence of Coverage says "we," "us," or "our," it means Blue Cross and Blue Shield of Georgia. When it says "retiree drug coverage," "the plan" or "your plan," it means Medicare Preferred (PPO) with Senior Rx Plus.)

Blue Cross and Blue Shield of Georgia, Inc. is an LPPO plan with a Medicare contract. Enrollment in Blue Cross and Blue Shield of Georgia, Inc. depends on contract renewal.

Blue Cross and Blue Shield of Georgia, Inc. is an independent licensee of the Blue Cross and Blue Shield Association. The Blue Cross and Blue Shield names and symbols are registered marks of the Blue Cross and Blue Shield Association.

Our plan has free language interpreter services available to answer questions from non-English speaking members. Please call the Customer Service number listed above to request interpreter services.

This document may be available in an alternate format, such as large print.
Please call the Customer Service number listed above for additional information.

Benefits, formulary, pharmacy network, premium and/or copayments/coinsurance may change on January 1, 2015 or upon renewal.

BCBSGA PPO-Passive PartB GA SHBP MAPD EOC Std 38763WPSENMUB_024
Y0071_14_17571_I_024 07/18/2013

Your 2014 Medical Benefit Chart
Local PPO Plan 25P – Standard Plan
State Health Benefit Plan
Effective January 1, 2014

Covered services	What you must pay for these covered services	
Important information	In-Network	Out-of-Network
Doctor and Hospital Choice You may go to doctors, specialists, and hospitals in or out of the network. You do not need a referral. However, some benefits may require authorization.		
Annual Deductible • The deductible applies to covered services as noted within each category below, prior to the copay or coinsurance, if any, being applied.	$0 Combined in-network and out-of-network	
Inpatient services		
Inpatient hospital care Covered services include: • Semi-private room (or a private room if medically necessary) • Meals including special diets • Regular nursing services • Costs of special care units (such as intensive or coronary care units) • Drugs and medications • Lab tests • X-rays and other radiology services • Necessary surgical and medical supplies • Use of appliances, such as wheelchairs • Operating and recovery room costs	Prior authorization is required for elective inpatient acute and long term admissions as well as rehabilitation, substance abuse, and Medicare-covered inpatient transplant admissions. For Medicare-covered hospital stays: 20% coinsurance per admission	Providers are encouraged to call the plan for a predetermination of coverage for elective, inpatient acute and long term admissions as well as rehabilitation, substance abuse, and Medicare-covered inpatient transplant admissions. For Medicare-covered hospital stays: 20% coinsurance per admission

Covered services	What you must pay for these covered services	
Important information	In-Network	Out-of-Network
Inpatient hospital care (con't) • Physical therapy, occupational therapy, and speech language therapy • Inpatient substance abuse services • Inpatient dialysis (if you are admitted as an inpatient to a hospital for special care) 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. Transplant providers may be local or outside of the service area. If local transplant providers are willing to accept the Original Medicare rate, then you can choose to obtain your transplant services locally or at a distant location offered by the plan. If the plan provides transplant services at a distant location (outside of the service area) and you chose to obtain transplants at this distant location, we will arrange or pay for appropriate lodging and transportation costs for you and a companion. The reimbursement for transportation costs are while you and your companion are traveling to and from the medical providers for services related to the transplant care. The plan defines the distant location as a location that is outside of the member's service area AND a minimum of 75 miles from the member's home. Transportation and lodging costs will be reimbursed for travel mileage and lodging consistent with current IRS travel mileage and lodging guidelines. Accommodations for lodging will be reimbursed at the lesser of: 1) billed charges, or 2) $50 per day per covered person up to a maximum of $100 per day per covered person consistent with IRS guidelines. • Blood – including storage and administration. Coverage of whole blood, packed red cells, and all other components of blood begins with the first pint. • Physician services	No limit to the number of days covered by the plan each benefit period 20% coinsurance for Medicare-covered physician services received while an inpatient during a Medicare-covered hospital stay	No limit to the number of days covered by the plan each benefit period 20% coinsurance for Medicare-covered physician services received while an inpatient during a Medicare-covered hospital stay If you get authorized inpatient care at an out-of-network hospital after your emergency condition is stabilized, your cost is the cost-sharing you would pay at an in-network hospital.

Covered services	What you must pay for these covered services	
Important information	In-Network	Out-of-Network
Inpatient hospital care (con't) In-network providers should notify us within one business day of any planned, and if possible, unplanned admissions or transfers, including to or from a hospital, skilled nursing facility, long term acute care hospital or acute rehabilitation center. If you get authorized inpatient care at an out-of-network hospital after your emergency condition is stabilized, your cost is the cost-sharing you would pay at an in-network hospital. **Note:** To be an inpatient, your provider must write an order to admit you formally as an inpatient of the hospital. Even if you stay in the hospital overnight, you might still be considered an "outpatient." If you are not sure if you are an inpatient, you should ask the hospital staff. You can also find more information in a Medicare fact sheet called "Are You a Hospital Inpatient or Outpatient? If You Have Medicare – Ask!" This fact sheet is available on the Web at http://www.medicare.gov/Publications/Pubs/pdf/11435.pdf or by calling 1-800-MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048. You can call these numbers for free, 24 hours a day, 7 days a week.		

Covered services	What you must pay for these covered services	
Important information	In-Network	Out-of-Network
Inpatient mental health care Covered services include mental health care services that require a hospital stay in a psychiatric hospital or the psychiatric unit of a general hospital. In-network providers should notify us within one business day of any planned, and if possible unplanned admissions or transfers, including to or from a hospital, skilled nursing facility, long term acute care hospital or acute rehabilitation center.	For Medicare-covered hospital stays: Prior authorization is required for mental nervous and mental nervous rehabilitation admissions. 20% coinsurance per admission No limit to the number of days covered by the plan each benefit period 20% coinsurance for Medicare-covered physician services received while an inpatient during a Medicare-covered hospital stay	For Medicare-covered hospital stays: Providers are encouraged to call the plan for a predetermination of coverage for elective inpatient admissions. 20% coinsurance per admission No limit to the number of days covered by the plan each benefit period 20% coinsurance for Medicare-covered physician services received while an inpatient during a Medicare-covered hospital stay

Covered services	What you must pay for these covered services	
Important information	In-Network	Out-of-Network
Skilled nursing facility (SNF) care Inpatient skilled nursing facility (SNF) coverage is limited to 100 days each benefit period. A "benefit period" begins on the first day you go to a Medicare-covered inpatient hospital or a SNF. The benefit period ends when you have not been an inpatient at any hospital or SNF for 60 days in a row. Covered services include but are not limited to: • Semi-private room (or a private room if medically necessary) • Meals, including special diets • Skilled nursing services • Physical therapy, occupational therapy and speech language 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 all other components of blood begins with the first pint • 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/Practitioner services Generally, you will receive 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)	Prior authorization is required for SNF services. For Medicare-covered SNF stays: $0 copay per day, days 1-20 $50 copay per day, days 21-100 No prior hospital stay required.	Providers are encouraged to call the plan for a predetermination of coverage for SNF. For Medicare-covered SNF stays: $0 copay per day, days 1-20 $50 copay per day, days 21-100 No prior hospital stay required.

Covered services	What you must pay for these covered services	
Important information	In-Network	Out-of-Network
Skilled nursing facility (SNF) care (con't) • A SNF where your spouse is living at the time you leave the hospital. • In-network providers should notify us within one business day of any planned, and if possible unplanned admissions or transfers, including to or from a hospital, skilled nursing facility.		
Inpatient services covered when the hospital or SNF days are not covered or are no longer covered If you have exhausted your inpatient benefits or if the inpatient stay is not reasonable and necessary, we will not cover your inpatient stay. However, in some cases, we will cover certain services you receive while you are in the hospital or the skilled nursing facility (SNF) stay. Covered services include, but are not limited to: • Physician services • Diagnostic tests (like 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 • Prosthetic and orthotic 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 • 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, occupational therapy and speech language therapy	After your SNF day limits are used up, this plan will still pay for covered physician services and other medical services outlined in this benefit chart at the deductible and/or cost share amounts indicated.	

Covered services	What you must pay for these covered services	
Important information	In-Network	Out-of-Network
Home health agency care Prior to receiving home health services, a doctor must certify that you need home health services and will order home health services to be provided by a home health agency. You must be homebound, which means leaving home is a major effort. Covered services include, but are not limited to: • Part-time or intermittent skilled nursing and home health aide services (to be covered under the home health care benefit, your skilled nursing and home health aide services combined must total fewer than 8 hours per day and 35 hours per week.) • Physical therapy, occupational therapy, and speech language therapy • Medical and social services • Medical equipment and supplies	Prior authorization may be required for home health therapy services. $0 copay for Medicare-covered home health visits DME copay or coinsurance, if any, may apply.	Prior authorization is requested for home health therapy services. $0 copay for Medicare-covered home health visits DME copay or coinsurance, if any, may apply.
Hospice care You may receive care from any Medicare-certified hospice program. Your hospice doctor can be an in-network provider or an out-of-network provider. Our plan will pay the hospice provider for the services you receive. Services covered by our plan include: • Drugs for symptom control and pain relief • Short-term respite care • Home care Our plan covers hospice consultation services (one time only) for a terminally ill person who hasn't elected the hospice benefit. For services that are covered by Medicare Part A or B and are not related to your terminal condition: If you need non-emergency, non-urgently needed services that are covered under Medicare Part A or B and that are not related to your terminal condition, your cost for these services depends on whether you use a provider in our plan's network:	All care related to the terminal illness must be provided by a Medicare-certified Hospice, which is billed directly to the plan. $0 copay for Medicare-covered Hospice care $0 copay for Medicare-covered drugs for symptom control and pain relief $0 copay for Medicare-covered short-term respite care	All care related to the terminal illness must be provided by a Medicare-certified Hospice, which is billed directly to the plan. $0 copay for Medicare-covered Hospice care $0 copay for Medicare-covered drugs for symptom control and pain relief $0 copay for Medicare-covered short-term respite care

Covered services	What you must pay for these covered services	
Important information	In-Network	Out-of-Network
Hospice care (con't) • If you obtain the covered services from an in-network provider, you only pay the plan cost-sharing amount for in-network services • If you obtain the covered services from an out-of-network provider, you pay the plan cost sharing for out-of-network services For services that are covered by this plan but are not covered by Medicare Part A or B: This plan will continue to cover plan-covered services that are not covered under Part A or B whether or not they are related to your terminal condition. You pay your plan cost sharing amount for these services. Note: If you need non-hospice care (care that is not related to your terminal condition), you should contact us to arrange the services. Getting your non-hospice care through our in-network providers will lower your share of the costs for the services.	$0 copay for the one time only hospice consultation	$0 copay for the one time only hospice consultation

Covered services	What you must pay for these covered services	
Important information	In-Network	Out-of-Network
Outpatient services		
Physician services, including doctor's office visits Covered services include: • Office visits, including medical and surgical services in a physician's office • Consultation, diagnosis and treatment by a specialist • Retail health clinics • Basic diagnostic hearing and balance exams, if your doctor orders it to see if you need medical treatment, when furnished by a physician, audiologist, or other qualified provider • Telehealth office visits including consultation, diagnosis and treatment by a specialist • Second opinion by another in-network provider prior to surgery • Physician services rendered in the home • 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 physician) • Allergy testing and allergy injections	$25 copay per visit to an in-network primary care physician (PCP) for Medicare-covered services $30 copay per visit to an in-network specialist for Medicare-covered services $25 copay per visit to an in-network retail health clinic for Medicare-covered services $0 copay for Medicare-covered allergy testing $0 copay for Medicare-covered allergy injections	$25 copay per visit to an out-of-network primary care physician (PCP) for Medicare-covered services $30 copay per visit to an out-of-network specialist for Medicare-covered services $25 copay per visit to an out-of-network retail health clinic for Medicare-covered services $0 copay for Medicare-covered allergy testing $0 copay for Medicare-covered allergy injections
Chiropractic services Covered services include: • Manual manipulation of the spine to correct subluxation	Prior authorization may be required for chiropractic services. $18 copay for each Medicare-covered visit	Prior authorization may be requested for chiropractic services. $18 copay for each Medicare-covered visit

Covered services	What you must pay for these covered services	
Important information	In-Network	Out-of-Network
Podiatry services Covered services include: • Diagnosis and the medical or surgical treatment in an office setting, of injuries and disease of the feet (such as hammer toe or heel spurs) • Medicare-covered routine foot care for members with certain medical conditions affecting the lower limbs. • A foot exam is covered every six months for people with diabetic peripheral neuropathy and loss of protective sensations.	$30 copay for each Medicare-covered visit	$30 copay for each Medicare-covered visit
Outpatient mental health care, including partial hospitalization services Covered services include: • Mental health services provided by a state-licensed psychiatrist or 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 psychiatric treatment provided in a hospital outpatient setting, that is more intense than the care received in your doctor's or therapist's office and is an alternative to inpatient hospitalization.	Prior authorization is required for intensive outpatient mental health service. Prior authorization is required for partial hospitalization services related to mental health. $30 copay for each Medicare-covered professional individual therapy visit $30 copay for each Medicare-covered professional group therapy visit $55 copay for each Medicare-covered professional partial hospitalization visit $0 copay for each Medicare-covered outpatient hospital facility individual therapy visit	Prior authorization is requested for intensive outpatient mental health service. Prior authorization is requested for partial hospitalization services related to mental health. $30 copay for each Medicare-covered professional individual therapy visit $30 copay for each Medicare-covered professional group therapy visit $55 copay for each Medicare-covered professional partial hospitalization visit $0 copay for each Medicare-covered outpatient hospital facility individual therapy visit

Covered services	What you must pay for these covered services	
Important information	In-Network	Out-of-Network
Outpatient mental health care, including partial hospitalization services (con't)	$0 copay for each Medicare-covered outpatient hospital facility group therapy visit $0 copay for each Medicare-covered partial hospitalization facility visit	$0 copay for each Medicare-covered outpatient hospital facility group therapy visit $0 copay for each Medicare-covered partial hospitalization facility visit
Outpatient substance abuse services, including partial hospitalization services "Partial hospitalization" is a structured program of active psychiatric treatment provided in a hospital outpatient setting, that is more intense than the care received in your doctor's or therapist's office and is an alternative to inpatient hospitalization.	Prior authorization is required for intensive outpatient substance abuse service. Prior authorization is required for partial hospitalization services related to substance abuse. $30 copay for each Medicare-covered professional individual therapy visit $30 copay for each Medicare-covered professional group therapy visit $55 copay for each Medicare-covered professional partial hospitalization visit $0 copay for each Medicare-covered outpatient hospital facility individual therapy visit	Prior authorization is requested for intensive outpatient substance abuse service. Prior authorization is requested for partial hospitalization services related to substance abuse. $30 copay for each Medicare-covered professional individual therapy visit $30 copay for each Medicare-covered professional group therapy visit $55 copay for each Medicare-covered professional partial hospitalization visit $0 copay for each Medicare-covered outpatient hospital facility individual therapy visit

Covered services	What you must pay for these covered services	
Important information	In-Network	Out-of-Network
Outpatient substance abuse services, including partial hospitalization services (con't)	$0 copay for each Medicare-covered outpatient hospital facility group therapy visit $0 copay for each Medicare-covered partial hospitalization facility visit	$0 copay for each Medicare-covered outpatient hospital facility group therapy visit $0 copay for each Medicare-covered partial hospitalization facility visit
Outpatient surgery including services provided at hospital outpatient facilities and ambulatory surgical centers Facilities where surgical procedures are performed and the patient is released the same day. **Note:** If you are having surgery in a hospital, you should check with your provider about whether you will be an inpatient or outpatient. Unless the provider writes an order to admit you as an inpatient to the hospital, you are an outpatient and pay the cost-sharing amounts for outpatient surgery. Even if you stay in the hospital overnight, you might still be considered an "outpatient." You can also find more information in a Medicare fact sheet called "Are You a Hospital Inpatient or Outpatient? If You Have Medicare – Ask!" This fact sheet is available on the Web at http://www.medicare.gov/Publications/Pubs/pdf/11435.pdf or by calling 1-800-MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048. You can call these numbers for free, 24 hours a day, 7 days a week.	Prior authorization is required for select outpatient surgeries and procedures. $95 copay for each Medicare-covered outpatient hospital facility or ambulatory surgical center visit for surgery $95 copay for each Medicare-covered outpatient observation room visit	Prior authorization is requested for select outpatient surgeries and procedures. $95 copay for each Medicare-covered outpatient hospital facility or ambulatory surgical center visit for surgery $95 copay for each Medicare-covered outpatient observation room visit

Covered services	What you must pay for these covered services	
Important information	In-Network	Out-of-Network
Outpatient hospital services, non-surgical Covered services include medically necessary services you get in the outpatient department of a hospital for diagnosis or treatment of an illness or injury. **Note:** Unless the provider has written an order to admit you as an inpatient to the hospital, you are an outpatient and pay the cost-sharing amounts for outpatient hospital services. Even if you stay in the hospital overnight, you might still be considered an "outpatient." If you are not sure if you are an outpatient, you should ask the hospital staff. You can also find more information in a Medicare fact sheet called "Are You a Hospital Inpatient or Outpatient? If You Have Medicare – Ask!" This fact sheet is available on the Web at http://www.medicare.gov/Publications/Pubs/pdf/11435.pdf or by calling 1-800-MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048. You can call these numbers for free, 24 hours a day, 7 days a week.	$25 copay for a visit to an in-network primary care physician in an outpatient hospital setting/clinic for Medicare-covered non-surgical services $30 copay for a visit to an in-network specialist in an outpatient hospital setting/clinic for Medicare-covered non-surgical services $95 copay for each Medicare-covered outpatient observation room visit	$25 copay for a visit to an out-of-network primary care physician in an outpatient hospital setting/clinic for Medicare-covered non-surgical services $30 copay for a visit to an out-of-network specialist in an outpatient hospital setting/clinic for Medicare-covered non-surgical services $95 copay for each Medicare-covered outpatient observation room visit
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 the services are furnished to a member whose medical condition is such that other means of transportation are contraindicated (could endanger the person's health) or if authorized by the plan. • 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. • Ambulance service is not covered for physician office visits.	Prior authorization for non-emergent air and water transportation is required for in-network providers and requested for out-of-network providers. $50 copay for Medicare-covered ambulance services Cost share, if any, is applied per one-way trip for Medicare-covered ambulance services.	

Covered services	What you must pay for these covered services	
Important information	In-Network	Out-of-Network
Emergency care Emergency care refers to services that are: • Furnished by a provider qualified to furnish emergency services, and • Needed to evaluate or stabilize an emergency medical condition • Emergency outpatient copay is waived if the member is admitted to the hospital within 72 hours for the same condition. A medical emergency is when you, or any other prudent layperson with an average knowledge of health and medicine, believe that you have medical symptoms that require immediate medical attention to prevent loss of life, loss of a limb, or loss of function of a limb. The medical symptoms may be an illness, injury, severe pain, or a medical condition that is quickly getting worse. This coverage is worldwide and is limited to what is allowed under the Medicare fee schedule for the services performed/received in the United States. If you get authorized inpatient care at an out-of-network hospital after your emergency condition is stabilized, your cost is the cost-sharing you would pay at an in-network hospital.	$50 copay for each Medicare-covered emergency room visit	
Urgently needed care • Urgently needed care is available on a worldwide basis. • The urgently needed care copay is waived if the member is admitted to the hospital within 72 hours for the same condition. If you are outside of the service area for your plan, your plan covers urgently needed care, including urgently required renal dialysis. Urgently needed care is care provided to treat a non-emergency, unforeseen medical illness, injury, or condition that requires immediate medical care. Urgently needed care may be furnished by in-network providers or by out-of-network providers when in-network providers are temporarily unavailable or inaccessible. Generally, however, if you are in the plan's service area and your health is not in serious danger, you should obtain care from an in-network provider.	$25 copay for each Medicare-covered urgently needed care visit	

Covered services	What you must pay for these covered services	
Important information	In-Network	Out-of-Network
Outpatient rehabilitation services Covered services include: physical therapy, occupational therapy, and speech language therapy. Outpatient rehabilitation services are provided in various outpatient settings, such as hospital outpatient departments, independent therapist offices, and Comprehensive Outpatient Rehabilitation Facilities (CORFs).	Prior authorization may be required for physical therapy, occupational therapy and speech language therapy visits. $25 copay for Medicare-covered physical therapy, occupational therapy and speech language therapy visits	Prior authorization is requested for physical therapy, occupational therapy and speech language therapy visits. $25 copay for Medicare-covered physical therapy, occupational therapy and speech language therapy visits
Cardiac rehabilitation services Comprehensive programs of cardiac rehabilitation services that include exercise, education, and counseling are covered for members who meet certain conditions with a doctor's order. The plan covers intensive cardiac rehabilitation programs that are typically more rigorous or more intense than cardiac rehabilitation programs.	$25 copay for Medicare-covered cardiac rehabilitation therapy visits	$25 copay for Medicare-covered cardiac rehabilitation therapy visits
Pulmonary rehabilitation services Comprehensive programs of pulmonary rehabilitation are covered for members who have moderate to very severe chronic obstructive pulmonary disease (COPD) and a referral for pulmonary rehabilitation from the doctor treating their chronic respiratory disease.	$25 copay for Medicare-covered pulmonary rehabilitation therapy visits	$25 copay for Medicare-covered pulmonary rehabilitation therapy visits

Covered services	What you must pay for these covered services	
Important information	In-Network	Out-of-Network
Durable medical equipment (DME) and related supplies (For a definition of "durable medical equipment," see the "Definition of important words chapter," later in this booklet.) Covered items include, but are not limited to: wheelchairs, crutches, hospital bed, IV infusion pump, oxygen equipment, nebulizer, and walker. Copay or coinsurance only applies when you are not currently receiving inpatient care. If you are receiving inpatient care your DME will be included in the copay or coinsurance for those services. We cover all medically necessary durable medical equipment covered by Original Medicare. If our supplier in your area does not carry a particular brand or manufacturer, you may ask them if they can special order it for you.	Prior authorization is required for DME, including, but not limited to, power operated vehicles, power wheelchairs and accessories, non-standard wheelchairs, non-standard beds, and continuous glucose monitoring systems. 20% coinsurance on all Medicare-covered DME	Prior authorization is requested for DME, including, but not limited to, power operated vehicles, power wheelchairs and accessories, non-standard wheelchairs, non-standard beds and continuous glucose monitoring systems. 20% coinsurance on all Medicare-covered DME
Prosthetic devices and related supplies Devices (other than dental) that replace all or a body part or function. These include, but not limited to, colostomy bags and supplies directly related to colostomy care, pacemakers, braces, prosthetic shoes, artificial limbs and breast prostheses (including a surgical brassiere after a mastectomy). Includes certain supplies related to prosthetic devices and repair and/or replacement of prosthetic devices. Also includes some coverage following cataract removal or cataract surgery, see "Vision care" later in this section for more detail.	Prior authorization is required for prosthetics and orthotics. 20% coinsurance on all Medicare-covered prosthetics and orthotics	Prior authorization is requested for prosthetics and orthotics. 20% coinsurance on all Medicare-covered prosthetics and orthotics

Covered services	What you must pay for these covered services	
Important information	In-Network	Out-of-Network
Diabetes self-management training, diabetic services and supplies For all people who have diabetes (insulin and non-insulin users). Covered services include: • Supplies to monitor your blood glucose: Blood glucose monitor, blood glucose test strips, urine test strips, lancet devices and lancets and glucose control solutions for checking the accuracy of test strips and monitors • One pair per year of therapeutic custom molded shoes (including inserts provided with such shoes) and two additional pairs of inserts or one pair of depth shoes and three pairs of inserts (not including the non-customized removable inserts provided with such shoes) for people with diabetes who have severe diabetic foot disease, including fitting of shoes or insert. • Diabetes self-management training is covered under certain conditions.	Prior authorization is required for continuous glucose monitoring systems. 20% coinsurance for each Medicare-covered purchase of blood glucose test strips, urine test strips, lancets, lancet devices, and glucose control solutions for checking the accuracy of test strips and monitors 20% coinsurance for Medicare-covered blood glucose monitor 20% coinsurance for Medicare-covered therapeutic shoes $0 copay for Medicare-covered self-management training	Prior authorization is requested for continuous glucose monitoring systems. 20% coinsurance for each Medicare-covered purchase of blood glucose test strips, urine test strips, lancets, lancet devices, and glucose control solutions for checking the accuracy of test strips and monitors 20% coinsurance for Medicare-covered blood glucose monitor 20% coinsurance for Medicare-covered therapeutic shoes $0 copay for Medicare-covered self-management training

Covered services	What you must pay for these covered services	
Important information	In-Network	Out-of-Network
Outpatient diagnostic tests and therapeutic services and supplies Covered services include, but are not limited to: • X-rays • Complex diagnostic tests and X-rays • Radiation (radium and isotope) therapy including technician materials and supplies • Testing to confirm chronic obstructive pulmonary disease (COPD) • Surgical supplies, such as dressings • Splints, casts and other devices used to reduce fractures and dislocations • Laboratory tests • Blood - including storage and administration. Coverage of whole blood, packed red cells, and all other components of blood begins with the first pint. • Other outpatient diagnostic tests Certain diagnostic tests and X-rays are considered complex and include heart catheterizations, and computed tomography (CT), magnetic resonance procedures (MRIs and MRAs) and nuclear medicine studies, which includes PET scans.	Prior authorization may be required for complex imaging and limited diagnostic and therapeutic radiology services, including, but not limited to radiation therapy, PET, CT, SPECT, MRI scans and echocardiograms, diagnostic laboratory tests, genetic testing, sleep studies, and related sleep study equipment and supplies. $0 copay for each Medicare-covered X-ray visit and/or simple diagnostic test 20% coinsurance for each Medicare-covered diagnostic (complex) radiology service when performed at a hospital outpatient facility or a free-standing facility (imaging or diagnostic center) $35 copay for each Medicare-covered diagnostic (complex) radiology service received in a doctor's office	Prior authorization is requested for complex imaging, and limited diagnostic and therapeutic radiology services including but not limited to, radiation therapy, PET, CT, SPECT, MRI scans and echocardiograms, diagnostic laboratory tests, genetic testing, sleep studies and related sleep study equipment and supplies. $0 copay for each Medicare-covered X-ray visit and/or simple diagnostic test 20% coinsurance for each Medicare-covered diagnostic (complex) radiology service when performed at a hospital outpatient facility or a free-standing facility (imaging or diagnostic center) $35 copay for each Medicare-covered diagnostic (complex) radiology service received in a doctor's office

Covered services	What you must pay for these covered services	
Important information	In-Network	Out-of-Network
Outpatient diagnostic tests and therapeutic services and supplies (con't)	20% coinsurance for each Medicare-covered radiation therapy service performed at a hospital outpatient facility of a free-standing facility (imaging or diagnostic center)	20% coinsurance for each Medicare-covered radiation therapy service performed at a hospital outpatient facility of a free-standing facility (imaging or diagnostic center)
	$35 copay for each Medicare-covered radiation therapy service received in a doctor's office	$35 copay for each Medicare-covered radiation therapy service received in a doctor's office
	$0 copay for Medicare-covered testing to confirm chronic obstructive pulmonary disease	$0 copay for Medicare-covered testing to confirm chronic obstructive pulmonary disease
	20% coinsurance for Medicare-covered supplies	20% coinsurance for Medicare-covered supplies
	$0 copay for each Medicare-covered clinical/diagnostic lab test	$0 copay for each Medicare-covered clinical/diagnostic lab test
	$0 copay per Medicare-covered pint of blood	$0 copay per Medicare-covered pint of blood
	$0 copay for each Medicare-covered diagnostic test received in a doctor's office	$0 copay for each Medicare-covered diagnostic test received in a doctor's office

Covered services	What you must pay for these covered services	
Important information	In-Network	Out-of-Network
Outpatient diagnostic tests and therapeutic services and supplies (con't)	$95 copay for each Medicare-covered diagnostic test performed at a hospital outpatient facility or a free-standing facility Example includes, but not limited to, pulmonary function test, sleep studies and treadmill stress tests.	$95 copay for each Medicare-covered diagnostic test performed at a hospital outpatient facility or a free-standing facility Example includes, but not limited to, pulmonary function test, sleep studies and treadmill stress tests.
Vision care (non-routine) Covered services include: • Outpatient physician services for the diagnosis and treatment of diseases and injuries of the eye, including treatment for age-related macular degeneration. • 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. • An eye exam to check for diabetic retinopathy once every 12 months. • One pair of eyeglasses or contact lenses after each cataract surgery that includes insertion of an intraocular lens. (If you have two separate cataract operations, you cannot reserve the benefit after the first surgery and purchase two eyeglasses after the second surgery.) Corrective lenses/frames (and replacements) needed after a cataract removal without a lens implant.	$25 copay for visits to an in-network primary care physician for Medicare-covered exams to diagnose and treat diseases of the eye $30 copay for visits to an in-network specialist for Medicare-covered exams to diagnose and treat diseases of the eye $0 copay for Medicare-covered glaucoma screening $0 copay for glasses/contacts following Medicare-covered cataract surgery	$25 copay for visits to an out-of-network primary care physician for Medicare-covered exams to diagnose and treat diseases of the eye $30 copay for visits to an out-of-network specialist for Medicare-covered exams to diagnose and treat diseases of the eye $0 copay for Medicare-covered glaucoma screening $0 copay for glasses/contacts following Medicare-covered cataract surgery

Covered services	What you must pay for these covered services	
Important information	In-Network	Out-of-Network
Preventive services and screening tests You will see this apple next to preventive services throughout this chart. For all preventive services that are covered at no cost under Original Medicare, we also cover the service at no cost to you in-network. However, if you are treated or monitored for an existing medical condition or an additional non-preventive service, during the visit when you receive the preventive service, a copay or coinsurance may apply for that care received. In addition, if an office visit is billed for the existing medical condition or an additional non-preventive service received, the applicable in-network primary care physician or in-network specialist copay or coinsurance will apply.		
Abdominal aortic aneurysm screening A one-time screening ultrasound for people at risk. The plan only covers this screening if you get a referral for it as a result of your "Welcome to Medicare" preventive visit.	$0 copay for Medicare-covered screening	$0 copay for Medicare-covered screening
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 24 months, or more frequently if medically necessary: procedures to identify bone mass, detect bone loss, or determine bone quality, including a physician's interpretation of the results.	$0 copay for Medicare-covered bone mass measurement	$0 copay for Medicare-covered bone mass measurement

Covered services	What you must pay for these covered services	
Important information	In-Network	Out-of-Network
Colorectal cancer screening and colorectal services: 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 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 Colorectal services • Includes the biopsy and removal of any growth during the procedure, in the event the procedure goes beyond a screening exam	$0 copay for Medicare-covered screenings and services	$0 copay for Medicare-covered screenings and services
HIV screening For people who ask for an HIV screening test or who are at increased risk for HIV infection, we cover: • One screening exam every 12 months For women who are pregnant, we cover: • Up to three screening exams during a pregnancy	$0 copay for Medicare-covered screening	$0 copay for Medicare-covered screening

Covered services	What you must pay for these covered services	
Important information	In-Network	Out-of-Network
Screening for sexually transmitted infections (STIs) and counseling to prevent STIs We cover sexually transmitted infection (STI) screenings for chlamydia, gonorrhea, syphilis, and Hepatitis B. These screenings are covered for pregnant women and for certain people who are at increased risk for an STI when the tests are ordered by a primary care provider. We cover these tests once every 12 months or at certain times during pregnancy. We also cover up to 2 individual 20 to 30 minute, face-to-face high-intensity behavioral counseling sessions each year for sexually active adults at increased risk for STIs. We will only cover these counseling sessions as a preventive service if they are provided by a primary care provider and take place in a primary care setting, such as a doctor's office.	$0 copay for Medicare-covered services	$0 copay for Medicare-covered services
Medicare Part B immunizations Covered services include: • Pneumonia vaccine • Flu shots, including H1N1, 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 and they meet Medicare Part B coverage rules **If Part D prescription drug coverage is included with your medical plan, we also cover some vaccines under our outpatient prescription drug benefit, for example the Shingles vaccine. Please refer to your outpatient prescription drug benefits.**	$0 copay for Medicare-covered immunizations	$0 copay for Medicare-covered immunizations

Covered services	What you must pay for these covered services	
Important information	In-Network	Out-of-Network
Breast cancer screening (mammograms) Covered services include: • One baseline mammogram between the ages of 35 and 39 • One screening mammogram every 12 months for women age 40 and older Clinical breast exams once every 24 months	$0 copay for Medicare-covered screening exams	$0 copay for Medicare-covered screening exams
Cervical and vaginal cancer screening Covered services include: • For all women, Pap tests and pelvic 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, 1 Pap test every 12 months.	$0 copay for Medicare-covered screening exams	$0 copay for Medicare-covered screening exams
Prostate cancer screening exams For men age 50 and older, the following are covered once every 12 months: • Digital rectal exam Prostate Specific Antigen (PSA) test	$0 copay for Medicare-covered screening exams	$0 copay for Medicare-covered screening exams
Cardiovascular disease risk reduction visit (therapy for cardiovascular disease) We cover one visit per year with your primary care doctor to help lower your risk for cardiovascular disease. During this visit, your doctor may discuss aspirin use (if appropriate), check your blood pressure, and give you tips to make sure you're eating well.	$0 copay for Medicare-covered visits	$0 copay for Medicare-covered visits

Covered services	What you must pay for these covered services	
Important information	In-Network	Out-of-Network
Cardiovascular disease testing Blood tests for the detection of cardiovascular disease (or abnormalities associated with an elevated risk of cardiovascular disease) once every 5 years (60 months).	$0 copay for Medicare-covered tests	$0 copay for Medicare-covered tests
"Welcome to Medicare" preventive visit The plan covers a one-time "Welcome to Medicare" preventive visit. The visit includes a review of your health, measurements of height, weight, body mass index, blood pressure as well as education and counseling about the preventive services you need (including certain screenings and shots), and referrals for other care if needed. **Important:** We cover the "Welcome to Medicare" preventive visit only within the first 12 months you have Medicare Part B. When you make your appointment, let your doctor's office know you would like to schedule your "Welcome to Medicare" preventive visit.	$0 copay for Medicare-covered exam	$0 copay for Medicare-covered exam
Annual wellness visit If you've had Part B for longer than 12 months, you can get an annual wellness visit to develop or update a personalized prevention plan based on your current health and risk factors. This is covered once every 12 months. **Note:** Your first annual wellness visit can't take place within 12 months of your "Welcome to Medicare" preventive visit. However, you don't need to have had a "Welcome to Medicare" visit to be covered for annual wellness visits after you've had Part B for 12 months.	$0 copay for Medicare-covered visits	$0 copay for Medicare-covered visits
Depression screening We cover one screening for depression per year. The screening must be done in a primary care setting that can provide follow-up treatment and referrals.	$0 copay for Medicare-covered screening	$0 copay for Medicare-covered screening

Covered services	What you must pay for these covered services	
Important information	In-Network	Out-of-Network
Diabetes screening We cover this screening (includes fasting glucose tests) if you have any of the following risk factors: high blood pressure (hypertension), history of abnormal cholesterol and triglyceride levels (dyslipidemia), obesity, or a history of high blood sugar (glucose). Tests may also be covered if you meet other requirements, like being overweight and having a family history of diabetes. Based on the results of these tests, you may be eligible for up to 2 diabetes screenings every 12 months.	$0 copay for Medicare-covered diabetes screening including fasting plasma glucose tests	$0 copay for Medicare-covered diabetes screening including fasting plasma glucose tests
Obesity screening and therapy to promote sustained weight loss If you have a body mass index of 30 or more, we cover intensive counseling to help you lose weight. This counseling is covered if you get it in a primary care setting, where it can be coordinated with your comprehensive prevention plan. Talk to your primary care doctor or practitioner to find out more.	$0 copay for Medicare-covered services	$0 copay for Medicare-covered services
Screening and counseling to reduce alcohol misuse We cover one alcohol misuse screening for adults with Medicare (including pregnant women) who misuse alcohol, but aren't alcohol dependent. If you screen positive for alcohol misuse, you can get up to four brief face-to-face counseling sessions per year (if you're competent and alert during counseling) provided by a qualified primary care doctor or practitioner in a primary care setting.	$0 copay for Medicare-covered services	$0 copay for Medicare-covered services

Covered services	What you must pay for these covered services	
Important information	In-Network	Out-of-Network
Medical nutrition therapy This benefit is for people with diabetes, renal (kidney) disease (but not on dialysis), or after a kidney transplant when referred by your doctor. We cover three hours of one-on-one counseling services during your first year that you receive medical nutrition therapy services under Medicare (this includes our plan, any other Medicare Advantage plan, or Original Medicare), and two hours each year after that. If your condition, treatment, or diagnosis changes, you may be able to receive more hours of treatment with a physician's referral. A physician must prescribe these services and renew their referral yearly if your treatment is needed into another plan year.	$0 copay for each Medicare-covered visit	$0 copay for each Medicare-covered visit
Smoking and tobacco use cessation (counseling to quit smoking) If you use tobacco, but do not have signs or symptoms of tobacco-related disease: We cover 2 counseling quit attempts within a 12 month period. Each counseling attempt includes up to 4 face-to-face visits. If you use tobacco and have been diagnosed with a tobacco-related disease or are taking medicine that may be affected by tobacco: We cover cessation counseling services. We cover 2 counseling quit attempts within a 12 month period. Each counseling attempt includes up to 4 face-to-face visits. These visits must be ordered by your doctor and provided by a qualified doctor or other Medicare-recognized practitioner.	$0 copay for each Medicare-covered visit	$0 copay for each Medicare-covered visit

Covered services	What you must pay for these covered services	
Important information	In-Network	Out-of-Network
Other services		
Services to treat outpatient kidney disease and conditions Covered services include: • Kidney disease education services to teach kidney care and help members make informed decisions about their care. For members with stage IV chronic kidney disease when referred by their doctor, we cover up to six sessions of kidney disease education services per lifetime. • Outpatient dialysis treatments (including dialysis treatments when temporarily out of the service area) • Home dialysis or 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) • Self-dialysis training (includes training for you and anyone helping you with your home dialysis treatments) • Home dialysis equipment and supplies Certain drugs for dialysis are covered under your Medicare Part B drug benefit. For information about coverage for Part B Drugs, please go to the section below, "Medicare Part B prescription drugs."	No prior authorization is required, however notice is requested for all members initiating dialysis treatment. $0 copay for each Medicare-covered kidney education session 20% coinsurance for Medicare-covered outpatient or physician office dialysis $0 copay for Medicare-covered home dialysis or home support services $0 copay for Medicare-covered self-dialysis training 20% coinsurance for Medicare-covered home dialysis equipment and supplies	No prior authorization is required, however notice is requested for all members initiating dialysis treatment. $0 copay for each Medicare-covered kidney education session 20% coinsurance for Medicare-covered outpatient or physician office dialysis $0 copay for Medicare-covered home dialysis or home support services $0 copay for Medicare-covered self-dialysis training 20% coinsurance for Medicare-covered home dialysis equipment and supplies

Covered services	What you must pay for these covered services	
Important information	In-Network	Out-of-Network
Medicare Part B prescription drugs, covered under your medical plan (Part B drugs) These drugs are covered under Part B of Original Medicare. Members of our plan receive coverage for these drugs through our plan. Covered drugs include: • "Drugs" includes substances that are naturally present in the body, such as blood clotting factors. • Drugs that usually are not self-administered by the patient and are injected or infused while receiving physician, hospital outpatient, or ambulatory surgical center 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 the organ transplant • Injectable osteoporosis drugs, if you are homebound, have a bone fracture that a doctor certifies was related to post-menopausal osteoporosis and cannot self-administer the drug • Antigens • Certain oral anti-cancer drugs and anti-nausea drugs • Certain drugs for home dialysis, including heparin, the antidote for heparin when medically necessary, topical anesthetics and erythropoisis-stimulating agents (such as Erythropoietin (Epogen®), Procrit® or Epoetin Alfa and Darboetin Alfa (Aranesp®) • Intravenous Immune Globulin for the home treatment of primary immune deficiency diseases • **If Part D prescription drug coverage is included with your medical plan, please refer to your Evidence of Coverage for information on your Part D prescription drug benefits.**	Prior authorization may be required for certain injectable/ infusible drugs. 20% coinsurance for Medicare-covered Part B drugs 20% coinsurance for Medicare-covered Part B drug administration 20% coinsurance for Medicare-covered Part B chemotherapy drugs 20% coinsurance for Medicare-covered Part B chemotherapy drug administration	Prior authorization is requested for certain injectable/ infusible drugs. 20% coinsurance for Medicare-covered Part B drugs 20% coinsurance for Medicare-covered Part B drug administration 20% coinsurance for Medicare-covered Part B chemotherapy drugs 20% coinsurance for Medicare-covered Part B chemotherapy drug administration

Covered services	**What you must pay for these covered services**	
Important information	In-Network	Out-of-Network
Additional benefits		
Hearing services • Routine hearing exams Routine hearing exam is limited to one per year combined in-network and out-of-network. • Hearing aids Hearing aids are limited to a $1,000 maximum benefit every 4 years combined in-network and out-of-network. • Hearing aid fitting evaluations are limited to one per year combined in-network and out-of-network.	$30 copay for routine hearing exams $0 copay for hearing aids $0 copay for hearing aid fitting evaluations After plan paid benefits for routine hearing exams, hearing aids and hearing aid fitting evaluations you are responsible for the remaining cost.	$30 copay for routine hearing exams $0 copay for hearing aids $0 copay for hearing aid fitting evaluations After plan paid benefits for routine hearing exams, hearing aids and hearing aid fitting evaluations you are responsible for the remaining cost.
Routine vision care • Routine vision exams Routine vision exam is limited to one per year combined in-network and out-of-network. • Eyewear Eyewear is limited to a $125 maximum benefit every 2 years for Contact Lenses or Eyeglasses (Lenses and Frames) combined in-network and out-of-network.	$30 copay for routine vision exams $0 copay for eyewear After plan paid benefits for routine vision exams and eyewear you are responsible for the remaining cost.	$30 copay for routine vision exams $0 copay for eyewear After plan paid benefits for routine vision exams and eyewear you are responsible for the remaining cost.

Covered services	What you must pay for these covered services	
Important information	In-Network	Out-of-Network
Routine foot care Up to six covered visits per year. Routine foot care includes the cutting or removal of corns and calluses, the trimming, cutting, clipping or debriding of nails and other hygienic and preventive maintenance care.	$25 copay for each visit to an in-network primary care physician for routine foot care $30 copay for each visit to an in-network specialist for routine foot care After plan paid benefits for routine foot exams, you are responsible for the remaining cost.	$25 copay for each visit to an out-of-network primary care physician for routine foot care $30 copay for each visit to an out-of-network specialist for routine foot care After plan paid benefits for routine foot exams, you are responsible for the remaining cost.
Additional Chiropractic Services (Medicare non-covered services) The Medicare non-covered services rendered by a chiropractor to treat a disease, illness or injury. Benefits include: • Examinations or re-examination; • Adjustments; • Radiological x-rays and • Medically necessary therapy when provided in conjunction with the visit specifically for spinal or joint adjustment. Non-Medicare covered chiropractic services are limited to 20 visits per year combined in-network and out-of network.	$30 copay per visit After plan paid benefits for chiropractic services you are responsible for the remaining cost.	$30 copay per visit After plan paid benefits for chiropractic services you are responsible for the remaining cost.

Covered services	What you must pay for these covered services	
Important information	In-Network	Out-of-Network
Health and wellness education programs **SilverSneakers®** You can enroll in this fitness program provided by SilverSneakers, an independent company. As a member, you can participate in the SilverSneakers® Fitness Program or SilverSneakers® Steps at no additional cost. The SilverSneakers Fitness Program, designed exclusively for Medicare-eligible individuals, offers physical activity, health education and social events. With the SilverSneakers premier fitness center network, you'll have a complimentary membership with access to a variety of participating fitness centers throughout the country. Many sites offer amenities such as: • Fitness equipment, treadmills and free weights • The signature SilverSneakers Fitness Program classes, designed specifically for older adults and taught by certified instructors • Additional signature classes, such as YogaStretch, SilverSplash®, CardioFit and WeightCircuit, available at select locations • A designated staff member to help you along the way. The SilverSneakers Fitness Program is not a gym membership, but a specialized program designed specifically for seniors. Gym memberships or other fitness programs that do not meet the SilverSneakers Fitness Program criteria are excluded. Contact Customer Service for more information on this program, or visit www.SilverSneakers.com.	$0 copay for the SilverSneakers fitness benefit	

Covered services	What you must pay for these covered services	
Important information	In-Network	Out-of-Network
Foreign travel emergency and urgently needed care Emergency or urgently needed care services while traveling outside the United States during a temporary absence of less than six months. Outpatient copay is waived if member is admitted to hospital within 72 hours for the same condition. • Emergency outpatient care • Urgently needed care This coverage is worldwide and is limited to what is allowed under the Medicare fee schedule for the services performed/received in the United States.	$50 copay for emergency care $25 copay for urgently needed care 20% coinsurance per admission for emergency inpatient care	
Medicare-approved clinical research studies A clinical research study is a way that doctors and scientists test new types of medical care, like how well a new cancer drug works. They test new medical care procedures or drugs by asking for volunteers to help with the study. If you participate in a Medicare-approved study, Original Medicare pays the doctors and other providers for the covered services you receive as part of the study. Although not required, we ask that you notify us if you participate in a Medicare-approved research study.	After Original Medicare has paid its share of the Medicare-approved study, this plan will pay the difference between what Medicare has paid and this plan's cost-sharing for like services. Any remaining plan cost-sharing you are responsible for will accrue toward this plan's out-of-pocket maximum.	
Annual out-of-pocket maximum All copays, coinsurance and deductibles listed in this benefit chart are accrued toward the medical plan out-of-pocket maximum with the exception of foreign travel emergency and urgently needed care copay or coinsurance amounts. Part D Prescription drug deductibles and copays do not apply to the medical plan out-of-pocket maximum.	$3,500	

Your 2014 LPPO Prescription Drug Benefit Chart
15/45/85/85 (with Senior Rx Plus)
State Health Benefit Plan
Effective January 1, 2014

Your Retiree Drug Plan includes two drug benefits. The chart below shows your cost after you receive basic coverage provided by your Group Part D drug benefits and additional coverage provided under your Senior Rx Plus supplemental benefits.

Formulary	**4 Tier – Open**
Deductible	**$0**
Covered Services	**What you pay**
Initial Coverage	
Below is your payment responsibility from the time you meet your deductible, if you have one, until the amount paid by you and the Coverage Gap Discount Program for covered prescriptions reaches your True Out of Pocket limit of $4,550.	
Retail Pharmacy	per 31-day supply
• Generics	$15 copay
• Select Generics	$0 copay for Select Generics
• Preferred Brands	$45 copay
• Non-Preferred Brands and Non-Formulary Drugs	$85 copay
• Specialty Drugs (Generic and Brand)	$85 copay
Typically retail pharmacies dispense a 30-day supply of medication. Some of our retail pharmacies can dispense up to a 90-day supply of medication. If you purchase more than a 31-day supply at one of these retail pharmacies, you only pay the mail order copay shown below.	
Mail Order Pharmacy	per 90-day supply
• Generics	$37.50 copay
• Select Generics	$0 copay for Select Generics
• Preferred Brands	$112.50 copay
• Non-Preferred Brands and Non-Formulary Drugs	$212.50 copay
• Specialty Drugs (Generic and Brand)	$212.50 copay

Generally you must fill prescriptions at a network pharmacy to receive benefits under this Plan. In certain circumstances you may be reimbursed for drug costs when you must get a covered prescription filled at an out-of-network pharmacy. You will have to pay the cost of the drug and submit a claim to us. You will be responsible for all amounts over our negotiated cost, plus any deductible, copayment or coinsurance listed in this benefit chart. Please see "When can you use a pharmacy that is not in your plan's network?" section of your Evidence of Coverage for complete information.

Blue Cross and Blue Shield of Georgia, Inc. is a PPO plan with a Medicare contract.

Covered Services	**What you pay**
Vaccine Coverage	
The up front costs for vaccines will vary based upon where the vaccine is purchased and administered. Some vaccines, such as Flu Vaccines, are paid under your Medicare Part B coverage. Vaccines that are covered by Medicare Part B are not covered by your Part D plan. Please see your Evidence of Coverage booklet for a complete explanation of your vaccine coverage.	
Catastrophic Coverage	
Your payment responsibility changes after the cost you have paid for covered prescription drugs and the amount of the Coverage Gap Discount reaches your True Out of Pocket limit of $4,550.	
• Generic Drugs	5% coinsurance with a minimum copay of $2.55 and a maximum copay of $15.00
• Select Generics	$0 copay for Select Generics
• Brand-Name Drugs	5% coinsurance with a minimum copay of $6.35 and a maximum copay of $45.00
Extra Covered Drug Group	
These are drugs that are covered by your retiree drug plan that are often excluded from Part D coverage. These drugs do not count towards your True Out of Pocket expenses. They do not qualify for lower Catastrophic copays. These drugs are covered by your Senior Rx Plus benefits.	
Barbiturates **Cough and Cold** **DESI** **Vitamins and Minerals**	See Formulary for complete list of drugs covered
Erectile Dysfunction (ED)	Immediate dose ED drugs Immediate dose formats are limited to 12 pills each 31 days. Copay or coinsurance per 31-day supply
• Generics	$15 copay
• Preferred Brands	$45 copay
• Non-Preferred Brands	$85 copay
Extra Covered Drugs - Georgia	
These are drugs that are covered on retiree drug plans issued in Georgia. These drugs are often excluded from Part D coverage, but are covered by your Senior Rx Plus benefits. If you have a deductible, it does not apply to these drugs.	
Contraceptive Devices	Copay or coinsurance per Covered Device
• Prescription	$45 copay

- **Coverage Gap Discount Program:** If you are not receiving help to pay your share of drug cost through the Low Income Subsidy or PACE programs, you qualify for a discount on the cost you pay for most covered brand drugs through the Medicare Coverage Gap Discount Program. For prescriptions filled in 2014, once the cost paid by you and your retiree drug plan reaches $2,850 the cost share you pay will reflect all benefits provided by your retiree drug coverage and the Coverage Gap Discount. The Coverage Gap Discount applies until the cost paid by you and the Discount reaches $4,550. Drug manufacturers have agreed to provide a discount on brand drugs which Medicare considers Part D qualified drugs. **Please note:** Your retiree drug plan may cover some brand drugs beyond those covered by Medicare. The discount will not apply to drugs listed as "Extra Covered Drugs" in your benefits.

- **Senior Rx Plus:** Your supplemental drug benefit is non-Medicare coverage that reduces the amount you pay, after your Group Part D benefits and the Coverage Gap Discount. The copay or coinsurance shown in this benefit chart is the amount you pay for covered drugs filled at network pharmacies.

TABLE OF CONTENTS

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

Chapter | Page

1. Getting started as a member 1

Explains what it means to be in a group sponsored Medicare health plan and how to use this booklet. Tells about materials we will send you, your plan premium, your plan membership card, and keeping your membership record up-to-date.

2. Important phone numbers and resources 15

Tells you how to get in touch with your plan and with other organizations including Medicare, the State Health Insurance Assistance Program (SHIP), the Quality Improvement Organization, Social Security, Medicaid (the state health insurance program for people with low incomes), programs that help people pay for their prescription drugs, and the Railroad Retirement Board.

3. Using the plan's coverage for your medical services 27

Explains important things you need to know about getting your medical care as a member of your plan. Topics include using the providers in the plan's network and how to get care when you have an emergency.

4. Medical Benefits (What is covered and what you pay) 42

Gives information about which types of medical care are covered and not covered for you as a member of your plan.

5. Using the plan's coverage for your Part D prescription drugs 51

Explains rules you need to follow when you get your Part D drugs. Tells how to use your plan's List of Covered Drugs (Formulary) to find out which drugs are covered. Tells which kinds of drugs are *not* covered. Explains several kinds of restrictions that apply to your coverage for certain drugs. Explains where to get your prescriptions filled. Tells about your plan's programs for drug safety and managing medications.

6. What you pay for your Part D prescription drugs 72

Tells about the stages of drug coverage including Deductible Stage, Initial Coverage Stage, Coverage Gap Stage, Catastrophic Coverage Stage and how these stages affect what you pay for your drugs. Explains the cost-sharing tiers for your Part D drugs. This chapter and the benefit chart located in the front of this booklet, tell what you must pay as your share of the cost for a drug in each cost-sharing tier. Tells about the late enrollment penalty.

TABLE OF CONTENTS (con't)

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

Chapter | Page

7. Asking the plan to pay its share of a bill you have received for covered medical services or drugs 93

Explains when and how to send a bill to us when you want to ask us to pay you back for our share of the cost for your covered services or drugs.

8. Your rights and responsibilities 101

Explains the rights and responsibilities you have as a member of your plan. Tells what you can do if you think your rights are not being respected.

9. What to do if you have a problem or complaint (coverage decisions, appeals, complaints) 117

Tells you step-by-step what to do if you are having problems or concerns as a member of your plan.

- Explains how to ask for coverage decisions and make appeals if you are having trouble getting the medical care or prescription drugs you think are covered by your plan. This includes asking us to make exceptions to the rules or extra restrictions on your coverage for prescription drugs, and asking us to keep covering hospital care and certain types of medical services if you think your coverage is ending too soon.
- Explains how to make complaints about quality of care, waiting times, customer service, and other concerns.

10. Ending your membership in your plan 175

Explains when and how you can end your membership in the plan. Explains situations in which your plan is required to end your membership.

11. Legal notices 185

Includes notices about governing law and about nondiscrimination.

12. Definitions of important words 192

Explains key terms used in this booklet.

13. State organization contact information 204

Tells you how to get in touch with other organizations including the State Health Insurance Assistance Program, the Quality Improvement Organization, etc.

Chapter

1.

2014 Evidence of Coverage for Medicare Preferred (PPO) with Senior Rx Plus

Getting started as a member

Section		Page
1	**Introduction**	2
1.1	You are enrolled in Medicare Preferred (PPO) with Senior Rx Plus, which is a group sponsored Medicare PPO with supplemental drug coverage	2
1.2	What is the Evidence of Coverage booklet about?	2
1.3	What does this Chapter tell you?	3
1.4	What if you are new to this plan?	3
1.5	Legal information about the Evidence of Coverage	3
2	**What makes you eligible to be a plan member?**	4
2.1	Your eligibility requirements	4
2.2	What are Medicare Part A and Medicare Part B?	4
2.3	Here is the plan service area for your plan	4
3	**What other materials will you get from us?**	5
3.1	Your plan membership card—Use it to get all covered care and prescription drugs	5
3.2	The Provider Directory: Your guide to all providers in the plan's network	6
3.3	The Pharmacy Directory: Your guide to pharmacies in our network	8
3.4	The plan's List of Covered Drugs (Formulary)	8
3.5	The Explanation of Benefits (the "EOB"): Reports with a summary of payments made for your Part D prescription drugs	8
4	**Your monthly premium for this plan**	9
4.1	How much is your plan premium?	9
4.2	Can we change your monthly plan premium during the year?	11
5	**Please keep your plan membership record up-to-date**	11
5.1	How to help make sure that we have accurate information about you	11
6	**We protect the privacy of your personal health information**	13
6.1	We make sure that your health information is protected	13
7	**How other insurance works with this plan**	13
7.1	Which plan pays first when you have other insurance?	13

SECTION 1 Introduction

Section 1.1 You are enrolled in Medicare Preferred (PPO) with Senior Rx Plus, which is a group sponsored Medicare PPO with supplemental drug coverage

You are covered by Medicare, and you have chosen to get your Medicare health care and your prescription drug coverage through your plan, Medicare Preferred (PPO) with Senior Rx Plus.

Blue Cross and Blue Shield of Georgia, Inc. is an independent licensee of the Blue Cross and Blue Shield Association. The Blue Cross and Blue Shield names and symbols are registered marks of the Blue Cross and Blue Shield Association.

There are different types of Medicare health plans. Medicare Preferred (PPO) is a Medicare Advantage PPO Plan (PPO stands for Preferred Provider Organization). Like all Medicare health plans, this Medicare PPO is approved by Medicare and run by a private company. In addition your retiree drug coverage includes non-Medicare supplemental drug coverage provided by your Senior Rx Plus benefits.

Section 1.2 What is the Evidence of Coverage booklet about?

This Evidence of Coverage booklet tells you how to get your Medicare medical care and prescription drugs coverage through your plan. This booklet explains your rights and responsibilities, what is covered, and what you pay as a member of the plan.

This booklet explains benefits you have under your Medicare prescription coverage (also referred to as Group Part D) and your non-Medicare supplemental drug coverage. We will refer to your complete drug coverage as your “retiree drug coverage” or “this plan.” Your retiree drug coverage includes basic coverage provided by Group Part D and supplemental coverage provided by Senior Rx Plus.

You are receiving a Certificate of Coverage for your Senior Rx Plus plan benefits, which explains in more detail how these supplemental benefits work.

This plan, Medicare Preferred (PPO) with Senior Rx Plus, is offered by Blue Cross and Blue Shield of Georgia. (When this Evidence of Coverage says “we,” “us,” or “our,” it means Blue Cross and Blue Shield of Georgia. When it says “retiree drug plan,” “plan” or “your plan,” it means Medicare Preferred (PPO) with Senior Rx Plus.)

The words “coverage” and “covered services” refer to the medical care and services and the prescription drugs available to you as a member of Medicare Preferred (PPO) with Senior Rx Plus.

Section 1.3 What does this Chapter tell you?

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

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

Section 1.4 What if you are new to your plan?

If you are a new member, then it's important for you to learn what your plan's rules are and what services are available to you. We encourage you to set aside some time to look through this Evidence of Coverage booklet.

If you are confused or concerned or just have a question, please contact Customer Service (phone numbers are printed on the front cover of this booklet).

Section 1.5 Legal information about the Evidence of Coverage

It's part of our contract with you

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

The benefits described in this Evidence of Coverage are in effect during the months listed on the first page, as long as you are a validly enrolled member in this plan.

Each calendar year, Medicare allows us to make changes to the plans that we offer. This means we can change the costs and benefits of your plan after December 31, 2014 or on your group sponsored plan's renewal date. We can also choose to stop offering the plan, or to offer it in a different service area, after December 31, 2014.

Medicare must approve your plan each year

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

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

Section 2.1 Your eligibility requirements

You are eligible for membership in your plan as long as:

- You live in our geographic service area (section 2.3 below describes our service area)
- —*and*— you have both Medicare Part A *and* Medicare Part B or you have Part B and your plan sponsor has made arrangements to cover Part A benefits as part of your plan.
- —*and*— you do *not* have End-Stage Renal Disease (ESRD), with limited exceptions, such as if you develop ESRD when you are already a member of a plan that we offer, or you were a member of a different plan that was terminated.
- You are eligible for coverage under your (or your spouse's) group sponsored health plan retiree benefits. If you have questions regarding your eligibility for coverage under your (or your spouse's) group sponsored retiree benefits, please contact the group's benefit administrator.

Section 2.2 What are Medicare Part A and Medicare Part B?

When you first signed up for Medicare, you received information about what services are covered under Medicare Part A and Medicare Part B. Remember:

- Medicare Part A generally helps cover services furnished by institutional providers such as hospitals (for inpatient services), skilled nursing facilities or home health agencies.
- Medicare Part B is for most other medical services (such as physician's services and other outpatient services) and certain items (such as durable medical equipment and supplies).

If you are not entitled to Medicare Part A, please refer to your plan sponsor's enrollment materials, or contact your plan sponsor directly. Some plan sponsors have made arrangements with us to cover Medicare Part A benefits as part of your plan.

Section 2.3 Here is the plan service area for your plan

Although Medicare is a Federal Program, your plan is available only to individuals who live in our geographic service area. To remain a member of your plan, you must keep living in this service area. The service area is described below. However, in certain situations, groups are allowed to cover their out-of-state retirees under this plan.

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

Our CMS defined geographic service area includes all 50 states, Washington, DC and Puerto Rico.

Your plan includes Medicare prescription drug coverage. Prescriptions may be purchased anywhere in the United States. In order to enroll in this prescription drug plan, your permanent residence must be in the geographic service area. If you move out of the service area, you must call your group and enroll in another retiree product. If you don't, you may be disenrolled from this plan.

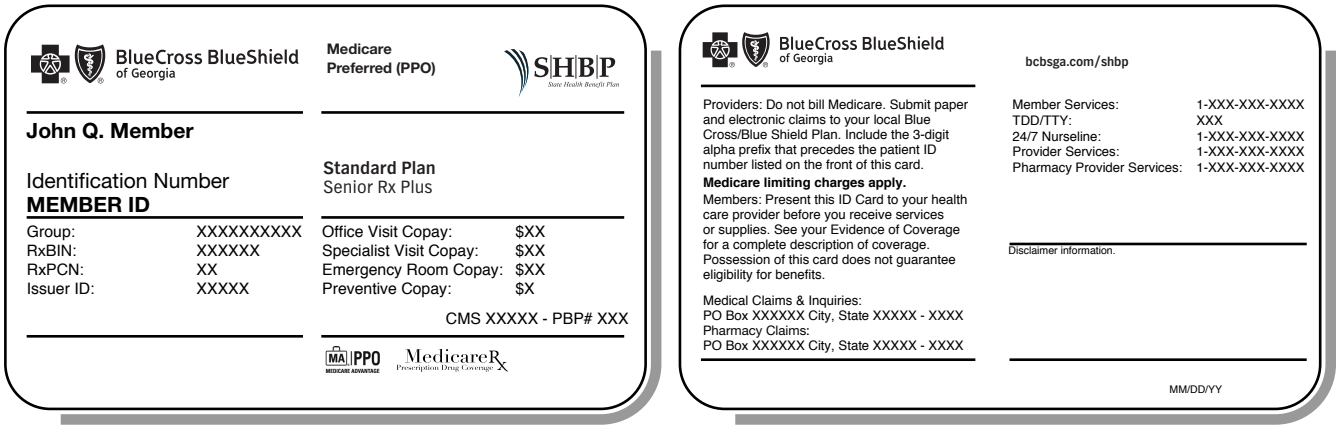
If you plan to move out of the service area, please contact Customer Service (phone numbers are printed on the front cover of this booklet).

It is also important that you call Social Security if you move or change your mailing address. You can find phone numbers and contact information for Social Security in Chapter 2, Section 5.

SECTION 3 What other materials will you get from us?

Section 3.1 Your plan membership card—Use it to get all covered care and prescription drugs

While you are a member of this plan, you must use your membership card for your plan whenever you get any services covered by this plan and for prescription drugs you get at network pharmacies. Here's a sample membership card to show you what yours will look like:



Sample Membership Card (Front and Back)

As long as you are a member of your plan **you must <u>not</u> use your red, white, and blue Medicare card** to get covered medical services. Keep your red, white, and blue Medicare card in a safe place in case you need it later.

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

If your plan membership card is damaged, lost, or stolen, call Customer Service right away and we will send you a new card. (Phone numbers for Customer Service are printed on the front cover of this booklet.)

Section 3.2 The Provider Directory: Your guide to all providers in the plan's network

The Provider Directory lists our in-network providers.

What are "in-network providers"?

In-network providers are the doctors and other health care professionals, medical groups, hospitals, and other health care facilities that have an agreement with us to accept our payment and any plan cost-sharing as payment in full. We have arranged for these providers to deliver covered services to members in your plan.

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

As a member of your plan, you can choose to receive care from out-of-network providers. Your plan will cover services from either in-network or out-of-network providers, as long as the services are covered benefits and medically necessary. However, if you use an out-of-network provider, your share of the costs for your covered services may be higher. See Chapter 3 (Using the plan's coverage for your medical services) for more specific information.

Please note: While you can get your care from an out-of-network provider, the provider must be enrolled and eligible to participate in Medicare. Except for emergency care, we cannot pay a provider who is not eligible to participate in Medicare. If you go to a provider who is not eligible to participate in Medicare, you will be responsible for the full cost of the services you receive. Check with your provider before receiving services to confirm that they are enrolled and eligible to participate in Medicare.

If you don't have your copy of the Provider Directory, you can request a copy from Customer Service (phone numbers are printed on the front cover of this booklet). You may ask Customer Service for more information about our network providers, including their qualifications.

How do you know if you are in an area with access to PPO participating providers?

To determine if you are in an area with access to a PPO participating provider (designated as a network county), please refer to your Provider Directory for information on participating network areas or call the Customer Service number on the back of your membership card.

How do you locate a provider?

To locate a Blue Medicare Advantage PPO in-network provider, you should:

- Call your plan's Customer Service phone number on the back of your membership card during regular business hours,
- Call 1-800-810-Blue (1-800-810-2583) to find a Blue Medicare Advantage PPO provider, or
- Visit the "Doctor & Hospital Finder" on our website to find a Blue Medicare Advantage PPO provider.

If you are in an area without access to Blue Medicare Advantage PPO in-network providers (designated as a non-network county), you can access care from an out-of-network provider.

1. If you are currently using providers that participate with Medicare, you should first inform your current providers that:
    - You are enrolled under a new plan.
    - Although the new plan is a PPO, you can continue to be seen by them if they agree.
2. If the provider elects to not provide services, you can self-refer to another provider that participates with Medicare.
3. If you are unable to find a provider, please contact Customer Service who will:
    - Respond with at least one provider of the requested provider type(s) within reasonable travel distance.
    - Respond within 72 hours for standard requests for a provider
    - Respond on the same day for urgent care services (medical services to be furnished within 12 hours in order to avoid the likely onset of an emergency medical condition).

Please note: Independent laboratory and specialty pharmacy claims are submitted to the plan based on the location of your referring/ordering provider. The independent lab and specialty pharmacy network status is determined based on the plan's service area for the referring provider. Durable Medical Equipment (DME) and supplies claims are submitted to the plan based on the location where the item is shipped to (your residence), or the location where the item was purchased from a retail store. The DME network status is determined based on the plan's service area for the location where the item was shipped to or where the item was purchased from a retail store.

Section 3.3 The Pharmacy Directory: Your guide to pharmacies in our network

What are "network pharmacies"?

Our Pharmacy Directory gives you a complete list of network pharmacies–that means all of the pharmacies that have agreed to fill covered prescriptions for plan members.

Your Group Part D and Senior Rx Plus coverage use the same network pharmacies.

Why do you need to know about network pharmacies?

You can use the Pharmacy Directory to find the network pharmacy you want to use. This is important because, with few exceptions, you must get your prescriptions filled at one of our network pharmacies if you want your plan to cover (help you pay for) them.

If you don't have the Pharmacy Directory, you can get a copy from Customer Service (phone numbers are printed on the front cover of this booklet). At any time, you can call Customer Service to get up-to-date information about changes in the pharmacy network. You can also find this information on our website.

Section 3.4 Your plan's List of Covered Drugs (Formulary)

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

The Drug List also tells you if there are any rules that restrict coverage for your drugs.

We will send you a copy of the Drug List. To get the most complete and current information about which drugs are covered, you can call Customer Service (phone numbers are printed on the front cover of this booklet).

Section 3.5 The Explanation of Benefits (the "EOB"): Reports with a summary of payments made for your Part D prescription drugs

When you use your Part D prescription drug benefits, we will send you a summary report to help you understand and keep track of payments for your Part D prescription drugs. This summary report is called the Explanation of Benefits (or the "EOB").

The Explanation of Benefits tells you the total amount you have spent on your Part D prescription drugs and the total amount your retiree drug coverage has paid for each of your Part D prescription drugs during the month. Chapter 6 (What you pay for your Part D

prescription drugs) gives more information about the Explanation of Benefits and how it can help you keep track of your drug coverage.

An Explanation of Benefits summary is also available upon request. To get a copy, please contact Customer Service (phone numbers are printed on the front cover of this booklet).

SECTION 4 Your monthly premium for your plan

Section 4.1 How much is your plan premium?

Your (or your spouse's) coverage is provided through a contract with your group. Please contact your (or your spouse's) group's benefit administrator to get information, on any plan premium amounts for which you may be responsible. Or, if you are billed directly by your plan, please contact Customer Service.

In some situations, your plan premium could be less

There are programs to help people with limited resources pay for their drugs. These include "Extra Help" and State Pharmaceutical Assistance Programs. Chapter 2 tells more about these programs. If you qualify, enrolling in the program might lower your monthly plan premium.

If you are already enrolled and getting "Extra Help" from one of these programs, we will send you a separate insert called the "Evidence of Coverage Rider for People Who Get 'Extra Help' Paying for Prescription Drugs" (also known as the "Low Income Subsidy Rider" or the "LIS Rider"), which tells you about your drug coverage. If you don't have this rider, please call Customer Service and ask for the "LIS Rider." (Phone numbers for Customer Service are printed on the front cover of this booklet.) Or, if you are a member of a State Pharmacy Assistance Program (SPAP) and they are helping with your premium costs, please contact your SPAP to determine what help is available to you. For contact information, please refer to the state-specific agency listing located in Chapter 13.

Because you are enrolled in a group sponsored plan, we will credit the amount of "Extra Help" received to your group's bill on your behalf. If your employer or union pays 100% of the premium for your retiree coverage, then they are entitled to keep these funds. However, if you contribute to the premium, your group must apply the subsidy toward the amount you contribute to this plan.

In some situations, your plan premium could be more

In some situations, you may owe additional money because of your income or when you enrolled in Part D. These situations are described below.

- Some members are required to pay a **late enrollment penalty** because they did not join a Medicare drug plan when they first became eligible or because they had a continuous period of 63 days or more when they didn't have "creditable" prescription drug coverage. ("Creditable" means the drug coverage is at least as good as Medicare's Part D coverage.) For these members, the monthly late enrollment penalty amount is added to the plan's monthly premium. Their premium amount will be the monthly plan premium plus the amount of their late enrollment penalty. For members on group sponsored plans, this amount is usually charged to the group.
    - If you are required to pay the late enrollment penalty, the amount of your penalty depends on how long you waited before you enrolled in drug coverage or how many months you were without drug coverage after you became eligible. Chapter 6, Section 10 explains the late enrollment penalty.
    - If you think that you may have a late enrollment penalty, you may want to contact your (or your spouse's) group's benefit administrator to find out what you will have to pay towards the penalty. Or, if you are billed directly by your plan, please contact Customer Service.
    - If you have a late enrollment penalty and do not pay it, you could be disenrolled from the plan.

Many members are required to pay other Medicare premiums

In addition to paying the monthly plan premium, many members are required to pay other Medicare premiums. As explained in Section 2 above, in order to be eligible for your plan, you must be enrolled in Medicare Part B. **You must continue paying your Medicare premiums for you to remain as a member of the plan.**

Some people pay an extra amount for Part D because of their yearly income. If your income is $85,000 or above for an individual (or married individuals filing separately) or $170,000 or above for married couples, you must pay an extra amount directly to the government (not the Medicare plan) for your Medicare Part D coverage.

- **If you are required to pay the extra amount and you do not pay it, you <u>will</u> be disenrolled from the plan and lose prescription drug coverage.**
- If you have to pay an extra amount, Social Security, **not your Medicare plan,** will send you a letter telling you what that extra amount will be.

- For more information about Part D premiums based on income, go to Chapter 4, Section 11 of this booklet. You can also visit http://www.medicare.gov on the web or call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048. Or you may call Social Security at 1-800-772-1213. TTY users should call 1-800-325-0778

Your copy of *Medicare & You 2014* gives information about the Medicare premiums in the section called "2014 Medicare Costs." This explains how the Medicare Part B and Part D premiums differ for people with different incomes. Everyone with Medicare receives a copy of *Medicare & You* each year in the fall. Those new to Medicare receive it within a month after first signing up. You can also download a copy of *Medicare & You 2014* from the Medicare website (http://www.medicare.gov). Or, you can order a printed copy by phone at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users call 1-877-486-2048.

Section 4.2 Can we change your monthly plan premium during the year?

Generally, your plan premium won't change during the benefit year. We will tell you in advance if there will be any changes for the next benefit year in your plan premiums or in the amounts you will have to pay when you get your prescriptions covered.

However, in some cases the part of the premium that you have to pay can change during the year. This happens if you become eligible for the "Extra Help" program or if you lose your eligibility for the "Extra Help" program during the year. If you qualify for the "Extra Help" program with your prescription drug costs, the "Extra Help" program will pay part of your monthly plan premium. So if you become eligible for "Extra Help" during the year, you would begin to pay less towards your monthly premium. And if you lose eligibility during the year, you will need to start paying the full monthly premium.

You can find out more about the "Extra Help" program in Chapter 2, Section 7.

SECTION 5 Please keep your plan membership record up to date

Section 5.1 How to help make sure that we have accurate information about you

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

The doctors, hospitals, pharmacists and other providers in the plan's network need to have correct information about you. **These network providers use your membership record**

to know what services and drugs are covered and the cost-sharing amounts for you. Because of this, it is very important that you help us keep your information up to date.

Let us know about these changes:

- Changes to your name, your address or your phone number
- Changes in any other health insurance coverage you have (such as from a group, employer or union, your spouse's employer or union, workers' compensation or Medicaid)
- If you have any liability claims, such as claims from an automobile accident
- If you have been admitted to a nursing home
- If you receive care in an out-of-area or out-of-network hospital or emergency room
- If your designated responsible party (such as a caregiver) changes
- If you are participating in a clinical research study

If any of this information changes, please let us know by calling Customer Service (phone numbers are printed on the front cover of this booklet).

It is also important to contact Social Security if you move or change your mailing address. You can find phone numbers and contact information for Social Security in Chapter 2, Section 5.

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

Medicare requires that we collect information from you about any other medical or drug insurance coverage that you have in addition to this retiree drug coverage. That's because we must coordinate any other coverage you have with your benefits under this plan. (For more information about how our coverage works when you have other insurance, see Section 7 in this chapter.)

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

SECTION 6 We protect the privacy of your personal health information

Section 6.1 We make sure that your health information is protected

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

For more information about how we protect your personal health information, please go to Chapter 8, Section 1.4 of this booklet.

SECTION 7 How other insurance works with this plan

Section 7.1 Which plan pays first when you have other insurance?

When you have other insurance, there are rules set by Medicare that decide which of your insurance plans pays first, and which pays second or even third. The insurance that pays first is called the "primary payer" and pays up to the limits of its coverage. The one that pays second, called the "secondary payer," only pays if there are costs left uncovered by the primary coverage. The secondary payer may not pay all of the uncovered costs. This retiree drug coverage includes basic coverage provided by Group Part D benefits and additional coverage provided by your Senior Rx Plus supplemental benefits.

Your Group Part D and Senior Rx Plus coverage always work together so that you pay the copay or coinsurance shown in the benefit chart in front of this booklet when you get covered drugs at a network pharmacy. Between these two coverages, Group Part D makes the primary payment and Senior Rx Plus makes secondary payments for all Part D eligible drugs.

Additionally, if your plan covers drugs beyond those covered by Medicare (we call these drugs "Extra Covered Drugs") your Senior Rx Plus coverage will make the primary payment for these drugs.

If you have another group sponsored health plan in addition to this plan, the following rules will be used to determine whether this retiree drug coverage or your other coverage pays first:

- If you have retiree coverage, Medicare pays first.
- If your group sponsored health plan coverage is based on your or a family member's current employment, who pays first depends on your age, the size of the group, and whether you have Medicare based on age, disability, or End-Stage Renal Disease (ESRD):

  - If you're under 65 and disabled and you or your family member is still working, your plan pays first if the group has 100 or more employees or at least one group in a multiple group sponsored plan has more than 100 employees.
  - If you're over 65 and you or your spouse is still working, the plan pays first if the group has 20 or more employees or at least one group in a multiple group sponsored plan has more than 20 employees.
- If you have Medicare because of ESRD, your group sponsored health plan will pay first for the first 30 months after you become eligible for Medicare.

These types of coverage usually pay first for services related to each type:

- No-fault insurance (including automobile insurance)
- Liability (including automobile insurance)
- Black lung benefits
- Workers' compensation

Medicaid and TRICARE never pay first for Medicare-covered services. They only pay after Medicare, group sponsored health plans, and/or Medigap have paid.

If you have other insurance, tell your doctor, hospital, and pharmacy. If you have questions about who pays first, or you need to update your other insurance information, call Customer Service (phone numbers are printed on the front cover of this booklet.) You may need to give your plan member ID number to your other insurers (once you have confirmed their identity) so your bills are paid correctly and on time.

Important phone numbers and resources

Section		Page
1	**Your plan contacts** (how to contact us, including how to reach Customer Service for the plan)	16
2	**Medicare** (how to get help and information directly from the Federal Medicare program)	19
3	**State Health Insurance Assistance Program** (free help, information, and answers to your questions about Medicare)	20
4	**Quality Improvement Organization** (paid by Medicare to check on the quality of care for people with Medicare)	21
5	**Social Security**	22
6	**Medicaid** (a joint Federal and State Program that helps with medical costs for some people with limited income and resources)	23
7	**Information about programs to help people pay for their prescription drugs**	23
8	**How to contact the Railroad Retirement Board**	26
9	**Do you have "group insurance" or other health insurance from another group?**	26

SECTION 1 Your plan contacts (how to contact us, including how to reach Customer Service at your plan)

How to contact your plan's Customer Service

For assistance with claims, billing or member card questions, please call or write to Customer Service. We will be happy to help you.

	Customer Service
CALL	1-855-322-7062 Calls to this number are free. 8 a.m. to 8 p.m. ET, Monday through Friday. Customer Service also has free language interpreter services available for non-English speakers.
TTY	711 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free. 8 a.m. to 8 p.m. ET, Monday through Friday.
WRITE	Medicare Preferred (PPO) with Senior Rx Plus P.O. Box 110 Fond du Lac, WI 54936
WEBSITE	www.bcbsga.com/shbp

How to contact us when you are asking for a coverage decision, making an appeal or complaint about your medical care or Part D prescription drugs

A coverage decision is a decision we make about your benefits and coverage or about the amount we will pay for your medical services or Part D prescription drugs. For more information on asking for coverage decisions about your medical care or Part D prescription drugs, see Chapter 9 (What to do if you have a problem or complaint (coverage decisions, appeals, complaints)).

An appeal is a formal way of asking us to review and change a coverage decision we have made. For more information on making an appeal about your medical care or Part D prescription drugs, see Chapter 9 (What to do if you have a problem or complaint (coverage decisions, appeals, complaints)).

You can make a complaint about us or one of our network providers or pharmacies, including a complaint about the quality of your care. This type of complaint does not involve coverage or payment disputes. (If you have a problem about the plan's coverage or payment, you should look at the section above about making an appeal.) For more information on making a complaint about your medical care or Part D prescription drugs, see Chapter 9 (What to do if you have a problem or complaint (coverage decisions, appeals, complaints)).

You may call us if you have questions about our coverage decision, appeals or complaint processes. You only need to request a coverage decision, submit an appeal or a complaint once. We will process your request against both your Medicare medical and prescription coverage and Senior Rx Plus supplemental drug coverages.

	Coverage Decisions, Appeals, or Complaints
CALL	1-855-322-7062 Calls to this number are free. 8 a.m. to 8 p.m. ET, Monday through Friday If you have a request for an expedited appeal, please call the Customer Service number listed on your membership card.
TTY	711 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free. 8 a.m. to 8 p.m. ET, Monday through Friday If you have a request for an expedited appeal, please call the Customer Service number listed on your membership card.
WRITE	Senior Appeals and Grievances 4361 Irwin Simpson Rd. Mason, OH 45040
WEBSITE	www.bcbsga.com/shbp
MEDICARE WEBSITE	You can submit a complaint about your plan directly to Medicare. To submit an online complaint to Medicare go to www.medicare.gov/MedicareComplaintForm/home.aspx.

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

For more information on situations in which you may need to ask us for reimbursement or to pay a bill you have received from a provider, see Chapter 7 (Asking your plan to pay our share of a bill you have received for covered medical services or drugs).

Please note: If you send us a payment request and we deny any part of your request, you can appeal our decision. See Chapter 9 (What to do if you have a problem or complaint (coverage decisions, appeals, complaints)) for more information.

	Payment Requests
CALL	1-855-322-7062 8 a.m. to 8 p.m. ET, Monday through Friday Calls to this number are free.
TTY	711 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free.
WRITE	Medicare Preferred (PPO) with Senior Rx Plus P.O. Box 110 Fond du Lac, WI 54936

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

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

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

Medicare

CALL
1-800-MEDICARE, or 1-800-633-4227
Calls to this number are free.
24 hours a day, 7 days a week.

TTY
1-877-486-2048
This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.

Calls to this number are free.

WEBSITE
http://www.medicare.gov

This is the official government website for Medicare. It gives you up-to-date information about Medicare and current Medicare issues. It also has information about hospitals, nursing homes, physicians, home health agencies, and dialysis facilities. It includes booklets you can print directly from your computer. You can also find Medicare contacts in your state.

The Medicare website also has detailed information about your Medicare eligibility and enrollment options with the following tools:

- **Medicare Eligibility Tool:** Provides Medicare eligibility status information.
- **Medicare Plan Finder:** Provides personalized information about available Medicare prescription drug plans, Medicare health plans, and Medigap (Medicare Supplement Insurance) policies in your area. These tools provide an *estimate* of what your out-of-pocket costs might be in different Medicare plans.

WEBSITE (con't)

You can also use the website to tell Medicare about any complaints you have about your plan:

- **Tell Medicare about your complaint:** You can submit a complaint about your plan directly to Medicare. To submit a complaint to Medicare, go to www.medicare.gov/MedicareComplaintForm/home.aspx. Medicare takes your complaints seriously and will use this information to help improve the quality of the Medicare program.

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. Or, you can call Medicare at the number above and tell them what information you are looking for. They will find the information on the website, print it out, and send it to you. (You can call Medicare at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.)

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

The State Health Insurance Assistance Program (SHIP) is a government program with trained counselors in every state. The State Health Insurance Assistance Program (SHIP) is independent (not connected with any insurance company or health plan). It is a State Program that gets money from the Federal government to give free local health insurance counseling to people with Medicare.

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

For contact information, please refer to the state-specific agency listing, which is located in Chapter 13 of this booklet.

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

There is a Quality Improvement Organization (QIO) for each state. QIOs have different names depending on which state they are in.

The Quality Improvement Organization has a group of doctors and other health care professionals who are paid by the Federal government. This organization is paid by Medicare to check on and help improve the quality of care for people with Medicare. It is an independent organization. It is not connected with your plan.

You should contact QIO in any of these situations:

- You have a complaint about the quality of care you have received.
- You made a complaint to your plan and you don't like our response to your complaint.
- You think coverage for your hospital stay is ending too soon.
- You think coverage for your home health care, skilled nursing facility care, or Comprehensive Outpatient Rehabilitation Facility (CORF) services are ending too soon.

For contact information, please refer to the state-specific agency listing located in Chapter 13 of this booklet.

SECTION 5 Social Security

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

Social Security is also responsible for determining who has to pay an extra amount for their Part D drug coverage because they have a higher income. If you got a letter from Social Security telling you that you have to pay the extra amount and have questions about the amount or if your income went down because of a life-changing event, you can call Social Security to ask for a reconsideration.

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

Social Security

CALL

1-800-772-1213

Calls to this number are free.
Available 7:00 a.m. to 7:00 p.m. ET, Monday through Friday.

You can use Social Security's automated telephone services to get recorded information and conduct some business 24 hours a day.

TTY

1-800-325-0778

This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.

Calls to this number are free.

Available 7:00 a.m. to 7:00 p.m. ET, Monday through Friday.

WEBSITE

http://www.ssa.gov

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

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

In addition, there are programs offered through Medicaid that help people with Medicare pay their Medicare costs, such as their Medicare premiums. These "Medicare Savings Programs" help people with limited income and resources save money each year:

- **Qualified Medicare Beneficiary (QMB):** Helps pay Medicare Part A and Part B premiums, and other cost-sharing (like deductibles, coinsurance, and copayments). (Some people with QMB are also eligible for full Medicaid benefits (QMB+).)
- **Specified Low-Income Medicare Beneficiary (SLMB):** Helps pay Part B premiums. (Some people with SLMB are also eligible for full Medicaid benefits (SLMB+).)
- **Qualified Individual (QI):** Helps pay Part B premiums.
- **Qualified Disabled & Working Individuals (QDWI):** Helps pay Part A premiums.

To find out more about Medicaid and its programs, please refer to the state-specific agency listing located in Chapter 13.

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

Medicare's "Extra Help" Program

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

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

You may be able to get "Extra Help" to pay for your prescription drug premiums and costs. To see if you qualify for getting "Extra Help," call:

- 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048, 24 hours a day, 7 days a week;
- The Social Security Office at 1-800-772-1213, between 7 a.m. to 7 p.m., Monday through Friday. TTY users should call 1-800-325-0778; or
- Your State Medicaid Office. (See Section 6 of this chapter for contact information.)

If you believe you have qualified for "Extra Help" and you believe that you are paying an incorrect cost-sharing amount when you get your prescription at a pharmacy, your plan has established a process that allows you to either request assistance in obtaining evidence of your proper copayment level, or, if you already have the evidence, to provide this evidence to us.

- When we receive the evidence showing your copayment level, we will update our system so that you can pay the correct copayment when you get your next prescription at the pharmacy. If you overpay your copayment, we will reimburse you. Either we will forward a check to you in the amount of your overpayment or we will offset future copayments. If the pharmacy hasn't collected a copayment from you and is carrying your copayment as a debt owed by you, we may make the payment directly to the pharmacy. If a state paid on your behalf, we may make payment directly to the state. Please contact Customer Service if you have questions (phone numbers are printed on the front cover of this booklet).
- There are programs in Puerto Rico, the Virgin Islands, Guam, the Northern Mariana Islands, and American Samoa to help people with limited income and resources pay their Medicare costs. Programs vary in these areas. Call your local Medical Assistance (Medicaid) office to find out more about their rules (phone numbers are in Section 6 of this chapter). Or call 1-800-MEDICARE (1-800-633-4227) 24 hours a day, 7 days a week and say "Medicaid" for more information. TTY users should call 1-877-486-2048. You can also visit http://www.medicare.gov for more information.

Medicare Coverage Gap Discount Program

If you are not receiving help to pay your share of drug costs through the Low Income Subsidy or PACE programs, you qualify for a discount on the cost you pay for most covered brand drugs through the Medicare Coverage Gap Discount Program. For prescriptions filled in 2014, once the cost paid by you and your retiree drug plan reaches $2,850 the cost share you pay will reflect all benefits provided by your retiree drug coverage and the Coverage Gap Discount. The Coverage Gap Discount applies until the cost paid by you and the Discount reaches $4,550. Drug manufacturers have agreed to provide a discount on brand drugs which Medicare considers Part D qualified drugs. **Please note:** Your retiree drug plan may cover some brand drugs beyond those covered by Medicare. The discount will not apply to drugs listed as "Extra Covered Drugs" in your benefits.

If you reach the coverage gap, we will automatically apply the discount when your pharmacy bills you for your prescription and your Explanation of Benefits (EOB) will show any discount provided. It will also reflect the coverage provided by your Senior Rx Plus supplemental coverage after the discount is applied. Both the amount you pay and the amount discounted by the manufacturer count toward your out-of-pocket costs as if you had paid them and moves you through the coverage gap.

If you have any questions about the availability of discounts for the drugs you are taking or about the Medicare Coverage Gap Discount Program in general, please contact Customer Service (phone numbers are printed on the front cover of this booklet).

What if you have coverage from a State Pharmaceutical Assistance Program (SPAP)?

If you are enrolled in a State Pharmaceutical Assistance Program (SPAP), or any other program that provides coverage for Part D drugs (other than "Extra Help"), you still get the 50% discount on covered brand-name drugs. The 50% discount is applied to the price of the drug before any SPAP or other coverage.

What if you get "Extra Help" from Medicare to help pay your prescription drug costs? Can you get the discounts?

No. If you get "Extra Help," you already get coverage for your prescription drug costs during the coverage gap.

What if you don't get a discount, and you think you should have?

If you think that you have reached the coverage gap and did not get a discount when you paid for your brand-name drug, you should review your next Explanation of Benefits (EOB) notice. If the discount doesn't appear on your Explanation of Benefits, you should contact us to make sure that your prescription records are correct and up to date. If we don't agree that you are owed a discount, you can appeal. You can get help filing an appeal from your State Health Insurance Assistance Program (SHIP) (telephone numbers are located in Chapter 13 of this booklet) or by calling 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

State Pharmaceutical Assistance Programs

Many states have State Pharmaceutical Assistance Programs that help some people pay for prescription drugs based on financial need, age, or medical condition. Each state has different rules to provide drug coverage to its members.

These programs provide limited income and medically needy Medicare beneficiaries and individuals with disabilities financial help for prescription drugs. To find out more about SPAP, please refer to the state-specific agency listing located in Chapter 13 of this booklet.

SECTION 8 How to contact the Railroad Retirement Board

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

If you receive your Medicare through the Railroad Retirement Board, it is important that you let them know if you move or change your mailing address.

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

SECTION 9 Do you have "group insurance" or other health insurance from another group?

If you have group insurance from another group, employer or union, please contact that group's benefits administrator to identify how that coverage will work with these benefits.

Chapter 3.

2014 Evidence of Coverage for Medicare Preferred (PPO) with Senior Rx Plus

Using the plan's coverage for your medical services

Section		Page
1	**Things to know about getting your medical care covered as a member of your plan**	29
1.1	What are "in-network providers" and "covered services"?	29
1.2	Basic rules for getting your medical care covered by the plan	29
2	**Using in-network and out-of-network providers to get your medical care**	30
2.1	How to get care from specialists and other in-network providers	30
2.2	How to get care from out-of-network providers	31
3	**How to get covered services when you have an emergency or urgent need for care**	32
3.1	Getting care if you have a medical emergency	32
3.2	Getting care when you have an urgent need for care	33
4	**What if you are billed directly for the full cost of your covered services?**	34
4.1	You can ask the plan to pay our share of the cost of your covered services	34
4.2	If services are not covered by your plan, you must pay the full cost	34
5	**How are your medical services covered when you are in a "clinical research study"?**	35
5.1	What is a "clinical research study"?	35
5.2	When you participate in a clinical research study, who pays for what?	36
6	**Rules for getting care covered in a "religious non-medical health care institution"**	37
6.1	What is a religious non-medical health care institution?	37
6.2	What care from a religious non-medical health care institution is covered by your plan?	37
7	**Rules for ownership of durable medical equipment**	38
7.1	Will you own the durable medical equipment after making a certain number of payments under your plan?	38

Section		Page
8	**Information about hospice care**	39
8.1	What is hospice care?	39
8.2	How do you get hospice care if you are terminally ill?	39
8.3	How is your hospice care paid for?	40
9	**Information about organ transplants**	40
9.1	How to get an organ transplant if you need it	40

SECTION 1 Things to know about getting your medical care covered as a member of your plan

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

For the details on what medical care is covered by the plan and how much you pay when you get this care, use the benefit chart located in the front of this booklet and Chapter 4 Medical Benefits (What is covered and what you pay).

Section 1.1 What are "in-network providers" and "covered services"?

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

- **"Providers"** are doctors and other health care professionals licensed by the state to provide medical services and care. The term "providers" also includes hospitals and other health care facilities. Your plan may cover additional supplemental benefits such as dental, hearing and vision. Please review the benefit chart located in the front of this booklet to see if you have coverage for these benefits. These benefits are typically located under the "Additional Benefits" section of the benefit chart. These benefits do not require you to see an in-network provider. (Definition of an **In-Network Provider** is located in Chapter 12.)
- **"Covered services"** include all the medical care, health care services, supplies and equipment that are covered by your plan. Your covered services for medical care are listed in the benefits chart located in the front of this booklet.

Section 1.2 Basic rules for getting your medical care covered by your plan

As a Medicare health plan, your plan must cover all services covered by Original Medicare and must follow Original Medicare's coverage rules.

Your plan will generally cover your medical care as long as:

- **The care you receive is included in the plan's medical benefit chart** (this chart is located in the front of this booklet).
- **The care you receive is considered medically necessary**. "Medically necessary" means that the services, supplies, or drugs are needed for the prevention, diagnosis, or treatment of your medical condition and meet accepted standards of medical practice.

- **You receive your care from a provider who is eligible to provide services under Original Medicare.** As a member of your plan, you can receive your care from either an in-network provider or an out-of-network provider (for more about this, see Section 2 in this chapter).
  - The providers in our network are listed in the Provider Directory.
  - If you are in an area without in-network providers available to see (designated as a non-network county), you can go to an out-of-network provider but you will only be responsible to pay the in-network cost-sharing amounts.
- **Please note:** While you can get your care from an out-of-network provider, the provider must be eligible to participate in Medicare. Except for emergency care, we cannot pay a provider who is not eligible to participate in Medicare. If you go to provider who is not eligible to participate in Medicare, you will be responsible for the full cost of the services you receive. Check with your provider before receiving services to confirm that they are eligible to participate in Medicare.

SECTION 2 Using in-network and out-of-network providers to get your medical care

Section 2.1 How to get care from specialists and other in-network providers

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

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

You do not need to obtain a referral before going to an in-network specialist. See your Provider Directory and our website for provider information about in-network specialists.

For certain services, your in-network physician will need to get prior approval from us. This is called getting "prior authorization." Please refer to your benefit chart located in the front of this booklet for the services which require prior authorization.

What if a specialist or another in-network provider leaves your plan?

Sometimes a specialist, clinic, hospital or other in-network provider you are using might leave the plan. If your provider leaves the network, you may choose another provider who is part of your plan for covered services.

If that happens, we will notify you by mail. If a specialist you used leaves the network, you may choose another specialist by looking in the provider directory we send you; by going to our website for your plan and searching the provider finder; or by calling Customer Service for assistance (phone numbers are printed on the front cover of this booklet). If a facility provider you used leaves the network, the notification letter we send you will include the names of similar facilities in your area that remain in the network.

Section 2.2 How to get care from out-of-network providers

As a member of your plan, you can choose to receive care from out-of-network providers. Your plan will cover services from either in-network or out-of-network providers, as long as the services are covered benefits and are medically necessary. **However, if you use an out-of-network provider, your share of the costs for your covered services may be higher.** Here are other important things to know about using out-of-network providers:

- You can get your care from an out-of-network provider, however, in most cases that provider must be eligible to participate in Medicare. Except for emergency care, we cannot pay a provider who is not eligible to participate in Medicare. If you receive care from a provider who is not eligible to participate in Medicare, you will be responsible for the full cost of the services you receive. Check with your provider before receiving services to confirm that they are eligible to participate in Medicare.
- You don't need to get a referral or prior authorization when you get care from out-of-network providers. However, before getting services from out-of-network providers you may want to ask for a pre-visit coverage decision to confirm that the services you are getting are covered and are medically necessary. (See Chapter 9, Section 4 for information about asking for coverage decisions.) This is important because:
    - Without a pre-visit coverage decision, if we later determine that the services are not covered or were not medically necessary, we may deny coverage and you will be responsible for the entire cost. If we say we will not cover your services, you have the right to appeal our decision not to cover your care. See Chapter 9 (What to do if you have a problem or complaint) to learn how to make an appeal.
- It is best to ask an out-of-network provider to bill their local Blue Cross and Blue Shield plan first. But, if you have already paid for the covered services, we will reimburse you for our share of the cost for covered services. Or if an out-of-network provider sends you a bill that you think we should pay, you can send it to us for payment. See Chapter 7 (Asking the plan to pay its share of a bill you have received for covered medical services or drugs) for information about what to do if you receive a bill or if you need to ask for reimbursement.

- Our CMS defined geographic service area includes all 50 states, Puerto Rico and Washington, DC. Although most Medicare Advantage PPO members will have access to contracting providers, you may need to obtain services from out-of-network providers. If you are in an area without in-network providers available for you to see (designated as a non-network county), you can go to an out-of-network provider for covered services.

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

Section 3.1 Getting care if you have a medical emergency

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

A **"medical emergency"** is when you, or any other prudent layperson with an average knowledge of health and medicine, believe that you have medical symptoms that require immediate medical attention to prevent loss of life, loss of a limb, or loss of function of a limb. The medical symptoms may be an illness, injury, severe pain, or a medical condition that is quickly getting worse.

If you have a medical emergency:

- **Get help as quickly as possible.** Call 911 for help or go to the nearest emergency room or hospital. Call for an ambulance if you need it. You do *not* need to get approval or a referral first from your provider.
- As soon as possible, notify us of your emergency by calling Customer Service (phone numbers are listed on the front cover of this booklet).

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 or its territories. (Please refer to the benefit chart, located in the front of this booklet to see if your plan offers Foreign Travel emergency coverage.) Your plan covers ambulance services in situations where getting to the emergency room in any other way could endanger your health. For more information, see the benefit chart in the front of this booklet.

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

After the emergency is over, you are entitled to follow-up care to be sure your condition continues to be stable. Your follow-up care will be covered by your plan. If you get your follow-up care from out-of-network providers, you may have to pay the higher out-

of-network cost-sharing. For more information, please refer to the benefit chart in the beginning of this booklet.

Your plan may cover emergency care outside of the United States. Please refer to the benefit chart at the front of this booklet for additional information.

What if it wasn't a medical emergency?

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

Medical care when a federal disaster/emergency is declared

In the event of a Presidential or Governor emergency or major disaster declaration or an announcement of a public health emergency by the Secretary of Health and Human Services, your plan will make the following exceptions to assure adequate care during the emergency:

- Approve services to be furnished at specified non-contracted facilities that are considered a Medicare certified facility;
- Temporarily reduce cost-sharing for plan-approved out-of-network services to the in-network cost-sharing amounts; and
- Waive, in full, the requirements for a primary physician referral where applicable;

Typically, the source that declared the disaster will clarify when the disaster or emergency is over. If, however, the disaster or emergency time frame has not been closed within 30 days from the initial declaration, and if CMS has not indicated an end date to the disaster or emergency, your plan will resume normal operations 30 days from the initial declaration.

When a disaster or emergency is declared, it is specific to a geographic location (ie: county). Your plan will apply the above exceptions only if you reside in the geographic location indicated.

Section 3.2 Getting care when you have an urgent need for care

What is "urgently needed care"?

"Urgently needed care" is a non-emergency, unforeseen medical illness, injury, or condition, that requires immediate medical care. Urgently needed care may be furnished by in-network providers or by out-of-network providers when in-network providers are temporarily unavailable or inaccessible. The unforeseen condition could, for example, be an unforeseen flare-up of a known condition that you have.

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

Your plan may cover urgently needed care outside of the United States. Please refer to the benefit chart located in the front of this booklet for additional information.

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

Section 4.1 You can ask the plan to pay our share of the cost of your covered services

If you have paid more than your share for covered services, or if you have received a bill for the full cost of covered medical services, go to Chapter 7 (Asking the plan to pay its share of a bill you have received for covered medical services or drugs) for information about what to do.

Section 4.2 If services are not covered by your plan, you must pay the full cost

The plan covers all medical services that are medically necessary, are listed in the plan's medical benefit chart (located in the front of this book), and are obtained consistent with plan rules. You are responsible for paying the full cost of services that aren't covered by your plan, either because they are not plan-covered services, or plan rules were not followed.

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

Chapter 9 (What to do if you have a problem or complaint (coverage decisions, appeals, complaints)) has more information about what to do if you want a coverage decision from us or want to appeal a decision we have already made. You may also call Customer Service to get more information about how to do this (phone numbers are printed on the front cover of this booklet).

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. These costs will not count towards your out-of-pocket maximum. You can call Customer Service when you want to know how much of your benefit limit you have already used.

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

Section 5.1 What is a "clinical research study"?

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

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

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

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

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

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

1. We can let you know whether the clinical research study is Medicare-approved.
2. We can tell you what services you will get from clinical research study providers instead of from your plan.

If you plan on participating in a clinical research study, contact Customer Service (phone numbers are printed on the front cover of this booklet).

Section 5.2 When you participate in a clinical research study, who pays for what?

Once you join a Medicare-approved clinical research study, original Medicare may provide coverage for routine items and services you receive as part of the study, depending upon Medicare approval, including:

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

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

Original Medicare pays most of the cost of the covered services received as part of the study. After Medicare has paid its share of the cost for these services, your plan will also pay for part of the Part B related costs. We will pay the difference between the cost-sharing in Original Medicare and your cost-sharing as a member of your plan. This means you will pay the same amount for the services you receive as part of the study as you would if you received these services from your plan.

Here's an example of how the cost-sharing works: Let's say that you have a lab test that costs $100 as part of the research study. Let's also say that your share of the costs for this test is $20 under Original Medicare, but the test would be $10 under your plan's benefits. In this case, Original Medicare would pay $80 for the test and we would pay another $10. This means that you would pay $10, which is the same amount you would pay under your plan's benefits.

In order for us to pay for our share of the costs, you will need to submit a request for payment. With your request, you will need to send us a copy of your Medicare Summary Notices or other documentation that shows what services you received as part of the study and how much you owe. Please see Chapter 7 for more information about submitting requests for payment.

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

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

Do you want to know more?

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

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

Section 6.1 What is a religious non-medical health care institution?

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

Section 6.2 What care from a religious non-medical health care institution is covered by your plan?

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

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

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

- The facility providing the care must be certified by Medicare.
- Your plan's coverage of services you receive is limited to *non-religious* aspects of care.
- If you get services from this institution that are provided to you in your home, your plan will cover these services only if your condition would ordinarily meet the conditions for coverage of services given by home health agencies that are not religious non-medical health care institutions.
- If you get services from this institution that are provided to you in a facility, the following conditions apply:
  - You must have a medical condition that would allow you to receive covered services for inpatient hospital care or skilled nursing facility care.
  - And you must get approval in advance from our plan before you are admitted to the facility or your stay will not be covered.

SECTION 7 Rules for ownership of durable medical equipment

Section 7.1 Will you own the durable medical equipment after making a certain number of payments under your plan?

Durable medical equipment includes items such as oxygen equipment and supplies, wheelchairs, walkers, and hospital beds ordered by a provider for use in the home. Certain items, such as prosthetics, are always owned by the member. In this section, we discuss other types of durable medical equipment that must be rented.

In Original Medicare, people who rent non-oxygen related types of durable medical equipment (DME) own the equipment after paying coinsurance or copayments for the item for a period of 13 months. As a member of your plan, you will acquire ownership of rented durable medical equipment provided by a contracted DME supplier in 10 months. Some of the out-of-network DME providers are reimbursed for a period of 13 months before ownership transfers to the member.

Oxygen related equipment provided by an in-network provider has no limit on the months of rental, however, the coinsurance or copayments are limited to the first 36 months. You will not acquire ownership of the oxygen equipment provided by an in-network provider. Some out-of network DME provider oxygen equipment will transfer ownership to the member after 36 months of rental.

If you made payments for the durable medical equipment item under a previous Medicare Advantage plan *before* you joined this plan, these previous Medicare Advantage payments will count toward the consecutive payments.

What happens to payments you have made for durable medical equipment if you switch to Original Medicare?

If you switch to Original Medicare after being a member of your plan: If you did not acquire ownership of the durable medical equipment item while in your plan, you will have to make 13 consecutive payments for the item while in Original Medicare in order to acquire ownership of the item. Your previous payments while in your plan do not count toward these new 13 consecutive payments.

If you made payments for the durable medical equipment item under Original Medicare *before* you joined our plan, these previous Original Medicare payments also do not count toward the 13 consecutive payments. You will have to make 13 consecutive payments for the item under Original Medicare in order to acquire ownership. There are no exceptions to this case when you return to Original Medicare.

SECTION 8 Information about hospice care

Section 8.1 What is hospice care?

"Hospice" is 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 who qualify for hospice care in the last months of life by giving comfort and relief from pain. The focus is on care, not cure.

Section 8.2 How do you get hospice care if you are terminally ill?

As a member of your plan, you may receive care from any Medicare-certified hospice program. Your doctor can help you arrange hospice care. If you are interested in using hospice services, you may call Customer Service (phone numbers are printed on the front cover of this booklet) to get a list of the Medicare-certified hospice providers in your area or you may call the Regional Home Health Intermediary at 1-800-633-4227. To get more information, visit www.medicare.gov on the Web. Under "Search Tools," "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.

Section 8.3 How is your hospice care paid for?

If you enroll in a Medicare-certified hospice program, your plan (rather than Original Medicare) will pay the hospice provider for the services you receive. Your plan will also pay for any services you receive that are not related to your terminal condition.

SECTION 9 Organ transplants

Section 9.1 How to get an organ transplant if you need it

If you need an organ transplant, we will arrange to have your case reviewed by one of the transplant centers that is approved by Medicare and your plan (some hospitals that perform transplants are approved by Medicare, and others aren't). The Medicare-approved transplant center, in conjunction with your plan, will decide whether you are a candidate for a transplant. When all requirements are met and your plan has authorized the transplant and all associated care, the following types of transplants are covered: Heart, Lung, Combined Heart/Lung, Liver, Intestine, Combined Liver/ Intestine, Kidney, Pancreas, Combined Kidney/Pancreas, Multi-visceral transplant, Corneal, Stem Cell/ Bone Marrow, Donor Leukocyte Infusion. The following transplants are covered only if they are performed in a Medicare and plan-approved transplant center: Heart, Lung, Combined Heart/Lung, Liver, Intestine, Combined Liver/Intestine, Kidney, Pancreas, Combined Kidney/Pancreas.

When it is determined that a transplant may be needed, your doctor will need to prior authorize your transplant by calling the Customer Service number on the back of your membership card and ask to speak with a Transplant Coordinator. All transplants are required to be prior authorized. Although certain transplants are covered, you must meet specific medical criteria for benefit coverage and the transplant must be performed in an approved facility. The Transplant Coordinator will help you in determining whether the proposed transplant is a covered benefit and that you have met all the requirements. The Transplant Coordinator will also advocate on your behalf with your transplant team to assure your best outcome.

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 and plan-approved transplant center that will decide whether you are a candidate for a transplant. Transplant providers may be local or outside of the service area. If local transplant providers are willing to accept the Original Medicare rate, then you can choose

to obtain your transplant services locally or at a distant location offered by the plan. If the plan provides transplant services at a distant location (outside of the service area) and you chose to obtain transplants at this distant location, we will arrange or pay for appropriate lodging and transportation costs for you and a companion. The reimbursement for transportation costs are while you and your companion are traveling to and from the medical providers for services related to the transplant care. The plan defines the distant location as a location that is outside of the member's service area AND a minimum of 75 miles from the member's home. Transportation and lodging costs will be reimbursed for travel mileage and lodging consistent with current IRS travel mileage and lodging guidelines. Accommodations for lodging will be reimbursed at the lesser of: 1) billed charges, or 2) $50 per day per covered person up to a maximum of $100 per day per covered person consistent with IRS guidelines.

Medical Benefits (What is covered and what you pay)

Section		Page
1	**Understanding your out-of-pocket costs for covered services**	43
1.1	Types of out-of-pocket costs you may pay for your covered services	43
1.2	What is your yearly plan deductible?	44
1.3	What is the most you will pay for Medicare Part A and Part B covered medical services?	44
1.4	Your plan also limits your out-of-pocket costs for certain types of services	45
1.5	Your plan does not allow providers to “balance bill” you	45
2	**Use the medical benefit chart located in the front of this booklet, along with this chapter, to find out what is covered for you and how much you will pay**	46
2.1	Your medical benefits and costs as a member of this plan	46
3	**What benefits are not covered by the plan?**	47
3.1	Benefits we do *not* cover (exclusions)	47

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

This chapter focuses on your covered services and what you pay for your medical benefits. The medical benefit chart located in the front of this booklet lists your covered services and shows how much you will pay for each covered service as a member of your plan. Later in this chapter, you can find information about medical services that are not covered and explains limits on certain services.

Section 1.1 Types of out-of-pocket costs you may pay for your covered services

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

- The **"deductible"** is the amount you must pay for medical services before our plan begins to pay its share. Section 1.2 tells you more about your yearly deductible for certain categories of service.
- A **"copayment"** is the fixed amount you pay each time you receive certain medical services. You pay a copayment at the time you get the medical service. (The medical benefit chart in front of this booklet tells you more about your copayments.)
- **"Coinsurance"** is the percentage you pay of the total cost of certain medical services. You pay a coinsurance at the time you get the medical service. (The medical benefit chart in the front of this booklet tells you more about your coinsurance.)

Some people qualify for State Medicaid programs to help them pay their out-of-pocket costs for Medicare. (These "Medicare Savings Programs" include the Qualified Medicare Beneficiary (QMB), Specified Low-Income Medicare Beneficiary (SLMB), Qualifying Individual (QI), and Qualified Disabled & Working Individuals (QDWI) programs.) If you are enrolled in one of these programs, you may still have to pay a copayment for the service, depending on the rules in your state.

The cost of the service, on which your member liability copayment/coinsurance is based, will be either:

- The Medicare allowable amount for covered services.
  —or—
- The amount either we negotiate with the provider or the local Blue Medicare Advantage plan negotiates with its provider on behalf of our members, if applicable. The amount negotiated may be either higher than, lower than or equal to the Medicare allowable amount.

Section 1.2 What is your yearly plan deductible?

Please refer to the benefit chart in the front of this booklet to determine if your plan has an annual deductible. If you have a yearly deductible, this is the amount you have to pay out-of-pocket before we will pay our share for your covered medical services.

Until you have paid the deductible amount, you must pay the full cost for most of your covered services. (The deductible does not apply to services that are listed below.) Once you have paid your deductible, we will begin to pay our share of the costs for covered medical services and you will pay your share for the rest of the plan year.

The deductible does not apply to some services, including certain **in-network** preventive services. This means that we will pay our share of the costs for these services even if you haven't paid your yearly deductible yet. Please refer to the benefit chart located at the front of this booklet to determine which services are not subject to the plan deductible.

Section 1.3 What is the most you will pay for Medicare Part A and Part B covered medical services?

Under our plan, there are two different limits on what you have to pay out-of-pocket for covered medical services:

- Your **in-network maximum out-of-pocket amount** is located on the benefit chart in the front of this booklet. This is the most you pay during the plan year for covered Medicare Part A and Part B services received from in-network providers. The amounts you pay for deductibles, copayments, and coinsurance for covered services from in-network providers count toward this in-network maximum out-of-pocket amount. (The amounts you pay for plan premiums, if any, Part D prescription drugs, and services from out-of-network providers do not count toward your in-network maximum out-of-pocket amount.) If you have paid the amount located on the benefit chart in the front of this Evidence of Coverage for covered Part A and Part B services from in-network providers, you will not have any out-of-pocket costs for the rest of the year when you see our in-network providers. However, you must continue to pay your plan premium, if any, and the Medicare Part B premium (unless your Part B premium is paid for you by Medicaid or another third party).
- Your **combined maximum out-of-pocket amount** is located on the benefit chart in the front of this booklet. This is the most you pay during the plan year for covered Medicare Part A and Part B services received from both in-network and out-of-network providers. The amounts you pay for deductibles, copayments, and

coinsurance for covered services count toward this combined maximum out-of-pocket amount. (The amounts you pay for your plan premiums and for your Part D prescription drugs do not count toward your combined maximum out-of-pocket amount.) If you have paid the amount located on the benefit chart in the front of this booklet for covered services, you will have 100% coverage and will not have any out-of-pocket costs for the rest of the year for covered Part A and Part B services. However, you must continue to pay your plan premium and the Medicare Part B premium (unless your Part B premium is paid for you by Medicaid or another third party).

When a plan member moves from one MA plan type to another MA plan of the same type offered under the same contract (HMO to HMO or PPO to PPO plan) in the same contract year, his/her accrued contribution toward the annual maximum out-of-pocket (MOOP) limit will count toward the annual MOOP in his/her new MA plan.

Section 1.4 Your plan also limits your out-of-pocket costs for certain types of services

In addition to the in-network and combined maximum out-of-pocket amounts for covered Part A and Part B services (see Section 1.3 above), you may also have a separate maximum out-of-pocket amount that applies only to certain types of medical services. Please refer to the benefit chart at the front of this booklet to see if you have separate maximum out-of-pocket amounts and what medical services are included.

Section 1.5 Your plan does not allow providers to “balance bill” you

As a member of your plan, an important protection for you is that after you meet any deductibles, you only have to pay your cost-sharing amount when you get services covered by your plan. We do not allow providers to add additional separate charges called “balance billing.” This protection (that you never pay more than your cost-sharing amount) applies even if we pay the provider less than the provider charges for a service and even if there is a dispute and we don’t pay certain provider charges.

Here is how this protection works.

- If your cost-sharing is a copayment (a set amount of dollars, for example, $15.00), then you pay only that amount for any covered services from an in-network provider.
- If your cost-sharing is a coinsurance (a percentage of the total charges), then you never pay more than that percentage. However, your cost depends on which type of provider you see:

- If you obtain covered services from an in-network provider, you pay the coinsurance percentage multiplied by the plan's reimbursement rate (as determined in the contract between the provider and the plan).
- If you obtain covered services from an out-of-network provider who participates with Medicare, you pay the coinsurance percentage multiplied by the Medicare payment rate for participating providers.
- If you obtain covered services from an out-of-network provider who does not participate with Medicare, then you pay the coinsurance percentage multiplied by the total provider bill. Note that the total provider bill may include permitted balance billing.

SECTION 2 Use the medical benefit chart located in the front of this booklet, along with this chapter, to find out what is covered for you and how much you will pay

Section 2.1 Your medical benefits and costs as a member of the plan

The medical benefit chart located in the front of this booklet lists the services your plan covers and what you pay out-of-pocket for each service. The services listed in the medical benefit chart are covered only when the following coverage requirements are met:

- Your Medicare covered services must be provided according to the coverage guidelines established by Medicare.
- Your services (including medical care, services, supplies, and equipment) *must* be medically necessary. "Medically necessary" means that the services, supplies, or drugs are needed for the prevention, diagnosis, or treatment of your medical condition and meet the accepted standards of medical practice.
- Some of the services listed in the medical benefit chart are covered as in-network services *only* if your doctor or other in-network provider gets approval in advance (sometimes called "prior authorization") from us.
- Covered services that need approval in advance to be covered as in-network services are identified in the medical benefit chart.
- Prior authorization is only required for services obtained from an in-network provider. You never need prior authorization for out-of-network services from out-of-network providers but we do request that you notify us of services so specified.

Other important things to know about our coverage:

- For benefits where your cost-sharing is a coinsurance percentage, the amount you pay depends on what type of provider you receive the services from:
  - If you receive the covered services from an in-network provider, you pay the coinsurance percentage multiplied by the plan's reimbursement rate (as determined in the contract between the provider and the plan)
  - If you receive the covered services from an out-of-network provider who participates with Medicare, you pay the coinsurance percentage multiplied by the Medicare payment rate for participating providers
  - If you receive the covered services from an out-of-network provider who does not participate with Medicare, you pay the coinsurance percentage multiplied by the Medicare limiting charge for non-participating providers.
- Like all Medicare health plans, we cover everything that Original Medicare covers. For some of these benefits, you pay *more* in our plan than you would in Original Medicare. For others, you pay *less*. (If you want to know more about the coverage and costs of Original Medicare, look in your *Medicare & You 2014* Handbook. View it online at http://www.medicare.gov or ask for a copy by calling 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.)
- For all **in-network** preventive services that are covered at no cost under Original Medicare, we also cover the service at no cost to you. However, if you also are treated or monitored for an existing medical condition during the visit when you receive the preventive service, a copayment will apply for the care received for the existing medical condition.
- Sometimes, Medicare adds coverage under Original Medicare for new services during the year. If Medicare adds coverage for any services during 2014, either Medicare or our plan will cover those services.

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

Section 3.1 Benefits we do not cover (exclusions)

This section tells you what kinds of benefits are "excluded." Excluded means that the plan doesn't cover these benefits.

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

If you get benefits that are excluded, you must pay for them yourself. We won't pay for the excluded medical benefits listed in this section (or elsewhere in this booklet), and neither will Original Medicare. The only exception: If a benefit on the exclusion list is found upon appeal to be a medical benefit that we should have paid for or covered because of your specific situation. (For information about appealing a decision we have made to not cover a medical service, go to Chapter 9, Section 5.3 in this booklet.)

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

1. Services considered not reasonable and necessary, according to the standards of Original Medicare, unless these services are listed by your plan as covered services.
2. Experimental medical and surgical procedures, equipment and medications, unless covered by Original Medicare or under a Medicare-approved clinical research study or by our plan. (See Chapter 3 for more information on clinical research studies.) Experimental procedures and items are those items and procedures determined by your plan and Original Medicare to not be generally accepted by the medical community.
3. Surgical treatment for morbid obesity, except when it is considered medically necessary and covered under Original Medicare.
4. Private room in a hospital, except when it is considered medically necessary.
5. Private duty nurses.
6. Personal items in your room at a hospital or a skilled nursing facility, such as a telephone or a television.
7. Full-time nursing care in your home.
8. Custodial care is care provided in a nursing home, hospice, or other facility setting when you do not require skilled medical care or skilled nursing care. Custodial care is personal care that does not require the continuing attention of trained medical or paramedical personnel, such as care that helps you with activities of daily living, such as bathing or dressing.
9. Homemaker services which provide basic household assistance, including light housekeeping or light meal preparation.
10. Fees charged by your immediate relatives or members of your household.
11. Meals delivered to your home.
12. Elective or voluntary enhancement procedures or services (including weight loss, hair growth, sexual performance, athletic performance, cosmetic purposes, anti-aging and mental performance), except when medically necessary.

13. Cosmetic surgery or procedures, unless needed because of an accidental injury or to improve a malformed part of the body. However, all stages of reconstruction are covered for a breast after a mastectomy, as well as for the unaffected breast to produce a symmetrical appearance.
14. Routine dental care, such as cleanings, fillings or dentures unless specified otherwise in the benefit chart. However, non-routine dental care required to treat illness or injury may be covered as inpatient or outpatient care.
15. Unless specified otherwise in the benefit chart, chiropractic care, other than manual manipulation of the spine consistent with Medicare coverage guidelines.
16. Unless specified otherwise in the benefit chart, routine foot care, except for the limited coverage provided according to Medicare guidelines.
17. Unless specified otherwise in the benefit chart, Orthopedic shoes, unless the shoes are part of a leg brace and are included in the cost of the brace or the shoes are for a person with diabetic foot disease.
18. Supportive devices for the feet, except for orthopedic or therapeutic shoes for people with diabetic foot disease.
19. Unless specified otherwise in the benefit chart, routine hearing exams, hearing aids, or exams to fit hearing aids.
20. Unless specified otherwise in the benefit chart, eyeglasses, routine eye examinations, radial keratotomy, LASIK surgery, vision therapy and other low vision aids. However, eyeglasses are covered for people after cataract surgery.
21. Unless specified otherwise in the benefit chart, prescription drugs for treatment of sexual dysfunction, including erectile dysfunction, impotence, and anorgasmy or hyporgasmy.
22. Reversal of sterilization procedures, sex change operations, and non-prescription contraceptive supplies.
23. Unless specified otherwise in the benefit chart, acupuncture.
24. Naturopath services (uses natural or alternative treatments).
25. Services provided to veterans in Veterans Affairs (VA) facilities. However, when emergency services are received at a VA hospital and the VA cost-sharing is more than the cost-sharing under your plan, we will reimburse veterans for the difference. Members are still responsible for our cost-sharing amounts.
26. Benefits to the extent that they are available as benefits through any governmental unit (except Medicaid), unless otherwise required by law or regulation. The payment of benefits under this Evidence of Coverage will be coordinated with such governmental units to the extent required under existing state or federal laws.

27. Services for illness or injury that occurs as a result of any act of war, declared or undeclared if care is received in a governmental facility.
28. Services for court-ordered testing or care unless medically necessary and authorized by your plan.
29. Services for which you have no legal obligation to pay in the absence of this or like coverage.
30. Services received from a dental or medical department maintained by or on behalf of an employer, mutual benefit association, labor union, trust or similar person or group.
31. Charges in excess of the maximum allowable amount, unless otherwise specified in this Evidence of Coverage.
32. Charges for completion of claim forms or charges for medical records or reports unless otherwise required by law.
33. Charges for missed or canceled appointments.
34. Charges for services incurred prior to your effective date.
35. Charges for services incurred after the termination date of this coverage, except as specified elsewhere in this Evidence of Coverage.
36. Services or supplies primarily for educational, vocational or training purposes, except as otherwise specified in the benefit chart in the front of this Evidence of Coverage.
37. For self-help training and other forms of non-medical self-care, except as otherwise provided in the benefit chart at the front of this Evidence of Coverage.
38. Unless specified otherwise in the benefit chart, services that are not covered by Medicare.
39. Outpatient prescription drugs, when you have a Medicare Advantage plan that does not cover prescription drugs.
40. Any services listed above. Even if you receive the services at an emergency facility, the excluded services are still not covered. 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.

Chapter

5.

2014 Evidence of Coverage for Medicare Preferred (PPO) with Senior Rx Plus

Using the plan's coverage for your Part D prescription drugs

Section		Page
1	**Introduction**	53
1.1	This chapter describes your coverage for Part D drugs	53
1.2	Basic rules for the plan's Part D drug coverage	54
2	**Fill your prescription at a network pharmacy or through the plan's mail-order service**	55
2.1	To have your prescription covered, use a network pharmacy	55
2.2	Finding network pharmacies	55
2.3	Using the plan's mail-order services	56
2.4	How can you get a long-term supply of drugs?	57
2.5	When can you use a pharmacy that is not in the plan's network?	58
3	**If you have a Closed Formulary Plan, your drugs need to be on the plan's "Drug List"**	59
3.1	The "Drug List" tells which Part D drugs are covered	59
3.2	How do "cost-sharing tiers" for drugs on the Drug List impact my cost?	60
3.3	How can you find out if a specific drug is on the Drug List?	60
4	**There are restrictions on coverage for some drugs**	60
4.1	Why do some drugs have restrictions?	60
4.2	What kinds of restrictions?	61
4.3	Do any of these restrictions apply to your drugs?	61
5	**What if one of your drugs is not covered in the way you'd like it to be covered?**	62
5.1	There are things you can do if your drug is not covered in the way you'd like it to be covered	62
5.2	What can you do if your drug is restricted in some way?	63
5.3	What can you do if your drug is in a cost-sharing tier you think is too high?	65
6	**What if your coverage changes for one of your drugs?**	65
6.1	The Drug List can change during the year	65
6.2	What happens if coverage changes for a drug you are taking?	66

Section		Page
7	**What types of drugs are *not* covered by the plan?**	67
7.1	Types of drugs we do not cover	67
8	**Show your plan membership card when you fill a prescription**	68
8.1	Show your membership card	68
8.2	What if you don't have your membership card with you?	69
9	**Part D drug coverage in special situations**	69
9.1	What if you're in a hospital or a skilled nursing facility for a stay that is covered by the plan?	69
9.2	What if you're a resident in a long-term care facility?	69
9.3	What if you're also getting drug coverage from another retiree group sponsored plan?	70
10	**Programs on drug safety and managing medications**	70
10.1	Programs to help members use drugs safely	70
10.2	Programs to help members manage their medications	71

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

There are programs to help people with limited resources pay for their drugs. These include "Extra Help" and State Pharmaceutical Assistance Programs. For more information on these programs, see Chapter 2, Section 7.

Are you currently getting help to pay for your drugs?

If you are in a program that helps pay for your drugs, **some information in this Evidence of Coverage about the costs for Part D prescription drugs may not apply to you.** We will send you a separate insert, called "Evidence of Coverage Rider for People Who Get 'Extra Help' Paying for Prescription Drugs" (also known as the "Low Income Subsidy Rider" or the "LIS Rider"), which tells you about your drug coverage. If you don't have this rider, please call Customer Service and ask for the "LIS Rider." (Phone numbers for Customer Service are printed on the front cover of this booklet.)

SECTION 1 Introduction

Section 1.1 This chapter describes your coverage for Part D drugs

This chapter explains rules for using your coverage for Part D drugs. The next chapter tells what you pay for Part D drugs (Chapter 6, What you pay for your Part D prescription drugs).

In addition to your coverage for Part D drugs, the plan also covers some drugs under the plan's medical benefits:

- The plan covers drugs you are given during covered stays in the hospital or in a skilled nursing facility. The benefit chart located in the front of this booklet and Chapter 4 tells about the benefits and costs for drugs during a covered hospital or skilled nursing facility stay.
- Medicare Part B also provides benefits for some drugs. Part B drugs include certain chemotherapy drugs, drug injections you are given during an office visit, drugs you are given at a dialysis facility and certain drugs you receive via medical equipment such as nebulizers. The benefit chart tells about your benefits and costs for Part B drugs.

The two examples of drugs described above are covered by the plan's medical benefits. The rest of your prescription drugs are covered under the plan's Part D benefits.

Section 1.2 Basic rules for the plan's Part D drug coverage

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

- You must have a provider (a doctor or other prescriber) write your prescription.
- You must use a network pharmacy to fill your prescription. (See Section 3, Fill your prescriptions at a network pharmacy.)
- If your plan uses a Closed Formulary (Closed Drug List), you have coverage for most, but not all, Medicare Part D eligible drugs. The drugs on this list are all approved by the FDA and are selected by the plan with the help of a team of doctors and pharmacists. Not all drugs are on the Closed Formulary. The drugs covered under your retiree drug coverage are listed in your plan's Drug List. (The benefit chart in the front of this booklet will tell you if your plan has a Closed Formulary.)
- If your plan uses an Open Formulary (Open Drug List), you have coverage for all Medicare Part D eligible drugs. You also have coverage for certain additional drugs not typically covered by Medicare Part D plans. The additional drugs beyond those typically covered by Medicare are all approved by the FDA and are selected by the plan with the help of a team of doctors and pharmacists. These drugs are covered by your Senior Rx Plus supplemental benefits. The drugs covered under your retiree drug coverage are listed in your plan's Drug List or your benefit chart. (The benefit chart in the front of this booklet will tell you if your plan has an Open Formulary.)
- We evaluate new drugs as they come onto the market. Once we have completed a full evaluation based upon clinical effectiveness and cost relative to other drug therapies, the drug will be assigned to a drug plan tier or non-formulary designation. If your plan uses an Open Formulary you will have coverage for a new Part D eligible drug designated non-formulary following our review. During the period between the time the drug is first available and our review, the drug will not be automatically covered. If your physician feels you should use the new drug, you or your physician may request a coverage exception.
- Your drug must be used for a medically necessary indication. A "medically accepted indication" is a use of the drug that is either approved by the Food and Drug Administration or supported by certain reference books. (See Section 4 for more information about a medically accepted indication.)

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

Section 2.1 To have your prescription covered, use a network pharmacy

In most cases, your prescriptions are covered *only* if they are filled at the plan's network pharmacies. (See Section 2.5 for information about when we would cover prescriptions filled at out-of-network pharmacies.)

A network pharmacy is a pharmacy that has a contract with the plan to provide your covered prescription drugs. The term "covered drugs" means certain Part D eligible prescription drugs and "Extra Covered Drugs" if shown in the benefit chart located in the front of this booklet. All "covered drugs" are listed in your plan's Drug List.

Section 2.2 Finding network pharmacies

How do you find a network pharmacy in your area?

To find a network pharmacy, you can look in your Pharmacy Directory, or call Customer Service (phone numbers are printed on the front cover of this booklet). Choose whichever is easiest for you.

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

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

If the pharmacy you have been using leaves the plan's network, you will have to find a new pharmacy that is in the network. To find another network pharmacy in your area, you can get help from Customer Service (phone numbers are printed on the front cover of this booklet) or use the Pharmacy Directory.

What if you need a specialized pharmacy?

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

- Pharmacies that supply drugs for home infusion therapy.
- Pharmacies that supply drugs for residents of a long-term care facility. Usually, a long-term care facility (such as a nursing home) has its own pharmacy. Residents may get prescription drugs through the facility's pharmacy as long as it is part of

our network. If your long-term care pharmacy is not in our network, please contact Customer Service (phone numbers are listed on the front cover of this booklet).

- Pharmacies that serve the Indian Health Service/Tribal/Urban Indian Health Program (not available in Puerto Rico). Except in emergencies, only Native Americans or Alaska Natives have access to these pharmacies in our network.
- Pharmacies that dispense drugs that are restricted by the FDA to certain locations or that require special handling, provider coordination, or education on their use. (Note: This scenario should happen rarely.)

To locate a specialized pharmacy, look in your Pharmacy Directory or call Customer Service (phone numbers are printed on the front cover of this booklet).

Section 2.3 Using the plan's mail-order services

Your plan's mail-order service requires you to order up to a 90-day supply for most drugs. Specialty drugs are only available in a 30-day supply on most plans. Please check the benefit chart located in the front of this booklet to verify the maximum day supply limits in your plan for mail-order drugs.

To get order forms and information about filling your prescriptions by mail please call Customer Service.

Usually a mail-order pharmacy order will get to you in no more than 14 days. Pharmacy processing time will average about two to five business days; however, you should allow additional time for postal service delivery. It is advisable for first-time users of the mail-order pharmacy to have at least a 30-day supply of medication on hand when a mail-order request is placed. If the prescription order has insufficient information, or if we need to contact the prescribing physician, delivery could take longer. It is advisable for first-time users of the mail-order pharmacy to ask the doctor for two signed prescriptions:

- One for an initial supply to be filled at their local retail participating pharmacy.
- The second for up to a three-month supply with refills to send to the mail-order pharmacy.

Our plan's mail-order service provides members with mail-order drugs using an "automatic refill" service. If you used our "automatic refill" service in the past, we automatically sent you a refill of your drugs when our records indicated that you were about to run out. However, starting in January 2014, unless your group sponsored plan will not require pre-approval, we will need to get your permission before we can send you a refill by mail. We will not need to get your permission to send your drugs by mail when you ask us for the refill or ask us for a new prescription.

If you will not need to give us permission for each prescription fill shipment, your benefit chart will include a bullet stating that you do not need to pre-approve all prescription fill shipments. Your benefit chart is located in the front of this booklet.

So that we can reach you to make sure that you want a refill, please tell us the best way to reach you. Please call 1-888-565-8361 (TTY/TDD: 1-800-221-6915) to ensure that we have the following information on file to contact you: email address, preferred phone number and your mailing address. If we don't know the best way to reach you, you might miss the chance to tell us whether you want a refill and you could run out of your prescription drugs. Remember, your drugs will not be automatically shipped unless you confirm you still want to receive the order. This new policy won't affect refill reminder programs in which you go in person to pick up the prescription and it won't apply to long–term care pharmacies that give out and deliver prescription drugs.

Section 2.4 How can you get a long-term supply of drugs?

When you get a long-term supply of "maintenance" drugs, your cost-sharing may be lower. The plan offers two ways to get a long-term supply of mail-order drugs on your plan's Drug List. (Maintenance drugs are drugs that you take on a regular basis, for a chronic or long-term medical condition.)

1. **Some retail pharmacies** in our network allow you to get a longer-term supply of maintenance drugs.You are not required to use the mail-order service to get a longer-term supply of maintenance drugs. If you get a longer-term supply of mail-order drugs at a retail network pharmacy, your cost-sharing may be different than it is for a longer-term supply from the mail-order service. Please check the benefit chart located in the front of this booklet to find out what your costs will be if you get a longer-term supply of maintenance drugs from a retail pharmacy. Your Pharmacy Directory tells you which pharmacies in our network can give you a longer-term supply of maintenance drugs. You can also call Customer Service for more information. (Phone numbers are printed on the front cover of this booklet.)
2. For many drugs, you can use your plan's network **mail-order services.** Our plan's mail-order service allows you to order up to a 90-day supply for most drugs. **Specialty drugs are typically only available in a 30-day supply. Please check the benefit chart in the front of this booklet to verify the maximum day supply limits in your plan for mail-order drugs**. See Section 2.3 for more information about using our mail-order services.

Section 2.5 When can you use a pharmacy that is not in the plan's network?

Your prescription may be covered in certain situations

Generally, we cover drugs filled at an out-of-network pharmacy only when you are not able to use a network pharmacy.

We will cover your prescription at a non-network pharmacy if at least one of the following applies:

- You are traveling within the United States and territories and become ill, lose or run out of your prescription drugs.
- The prescription is for a medical emergency or urgent care.
- You are unable to obtain a covered drug in a timely manner within our service area because a network pharmacy that provides 24-hour service is not available within a 25-mile driving distance.
- You are filling a prescription for a covered drug and that particular drug (for example, an orphan drug or other specialty pharmaceutical) is not regularly stocked at an accessible network retail or mail-order pharmacy.

In these situations, **please check first with Customer Service** to see if there is a network pharmacy nearby. (Phone numbers for Customer Service are printed on the front cover of this booklet.)

How do you ask for reimbursement from the plan?

If you must use an out-of-network pharmacy, you will generally have to pay the full cost (rather than paying your normal share of the cost) when you fill your prescription. You can ask us to reimburse you for our share of the cost. (Chapter 7, Section 2.1 explains how to ask the plan to pay you back.)

In addition to paying the copayments/coinsurances listed on the benefit chart located in the front of this booklet, you will be required to pay the difference between what we would pay for a prescription filled at an in-network pharmacy and what the out-of-network pharmacy charged for your prescriptions.

SECTION 3 If you have a closed formulary plan, your drugs need to be on the plan's "Drug List"

Section 3.1 The "Drug List" tells which Part D drugs are covered

The plan has a "List of Covered Drugs (Formulary)." In this Evidence of Coverage, **we call it the "Drug List" for short.**

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

We will generally cover a drug on the plan's Drug List as long as you follow the other coverage rules explained in this chapter and the use of the drug is a medically accepted indication. A "medically accepted indication" is a use of the drug that is either:

- approved by the Food and Drug Administration. (That is, the Food and Drug Administration has approved the drug for the diagnosis or condition for which it is being prescribed.)
- —*or*— supported by certain reference books. (These reference books are the American Hospital Formulary Service Drug Information, the DRUGDEX Information System, and the USPDI or its successor.)

The Drug List includes both brand-name and generic drugs

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

- This plan does not require you to pay the difference between the cost of a covered brand drug and the covered generic drug if your doctor feels you should use the brand drug. You will only pay the brand copay when you fill a covered brand drug at a network pharmacy.

What is *not* on the Drug List?

The plan does not cover all prescription drugs.

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

Section 3.2 How do "cost-sharing tiers" for drugs on the Drug List impact my costs?

Every drug on your plan's Drug List is in one of the plan's cost-sharing tiers. In general, the higher the cost-sharing tier, the higher your cost for the drug. The types of drugs placed into the cost-sharing tier used by this plan are shown in the benefit chart located in the front of this booklet.

To find out which cost-sharing tier your drug is in, please check the plan's Drug List.

The amount you pay for drugs in each cost-sharing tier is shown in the benefit chart located in the front of this booklet.

Section 3.3 How can you find out if a specific drug is on the Drug List?

You have two ways to find out:

1. Check the most recent Drug List we sent you in the mail.
2. Call Customer Service to find out if a particular drug is on the plan's Drug List or to ask for a copy of the list. Phone numbers for Customer Service are printed on the front cover of this booklet.

SECTION 4 There are restrictions on coverage for some drugs

Section 4.1 Why do some drugs have restrictions?

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

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

If there is a restriction for your drug, it usually means that you or your provider will have to take extra steps in order for us to cover the drug. If you want us to waive the restriction for you, you will need to use the coverage decision process and ask us to make an exception. We may or may not agree to waive the restriction for you. (See Chapter 9, Section 6.2 for information about asking for exceptions.)

Section 4.2 What kinds of restrictions?

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

Restricting brand-name drugs when a generic version is available

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

Getting plan approval in advance

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

Trying a different drug first

This requirement encourages you to try less costly but just as effective drugs before the plan covers another drug. For example, if Drug A and Drug B treat the same medical condition, the plan may require you to try Drug A first. If Drug A does not work for you, the plan will then cover Drug B. This requirement to try a different drug first is called **"step therapy."**

Quantity limits

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

Section 4.3 Do any of these restrictions apply to your drugs?

Your plan's Drug List includes information about the restrictions described above. To find out if any of these restrictions apply to a drug you take or want to take, check the Drug List. For the most up-to-date information, call Customer Service (phone numbers are printed on the front cover of this booklet).

If there is a restriction for your drug, it usually means that you or your provider will have to take extra steps in order for us to cover the drug. If there is a restriction on the drug you want to take, you should contact Customer Service to learn what you or your provider would need to do to get coverage for the drug. If you want us to waive the restriction for you, you will need to use the coverage decision process and ask us to make an exception. We may or may not agree to waive the restriction for you. (See Chapter 9, Section 6.2 for information about asking for exceptions.)

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

Section 5.1 There are things you can do if your drug is not covered in the way you'd like it to be covered

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

- **What if the drug you want to take is not covered by the plan?** For example, the drug might not be covered at all. Or maybe a generic version of the drug is covered but the brand-name version you want to take is not covered.
- **What if the drug is covered, but there are extra rules or restrictions on coverage for that drug?** As explained in Section 4, some of the drugs covered by the plan have extra rules to restrict their use. For example, there might be limits on what amount of the drug (number of pills, etc.) is covered during a particular time period. In some cases, you may want us to waive the restriction for you. For example, you might want us to cover a certain drug for you without having to try other drugs first. Or you may want us to cover more of a drug (number of pills, etc.) than we normally will cover.
- **What if the drug is covered, but it is in a cost-sharing tier that makes your cost-sharing more expensive than you think it should be?** The plan puts each covered drug into one of the different cost-sharing tiers. How much you pay for your prescription depends in part on which cost-sharing tier your drug is in.

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

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

Section 5.2 What can you do if your drug is restricted in some way?

If coverage for your drug is restricted, here are things you can do:

- You may be able to get a temporary supply of the drug (only members in certain situations can get a temporary supply). This will give you and your provider time to change to another drug or to file a request to have the drug covered.
- You can change to another drug.
- You can request an exception and ask the plan to cover the drug or remove restrictions from the drug.

You may be able to get a temporary supply

Under certain circumstances, the plan can offer a temporary supply of a drug to you when your drug is not on the Drug List or when it is restricted in some way. Doing this gives you time to talk with your provider about the change in coverage and figure out what to do.

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

1. **The change to your drug coverage must be one of the following types of changes:**
   - If you are on a Closed Formulary plan, the drug you have been taking is **no longer on the plan's Drug List**.
   - Or for all plans, the drug you have been taking is **now restricted in some way** (Section 5.2 in this chapter tells about restrictions).
2. **You must be in one of the situations described below:**
   - **For those members who were in the plan last year and aren't in a long-term care facility:**

     We will cover a temporary supply of your drug **one time only during the first 90 days of the benefit year**. This temporary supply will be for a maximum of a 30-day supply, or less if your prescription is written for fewer days. The prescription must be filled at a network pharmacy.

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

     We will cover a temporary supply of your drug **one time only during the first 90 days of your membership** in the plan. This temporary supply will be for a maximum of a 30-day supply, or less if your prescription is written for fewer days. The prescription must be filled at a network pharmacy.

- **For those members who are new to the plan and reside in a long-term care facility:**

  We will cover a temporary supply of your drug **during the first 90 days of your membership** in this plan. The first supply will be for a maximum of a 98-day supply, or less if your prescription is written for fewer days. If needed, we will cover additional refills during your first 90 days in the plan.

- **For those members who have been in the plan for more than 90 days, and reside in a long-term care facility and need a supply right away:**

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

To ask for a temporary supply, call Customer Service (phone numbers are printed on the front cover of this booklet).

During the time when you are getting a temporary supply of a drug, you should talk with your provider to decide what to do when your temporary supply runs out. You can either switch to a different drug covered by the plan or ask the plan to make an exception for you and cover your current drug. The sections below tell you more about these options.

You can change to another drug

Start by talking with your provider. Perhaps there is a different drug covered by the plan that might work just as well for you. You can call Customer Service to ask for a list of covered drugs that treat the same medical condition. This list can help your provider find a covered drug that might work for you. (Phone numbers for Customer Service are printed on the front cover of this booklet.)

You can ask for an exception

You and your provider can ask the plan to make an exception for you and cover the drug in the way you would like it to be covered. If your provider says that you have medical reasons that justify asking us for an exception, your provider can help you request an exception to the rule. For example, you can ask the plan to cover a drug even though it is not on the plan's Drug List. Or you can ask the plan to make an exception and cover the drug without restrictions.

If you and your provider want to ask for an exception, Chapter 9, Section 6.2 tells what to do. It explains the procedures and deadlines that have been set by Medicare to make sure your request is handled promptly and fairly.

Section 5.3 What can you do if your drug is in a cost-sharing tier you think is too high?

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

You can change to another drug

If your drug is in a cost-sharing tier you think is too high, start by talking with your provider. Perhaps there is a different drug in a lower cost-sharing tier that might work just as well for you. You can call Customer Service to ask for a list of covered drugs that treat the same medical condition. This list can help your provider find a covered drug that might work for you. (Phone numbers for Customer Service are printed on the front cover of this booklet.)

You can ask for an exception

You and your provider can ask the plan to make an exception in the cost-sharing tier for the drug so that you pay less for it. If your provider says that you have medical reasons that justify asking us for an exception, your provider can help you request an exception to the rule.

If you and your provider want to ask for an exception, Chapter 9, Section 6.4 tells what to do. It explains the procedures and deadlines that have been set by Medicare to make sure your request is handled promptly and fairly.

Drugs in some of our cost-sharing tiers are not eligible for this type of exception. If your plan has a separate specialty tier, specialty drugs are not eligible for a tiering exception.

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

Section 6.1 The Drug List can change during the year

Most of the changes in drug coverage happen at the beginning of each year (January 1). However, during the year, the plan might make many kinds of changes to the Drug List. For example, the plan might:

- **Add or remove drugs from the Drug List**. New drugs become available, including new generic drugs. Perhaps the government has given approval to a new use for an existing drug. Sometimes, a drug gets recalled and we decide not to cover it. Or we might remove a drug from the list because it has been found to be ineffective.
- **Move a drug to a higher or lower cost-sharing tier.**
- **Add or remove a restriction on coverage for a drug** (for more information about restrictions to coverage, see Section 5 in this chapter).
- **Replace a brand-name drug with a generic drug.**

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

Section 6.2 What happens if coverage changes for a drug you are taking?

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

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

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

Do changes to your drug coverage affect you right away?

If any of the following types of changes affect a drug you are taking, the change will not affect you until January 1 of the next year if you stay in the plan:

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

If any of these changes happens for a drug you are taking, then the change won't affect your use or what you pay as your share of the cost until January 1 of the next year. Until that date, you probably won't see any increase in your payments or any added restriction to your use of the drug. However, on January 1 of the next year, the changes will affect you.

In some cases, you will be affected by the coverage change before January 1:

- If a **brand-name drug you are taking is replaced by a new generic drug**, the plan must give you at least 60 days' notice or give you a 60-day refill of your brand-name drug at a network pharmacy.
  - During this 60-day period, you should be working with your provider to switch to the generic or to a different drug that we cover.
  - Or you and your provider can ask the plan to make an exception and continue to cover the brand-name drug for you. For information on how to ask for an exception, see Chapter 9 (What to do if you have a problem or complaint (coverage decisions, appeals, complaints)).

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

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

Section 7.1 Types of drugs we do not cover

This section tells you what kinds of prescription drugs are "excluded." This means Medicare does not pay for these drugs.

If you get drugs that are excluded, you must pay for them yourself, unless they are covered under your Senior Rx Plus coverage. If you have coverage for these drugs they will be listed in the "Extra Covered Drugs" section of the benefit chart in the front of this booklet. In some cases, excluded drugs may be covered under the medical part of your plan.

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

- Your plan's Part D drug coverage cannot cover a drug that would be covered under Medicare Part A or Part B.
- Your plan cannot cover a drug purchased outside the United States and its territories.
- Your plan usually cannot cover off-label use. "Off-label use" is any use of the drug other than those indicated on a drug's label as approved by the Food and Drug Administration.
  - Medicare sometimes allows us to cover "off-label uses" of a prescription drug. Coverage is allowed only when the use is supported by certain reference books. These reference books are the American Hospital Formulary Service Drug Information, the DRUGDEX Information System, and the USPDI or its successor. If the use is not supported by any of these reference books, then your plan cannot cover its "off-label use."

Also, by law, these categories of drugs are not covered by Medicare drug plans unless your plan covers them as "Extra Covered Drugs." Please see the "Extra Covered Drugs" section of the benefit chart located in the front of this booklet to find out which of the drugs listed below are covered under your Senior Rx Plus supplemental benefits.

- Non-prescription drugs (also called over-the-counter drugs)
- Drugs that Medicare does not classify as Part D drugs, including when these drugs are the main ingredient in a compounded drug

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

If you have coverage for some prescription drugs not normally covered in a Medicare prescription drug plan, shown in the "Extra Covered Drugs" section of the benefit chart located in the front of this booklet, the amount you pay when you fill a prescription for these drugs does not count towards qualifying you for the Catastrophic Coverage Stage. (The Catastrophic Coverage Stage is described in Chapter 6, Section 7 of this booklet.)

In addition, if you are **receiving "Extra Help" from Medicare** to pay for your prescriptions, the "Extra Help" program will not pay for the drugs not normally covered. (Please refer to your plan's Drug List or call Customer Service for more information. Phone numbers for Customer Service are printed on the front cover of this booklet.) However, if you have drug coverage through Medicaid, your state Medicaid program may cover some prescription drugs not normally covered in a Medicare drug plan. Please contact your state Medicaid program to determine what drug coverage may be available to you. For contact information, please refer to the state-specific agency listing located in Chapter 13.

SECTION 8 Show your plan membership card when you fill a prescription

Section 8.1 Show your membership card

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

Section 8.2 What if you don't have your membership card with you?

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

If the pharmacy is not able to get the necessary information, **you may have to pay the full cost of the prescription when you pick it up**. (You can then **ask us to reimburse you** for our share. See Chapter 7, Section 2.1 for information about how to ask the plan for reimbursement.)

SECTION 9 Part D drug coverage in special situations

Section 9.1 What if you're in a hospital or a skilled nursing facility for a stay that is covered by the plan?

If you are admitted to a hospital or to a skilled nursing facility for a stay covered by the plan, we will generally cover the cost of your prescription drugs during your stay. Once you leave the hospital or skilled nursing facility, the plan will cover your drugs as long as the drugs meet all of our rules for coverage. See the previous parts of this section that tell about the rules for getting drug coverage. Chapter 6 (What you pay for your Part D prescription drugs) gives more information about drug coverage and what you pay.

Please Note: When you enter, live in, or leave a skilled nursing facility, you are entitled to a Special Enrollment Period. During this time period, you can switch plans or change your coverage. (Chapter 10, Ending your membership in the plan, tells when you can leave your plan and join a different Medicare plan.)

Section 9.2 What if you're a resident in a long-term care facility?

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

Check your Pharmacy Directory to find out if your long-term care facility's pharmacy is part of our network. If it isn't, or if you need more information, please contact Customer Service (phone numbers are printed on the front cover of this booklet).

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

If you need a drug that is not on your Drug List or is restricted in some way, the plan will cover a **temporary supply** of your drug during the first 90 days of your membership. The first supply will be for a maximum of a 98-day supply, or less if your prescription is written for fewer days. If needed, we will cover additional refills during your first 90 days in the plan.

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

During the time when you are getting a temporary supply of a drug, you should talk with your provider to decide what to do when your temporary supply runs out. Perhaps there is a different drug covered by the plan that might work just as well for you. Or you and your provider can ask the plan to make an exception for you and cover the drug in the way you would like it to be covered. If you and your provider want to ask for an exception, Chapter 9, Section 6.4 tells what to do.

Section 9.3 What if you're also getting drug coverage from another retiree group sponsored plan?

Do you currently have other prescription drug coverage through your (or your spouse's) retiree group? If so, please contact **that group's benefits administrator.** He or she can help you determine how your current prescription drug coverage will work with your plan.

SECTION 10 Programs on drug safety and managing medications

Section 10.1 Programs to help members use drugs safely

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

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

- Possible medication errors
- Drugs that may not be necessary because you are taking another drug to treat the same medical condition
- Drugs that may not be safe or appropriate because of your age or gender
- Certain combinations of drugs that could harm you if taken at the same time
- Prescriptions written for drugs that have ingredients you are allergic to
- Possible errors in the amount (dosage) of a drug you are taking

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

Section 10.2 Programs to help members manage their medications

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

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

One program is called a Medication Therapy Management (MTM) program. Some members who take several medications for different medical conditions may qualify. A pharmacist or other health professional will give you a comprehensive review of all your medications. You can talk about how best to take your medications, your costs, or any problems you're having. You'll get a written summary of this discussion. The summary has a medication action plan that recommends what you can do to make the best use of your medications, with space for you to take notes or write down any follow-up questions. You'll also get a personal medication list that will include all the medications you're taking and why you take them.

If we have a program that fits your needs, we will automatically enroll you in the program and send you information. If you decide not to participate, please notify us and we will withdraw you from the program. If you have any questions about these programs, please contact Customer Service (phone numbers are printed on the front cover of this booklet).

What you pay for your Part D prescription drugs

Section | Page

Section		Page
1	**Introduction**	74
1.1	Use this chapter together with other materials that explain your drug coverage	74
1.2	Types of out-of-pocket costs you may pay for covered drugs	75
2	**What you pay for a drug depends on which "drug coverage stage" you are in when you get the drug**	75
2.1	What are the drug coverage stages?	75
3	**We send you reports that explain payments for your drugs and which coverage stage you are in**	77
3.1	We send you a monthly report called the "Explanation of Benefits" (the "EOB")	
3.2	Help us keep our information about your drug payments up-to-date	77
4	**During the Deductible Stage, you pay the full cost of your drugs**	78
4.1	You stay in the Deductible Stage until you have paid the amount listed in your benefit chart for your drugs	78
5	**During the Initial Coverage Stage, the plan pays its share of your drug costs and you pay your share**	79
5.1	What you pay for a drug depends on the drug and where you fill your prescription	79
5.2	When does the Initial Coverage Stage end?	80
5.3	If your doctor prescribes less than a full month's supply, you may not have to pay the cost of the entire month's supply	80
6	**Your cost for covered Part D drugs may change once the amount you and the plan pays reaches $2,850**	81
6.1	You can look at the benefit chart located in the front of this booklet to find out if your copay or coinsurance changes once you and the plan have paid $2,850 for covered Part D drugs	81
6.2	How Medicare calculates your out-of-pocket costs for prescription drugs	83
7	**During the Catastrophic Coverage Stage, the plan pays most of the cost for your drugs**	85
7.1	Once you are in the Catastrophic Coverage Stage, you will stay in this stage for the rest of the benefit year	85

Section		Page
8	**Additional benefits information**	85
8.1	Your plan offers additional benefits	85
9	**What you pay for vaccinations covered by Part D depends on how and where you get them**	85
9.1	Your plan has separate coverage for the Part D vaccine medication itself and for the cost of giving you the vaccination shot	85
9.2	You may want to call us at Customer Service before you get a vaccination	88
10	**Do you have to pay the Part D "late enrollment penalty"?**	88
10.1	What is the Part D "late enrollment penalty"?	88
10.2	How much is the Part D late enrollment penalty?	89
10.3	In some situations, you can enroll late and not have to pay the penalty	89
10.4	What can you do if you disagree about your late enrollment penalty?	90
11	**Do you have to pay an extra Part D amount because of your income?**	90
11.1	Who pays an extra Part D amount because of income?	90
11.2	How much is the extra Part D amount?	92
11.3	What can you do if you disagree about paying an extra Part D amount?	92
11.4	What happens if you do not pay the extra Part D amount?	92

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

There are programs to help people with limited resources pay for their drugs. The "Extra Help" program helps people with limited resources pay for their drugs. For more information, see Chapter 2 Section 7. For contact information, please refer to the state-specific agency listing located in Chapter 13.

Are you currently getting help to pay for your drugs?

If you are in a program that helps pay for your drugs, **some information in this Evidence of Coverage about the costs for Part D prescription drugs may not apply to you.** We will send you the "Evidence of Coverage Rider for People Who Get 'Extra Help' Paying for Prescription Drugs" (also known as the "Low Income Subsidy Rider" or the "LIS Rider"), which tells you about your drug coverage. If you don't have this rider, please call Customer Service and ask for the "LIS Rider." (Phone numbers for Customer Service are printed on the front cover of this booklet.)

SECTION 1 Introduction

Section 1.1 Use this chapter together with other materials that explain your drug coverage

This chapter focuses on what you pay for your Part D prescription drugs. To keep things simple, we use "drug" in this chapter to mean a Part D prescription drug. As explained in Chapter 5, not all drugs are Part D drugs–some drugs are covered under Medicare Part A or Part B and other drugs are excluded from Medicare coverage by law. Some excluded drugs may be covered by your plan. If your Senior Rx Plus supplemental benefits include coverage for any Part D excluded drugs, the benefit chart located in the front of this booklet will have a section called "Extra Covered Drugs."

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

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

  - If you need a copy of the Drug List, call Customer Service (phone numbers are listed on the front cover of this booklet).
- **Chapter 5 of this booklet.** Chapter 5 gives the details about your prescription drug coverage, including rules you need to follow when you get your covered drugs. Chapter 5 also tells which types of prescription drugs are not covered by your plan.
- **Your plan's Pharmacy Directory**. In most situations you must use a network pharmacy to get your covered drugs (see Chapter 5 for the details). The Pharmacy Directory has a list of pharmacies in the plan's network and it tells how you can use the plan's mail-order service. It also tells you which pharmacies in our network can give you a long-term supply of a drug (such as filling a prescription for a three-month supply).

Section 1.2 Types of out-of-pocket costs you may pay for covered drugs

To understand the payment information we give you in this chapter, you need to know about the types of out-of-pocket costs you may pay for your covered services. The amount that you pay for a drug is called "cost-sharing," and there are three ways you may be asked to pay.

- **"Deductible"** (if your plan has one) is the amount you pay for drugs before your plan begins to pay its share.
- **"Copayment"** is a fixed amount you pay each time you fill a prescription.
- **"Coinsurance"** is a percentage of the total cost of the drug you pay each time you fill a prescription.

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

Section 2.1 What are the drug coverage stages?

As shown in the table below, there are four "drug coverage stages" that may be used in this plan. The drug coverage stages used in this plan are shown in the benefit chart located at the front of this booklet. How much you pay for a drug depends on which of these stages you are in at the time you get a prescription filled or refilled. Keep in mind you are always responsible for the plan's monthly premium regardless of the drug payment stage.

Stage 1 ***Deductible Stage***	**Stage 2** ***Initial Coverage Stage***	**Stage 3** ***Coverage Gap Stage***	**Stage 4** ***Catastrophic Coverage Stage***
If your plan has a deductible stage, you begin in this stage when you fill your first prescription of the year. During this stage, **you pay the full cost** of your drugs. You stay in this stage until you have paid the deductible amount shown in the benefit chart located in the front of this booklet.	Your plan pays its share of the cost of your drugs and **you pay your share of the cost.** You stay in this stage until your payments for the year, plus your plan's payments, total the amount shown on the benefit chart located in the front of this booklet.	If your copay or coinsurance payment does not change until you reach your True Out of Pocket amount, the benefit chart located in the front of this booklet will not have a "Gap Coverage" section. If your copay or coinsurance payment does change once you reach the $2,850 Initial Coverage Limit, the benefit chart located in the front of this booklet will include a "Gap Coverage" section that shows what you must pay during the Coverage Gap Stage. The copay or coinsurance shown in the benefit chart is the amount you pay in this stage after your plan and the Coverage Gap Discount have paid their amounts.	Once you have paid enough for your drugs to move on to this last stage, **your cost** for your drugs may be reduced for the rest of the benefit year. The amount you pay for drugs in the Catastrophic Stage is shown in the benefit chart located in the front of this booklet.

SECTION 3 We send you reports that explain payments for your drugs and which coverage stage you are in

Section 3.1 We send you a monthly report called the "Explanation of Benefits" (the "EOB")

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

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

Your plan will prepare a written report called the Explanation of Benefits (it is sometimes called the "EOB") when you have had one or more prescriptions filled through the plan during the previous month. It includes:

- **Information for that month**. This report gives the payment details about the prescriptions you have filled during the previous month. It shows the total drugs costs, what your Group Part D and Senior Rx Plus coverage paid, what the Coverage Gap Discount paid and what you and others on your behalf paid.
- **Important note about the way amounts paid by your retiree drug coverage may look in your EOB.** Your retiree drug coverage is always equal to or greater than basic Part D coverage by itself. However, on a specific drug, your plan copay or coinsurance amount may be greater than it would be if you had basic Part D coverage by itself. If the basic Part D coverage would be greater than your retiree drug coverage, the amount shown in the "other payments" column in the EOB may be negative. In this case the negative amount is the way Medicare wants us to account for this difference. It is not an error and it does not mean you made an over-payment.
- **Totals for the calendar year.** This is called "year-to-date" information. It shows you the total drug costs and total payments for your drugs since the benefit year began.

Section 3.2 Help us keep our information about your drug payments up to date

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

- **Show your membership card when you get a prescription filled.** To make sure we know about the prescriptions you are filling and what you are paying, show your plan membership card every time you get a prescription filled.

- **Make sure we have the information we need.** There are times you may pay for prescription drugs when we will not automatically get the information we need to keep track of your out-of-pocket costs. To help us keep track of your out-of-pocket costs, you may give us copies of receipts for drugs that you have purchased. (If you are billed for a covered drug, you can ask your plan to pay our share of the cost. For instructions on how to do this, go to Chapter 7, Section 2 of this booklet.) Here are some types of situations when you may want to give us copies of your drug receipts to be sure we have a complete record of what you have spent for your drugs:
  - When you purchase a covered drug at a network pharmacy at a special price or using a discount card that is not part of your plan's benefit.
  - When you made a copayment for drugs that are provided under a drug manufacturer patient assistance program.
  - Any time you have purchased covered drugs at out-of-network pharmacies or other times you have paid the full price for a covered drug under special circumstances.
- **Send us information about the payments others have made for you.** Payments made by certain other individuals and organizations also count toward your out-of-pocket costs and help qualify you for catastrophic coverage. For example, payments made by a State Pharmaceutical Assistance Program, an AIDS drug assistance program, the Indian Health Service, and most charities count toward your out-of-pocket costs. You should keep a record of these payments and send them to us so we can track your costs.
- **Check the written report we send you.** When you receive an Explanation of Benefits (an EOB) in the mail, please look it over to be sure the information is complete and correct. If you think something is missing from the report, or you have any questions, please call Customer Service (phone numbers are printed on the front cover of this booklet). Be sure to keep these reports. They are an important record of your drug expenses.

SECTION 4 During the Deductible Stage, you pay the full cost of your drugs

Section 4.1 You stay in the Deductible Stage until you have paid the amount listed in your benefit chart for your drugs

If your plan has a Deductible Stage, this stage is the first coverage stage for your drug coverage. This stage begins when you fill your first prescription in the calendar year. When you are in this coverage stage, **you must pay the full cost of your drugs** until you reach the plan's deductible amount.

- Your **"full cost"** is usually lower than the normal full price of your drug, since your plan has negotiated lower costs for most drugs.
- The **"deductible"** is the amount you must pay for your Part D prescription drugs before the plan begins to pay its share.

If the plan has a deductible, once you have paid the deductible amount for your drugs, you move on to the next drug coverage stage, which is the Initial Coverage Stage. If the plan does not have a deductible, you begin in the Initial Coverage Stage.

SECTION 5 During the Initial Coverage Stage, the plan pays its share of your drug costs and you pay your share

Section 5.1 What you pay for a drug depends on the drug and where you fill your prescription

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

The plan has cost-sharing tiers

Every drug on the plan's Drug List is in one of its cost-sharing tiers. In general, the higher the cost-sharing tier number, the higher your cost for the drug.

To find out what copayment or coinsurance you will pay for drugs in each cost-sharing tier, please see the benefit chart in the front of this booklet.

To find out which cost-sharing tier your drug is in, please check the plan's Drug List.

Your pharmacy choices

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

- A retail pharmacy that is in the plan's network
- A pharmacy that is not in your plan's network
- Your plan's mail-order pharmacy

For more information about these pharmacy choices and filling your prescriptions, see Chapter 5 in this booklet and the plan's Pharmacy Directory. You may also contact Customer Service. The phone numbers are printed on the front cover of this booklet.

Section 5.2 When does the Initial Coverage Stage end?

If your plan provides the same coverage until you reach your True Out of Pocket amount, your plan's Initial Coverage stage continues until you reach your True Out of Pocket limit. The benefit chart located in the front of this booklet will not show an Initial Coverage Limit amount. It will show the True Out of Pocket amount.

If this plan provides different coverage in the Coverage Gap stage after the Initial Coverage limit is reached, the benefit chart in the front of this booklet will show the Initial Coverage Limit amount and include a Coverage Gap section.

Your total drug cost is based on adding together what you have paid and what any Part D plan has paid:

- **What you have paid** for all the covered drugs you have gotten since you started with your first drug purchase of the benefit year. (See Section 6.2 for more information about how Medicare calculates your out-of-pocket costs.) This includes:
  - Any deductible amounts you paid when you were in the Deductible Stage.
  - The total you paid as your share of the cost for your drugs during the Initial Coverage Stage.
- **What the plan has paid** as its share of the cost for your drugs during the Initial Coverage Stage. (If you were enrolled in a different Part D plan at any time during 2014, the amount that plan paid during the Initial Coverage Stage also counts toward your total drug costs.)
- We offer additional coverage on some prescription drugs that are not normally covered in a Medicare Prescription Drug Plan. Payments made for these drugs will not count towards your initial coverage limit or total out-of-pocket costs.

Section 5.3 If your doctor prescribes less than a full month's supply, you may not have to pay the cost of the entire month's supply

Typically, you pay a copay to cover a full month's supply of a covered drug. However, your doctor can prescribe less than a month's supply of drugs. There may be times when you want to ask your doctor about prescribing less than a month's supply of a drug (for example, when you are trying a medication for the first time that is known to have serious side effects). If your doctor agrees, you will not have to pay for the full month's supply for certain drugs.

The amount you pay when you get less than a full month's supply will depend on whether you are responsible for paying coinsurance (a percentage of the total cost) or a copayment (a flat dollar amount).

- If you are responsible for coinsurance, you pay a *percentage* of the total cost of the drug. You pay the same percentage regardless of whether the prescription is for a full month's supply or for fewer days. However, because the entire drug cost will be lower if you get less than a full month's supply, the *amount* you pay will be less.
- If you are responsible for a copayment for the drug, your copay will be based on the number of days of the drug that you receive. We will calculate the amount you pay per day for your drug (the "daily cost-sharing rate") and multiply it by the number of days of the drug you receive.
  - Here's an example: Let's say the copay for your drug for a full month's supply (a 30-day supply) is $30. This means that the amount you pay per day for your drug is $1. If you receive a 7 days' supply of the drug, your payment will be $1 per day multiplied by 7 days, for a total payment of $7.
  - You should not have to pay more per day just because you begin with less than a month's supply. Let's go back to the example above. Let's say you and your doctor agree that the drug is working well and that you should continue taking the drug after your 7 days' supply runs out. If you receive a second prescription for the rest of the month, or 23 days more of the drug, you will still pay $1 per day, or $23. Your total cost for the month will be $7 for your first prescription and $23 for your second prescription, for a total of $30–the same as your copay would be for a full month's supply.

Daily cost-sharing allows you to make sure a drug works for you before you have to pay for an entire month's supply.

SECTION 6 Your cost for covered Part D drugs may change once the amount you and the plan pays reaches $2,850

Section 6.1 You can look at the benefit chart located in the front of this booklet to find out if your copay or coinsurance changes once you and the plan have paid $2,850 for covered Part D drugs

If your copay or coinsurance amount does not change until you reach your True Out of Pocket amount, the benefit chart located in the front of this booklet will not have a "Gap Coverage" section.

If your copay or coinsurance amount does change once you reach the $2,850 Initial Coverage Limit, the benefit chart located in the front of this booklet will include a "Gap Coverage" section that shows what you must pay during the Gap Coverage Stage.

If you are not receiving help to pay your share of drug costs through the Low Income Subsidy or PACE programs, you qualify for a discount on the cost you pay for most covered brand drugs through the Medicare Coverage Gap Discount Program. For prescriptions filled in 2014, once the cost paid by you and this plan reaches $2,850 the cost share you pay will reflect all benefits provided by your retiree drug coverage and the Coverage Gap Discount program. The Coverage Gap Discount program applies until the cost paid by you (or those paying on your behalf as defined in Section 6.2) reaches $4,550.

Drug Manufacturers have agreed to provide this discount on brand drugs which Medicare considers Part D qualified drugs. Your plan may cover some brand drugs beyond those covered by Medicare. The discount will not apply to benefits described in the "Extra Covered Drugs" section of the benefit chart located in the front of this booklet. The "Extra Covered Drugs" benefit, if included, is provided by your Senior Rx Plus coverage.

Once your True Out of Pocket costs reach the amount shown on the benefit chart located in the front of this booklet, you will move onto the Catastrophic Coverage Stage.

Section 6.2 How Medicare calculates your out-of-pocket costs for prescription drugs

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

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

*When you add up your out-of-pocket costs, **you can include** the payments listed below (as long as they are for Part D covered drugs and you followed the rules for drug coverage that are explained in Chapter 5 of this booklet):*

- The amount you pay for drugs when you are in any of the following drug coverage stages:
  - The Deductible Stage (if the plan has this stage).
  - The Initial Coverage Stage.
  - The Coverage Gap Stage (if the plan has this stage).
- Any payments you made during this calendar year as a member of a different Medicare prescription drug plan before you joined your plan.

It matters who pays:

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

Moving on to the Catastrophic Coverage Stage:

When the amount you (or those paying on your behalf) have paid for covered drugs reaches the True Out of Pocket (TrOOP) amount listed in the benefit chart located in the front of this booklet, you will move to the Catastrophic Coverage Stage.

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

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

- The amount you, or others pay on your behalf, pay for your monthly premium.
- Drugs you buy outside the United States and its territories.
- Drugs that are not covered by your plan.
- Drugs you get at an out-of-network pharmacy that do not meet the requirements for out-of-network coverage.
- Prescription drugs covered by Part A or Part B.
- Payments you make toward drugs covered under the "Extra Covered Drug" benefits, when these are included in your Senior Rx Plus coverage.
- Payments you make toward prescription drugs not normally covered in a Medicare Prescription Drug Plan.
- Payments for your drugs that are made by your Senior Rx Plus coverage.
- Payments for your drugs that are made by certain insurance plans and government-funded health programs such as TRICARE and the Veteran's Administration.
- Payments for your drugs made by a third-party with a legal obligation to pay for prescription costs (for example, Worker's Compensation).

Reminder: If any other organization pays part or all of your out-of-pocket costs for drugs, you are required to tell your plan. Call Customer Service to let us know (phone numbers are printed on the front cover of this booklet).

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

- **We will help you**. The Explanation of Benefits (EOB) report we send to you includes the current amount of your out-of-pocket costs (Section 3 in this chapter tells about this report).
- **Make sure we have the information we need**. Section 3.2 tells what you can do to help make sure that our records of what you have spent are complete and up to date.

SECTION 7 During the Catastrophic Coverage Stage, the plan pays most of the cost for your drugs

Section 7.1 Once you are in the Catastrophic Coverage Stage, you will stay in this stage for the rest of the benefit year

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

During this stage, the cost you pay for your drugs may be reduced. You can find your cost-sharing amounts in the Catastrophic Coverage section of the benefit chart located in the front of this booklet.

SECTION 8 Additional benefits information

Section 8.1 Your plan offers additional benefits

Your Senior Rx Plus coverage may include "Extra Covered Drug" benefits. Payments made for these drugs will not count towards your Initial Coverage Limit or your True Out of Pocket limit. If your plan includes coverage for additional drugs, the benefit chart located in the front of this booklet will have a section called "Extra Covered Drugs." You can find out which specific drugs are covered by checking your Drug List.

SECTION 9 What you pay for vaccinations covered by Part D depends on how and where you get them

Section 9.1 Your plan has separate coverage for the Part D vaccine medication itself and for the cost of giving you the vaccination shot

Your plan provides coverage for a number of Part D vaccines. We also cover vaccines that are considered medical benefits. You can find out about coverage of these vaccines by going to the medical benefit chart in the front of this booklet.

- There are two parts to your coverage of Part D vaccinations:The first part of coverage is the cost of **the vaccine medication itself**. The vaccine is a prescription medication.
- The second part of coverage is for the cost of **giving you the vaccination shot**. (This is sometimes called the "administration" of the vaccine.)

What do you pay for a Part D vaccination?

What you pay for a Part D vaccination depends on three things:

1. **The type of vaccine** (what you are being vaccinated for).
   - Some vaccines are considered medical benefits. You can find out about your coverage of these vaccines by going to the medical benefit chart located in the front of this booklet and Chapter 4 Medical Benefits (What is covered and what you pay).
   - Other vaccines are considered Part D drugs. You can find these vaccines listed in the plan's List of Covered Drugs (Formulary).
2. **Where you get the vaccine medication.**
3. **Who gives you the vaccination shot.**

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

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

To show how this works, here are three common ways you might get a Part D vaccination shot. If you have a Deductible or Coverage Gap Stage, you are responsible for all of the costs associated with vaccines (including their administration) during these coverage stages of your benefit.

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

- You will have to pay the pharmacy the amount of your copayment or coinsurance for the vaccine and its administration.
- Your plan will pay for the cost of giving you the vaccination shot.

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

- When you get the vaccination, you will pay for the entire cost of the vaccine and its administration.
- You can then ask your plan to pay our share of the cost by using the procedures that are described in Chapter 7 of this booklet (Asking your plan to pay its share of a bill you have received for covered medical services or drugs).

- You will be reimbursed the amount you paid less your normal copayment or coinsurance for the vaccine (including administration) less any difference between the amount the doctor charges and what we normally pay. (If you get "Extra Help," we will reimburse you for this difference.)

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

- You will have to pay the pharmacy the amount of your copayment or coinsurance for the vaccine itself.
- When your doctor gives you the vaccination shot, you will pay the entire cost for this service. You can then ask your plan to pay our share of the cost by using the procedures described in Chapter 7 of this booklet.
- You will be reimbursed the amount charged by the doctor for the administration of the vaccine, less any difference between the amount the doctor charges and what we normally pay. (If you are in the "Extra Help" program, we will reimburse you for this difference.)

Please note that Part B covers the vaccine and administration for influenza, pneumonia and Hepatitis B injections.

When billing us for a vaccine, please include a bill from the provider with the date of service, the NDC code, the vaccine name and the amount charged. Send the bill to:

Medicare Preferred (PPO) with Senior Rx Plus
P.O. Box 105370
Atlanta, GA 30348-5370

We can help you understand the costs associated with vaccines (including administration) available under the plan, especially before you go to your doctor. For more information, please contact Customer Service (phone numbers are printed on the front cover of this booklet).

Section 9.2 You may want to call Customer Service before you get a vaccination

The rules for coverage of vaccinations are complicated. We are here to help. We recommend that you call us first at Customer Service whenever you are planning to get a vaccination. (Phone numbers for Customer Service are printed on the cover of this booklet.)

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

SECTION 10 Do you have to pay the Part D "late enrollment penalty"?

Section 10.1 What is the Part D "late enrollment penalty"?

Note: If you receive "Extra Help" from Medicare to pay for your prescription drugs, the late enrollment penalty rules do not apply to you. You will not pay a late enrollment penalty, even if you go without "creditable" prescription drug coverage.

You may pay a financial penalty if you did not enroll in a plan offering Medicare Part D drug coverage when you first became eligible for this drug coverage or you experienced a continuous period of 63 days or more when you didn't have creditable prescription drug coverage. ("Creditable prescription drug coverage" is coverage that meets Medicare's minimum standards since it is expected to pay, on average, at least as much as Medicare's standard prescription drug coverage.) The amount of the penalty depends on how long you waited to enroll in a creditable prescription drug coverage plan any time after the end of your initial enrollment period or how many full calendar months you went without creditable prescription drug coverage. You will have to pay this penalty for as long as you have Part D coverage.

Your late enrollment penalty is considered to be part of your plan premium.

The penalty is added to the monthly premium charged to your (or your spouse's) group for your coverage. If you think you may have a late enrollment penalty, you should contact your (or your spouse's) group to see what amount you will have to pay. However, if you are billed directly by your plan for your monthly premium, the late enrollment penalty will be included in the bill you receive from us.

Section 10.2 How much is the Part D late enrollment penalty?

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

- First count the number of full months that you delayed enrolling in a Medicare drug plan, after you were eligible to enroll. Or count the number of full months in which you did not have creditable prescription drug coverage, if the break in coverage was 63 days or more. The penalty is 1% for every month that you didn't have creditable coverage. For example, if you go 14 months without coverage, the penalty will be 14%.
- Then Medicare determines the amount of the average monthly premium for Medicare drug plans in the nation from the previous year. For 2013, this average premium amount is $31.17. This amount may change for 2014.
- To get your monthly penalty, you multiply the penalty percentage and round it to the nearest 10 cents. In the example here it would be 14% times $31.17, which equals 4.36. This rounds to $4.40. This amount would be added **to the monthly premium for someone with a late enrollment penalty**.

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

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

Section 10.3 In some situations, you can enroll late and not have to pay the penalty

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

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

- If you already have prescription drug coverage that is expected to pay, on average, at least as much as Medicare's standard prescription drug coverage. Medicare calls this "**creditable drug coverage**." <u>Please note</u>:
  - Creditable coverage could include drug coverage from a group, former employer or union, TRICARE, or the Department of Veterans Affairs. Your insurer or your human resources department will tell you each year if your

drug coverage is creditable coverage. This information may be sent to you in a letter or included in a newsletter from the plan. Keep this information, because you may need it if you join a Medicare drug plan later.

- Please note: If you receive a "certificate of creditable coverage" when your health coverage ends, it may not mean your prescription drug coverage was creditable. The notice must state that you had "creditable" prescription drug coverage that expected to pay as much as Medicare's standard prescription drug plan pays.

- The following are *not* creditable prescription drug coverage: prescription drug discount cards, free clinics, and drug discount websites.

- For additional information about creditable coverage, please look in your *Medicare & You* 2014 Handbook or call Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048. You can call these numbers for free, 24 hours a day, 7 days a week.
- If you were without creditable coverage, but you were without it for less than 63 days in a row.
- If you are receiving "Extra Help" from Medicare.

Section 10.4 What can you do if you disagree about your late enrollment penalty?

If you disagree about your late enrollment penalty, you or your representative can ask for a review of the decision about your late enrollment penalty. Generally, you must request this review **within 60 days** from the date on the letter you receive stating you have to pay a late enrollment penalty. Call Customer Service to find out more about how to do this (phone numbers are printed on the front cover of this booklet).

Important: Do not stop paying your late enrollment penalty while you're waiting for a review of the decision about your late enrollment penalty. If you do, you could be disenrolled for failure to pay your plan premiums.

SECTION 11 Do you have to pay an extra Part D amount because of your income?

Section 11.1 Who pays an extra Part D amount because of income?

Most people pay a standard monthly Part D premium. However, some people pay an extra amount because of their yearly income. If your income is $85,000 or above for an individual (or married individuals filing separately) or $170,000 or above for married couples, you must pay an extra amount directly to the government for your Medicare Part D coverage.

Part D-Income Related Monthly Adjustment Amount (IRMAA) is assessed to all Medicare beneficiaries with Part D coverage whose incomes exceeds federal government established threshold amounts. CMS has emphasized that failure by a Medicare beneficiary to pay the Part D-IRMAA will result in involuntary disenrollment from their Medicare Advantage or Part D plan and, thus, the loss of retiree drug and/or health coverage through their group.

Please carefully review all communications you receive from CMS. As Part D plan sponsor we are not billing or collecting the Part D-IRMAA, however as plan sponsor we must be prepared to effectuate accurate disenrollments in situations where individuals fail to pay the income-related adjustment.

If you have to pay an extra amount, Social Security, not your Medicare plan, will send you a letter telling you what that extra amount will be and how to pay it. The extra amount will be withheld from your Social Security, Railroad Retirement Board, or Office of Personnel Management benefit check, no matter how you usually pay your plan premium, unless your monthly benefit isn't enough to cover the extra amount owed. If your benefit check isn't enough to cover the extra amount, you will get a bill from Medicare. **You must pay the extra amount to the government. It cannot be paid with your monthly plan premium.**

Section 11.2 How much is the extra Part D amount?

If your modified adjusted gross income (MAGI) as reported on your IRS tax return is above a certain amount, you will pay an extra amount in addition to your monthly plan premium.

The chart below shows the extra amount based on your income.

If you filed an individual tax return and your income in 2012 was:	If you were married but filed a separate tax return and your income in 2012 was:	If you filed a joint tax return and your income in 2012 was:	This is the monthly cost of your extra Part D amount (to be paid in addition to your plan premium):
Equal to or less than $85,000	Equal to or less than $85,000	Equal to or less than $170,000	Your plan premium
Greater than $85,000 and less than or equal to $107,000		Greater than $170,000 and less than or equal to $214,000	$12.10 + Your plan premium
Greater than $107,000 and less than or equal to $160,000		Greater than $214,000 and less than or equal to $320,000	$31.10 + Your plan premium
Greater than $160,000 and less than or equal to $214,000	Greater than $85,000 and less than or equal to $129,000	Greater than $320,000 and less than or equal to $428,000	$50.20 + Your plan premium
Greater than $214,000	Greater than $129,000	Greater than $428,000	$69.30 + Your plan premium

Section 11.3 What can you do if you disagree about paying an extra Part D amount?

If you disagree about paying an extra amount because of your income, you can ask Social Security to review the decision. To find out more about how to do this, contact Social Security at 1-800-772-1213 (TTY 1-800-325-0778).

Section 11.4 What happens if you do not pay the extra Part D amount?

The extra amount is paid directly to the government (not your Medicare plan) for your Medicare Part D coverage. If you are required to pay the extra amount and you do not pay it, you will be disenrolled from the plan and lose prescription drug coverage.

Chapter

7.

2014 Evidence of Coverage for Medicare Preferred (PPO) with Senior Rx Plus

Asking the plan to pay its share of a bill you have received for covered medical services or drugs

Section		Page
1	**Situations in which you should ask your plan to pay our share of the cost of your covered services or drugs**	94
1.1	If you pay your plan's share of the cost of your covered services or drugs, or if you receive a bill, you can ask us for payment	94
2	**How to ask us to pay you back or to pay a bill you have received**	97
2.1	How and where to send us your request for payment	97
3	**We will consider your request for payment and say yes or no**	98
3.1	We check to see whether we should cover the service or drug and how much we owe	98
3.2	If we tell you that we will not pay for all or part of the medical care or drug, you can make an appeal	98
4	**Other situations in which you should save your receipts and send copies of them to your plan**	99
4.1	In some cases, you should send copies of your receipts to your plan to help us track your out-of-pocket drug costs	99

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

Section 1.1 If you pay your plan's share of the cost of your covered services or drugs, or if you receive a bill, you can ask us for payment

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

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

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

1. **When you've received medical care from a provider who is not in your plan's network**

   NOTICE OF CLAIM: In the event that a service is rendered for which you are billed, you have 12 months from the date of service provided to submit such claims to your plan.

   - Physicians and practitioners are required to submit claims on behalf of beneficiaries for all items and services they provide for which Medicare payment may be made under Part B. Also, they are not allowed to charge beneficiaries in excess of the limits on allowed charges that apply to the item or service being furnished.

   However, a physician or practitioner may opt out of Medicare. A physician or practitioner who opts out is not required to submit claims on behalf of beneficiaries and also is excluded from receiving payment for non-emergent services.

   You can receive emergency services from any provider. You are only responsible for paying your share of the cost, not for the entire cost. You should ask the provider to bill us for our share of the cost.

- If you pay the entire amount yourself at the time you receive the care, you need to ask us to pay you back for our share of the cost. Send us the bill, along with documentation of any payments you have made.
- At times you may get a bill from the provider asking for payment that you think you do not owe. Send us this bill, along with documentation of any payments you have already made.
  - If the provider is owed anything, we will pay the provider directly.
  - If you have already paid more than your share of the cost of the service, we will determine how much you owed and pay you back for our share of the cost.
- **Please note:** While you can get your care from an out-of-network provider, the provider must be eligible to participate in Medicare. Except for emergency care, we cannot pay a provider who is not eligible to participate in Medicare. If the provider is not eligible to participate in Medicare, you will be responsible for the full cost of the services you receive.

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

NOTICE OF CLAIM**:** In the event that a service is rendered for which you are billed, you have 12 months from the date of service provided to submit such claims to your plan.

- Physicians and practitioners are required to submit claims on behalf of beneficiaries for all items and services they provide for which Medicare payment may be made under Part B. Also, they <u>are not allowed to charge beneficiaries in excess of the limits on charges that apply to the item or service being furnished.</u>

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

- You only have to pay your cost-sharing amount when you get services covered by our plan. We do not allow providers to add additional separate charges, called “balance billing.” This protection (that you never pay more than your cost-sharing amount) applies even if we pay the provider less than the provider charges for a service and even if there is a dispute and we don’t pay certain provider charges. For more information about “balance billing,” go to Chapter 4, Section 1.6.

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

3. If you are retroactively enrolled in your plan.

Sometimes a person's enrollment in the plan is retroactive. (Retroactive means that the first day of their enrollment has already passed. The enrollment date may even have occurred last year.)

If you were retroactively enrolled in your plan and you paid out-of-pocket for any of your covered services or drugs after your enrollment date, you can ask us to pay you back for our share of the costs. You will need to submit paperwork for us to handle the reimbursement.

- Please call Customer Service for additional information about how to ask us to pay you back and deadlines for making your request. (Phone numbers for Customer Service are printed on the front cover of this booklet.)

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

If you go to an out-of-network pharmacy and try to use your membership card to fill a prescription, the pharmacy may not be able to submit the claim directly to us. When that happens, you will have to pay the full cost of your prescription. (We cover prescriptions filled at out-of-network pharmacies only in a few special situations. Please go to Chapter 5, Section 2.5 to learn more.)

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

5. When you pay the full cost for a prescription because you don't have your plan membership card with you

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

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

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

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

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

All of the examples above are types of coverage decisions. This means that if we deny your request for payment, you can appeal our decision. Chapter 9 of this booklet (What to do if you have a problem or complaint (coverage decisions, appeals, complaints)) has information about how to make an appeal.

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

Section 2.1 How and where to send us your request for payment

NOTICE OF CLAIM: In the event that a service is rendered for which you are billed, you have 12 months from the date of service provided to submit such claims to your plan.

- Physicians and practitioners are required to submit claims on behalf of beneficiaries for all items and services they provide for which Medicare payment may be made under Part B. Also, they are not allowed to charge beneficiaries in excess of the limits on charges that apply to the item or service being furnished.

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

Mail your request for payment together with any bills or receipts to us at this address:

Medicare Preferred (PPO) with Senior Rx Plus
P.O. Box 110
Fond du Lac, WI 54936

You must submit your claim to us one year from the date you received the service, item, or drug.

Contact Customer Service if you have any questions (phone numbers are printed on the front cover of this booklet). If you don't know what you owe, or you receive bills and you don't know what to do about those bills, we can help. You can also call if you want to give us more information about a request for payment you have already sent to us.

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

Section 3.1 We check to see whether we should cover the service or drug and how much we owe

When we receive your request for payment, we will let you know if we need any additional information from you. Otherwise, we will consider your request and make a coverage decision.

- If we decide that the medical care or drug is covered and you followed all the rules for getting the care or drug, we will pay for our share of the cost. Medicare limiting charges may apply, and could be less than the billed amount. If you have already paid for the service or drug, we will mail your reimbursement of our share of the cost to you. If you have not paid for the service or drug yet, please contact your provider to file the claim on your behalf. The claim must be submitted within 12 months from the date of service. We will process covered services according to your plan benefits. Any payment will be made to the provider. (Chapter 3 explains the rules you need to follow for getting your medical services covered. Chapter 5 explains the rules you need to follow for getting your Part D prescription.)
- If we decide that the medical care or drug is *not* covered, or you did *not* follow all the rules, we will not pay for our share of the cost. Instead, we will send you a letter that explains the reasons why we are not sending the payment you have requested and your rights to appeal that decision.

Section 3.2 If we tell you that we will not pay for all or part of the medical care or drug, you can make an appeal

If you think we have made a mistake in turning down your request for payment or you don't agree with the amount we are paying, you can make an appeal. If you make an appeal, it means you are asking us to change the decision we made when we turned down your request for payment.

For the details on how to make this appeal, go to Chapter 9 of this booklet (What to do if you have a problem or complaint (coverage decisions, appeals, complaints)). The appeals

process is a formal process with detailed procedures and important deadlines. If making an appeal is new to you, you will find it helpful to start by reading Section 4 of Chapter 9. Section 4 is an introductory section that explains the process for coverage decisions and appeals and gives definitions of terms such as "appeal." Then after you have read Section 4, you can go to the section in Chapter 9 that tells what to do for your situation:

- If you want to make an appeal about getting paid back for a medical service, go to Section 5.3 in Chapter 9.
- If you want to make an appeal about getting paid back for a drug, go to Section 6.5 of Chapter 9.

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

Section 4.1 In some cases, you should send copies of your receipts to the plan to help us track your out-of-pocket drug costs

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

Here are two situations when you should send us copies of receipts to let us know about payments you have made for your drugs:

1. When you buy the drug for a price that is lower than our price

If your plan includes stages in which you are responsible for 100% of the drug costs, such as a deductible stage, sometimes you can buy your drug **at a network pharmacy** for a price that is lower than our price.

- For example, a pharmacy might offer a special price on the drug. Or you may have a discount card that is outside our benefit that offers a lower price.
- Unless special conditions apply, you must use a network pharmacy in these situations and your drug must be on our Drug List.
- Save your receipt and send a copy to us so that we can have your out-of-pocket expenses count toward qualifying you for the Catastrophic Coverage Stage.
- **Please note:** If you are in a Part D plan stage in which you are responsible for 100% of the drug costs, your Part D plan will not pay for any share of these drug costs. But sending a copy of the receipt allows us to calculate your out-of-pocket costs correctly and may help you qualify for the Catastrophic Coverage Stage more quickly.

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

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

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

Since you are not asking for payment in the two cases described above, these situations are not considered coverage decisions. Therefore, you cannot make an appeal if you disagree with our decision.

Your rights and responsibilities

Section		Page
1	**Your plan must honor your rights as a member of the plan**	102
1.1	We must provide information in a way that works for you (in Braille, in large print or other alternate formats)	102
1.2	We must treat you with fairness and respect at all times	102
1.3	We must ensure that you get timely access to your covered services and prescription drugs	103
1.4	We must protect the privacy of your personal health information	103
1.5	We must give you information about the plan and your covered services	109
1.6	We must support your right to make decisions about your care	110
1.7	You have the right to make complaints and to ask us to reconsider decisions we have made	112
1.8	What can you do if you believe you are being treated unfairly or your rights are not being respected?	113
1.9	How to get more information about your rights	113
2	**You have some responsibilities as a member of the plan**	114
2.1	What are your responsibilities?	114

SECTION 1 Your plan must honor your rights as a member of the plan

Section 1.1 We must provide information in a way that works for you (in Braille, in large print, or other alternate formats)

To get information from us in a way that works for you, please call Customer Service (phone numbers are printed on the front cover of this booklet).

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

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

Section 1.2 We must treat you with fairness and respect at all times

Your plan must obey laws that protect you from discrimination or unfair treatment. **We do not discriminate** based on a person's race, ethnicity, national origin, religion, gender, age, mental or physical health status, claims experience, medical history, genetic information, evidence of insurability, or geographic location within the service area.

If you want more information or have concerns about discrimination or unfair treatment, please call the Department of Health and Human Services' **Office for Civil Rights** 1-800-368-1019 (TTY 1-800-537-7697) or your local Office for Civil Rights. For contact information, please refer to the state-specific agency listing located in Chapter 13.

If you have a disability and need help with access to care, please call us at Customer Service (phone numbers are printed on the front cover of this booklet). If you have a complaint, such as a problem with wheelchair access, Customer Service can help.

Section 1.3 We must ensure that you get timely access to your covered services and drugs

You have the right to choose a provider in the plan's network. Call Customer Service to learn which doctors are accepting new patients (phone numbers are printed on the cover of this booklet). You also have the right to go to a women's health specialist (such as a gynecologist) without a referral and still pay the in-network cost-sharing amount. Prior authorization may be required on some services. Please refer to the benefit chart for more information.

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

If you think that you are not getting your medical care or Part D drugs within a reasonable amount of time, Chapter 9, Section 10 of this booklet tells what you can do. (If we have denied coverage for your medical care or drugs and you don't agree with our decision, Chapter 9, Section 4 tells what you can do.)

Section 1.4 We must protect the privacy of your personal health information

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

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

How do we protect the privacy of your health information?

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

- For example, we are required to release health information to government agencies that are checking on quality of care.
- Because you are a member of your plan through Medicare, we are required to give Medicare your health information including information about your Part D prescription drugs. If Medicare releases your information for research or other uses, this will be done according to Federal statutes and regulations.

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

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

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

If you have questions or concerns about the privacy of your personal health information, please call Customer Service (phone numbers are printed on the front cover of this booklet). Every year, we're required to send you specific information about your rights, your benefits and more. This can use up a lot of trees, so we've combined a couple of these required annual notices. Please take a few minutes to read about:

- State notice of privacy practices
- HIPAA notice of privacy practices
- Breast reconstruction surgery benefits

Want to save more trees? Go to our website and sign up to receive these types of notices by email.

State notice of privacy practices

As mentioned in our Health Insurance Portability and Accountability Act (HIPAA) notice, we must follow state laws that are stricter than the federal HIPAA privacy law. This notice explains your rights and our legal duties under state law. This applies to life insurance benefits, in addition to health, dental and vision benefits that you may have.

Your personal information

We may collect, use and share your nonpublic personal information (PI) as described in this notice. PI identifies a person and is often gathered in an insurance matter.

We may collect PI about you from other persons or entities, such as doctors, hospitals or other carriers. We may share PI with persons or entities outside of our company—without your OK in some cases. If we take part in an activity that would require us to give you a chance to opt out, we will contact you. We will tell you how you can let us know that you do not want us to use or share your PI for a given activity. You have the right to access and correct your PI. Because PI is defined as any information that can be used to make judgments about your health, finances, character, habits, hobbies, reputation, career and credit, we take reasonable safety measures to protect the PI we have about you. A more detailed state notice is available upon request. Please call the phone number printed on your membership card.

HIPAA Notice of Privacy Practices

This notice describes how health, vision and dental information about you may be used and disclosed, and how you can get access to this information with regard to your health benefits. Please review it carefully.

We keep the health and financial information of our current and former members private, as required by law, accreditation standards and our rules. This notice explains your rights. It also explains our legal duties and privacy practices. We are required by federal law to give you this notice.

Your Protected Health Information

We may collect, use and share your Protected Health Information (PHI) for the following reasons and others as allowed or required by law, including the HIPAA Privacy rule:

For payment: We use and share PHI to manage your account or benefits; or to pay claims for health care you get through your plan. For example, we keep information about your premium and deductible payments. We may give information to a doctor's office to confirm your benefits.

For health care operations: We use and share PHI for our health care operations. For example, we may use PHI to review the quality of care and services you get. We may also use PHI to provide you with case management or care coordination services for conditions like asthma, diabetes or traumatic injury.

For treatment activities: We do not provide treatment. This is the role of a health care provider, such as your doctor or a hospital. But, we may share PHI with your health care provider so that the provider may treat you.

To you: We must give you access to your own PHI. We may also contact you to let you know about treatment options or other health-related benefits and services. When you or your dependents reach a certain age, we may tell you about other products or programs for which you may be eligible. This may include individual coverage. We may also send you reminders about routine medical checkups and tests.

To others: In most cases, if we use or disclose your PHI outside of treatment, payment, operations or research activities, we must get your OK in writing first. We must receive your written OK before we can use your PHI for certain marketing activities. We must get your written OK before we sell your PHI. If we have them, we must get your OK before we disclose your provider's psychotherapy notes. Other uses and disclosures of your PHI not mentioned in this notice may also require your written OK. You always have the right to revoke any written OK you provide. You may tell us in writing that it is OK for us to give your PHI to someone else for any reason. Also, if you are present and tell us it is OK, we may give your PHI to a family member, friend or other person. We would do this if it has to do with your current treatment or payment for your treatment. If you are not present, if it is an emergency, or you are not able to tell us it is OK, we may give your PHI to a family member, friend or other person if sharing your PHI is in your best interest.

As allowed or required by law: We may also share your PHI, as allowed by federal law, for many types of activities. PHI can be shared for health oversight activities. It can also be shared for judicial or administrative proceedings, with public health authorities, for law enforcement reasons, and with coroners, funeral directors or medical examiners (about decedents). PHI can also be shared with organ donation groups for certain reasons, for research, and to avoid a serious threat to health or safety. It can be shared for special government functions, for Workers' Compensation, to respond to requests from the U.S. Department of Health and Human Services, and to alert proper authorities if we reasonably believe that you may be a victim of abuse, neglect, domestic violence or other crimes. PHI can also be shared as required by law. If you are enrolled with us through an employer-sponsored group health plan, we may share PHI with your group health plan. We and/or your group health plan may share PHI with the sponsor of the plan. Plan sponsors that receive PHI are required by law to have controls in place to keep it from being used for reasons that are not proper. If your employer pays your premium or part of your premium, but does not pay your health insurance claims, your employer is not allowed to receive your PHI—unless your employer promises to protect your PHI and makes sure the PHI will be used for legal reasons only.

Authorization: We will get an OK from you in writing before we use or share your PHI for any other purpose not stated in this notice. You may take away this OK at any time, in writing. We will then stop using your PHI for that purpose. But, if we have already used or shared your PHI based on your OK, we cannot undo any actions we took before you told us to stop.

Genetic information: We cannot use or disclose PHI that is an individual's genetic information for underwriting.

Your rights

Under federal law, you have the right to:

- Send us a written request to see or get a copy of certain PHI, or ask that we correct your PHI that you believe is missing or incorrect. If someone else (such as your doctor) gave us the PHI, we will let you know so you can ask him or her to correct it.
- Send us a written request to ask us not to use your PHI for treatment, payment or health care operations activities. We are not required to agree to these requests.
- Give us a verbal or written request to ask us to send your PHI using other means that are reasonable. Also, let us know if you want us to send your PHI to an address other than your home if sending it to your home could place you in danger.
- Send us a written request to ask us for a list of certain disclosures of your PHI. Call Customer Service at the phone number printed on your membership card to use any of these rights. Customer Service representatives can give you the address to send the request. They can also give you any forms we have that may help you with this process.
- Right to a restriction for services you pay for out of your own pocket: If you pay in full for any medical services out of your own pocket, you have the right to ask for a restriction. The restriction would prevent the use or disclosure of that PHI for treatment, payment or operations reasons. If you or your provider submits a claim to us, we do not have to agree to a restriction (see Your Rights section above). If a law requires the disclosure, we do not have to agree to your restriction.

How we protect information

We are dedicated to protecting your PHI, and have set up a number of policies and practices to help make sure your PHI is kept secure.

We have to keep your PHI private. If we believe your PHI has been breached, we must let you know.

We keep your oral, written and electronic PHI safe using physical, electronic, and procedural means. These safeguards follow federal and state laws. Some of the ways we keep your PHI safe include securing offices that hold PHI, password-protecting computers, and locking storage areas and filing cabinets. We require our employees to protect PHI through written policies and procedures. These policies limit access to PHI to only those employees who need the data to do their job. Employees are also required to wear ID badges to help keep people who do not belong out of areas where sensitive data is kept. Also, where required by law, our affiliates and nonaffiliates must protect the privacy of data we share in the normal course of business. They are not allowed to give PHI to others without your written OK, except as allowed by law.

Potential impact of other applicable laws

HIPAA (the federal privacy law) generally does not preempt, or override, other laws that give people greater privacy protections. As a result, if any state or federal privacy law requires us to provide you with more privacy protections, then we must also follow that law in addition to HIPAA.

Complaints

If you think we have not protected your privacy, you can file a complaint with us. You may also file a complaint with the Office for Civil Rights in the U.S. Department of Health and Human Services. We will not take action against you for filing a complaint.

Contact information

Please call Customer Service at the phone number printed on your membership card. Representatives can help you apply your rights, file a complaint or talk with you about privacy issues.

Copies and changes

You have the right to get a new copy of this notice at any time. Even if you have agreed to get this notice by electronic means, you still have the right to a paper copy. We reserve the right to change this notice. A revised notice will apply to PHI we already have about you, as well as any PHI we may get in the future. We are required by law to follow the privacy notice that is in effect at this time. We may tell you about any changes to our notice in a number of ways. We may tell you about the changes in a member newsletter or post them on our website. We may also mail you a letter that tells you about any changes.

Effective Date of this notice May 13, 2013

Breast reconstruction surgery benefits

If you ever need a benefit-covered mastectomy, we hope it will give you some peace of mind to know that your benefits comply with the Women's Health and Cancer Rights Act of 1998, which provides for:

- Reconstruction of the breast(s) that underwent a covered mastectomy.
- Surgery and reconstruction of the other breast to restore a symmetrical appearance.
- Prostheses and coverage for physical complications related to all stages of a covered mastectomy, including lymphedema.

All applicable benefit provisions will apply, including existing deductibles, copayments and/or coinsurance. Contact your plan administrator for more information.

Blue Cross and Blue Shield of Georgia

Section 1.5 We must give you information about the plan, its providers, and your covered services

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

If you want any of the following kinds of information, please call Customer Service (phone numbers are printed on the front cover of this booklet).

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

- **Information about our in-network providers including our network pharmacies**
  - For example, you have the right to get information from us about the qualifications of the providers and pharmacies in our network and how we pay the providers in our network.
  - For a list of the providers in the plan's network, see the plan's Provider directory.
  - For a list of the pharmacies in the plan's network, see the Pharmacy directory.
  - For more detailed information about our providers or pharmacies, you can call Customer Service (phone numbers are printed on the front cover of this booklet).

- **Information about your coverage and the rules you must follow when using your coverage.**
  - In Chapters 3 and 4 and the benefit chart located in the front of this booklet, we explain what medical services are covered for you, any restrictions to your coverage, and what rules you must follow to get your covered medical services.
  - To get the details on your Part D prescription drug coverage, see Chapters 5 and 6 of this booklet plus the plan's List of Covered Drugs (Formulary). These chapters, together with the List of Covered Drugs (Formulary), tell you what drugs are covered and explain the rules you must follow and the restrictions to your coverage for certain drugs.
  - If you have questions about the rules or restrictions, please call Customer Service (phone numbers are printed on the front cover of this booklet).
- **Information about why something is not covered and what you can do about it.**
  - If a medical service or Part D drug is not covered for you, or if your coverage is restricted in some way, you can ask us for a written explanation. You have the right to this explanation even if you received the drug from an out-of-network pharmacy.
  - If you are not happy or if you disagree with a decision we make about what medical care or Part D drug is covered for you, you have the right to ask us to change the decision. You can ask us to change the decision by making an appeal. For details on what to do if something is not covered for you in the way you think it should be covered, see Chapter 9 of this booklet. It gives you the details about how to make an appeal if you want us to change our decision. (Chapter 9 also tells about how to make a complaint about quality of care, waiting times, and other concerns.)
  - If you want to ask your plan to pay our share of a bill you have received for medical care or a Part D prescription drug, see Chapter 7 of this booklet.

Section 1.6 We must support your right to make decisions about your care

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

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

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

- **To know about all of your choices.** This means that you have the right to be told about all of the treatment options that are recommended for your condition, no matter what they cost or whether they are covered by your plan. It also includes being told about programs your plan offers to help members manage their medications and use drugs safely.
- **To know about the risks.** You have the right to be told about any risks involved in your care. You must be told in advance if any proposed medical care or treatment is part of a research experiment. You always have the choice to refuse any experimental treatments.
- **The right to say "no.**" You have the right to refuse any recommended treatment. This includes the right to leave a hospital or other medical facility, even if your doctor advises you not to leave. You also have the right to stop taking your medication. Of course, if you refuse treatment or stop taking medication, you accept full responsibility for what happens to your body as a result.
- **To receive an explanation if you are denied coverage for care.** You have the right to receive an explanation from us if a provider has denied care that you believe you should receive. To receive this explanation, you will need to ask us for a coverage decision. Chapter 9 of this booklet tells how to ask the plan for a coverage decision.

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

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

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

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

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

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

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

- If you are admitted to the hospital, they will ask you whether you have signed an advance directive form and whether you have it with you.
- If you have not signed an advance directive form, the hospital has forms available and will ask if you want to sign one.

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

What if your instructions are not followed?

If you have signed an advance directive, and you believe that a doctor or hospital did not follow the instructions in it, you may file a complaint with the appropriate state-specific agency (such as the State Department of Health). For contact information, please refer to the state-specific agency listing located in Chapter 13.

Section 1.7 You have the right to make complaints and to ask us to reconsider decisions we have made

If you have any problems or concerns about your covered services or care, Chapter 9 of this booklet tells what you can do. It gives the details about how to deal with all types of problems and complaints.

As explained in Chapter 9, what you need to do to follow up on a problem or concern depends on the situation. You might need to ask your plan to make a coverage decision for

you, make an appeal to us to change a coverage decision, or make a complaint. Whatever you do–ask for a coverage decision, make an appeal, or make a complaint–**we are required to treat you fairly.**

You have the right to get a summary of information about the appeals and complaints that other members have filed against your plan in the past. To get this information, please call Customer Service (phone numbers are printed on the front cover of this booklet).

Section 1.8 What can you do if you believe you are being treated unfairly or your rights are not being respected?

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

If you believe you have been treated unfairly or your rights have not been respected due to your race, disability, religion, sex, health, ethnicity, creed (beliefs), age, or national origin, you should call the Department of Health and Human Services' **Office for Civil Rights** at 1-800-368-1019 or TTY 1-800-537-7697, or call your local Office for Civil Rights. For contact information, please refer to the state-specific agency listing located in Chapter 13.

Is it about something else?

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

- You can **call Customer Service** (phone numbers are printed on the front cover of this booklet).
- You can **call the State Health Insurance Assistance Program**. For contact information, please refer to the state-specific agency listing located in Chapter 13.
- Or, you can **call Medicare** at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

Section 1.9 How to get more information about your rights

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

- You can **call Customer Service** (phone numbers are printed on the cover of this booklet).
- You can **call the State Health Insurance Assistance Program**. For details about this organization and how to contact it, go to Chapter 2, Section 3. For contact information, please refer to the state-specific agency listing located in Chapter 13.

- You can contact **Medicare**.
  - You can visit the Medicare website (http://www.medicare.gov) to read or download the publication "Your Medicare Rights & Protections." (The publication is available at: http://www.medicare.gov/Publications/Pubs/pdf/10112.pdf.)
  - Or, you can call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

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

Section 2.1 What are your responsibilities?

Things you need to do as a member of the plan are listed below. If you have any questions, please call Customer Service (phone numbers are printed on the front cover of this booklet). We're here to help.

- **Get familiar with your covered services and the rules you must follow to get these covered services.** Use this Evidence of Coverage booklet to learn what is covered for you and the rules you need to follow to get your covered services.
  - The benefit chart located in the front of this booklet and Chapters 3 and 4 give the details about your medical services, including what is covered, what is not covered, rules to follow, and what you pay.
  - The benefit chart located in the front of this booklet and Chapters 5 and 6 give the details about your coverage for Part D prescription drugs.
- **If you have any other health insurance coverage or prescription drug coverage in addition to your plan, you are required to tell us.** Please call Customer Service to let us know (phone numbers are printed on the front cover of this booklet).
  - We are required to follow rules set by Medicare to make sure that you are using all of your coverage in combination when you get your covered services from your plan. This is called "**coordination of benefits**" because it involves coordinating the health and drug benefits you get from your plan with any other health and drug benefits available to you. We'll help you coordinate your benefits. (For more information about coordination of benefits, go to Chapter 1, Section 7.)
- **Tell your doctor and other health care providers that you are enrolled in your plan.** Show your plan membership card whenever you get your medical care or Part D prescription drugs.

- **Help your doctors and other providers help you by giving them information, asking questions, and following through on your care.**
  - To help your doctors and other health care providers give you the best care, learn as much as you are able to about your health problems and give them the information they need about you and your health. Follow the treatment plans and instructions that you and your doctors agree upon.
  - Make sure your doctors know all of the drugs you are taking, including over-the-counter drugs, vitamins, and supplements.
  - If you have any questions, be sure to ask. Your doctors and other health care providers are supposed to explain things in a way you can understand. If you ask a question and you don't understand the answer you are given, ask again.
- **Be considerate.** We expect all our members to respect the rights of other patients. We also expect you to act in a way that helps the smooth running of your doctor's office, hospitals, and other offices.
- **Pay what you owe.** As a plan member, you are responsible for these payments:
  - You or your spouse's retiree group must pay your plan premiums for you to continue being a member of your plan.
  - You must pay your plan premiums, if any, to your (or your spouse's) group (or, if you are billed directly, you must send your payment to the address listed on your billing statement), to continue being a member of your plan.
  - In order to be eligible for your plan, you must be enrolled in Medicare Part B. For that reason, most plan members must pay a premium for Medicare Part B to remain a member of the plan.
  - For most of your medical services or drugs covered by the plan, you must pay your share of the cost when you get the service or drug. This will be a copayment (a fixed amount) or coinsurance (a percentage of the total cost). You can find this information listed in the benefit chart located in the front of this booklet.
  - If you get any medical services or drugs that are not covered by your plan or by other insurance you may have, you must pay the full cost.
    - If you disagree with our decision to deny coverage for a service or drug, you can make an appeal. Please see Chapter 9 of this booklet for information about how to make an appeal.
  - If you are required to pay a late enrollment penalty, you must pay the penalty to remain a member of the plan.

  - If you are required to pay the extra amount for Part D because of your yearly income, you must pay the extra amount directly to the government to remain a member of the plan.
- **Tell us if you move.** If you are going to move, it's important to tell us right away. Call Customer Service (phone numbers are printed on the front cover of this booklet). We need to keep your membership record up-to-date and know how to contact you.
  - **If you move *outside* of your plan service area, you cannot remain a member of our plan.** (Chapter 1 tells about our service area.) We can help you figure out whether you are moving outside our service area. If you are leaving our service area, you will have a Special Enrollment Period when you can join any Medicare plan available in your new area. We can let you know if we have a plan in your new area.
  - **If you move *within* your service area, we still need to know** so we can keep your membership record up-to-date and know how to contact you.
  - If you move, it is also important to tell Social Security (or the Railroad Retirement Board). You can find phone numbers and contact information for these organizations in Chapter 2.
- **Call Customer Service for help if you have questions or concerns.** We also welcome any suggestions you may have for improving your plan.
  - Phone numbers and calling hours for Customer Service are printed on the front cover of this booklet.
  - For more information on how to reach us, including our mailing address, please see Chapter 2.

Chapter

9.

2014 Evidence of Coverage for Medicare Preferred (PPO) with Senior Rx Plus

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

Section | Page

BACKGROUND

1 Introduction 120
1.1 What to do if you have a problem or concern 120
1.2 What about the legal terms? 120

2 You can get help from government organizations that are not connected with us 121
2.1 Where to get more information and personalized assistance 121

3 To deal with your problem, which process should you use? 122
3.1 Should you use the process for coverage decisions and appeals? Or should you use the process for making complaints? 122

COVERAGE DECISIONS AND APPEALS

4 A guide to the basics of coverage decisions and appeals 123
4.1 Asking for coverage decisions and making appeals: the big picture 123
4.2 How to get help when you are asking for a coverage decision or making an appeal 124
4.3 Which section of this chapter gives the details for your situation? 125

5 Your medical care: How to ask for a coverage decision or make an appeal 126
5.1 This tells what to do if you have problems getting coverage for medical care or if you want us to pay you back for our share of the cost of your care 126
5.2 Step-by-step: How to ask for a coverage decision (how to ask your plan to authorize or provide the medical care coverage you want) 127
5.3 Step-by-step: How to make a Level 1 Appeal (how to ask for a review of a medical care coverage decision made by your plan) 131
5.4 Step-by-step: How a Level 2 Appeal is done 134
5.5 What if you are asking us to pay you for our share of a bill you have received for medical care? 135

Section		Page
6	**Your Part D prescription drugs: How to ask for a coverage decision or make an appeal**	137
6.1	This section tells you what to do if you have problems getting a Part D drug or you want us to pay you back for a Part D drug	137
6.2	What is an exception?	139
6.3	Important things to know about asking for exceptions	140
6.4	Step-by-step: How to ask for a coverage decision, including an exception	141
6.5	Step-by-step: How to make a Level 1 Appeal (how to ask for a review of a coverage decision made by your plan)	144
6.6	Step-by-step: How to make a Level 2 Appeal	146
7	**How to ask us to cover a longer inpatient hospital stay if you think the doctor is discharging you too soon**	148
7.1	During your inpatient hospital stay, you will get a written notice from Medicare that tells about your rights	149
7.2	Step-by-step: How to make a Level 1 Appeal to change your hospital discharge date	150
7.3	Step-by-step: How to make a Level 2 Appeal to change your hospital discharge date	153
7.4	What if you miss the deadline for making your Level 1 Appeal?	155
8	**How to ask us to keep covering certain medical services if you think your coverage is ending too soon**	158
8.1	*This is about three services only:* Home health care, skilled nursing facility care, and Comprehensive Outpatient Rehabilitation Facility (CORF) services	158
8.2	We will tell you in advance when your coverage will be ending	159
8.3	Step-by-step: How to make a Level 1 Appeal to have your plan cover your care for a longer time	160
8.4	Step-by-step: How to make a Level 2 Appeal to have your plan cover your care for a longer time	162
8.5	What if you miss the deadline for making your Level 1 Appeal?	163

Section		Page
9	**Taking your appeal to Level 3 and beyond**	166
9.1	Levels of Appeal 3, 4, and 5 for Medical Service Appeals	166
9.2	Levels of Appeal 3, 4, and 5 for Part D Drug Appeals	168
	MAKING COMPLAINTS	
10	**How to make a complaint about quality of care, waiting times, customer service, or other concerns**	169
10.1	What kinds of problems are handled by the complaint process?	169
10.2	The formal name for "making a complaint" is "filing a grievance"	172
10.3	Step-by-step: Making a complaint	172
10.4	You can also make complaints about quality of care to the Quality Improvement Organization	173
10.5	You can also tell Medicare about your complaint	174

BACKGROUND

SECTION 1 Introduction

Section 1.1 What to do if you have a problem or concern

Please call us first

Your health and satisfaction are important to us. When you have a problem or concern, we hope you'll try an informal approach first: Please call Customer Service (phone numbers are listed on the front cover of this booklet). We will work with you to try to find a satisfactory solution to your problem.

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

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

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

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

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

Section 1.2 What about the legal terms?

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

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

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

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

Section 2.1 Where to get more information and personalized assistance

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

Get help from an independent government organization

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

The services of SHIP counselors are free. For contact information, please refer to the state-specific agency listing located in Chapter 13.

You can also get help and information from Medicare

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

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

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

Section 3.1 Should you use the process for coverage decisions and appeals? Or should you use the process for making complaints?

If you have a problem or concern you only need to read the parts of this chapter that apply to your situation. The guide that follows will help.

To figure out which part of this chapter will help with your specific problem or concern,
START HERE

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

Yes.	No.
My problem is about benefits or coverage.	My problem is not about benefits or coverage.
Go on to the next section of this chapter, **Section 4, "A guide to the basics of coverage decisions and appeals."**	Skip ahead to **Section 10** at the end of this chapter: **"How to make a complaint about quality of care, waiting times, customer service or other concerns."**

COVERAGE DECISIONS AND APPEALS

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

Section 4.1 Asking for coverage decisions and making appeals: the big picture

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

Asking for coverage decisions

A coverage decision is a decision we make about your benefits and coverage or about the amount we will pay for your medical services or drugs. For example, your plan in-network doctor makes a (favorable) coverage decision for you whenever you receive medical care from him or her or if your network doctor refers you to a medical specialist. You or your doctor can also contact us and ask for a coverage decision if your doctor is unsure whether we will cover a particular medical service or refuses to provide medical care you think that you need. In other words, if *you* want to know if we will cover a medical service before you receive it, you can ask us to make a coverage decision for you.

We are making a coverage decision for you whenever we decide what is covered for you and how much we pay. In some cases we might decide a service or drug is not covered or is no longer covered by Medicare for you. If you disagree with this coverage decision, you can make an appeal.

Making an appeal

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

When you make an appeal, we review the coverage decision we have made to check to see if we were following all of the rules properly. Your appeal is handled by different reviewers than those who made the original unfavorable decision. When we have completed the review, we give you our decision.

If we say no to all or part of your Level 1 Appeal, you can go on to a Level 2 Appeal. The Level 2 Appeal is conducted by an independent organization that is not connected to us.

(In some situations, your case will be automatically sent to the independent organization for a Level 2 Appeal. If this happens, we will let you know. In other situations, you will need to ask for a Level 2 Appeal.) If you are not satisfied with the decision at the Level 2 Appeal, you may be able to continue through additional levels of appeal.

Section 4.2 How to get help when you are asking for a coverage decision or making an appeal

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

- You **can call Customer Service** (phone numbers are printed on the front cover of this booklet).
- To **get free help from an independent organization** that is not connected with your plan, contact your State Health Insurance Assistance Program (see Section 2 of this chapter). For contact information, please refer to the state-specific agency listing located in Chapter 13.
- **Your doctor can make a request for you.**
  - For medical care, your doctor can request a coverage decision or a Level 1 Appeal on your behalf. If your appeal is denied at Level 1, it will be automatically forwarded to Level 2. To request any appeal after Level 2, your doctor must be appointed as your representative.
  - For Part D prescription drugs, your doctor or other prescriber can request a coverage decision or a Level 1 or Level 2 Appeal on your behalf. To request any appeal after Level 2, your doctor or other prescriber must be appointed as your representative.
- **You can ask someone to act on your behalf.** If you want to, you can name another person to act for you as your "representative" to ask for a coverage decision or make an appeal.
  - There may be someone who is already legally authorized to act as your representative under State law.
  - If you want a friend, relative, your doctor or other provider, or other person to be your representative, call Customer Service (phone numbers are printed on the front cover of this booklet) and ask for the "Appointment of Representative" form. (The form is also available on Medicare's website at http://www.cms.hhs.gov/cmsforms/downloads/cms1696.pdf.) The form gives that person permission to act on your behalf. It must be signed by you and by the person who you would like to act on your behalf. You must give us a copy of the signed form.

- **You also have the right to hire a lawyer to act for you.** You may contact your own lawyer, or get the name of a lawyer from your local bar association or other referral service. There are also groups that will give you free legal services if you qualify. However, **you are not required to hire a lawyer** to ask for any kind of coverage decision or appeal a decision.

Section 4.3 Which section of this chapter gives the details for your situation?

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

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

If you're not sure which section you should be using, please call Customer Service (phone numbers are printed on the front cover of this booklet). You can also get help or information from government organizations such as your State Health Insurance Assistance Program. For contact information, please refer to the state-specific agency listing located in Chapter 13.

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

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

Section 5.1 This section tells what to do if you have problems getting coverage for medical care or if you want us to pay you back for our share of the cost of your care

This section is about your benefits for medical care and services. These are the benefits described in the benefit chart located in the front of this booklet and in Chapter 4 of this booklet: Medical benefits (what is covered and what you pay). To keep things simple, we generally refer to "medical care coverage" or "medical care" in the rest of this section, instead of repeating "medical care or treatment or services" every time.

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

1. You are not getting certain medical care you want, and you believe that this care is covered by your plan.
2. Your plan will not approve the medical care your doctor or other medical provider wants to give you, and you believe that this care is covered by the plan.
3. You have received medical care or services that you believe should be covered by the plan, but we have said we will not pay for this care.
4. You have received and paid for medical care or services that you believe should be covered by the plan, and you want to ask your plan to reimburse you for this care.
5. You are being told that coverage for certain medical care you have been getting that we previously approved will be reduced or stopped, and you believe that reducing or stopping this care could harm your health.

   - NOTE: **If the coverage that will be stopped is for hospital care, home health care, skilled nursing facility care, or Comprehensive Outpatient Rehabilitation Facility (CORF) services**, you need to read a separate section of this chapter because special rules apply to these types of care. Here's what to read in those situations:
     - Chapter 9, Section 7: How to ask us to cover a longer inpatient hospital stay if you think the doctor is discharging you too soon.

- Chapter 9, Section 8: How to ask us to keep covering certain medical services if you think your coverage is ending too soon. This section is about three services only: home health care, skilled nursing facility care, and Comprehensive Outpatient Rehabilitation Facility (CORF) services.

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

Which of these situations are you in?

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

Section 5.2 Step-by-step: How to ask for a coverage decision (how to ask your plan to authorize or provide the medical care coverage you want)

Legal Terms When a coverage decision involves your medical care, it is called an **"organization determination."**

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

Legal Terms A "fast coverage decision" is called an **"expedited determination."**

How to request coverage for the medical care you want

- Start by calling, writing, or faxing your plan to make your request for us to authorize or provide coverage for the medical care you want. You, your doctor, or your representative can do this.
- For the details on how to contact us, go to Chapter 2, Section 1 and look for the section called "How to contact us when you are asking for a coverage decision about your medical care".

Generally we use the standard deadlines for giving you our decision

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

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

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

- **A fast coverage decision means we will answer within 72 hours.**
  - **However, we can take up to 14 more calendar days** if we find that some information that may benefit you is missing (such as medical records from out-of-network providers), or if you need time to get information to us for the review. If we decide to take extra days, we will tell you in writing.
  - If you believe we should *not* take extra days, you can file a "fast complaint" about our decision to take extra days. (For more information about the process for making complaints, including fast complaints, see Section 10 of this chapter.) We will call you as soon as we make the decision.
- **To get a fast coverage decision, you must meet two requirements:**
  - You can get a fast coverage decision only if you are asking for coverage for medical care *you have not yet received*. (You cannot get a fast coverage decision if your request is about payment for medical care you have already received.)

  - You can get a fast coverage decision *only* if using the standard deadlines could cause serious harm to your health or hurt your ability to function.
- **If your doctor tells us that your health requires a "fast coverage decision," we will automatically agree to give you a fast coverage decision.**
- If you ask for a fast coverage decision on your own, without your doctor's support, your plan will decide whether your health requires that we give you a fast coverage decision.
  - If we decide that your medical condition does not meet the requirements for a fast coverage decision, we will send you a letter that says so (and we will use the standard deadlines instead).
  - This letter will tell you that if your doctor asks for the fast coverage decision, we will automatically give a fast coverage decision.
  - The letter will also tell how you can file a "fast complaint" about our decision to give you a standard coverage decision instead of the fast coverage decision you requested. (For more information about the process for making complaints, including fast complaints, see Section 10 of this chapter.)

Step 2: Your plan considers your request for medical care coverage and gives you our answer.

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

- Generally, for a fast coverage decision, we will give you our answer **within 72 hours**.
  - As explained above, we can take up to 14 more calendar days under certain circumstances. If we decide to take extra days to make the coverage decision, we will tell you in writing.
  - If you believe we should *not* take extra days, you can file a "fast complaint" about our decision to take extra days. When you file a fast complaint, we will give you an answer to your complaint within 24 hours. (For more information about the process for making complaints, including fast complaints, see Section 10 of this chapter.)
  - If we do not give you our answer within 72 hours (or if there is an extended time period, by the end of that period), you have the right to appeal. Section 5.3 below tells how to make an appeal.
- **If our answer is yes to part or all of what you requested,** we must authorize or provide the medical care coverage we have agreed to provide within 72 hours after we received your request. If we extended the time needed to make our coverage decision, we will provide the coverage by the end of that extended period.
- **If our answer is no to part or all of what you requested,** we will send you a detailed written explanation as to why we said no.

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

- Generally, for a standard coverage decision, we will give you our answer **within 14 days of receiving your request.**
  - We can take up to 14 more calendar days ("an extended time period") under certain circumstances. If we decide to take extra days to make the coverage decision, we will tell you in writing.
  - If you believe we should *not* take extra days, you can file a "fast complaint" about our decision to take extra days. When you file a fast complaint, we will give you an answer to your complaint within 24 hours. (For more information about the process for making complaints, including fast complaints, see Section 10 of this chapter.)
  - If we do not give you our answer within 14 days (or if there is an extended time period, by the end of that period), you have the right to appeal. Section 5.3 below tells how to make an appeal.
- **If our answer is yes to part or all of what you requested,** we must authorize or provide the coverage we have agreed to provide within 14 days after we received your request. If we extended the time needed to make our coverage decision, we will provide the coverage by the end of that extended period.
- **If our answer is no to part or all of what you requested**, we will send you a written statement that explains why we said no.

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

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

Section 5.3 Step-by-step: How to make a Level 1 Appeal (how to ask for a review of a medical care coverage decision made by your plan)

Legal Terms An appeal to the plan about a medical care coverage decision is called a plan **"reconsideration."**

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

What to do

- **To start an appeal, you, your doctor, or your representative, must contact your plan.** For details on how to reach us for any purpose related to your appeal, go to Chapter 2, Section 1 and look for the section called "How to contact your plan when you are making an appeal about your medical care."
- **If you are asking for a standard appeal, make your standard appeal in writing by submitting a request.** You may also ask for an appeal by calling us at the phone number shown in Chapter 2, and look for a section called "How to contact our plan when you are making an appeal about your medical care."
    - If you have someone appealing our decision for you other than your doctor, your appeal must include an Appointment of Representative form authorizing this person to represent you. (To get the form, call Customer Service (phone numbers are printed on the front cover of this booklet) and ask for the "Appointment of Representative" form. It is also available on Medicare's website at http://www.cms.hhs.gov/cmsforms/downloads/cms1696.pdf.) While we can accept an appeal request without the form, we cannot complete our review until we receive it. If we do not receive the form within 44 days after receiving your appeal request (our deadline for making a decision on your appeal), your appeal request will be sent to the Independent Review Organization for dismissal.
- **If you are asking for a fast appeal, make your appeal in writing or call us** at the phone number shown in Chapter 2, and look for a section called How to contact us when you are making an appeal about your medical care.
- **You must make your appeal request within 60 calendar days** from the date on the written notice we sent to tell you our answer to your request for a coverage decision. If you miss this deadline and have a good reason for missing it, we may give you more time to make your appeal. Examples of good cause for missing the deadline may include if you had a serious illness that prevented you from contacting us or if we provided you with incorrect or incomplete information about the deadline for requesting an appeal.

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

If your health requires it, ask for a "fast appeal" (you can make a request by calling us)

Legal Terms	A "fast appeal" is also called an **"expedited reconsideration."**

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

If your doctor tells us that your health requires a "fast appeal," we will give you a fast appeal.

Step 2: Your plan considers your appeal and we give you our answer.

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

Deadlines for a **"fast" appeal**

- When we are using the fast deadlines, we must give you our answer **within 72 hours after we receive your appeal**. We will give you our answer sooner if your health requires us to do so.
  - However, if you ask for more time, or if we need to gather more information that may benefit you, we **can take up to 14 more calendar days.** If we decide to take extra days to make the decision, we will tell you in writing.
  - If we do not give you an answer within 72 hours (or by the end of the extended time period if we took extra days), we are required to automatically send your request on to Level 2 of the appeals process, where it will be reviewed by an independent organization. Later in this section, we tell you about this organization and explain what happens at Level 2 of the appeals process.

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

Deadlines for a **"standard" appeal**

- If we are using the standard deadlines, we must give you our answer within 30 calendar days after we receive your appeal if your appeal is about coverage for services you have not yet received. We will give you our decision sooner if your health condition requires us to.
  - However, if you ask for more time, or if we need to gather more information that may benefit you, **we can take up to 14 more calendar days.**
  - If you believe we should *not* take extra days, you can file a "fast complaint" about our decision to take extra days. When you file a fast complaint, we will give you an answer to your complaint within 24 hours. (For more information about the process for making complaints, including fast complaints, see Section 10 of this chapter.)
  - If we do not give you an answer by the deadline above (or by the end of the extended time period if we took extra days), we are required to send your request on to Level 2 of the appeals process, where it will be reviewed by an independent outside organization. Later in this section, we talk about this review organization and explain what happens at Level 2 of the appeals process.
- **If our answer is yes to part or all of what you requested,** we must authorize or provide the coverage we have agreed to provide within 30 days after we receive your appeal.
- **If our answer is no to part or all of what you requested**, we will send you a written denial notice informing you that we have automatically sent your appeal to the Independent Review Organization for a Level 2 Appeal.

Step 3: If your plan says no to part or all of your appeal, your case will *automatically* be sent on to the next level of the appeals process.

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

Section 5.4 Step-by-step: How a Level 2 Appeal Is done

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

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

Step 1: The Independent Review Organization reviews your appeal.

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

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

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

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

- If you had a standard appeal to your plan at Level 1, you will automatically receive a standard appeal at Level 2. The review organization must give you an answer to your Level 2 Appeal **within 30 calendar days** of when it receives your appeal.
- However, if the Independent Review Organization needs to gather more information that may benefit you, **it can take up to 14 more calendar days**.

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

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

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

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

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

Section 5.5 What if you are asking us to pay you for our share of a bill you have received for medical care?

If you want to ask us for payment for medical care, start by reading Chapter 7 of this booklet: Asking us to pay our share of a bill you have received for covered medical services or drugs. Chapter 7 describes the situations in which you may need to ask for reimbursement or to pay a bill you have received from a provider. It also tells how to send us the paperwork that asks us for payment.

Asking for reimbursement is asking for a coverage decision from us

If you send us the paperwork that asks for reimbursement, you are asking us to make a coverage decision (for more information about coverage decisions, see Section 4.1 of this chapter). To make this coverage decision, we will check to see if the medical care you paid for is a covered service (see the benefit chart located in the front of this booklet and Chapter 4: Medical Benefits (what is covered and what you pay)). We will also check to see if you followed all the rules for using your coverage for medical care (these rules are given in Chapter 3 of this booklet: Using the plan's coverage for your medical services).

We will say yes or no to your request

- If the medical care you paid for is covered and you followed all the rules, we will send you the payment for our share of the cost of your medical care within 60 calendar days after we receive your request. Or, if you haven't paid for the services, we will send the payment directly to the provider. (When we send the payment, it's the same as saying *yes* to your request for a coverage decision.)
- If the medical care is *not* covered, or you did *not* follow all the rules, we will not send payment. Instead, we will send you a letter that says we will not pay for the services and the reasons why in detail. (When we turn down your request for payment, it's the same as saying *no* to your request for a coverage decision.)

What if you ask for payment and we say that we will not pay?

If you do not agree with our decision to turn you down, **you can make an appeal**. If you make an appeal, it means you are asking us to change the coverage decision we made when we turned down your request for payment.

To make this appeal, follow the process for appeals that we describe in part 5.3 of this section. Go to this part for step-by-step instructions. When you are following these instructions, please note:

- If you make an appeal for reimbursement, we must give you our answer within 60 calendar days after we receive your appeal. (If you are asking us to pay you back for medical care you have already received and paid for yourself, you are not allowed to ask for a fast appeal.)
- If the Independent Review Organization reverses our decision to deny payment, we must send the payment you have requested to you or to the provider within 30 calendar days. If the answer to your appeal is yes at any stage of the appeals process after Level 2, we must send the payment you requested to you or to the provider within 60 calendar days.

SECTION 6 Your Part D prescription drugs: How to ask for a coverage decision or make an appeal

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

Section 6.1 This section tells you what to do if you have problems getting a Part D drug or you want us to pay you back for a Part D drug

Your benefits as a member of your plan include coverage for many prescription drugs. Please refer to your plan's List of Covered Drugs (Formulary). To be covered, the drug must be used for a medically accepted indication. (A "medically accepted indication" is a use of the drug that is either approved by the Food and Drug Administration or supported by certain reference books. See Chapter 5, Section 3 for more information about a medically accepted indication.)

- **This section is about your Part D drugs only.** To keep things simple, we generally say "drug" in the rest of this section, instead of repeating "covered outpatient prescription drug" or "Part D drug" every time.
- For details about what we mean by Part D drugs, the List of Covered Drugs (Formulary), rules and restrictions on coverage, and cost information, see Chapter 5 (Using your plan's coverage for your Part D prescription drugs) and Chapter 6 (What you pay for your Part D prescription drugs).

Part D coverage decisions and appeals

As discussed in Section 4 of this chapter, a coverage decision is a decision we make about your benefits and coverage or about the amount we will pay for your drugs.

Legal Terms An initial coverage decision about your Part D drugs is called a **"coverage determination."**

Here are examples of coverage decisions you ask us to make about your Part D drugs:

- You ask us to make an exception, including:
  - Asking us to cover a Part D drug that is not on the plan's List of Covered Drugs (Formulary)

  - Asking us to waive a restriction on the plan's coverage for a drug (such as limits on the amount of the drug you can get)
  - Asking to pay a lower cost-sharing amount for a covered non-preferred drug
- You ask us whether a drug is covered for you and whether you satisfy any applicable coverage rules. (For example, when your drug is on the plan's List of Covered Drugs (Formulary) but we require you to get approval from us before we will cover it for you.)
  - **Please note**: If your pharmacy tells you that your prescription cannot be filled as written, you will get a written notice explaining how to contact us to ask for a coverage decision.
- You ask us to pay for a prescription drug you already bought. This is a request for a coverage decision about payment.

If you disagree with a coverage decision we have made, you can appeal our decision.

This section tells you both how to ask for coverage decisions and how to request an appeal. Use the chart below to help you determine which part has information for your situation:

Which of these situations are you in?			
Do you need a drug that isn't on our Drug List or need us to waive a rule or restriction on a drug we cover?	Do you want us to cover a drug on our Drug List and you believe you meet any plan rules or restrictions (such as getting approval in advance) for the drug you need?	Do you want to ask us to pay you back for a drug you have already received and paid for?	Have we already told you that we will not cover or pay for a drug in the way that you want it to be covered or paid for?
You can ask us to make an exception. (This is a type of coverage decision.) Start with **Section 6.2** of this chapter.	You can ask us for a coverage decision. Skip ahead to **Section 6.4** of this chapter.	You can ask us to pay you back. (This is a type of coverage decision.) Skip ahead to **Section 6.4** of this chapter.	You can make an appeal. (This means you are asking us to reconsider.) Skip ahead to **Section 6.5** of this chapter.

Section 6.2 What is an exception?

If a drug is not covered in the way you would like it to be covered, you can ask your plan to make an "exception." An exception is a type of coverage decision. Similar to other types of coverage decisions, if we turn down your request for an exception, you can appeal our decision.

When you ask for an exception, your doctor or other prescriber will need to explain the medical reasons why you need the exception approved. We will then consider your request. Here are three examples of exceptions that you or your doctor or other prescriber can ask us to make:

1. **Covering a Part D drug for you that is not on your plan's List of Covered Drugs (Formulary).** (We call it the "Drug List" for short.)

   Legal Terms Asking for coverage of a drug that is not on the Drug List is sometimes called asking for a **"formulary exception."**

   - If we agree to make an exception and cover a drug that is not on the Drug List, you will need to pay the cost-sharing amount that applies to all of our drugs or drugs in the non-preferred brand tier. You cannot ask for an exception to the copayment or coinsurance amount we require you to pay for the drug.

2. **Removing a restriction on the plan's coverage for a covered drug**. There are extra rules or restrictions that apply to certain drugs on our List of Covered Drugs (Formulary) (for more information, go to Chapter 5 and look for Section 4).

   Legal Terms Asking for removal of a restriction on coverage for a drug is sometimes called asking for a **"formulary exception."**

   - The extra rules and restrictions on coverage for certain drugs include:
     - Getting plan approval in advance before we will agree to cover the drug for you. (This is sometimes called "prior authorization.")
     - Being required to try a different drug first before we will agree to cover the drug you are asking for. (This is sometimes called "step therapy.")
     - Quantity limits. For some drugs, there are restrictions on the amount of the drug you can have.

- If your plan agrees to make an exception and waive a restriction for you, you can ask for an exception to the copayment or coinsurance amount we require you to pay for the drug.

3. **Changing coverage of a drug to a lower cost-sharing tier.** Every drug on the plan's Drug List is in one of the cost-sharing tiers. The cost-sharing tiers used in your plan are shown in the benefit chart located in the front of this booklet. In general, the lower the cost-sharing tier number, the less you will pay as your share of the cost of the drug.

Legal Terms Asking to pay a lower preferred price for a covered non-preferred drug is sometimes called asking for a **"tiering exception."**

- If your drug is in the non-preferred brand tier you can ask us to cover it at the cost-sharing amount that applies to drugs in the preferred brand tier. This would lower your share of the cost for the drug.
- You cannot ask us to change the cost-sharing tier for any drug in the Specialty Drug tier.

Section 6.3 Important things to know about asking for exceptions

Your doctor must tell us the medical reasons

Your doctor or other prescriber must give us a statement that explains the medical reasons for requesting an exception. For a faster decision, include this medical information from your doctor or other prescriber when you ask for the exception.

Typically, our Drug List includes more than one drug for treating a particular condition. These different possibilities are called "alternative" drugs. If an alternative drug would be just as effective as the drug you are requesting and would not cause more side effects or other health problems, we will generally *not* approve your request for an exception.

Your plan can say yes or no to your request

- If we approve your request for an exception, our approval usually is valid until the end of the benefit year. This is true as long as your doctor continues to prescribe the drug for you and that drug continues to be safe and effective for treating your condition.
- If we say no to your request for an exception, you can ask for a review of our decision by making an appeal. Section 6.5 tells how to make an appeal if we say no.

The next section tells you how to ask for a coverage decision, including an exception.

Section 6.4 Step-by-step: How to ask for a coverage decision, including an exception

Step 1: You ask your plan to make a coverage decision about the drug(s) or payment you need. If your health requires a quick response, you must ask us to make a "fast coverage decision." You cannot ask for a fast coverage decision if you are asking us to pay you back for a drug you already bought.

What to do

- **Request the type of coverage decision you want.** Start by calling, writing, or faxing your plan to make your request. You, your representative, or your doctor (or other prescriber) can do this. For the details, go to Chapter 2, Section 1 and look for the section called "How to contact your plan when you are asking for a coverage decision about your Part D prescription drugs." Or if you are asking us to pay you back for a drug, go to the topic called "Where to send a request that asks us to pay for our share of the cost for medical care or a drug you have received."
- **You or your doctor or someone else who is acting on your behalf** can ask for a coverage decision. Section 4 of this chapter tells how you can give written permission to someone else to act as your representative. You can also have a lawyer act on your behalf.
- **If you want to ask us to pay you back for a drug,** start by reading Chapter 7 of this booklet: Asking us to pay our share of a bill you have received for covered medical services or drugs. Chapter 7 describes the situations in which you may need to ask for reimbursement. It also tells how to send us the paperwork that asks us to pay you back for our share of the cost of a drug you have paid for.
- **If you are requesting an exception, provide the "supporting statement."** Your doctor or other prescriber must give us the medical reasons for the drug exception you are requesting. (We call this the "supporting statement.") Your doctor or other prescriber can fax or mail the statement to us. Or your doctor or other prescriber can tell us on the phone and follow up by faxing or mailing a written statement if necessary. See Sections 6.2 and 6.3 for more information about exception requests.
- **We must accept any written request,** including a request submitted on the CMS Model Coverage Determination Request Form.

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

Legal Terms

A "fast coverage decision" is called an **"expedited coverage determination."**

- When we give you our decision, we will use the "standard" deadlines unless we have agreed to use the "fast" deadlines. A standard coverage decision means we will give you an answer within 72 hours after we receive your doctor's statement. A fast coverage decision means we will answer within 24 hours.
- **To get a fast coverage decision, you must meet two requirements:**
  - You can get a fast coverage decision only if you are asking for a *drug you have not yet received*. (You cannot get a fast coverage decision if you are asking us to pay you back for a drug you have already bought.)
  - You can get a fast coverage decision *only* if using the standard deadlines could *cause serious harm to your health or hurt your ability to function.*
- **If your doctor or other prescriber tells us that your health requires a "fast coverage decision," we will automatically agree to give you a fast coverage decision.**
- If you ask for a fast coverage decision on your own (without your doctor's or other prescriber's support), we will decide whether your health requires that we give you a fast coverage decision.
  - If we decide that your medical condition does not meet the requirements for a fast coverage decision, we will send you a letter that says so (and we will use the standard deadlines instead).
  - This letter will tell you that if your doctor or other prescriber asks for the fast coverage decision, we will automatically give a fast coverage decision.
  - The letter will also tell how you can file a complaint about our decision to give you a standard coverage decision instead of the fast coverage decision you requested. It tells how to file a "fast" complaint, which means you would get our answer to your complaint within 24 hours. (The process for making a complaint is different from the process for coverage decisions and appeals. For more information about the process for making complaints, see Section 10 of this chapter.)

Step 2: Your plan considers your request and we give you our answer.

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

- If we are using the fast deadlines, we must give you our answer **within 24 hours**.
  - Generally, this means within 24 hours after we receive your request. If you are requesting an exception, we will give you our answer within 24 hours after we receive your doctor's statement supporting your request. We will give you our answer sooner if your health requires us to.
  - If we do not meet this deadline, we are required to send your request on to Level 2 of the appeals process, where it will be reviewed by an independent

outside organization. Later in this section, we talk about this review organization and explain what happens at Appeal Level 2.

- **If our answer is yes to part or all of what you requested,** we must provide the coverage we have agreed to provide within 24 hours after we receive your request or doctor's statement supporting your request.
- **If our answer is no to part or all of what you requested,** we will send you a written statement that explains why we said no. We will also tell you how to appeal.

Deadlines for a **"standard"** coverage decision about a drug you have not yet received

- If we are using the standard deadlines, we must give you our answer **within 72 hours.**
  - Generally, this means within 72 hours after we receive your request. If you are requesting an exception, we will give you our answer within 72 hours after we receive your doctor's statement supporting your request. We will give you our answer sooner if your health requires us to.
  - If we do not meet this deadline, we are required to send your request on to Level 2 of the appeals process, where it will be reviewed by an independent organization. Later in this section, we talk about this review organization and explain what happens at Appeal Level 2.
- **If our answer is yes to part or all of what you requested–**
  - If we approve your request for coverage, we must **provide the coverage** we have agreed to provide **within 72 hours** after we receive your request or doctor's statement supporting your request.
- **If our answer is no to part or all of what you requested**, we will send you a written statement that explains why we said no. We will also tell you how to appeal.

Deadlines for a "standard" coverage decision about payment for a drug you have already bought

- We must give you our answer **within 14 calendar days** after we receive your request.
  - If we do not meet this deadline, we are required to send your request on to Level 2 of the appeals process, where it will be reviewed by an independent organization. Later in this section, we talk about this review organization and explain what happens at Appeal Level 2.

If our answer is yes to part or all of what you requested, we are also required to make payment to you within 14 calendar days after we receive your request.

- **If our answer is no to part or all of what you requested**, we will send you a written statement that explains why we said no. We will also tell you how to appeal.

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

- If your plan says no, you have the right to request an appeal. Requesting an appeal means asking us to reconsider–and possibly change–the decision we made.

Section 6.5 Step-by-step: How to make a Level 1 Appeal (how to ask for a review of a coverage decision made by your plan)

Legal Terms An appeal to the plan about a Part D drug coverage decision is called a plan **"redetermination."**

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

What to do

- **To start your appeal, you (or your representative or your doctor or other prescriber) must contact us.**
  - For details on how to reach us by phone, fax, or mail for any purpose related to your appeal, go to Chapter 2, Section 1, and look for the topic called "How to contact your plan when you are asking for a coverage decision, making an appeal or complaint about your Part D prescription drugs."
- **If you are asking for a standard appeal, make your appeal by submitting a written request.**
- **If you are asking for a fast appeal, you may make your appeal in writing or you may call us at the phone number shown in Chapter 2, Section 1** (How to contact your plan when you are making an appeal about your part D prescription drugs).
- **We must accept any written request,** including a request submitted on the CMS Model Coverage Determination Request Form.
- **You must make your appeal request within 60 calendar days** from the date on the written notice we sent to tell you our answer to your request for a coverage decision. If you miss this deadline and have a good reason for missing it, we may give you more time to make your appeal. Examples of good cause for missing the deadline may include if you had a serious illness that prevented you from contacting us or if we provided you with incorrect or incomplete information about the deadline for requesting an appeal.

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

If your health requires it, ask for a "fast appeal"

Legal Terms A "fast appeal" is also called an **"expedited redetermination."**

- If you are appealing a decision we made about a drug you have not yet received, you and your doctor or other prescriber will need to decide if you need a "fast appeal."
- The requirements for getting a "fast appeal" are the same as those for getting a "fast coverage decision" in Section 6.4 of this chapter.

Step 2: We consider your appeal and we give you our answer.

- When we are reviewing your appeal, we take another careful look at all of the information about your coverage request. We check to see if we were following all the rules when we said no to your request. We may contact you or your doctor or other prescriber to get more information.

Deadlines for a **"fast" appeal**

- If we are using the fast deadlines, we must give you our answer **within 72 hours after we receive your appeal**. We will give you our answer sooner if your health requires it.
  - If we do not give you an answer within 72 hours, we are required to send your request on to Level 2 of the appeals process, where it will be reviewed by an Independent Review Organization. Later in this section, we talk about this review organization and explain what happens at Level 2 of the appeals process.
- **If our answer is yes to part or all of what you requested,** we must provide the coverage we have agreed to provide within 72 hours after we receive your appeal.
- **If our answer is no to part or all of what you requested,** we will send you a written statement that explains why we said no and how to appeal our decision.

Deadlines for a **"standard" appeal**

- If we are using the standard deadlines, we must give you our answer **within 7 calendar days** after we receive your appeal. We will give you our decision sooner if you have not received the drug yet and your health condition requires us to do so. If you believe your health requires it, you should ask for "fast" appeal.

  - If we do not give you a decision within 7 calendar days, we are required to send your request on to Level 2 of the appeals process, where it will be reviewed by an Independent Review Organization. Later in this section, we tell about this review organization and explain what happens at Level 2 of the appeals process.
- **If our answer is yes to part or all of what you requested–**
  - If we approve a request for coverage, we must **provide the coverage** we have agreed to provide as quickly as your health requires, but **no later than 7 calendar days** after we receive your appeal.
  - If we approve a request to pay you back for a drug you already bought, we are required to **send payment to you within 30 calendar days** after we receive your appeal request.
- **If our answer is no to part or all of what you requested**, we will send you a written statement that explains why we said no and how to appeal our decision.

Step 3: If we say no to your appeal, you decide if you want to continue with the appeals process and make *another* appeal.

- If your plan says no to your appeal, you then choose whether to accept this decision or continue by making another appeal.
- If you decide to make another appeal, it means your appeal is going on to Level 2 of the appeals process (see below).

Section 6.6 Step-by-step: How to make a Level 2 Appeal

If your plan says no to your appeal, you then choose whether to accept this decision or continue by making another appeal. If you decide to go on to a Level 2 Appeal, the **Independent Review Organization** reviews the decision your plan made when we said no to your first appeal. This organization decides whether the decision we made should be changed.

Legal Terms

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

Step 1: To make a Level 2 Appeal, you (or your representative or your doctor or other prescriber) must contact the Independent Review Organization and ask for a review of your case.

- If your plan says no to your Level 1 Appeal, the written notice we send you will include **instructions on how to make a Level 2 Appeal** with the Independent

Review Organization. These instructions will tell you who can make this Level 2 Appeal, what deadlines you must follow, and how to reach the review organization.

- When you make an appeal to the Independent Review Organization, we will send the information we have about your appeal to this organization. This information is called your "case file." **You have the right to ask us for a copy of your case file**.
- You have a right to give the Independent Review Organization additional information to support your appeal.

Step 2: The Independent Review Organization does a review of your appeal and gives you an answer.

- **The Independent Review Organization is an independent organization that is hired by Medicare**. This organization is not connected with your plan and it is not a government agency. This organization is a company chosen by Medicare to review our decisions about your Part D benefits with your plan.
- Reviewers at the Independent Review Organization will take a careful look at all of the information related to your appeal. The organization will tell you its decision in writing and explain the reasons for it.

Deadlines for **"fast" appeal** at Level 2

- If your health requires it, ask the Independent Review Organization for a "fast appeal."
- If the review organization agrees to give you a "fast appeal," the review organization must give you an answer to your Level 2 Appeal **within 72 hours** after it receives your appeal request.
- **If the Independent Review Organization says yes to part or all of what you requested,** we must provide the drug coverage that was approved by the review organization **within 24 hours** after we receive the decision from the review organization.

Deadlines for **"standard" appeal** at Level 2

- If you have a standard appeal at Level 2, the review organization must give you an answer to your Level 2 Appeal **within 7 calendar days** after it receives your appeal.
- **If the Independent Review Organization says yes to part or all of what you requested–**
  - If the Independent Review Organization approves a request for coverage, we must **provide the drug coverage** that was approved by the review organization **within 72 hours** after we receive the decision from the review organization.
  - If the Independent Review Organization approves a request to pay you back for a drug you already bought, we are required to **send payment to you within 30 calendar days** after we receive the decision from the review organization.

What if the review organization says no to your appeal?

If this organization says no to your appeal, it means the organization agrees with our decision not to approve your request. (This is called "upholding the decision." It is also called "turning down your appeal.")

To continue and make another appeal at Level 3, the dollar value of the drug coverage you are requesting must meet a minimum amount. If the dollar value of the coverage you are requesting is too low, you cannot make another appeal and the decision at Level 2 is final. The notice you get from the Independent Review Organization will tell you the dollar value that must be in dispute to continue with the appeals process.

Step 3: If the dollar value of the coverage you are requesting meets the requirement, you choose whether you want to take your appeal further.

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

SECTION 7 How to ask us to cover a longer inpatient hospital stay if you think the doctor is discharging you too soon

When you are admitted to a hospital, you have the right to get all of your covered hospital services that are necessary to diagnose and treat your illness or injury. For more information about the plan's coverage for your hospital care, including any limitations on this coverage, see the benefit chart located in the front of this booklet and Chapter 4 of this booklet: Medical Benefits (what is covered and what you pay).

During your hospital stay, your doctor and the hospital staff will be working with you to prepare for the day when you will leave the hospital. They will also help arrange for care you may need after you leave.

- The day you leave the hospital is called your "**discharge date**." Your plan's coverage of your hospital stay ends on this date.
- When your discharge date has been decided, your doctor or the hospital staff will let you know.

- If you think you are being asked to leave the hospital too soon, you can ask for a longer hospital stay and your request will be considered. This section tells you how to ask.

Section 7.1 During your inpatient hospital stay, you will get a written notice from Medicare that tells about your rights

During your hospital stay, you will be given a written notice called *An Important Message from Medicare about Your Rights.* Everyone with Medicare gets a copy of this notice whenever they are admitted to a hospital. Someone at the hospital (for example, a caseworker or nurse) must give it to you within two days after you are admitted. If you do not get the notice, ask any hospital employee for it. If you need help, please call Customer Service (phone numbers are printed on the front cover of this booklet). You can also call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

1. **Read this notice carefully and ask questions if you don't understand it.**
   It tells you about your rights as a hospital patient, including:
   - Your right to receive Medicare-covered services during and after your hospital stay, as ordered by your doctor. This includes the right to know what these services are, who will pay for them, and where you can get them.
   - Your right to be involved in any decisions about your hospital stay, and know who will pay for it.
   - Where to report any concerns you have about quality of your hospital care.
   - Your right to appeal your discharge decision if you think you are being discharged from the hospital too soon.

Legal Terms

The written notice from Medicare tells you how you can **"request an immediate review."** Requesting an immediate review is a formal, legal way to ask for a delay in your discharge date so that we will cover your hospital care for a longer time. (Section 7.2 below tells you how you can request an immediate review)

2. **You must sign the written notice to show that you received it and understand your rights.**
   - You or someone who is acting on your behalf must sign the notice. (Section 4 of this chapter tells how you can give written permission to someone else to act as your representative.)
   - Signing the notice shows *only* that you have received the information about your rights. The notice does not give your discharge date (your doctor or hospital staff will tell you your discharge date). Signing the notice **does *not* mean** you are agreeing on a discharge date.
3. **Keep your copy** of the signed notice so you will have the information about making an appeal (or reporting a concern about quality of care) handy if you need it.
   - If you sign the notice more than 2 days before the day you leave the hospital, you will get another copy before you are scheduled to be discharged.
   - To look at a copy of this notice in advance, you can call Customer Service (phone numbers are printed on the front cover of this booklet) or 1-800 MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048. You can also see it online at http://www.cms.gov/BNI/12_HospitalDischargeAppealNotices.asp.

Section 7.2 Step-by-step: How to make a Level 1 Appeal to change your hospital discharge date

If you want to ask for your inpatient hospital services to be covered by your plan for a longer time, you will need to use the appeals process to make this request. Before you start, understand what you need to do and what the deadlines are.

- **Follow the process.** Each step in the first two levels of the appeals process is explained below.
- **Meet the deadlines.** The deadlines are important. Be sure that you understand and follow the deadlines that apply to things you must do.
- **Ask for help if you need it**. If you have questions or need help at any time, please call Customer Service (phone numbers are printed on the front cover of this booklet). Or call your State Health Insurance Assistance Program, a government organization that provides personalized assistance (see Section 2 of this chapter). For contact information, please refer to the state-specific agency listing located in Chapter 13.

During a Level 1 Appeal, the Quality Improvement Organization reviews your appeal. It checks to see if your planned discharge date is medically appropriate for you.

Step 1: Contact the Quality Improvement Organization in your state and ask for a "fast review" of your hospital discharge. You must act quickly.

Legal Terms	A "fast review" is also called an **"immediate review."**

What is the Quality Improvement Organization?

- This organization is a group of doctors and other health care professionals who are paid by the Federal government. These experts are not part of your plan. This organization is paid by Medicare to check on and help improve the quality of care for people with Medicare. This includes reviewing hospital discharge dates for people with Medicare.

How can you contact this organization?

- The written notice you received (*An Important Message from Medicare About Your Rights*) tells you how to reach this organization. (Or find the name, address, and phone number of the Quality Improvement Organization for your state in the state-specific agency listing located in Chapter 13.)

Act quickly

- To make your appeal, you must contact the Quality Improvement Organization *before* you leave the hospital and **no later than your planned discharge date.** (Your "planned discharge date" is the date that has been set for you to leave the hospital.)
  - If you meet this deadline, you are allowed to stay in the hospital *after* your discharge date *without paying for it* while you wait to get the decision on your appeal from the Quality Improvement Organization.
  - If you do *not* meet this deadline, and you decide to stay in the hospital after your planned discharge date, *you may have to pay all of the costs* for hospital care you receive after your planned discharge date.
- If you miss the deadline for contacting the Quality Improvement Organization about your appeal, you can make your appeal directly to your plan instead. For details about this other way to make your appeal, see Section 7.4.

Ask for a "fast review"

- You must ask the Quality Improvement Organization for a **"fast review"** of your discharge. Asking for a "fast review" means you are asking for the organization to use the "fast" deadlines for an appeal instead of using the standard deadlines.

Legal Terms

A "**fast review**" is also called an "**immediate review**" or an "**expedited review**."

Step 2: The Quality Improvement Organization conducts an independent review of your case.

What happens during this review?

- Health professionals at the Quality Improvement Organization (we will call them "the reviewers") will ask you (or your representative) why you believe coverage for the services should continue. You don't have to prepare anything in writing, but you may do so if you wish.
- The reviewers will also look at your medical information, talk with your doctor, and review information that the hospital and we have given to them.
- By noon of the day after the reviewers informed your plan of your appeal, you will also get a written notice that gives your planned discharge date and explains in detail the reasons why your doctor, the hospital, and we think it is right (medically appropriate) for you to be discharged on that date.

Legal Terms

This written explanation is called the **"Detailed Notice of Discharge."** You can get a sample of this notice by calling Customer Service (phone numbers are printed on the front cover of this booklet) or 1-800-MEDICARE (1-800-633-4227, 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.) Or you can get see a sample notice online at http://www.cms.hhs.gov/BNI/

Step 3: Within one full day after it has all the needed information, the Quality Improvement Organization will give you its answer to your appeal.

What happens if the answer is yes?

- If the review organization says *yes* to your appeal, **we must keep providing your covered inpatient hospital services for as long as these services are medically necessary.**
- You will have to keep paying your share of the costs (such as deductibles or copayments, if these apply). In addition, there may be limitations on your covered hospital services. (See the benefit chart and Chapter 4 of this booklet).

What happens if the answer is no?

- If the review organization says *no* to your appeal, they are saying that your planned discharge date is medically appropriate. If this happens, y**our plan's coverage for your inpatient hospital services will end** at noon on the day *after* the Quality Improvement Organization gives you its answer to your appeal.
- If the review organization says *no* to your appeal and you decide to stay in the hospital, then **you may have to pay the full cost** of hospital care you receive after noon on the day after the Quality Improvement Organization gives you its answer to your appeal.

Step 4: If the answer to your Level 1 Appeal is no, you decide if you want to make another appeal.

- If the Quality Improvement Organization has turned down your appeal, *and* you stay in the hospital after your planned discharge date, then you can make another appeal. Making another appeal means you are going on to "Level 2" of the appeals process.

Section 7.3 Step-by-step: How to make a Level 2 Appeal to change your hospital discharge date

If the Quality Improvement Organization has turned down your appeal, *and* you stay in the hospital after your planned discharge date, then you can make a Level 2 Appeal. During a Level 2 Appeal, you ask the Quality Improvement Organization to take another look at the decision they made on your first appeal. If the Quality Improvement Organization turns down your Level 2 Appeal, you may have to pay the full cost for your stay after your planned discharge date.

Here are the steps for Level 2 of the appeal process:

Step 1: You contact the Quality Improvement Organization again and ask for another review.

- You must ask for this review **within 60 calendar days** after the day when the Quality Improvement Organization said *no* to your Level 1 Appeal. You can ask for this review only if you stayed in the hospital after the date that your coverage for the care ended.

Step 2: The Quality Improvement Organization does a second review of your situation.

- Reviewers at the Quality Improvement Organization will take another careful look at all of the information related to your appeal.

Step 3: Within 14 calendar days, the Quality Improvement Organization reviewers will decide on your appeal and tell you their decision.

If the review organization says yes

- **Your plan must reimburse you** for our share of the costs of hospital care you have received since noon on the day after the date your first appeal was turned down by the Quality Improvement Organization. **We must continue providing coverage for your inpatient hospital care for as long as it is medically necessary**.
- You must continue to pay your share of the costs, and coverage limitations may apply.

If the review organization says no

- It means they agree with the decision they made on your Level 1 Appeal and will not change it.
- The notice you get will tell you in writing what you can do if you wish to continue with the review process. It will give you the details about how to go on to the next level of appeal, which is handled by a judge.

Step 4: If the answer is no, you will need to decide whether you want to take your appeal further by going on to Level 3.

- There are three additional levels in the appeals process after Level 2 (for a total of five levels of appeal). If the review organization turns down your Level 2 Appeal, you can choose whether to accept that decision or whether to go on to Level 3 and make another appeal. At Level 3, your appeal is reviewed by a judge.
- Section 9 in this chapter tells more about Levels 3, 4, and 5 of the appeals process.

Section 7.4 What if you miss the deadline for making your Level 1 Appeal?

You can appeal to us instead

As explained above in Section 7.2, you must act quickly to contact the Quality Improvement Organization to start your first appeal of your hospital discharge. ("Quickly" means before you leave the hospital and no later than your planned discharge date). If you miss the deadline for contacting this organization, there is another way to make your appeal.

If you use this other way of making your appeal, *the first two levels of appeal are different.*

Step-by-Step: How to make a Level 1 *Alternate* Appeal

If you miss the deadline for contacting the Quality Improvement Organization, you can make an appeal to us, asking for a "fast review." A fast review is an appeal that uses the fast deadlines instead of the standard deadlines.

Legal Terms A "fast" review (or "fast appeal") is also called an **"expedited appeal."**

Step 1: Contact your plan and ask for a "fast review."

- For details on how to contact us, go to Chapter 2, Section 1 and look for the section called "How to contact your plan when you are making an appeal about your medical care."
- **Be sure to ask for a "fast review**." This means you are asking us to give you an answer using the "fast" deadlines rather than the "standard" deadlines.

Step 2: Your plan does a "fast" review of your planned discharge date, checking to see if it was medically appropriate.

- During this review, we take a look at all of the information about your hospital stay. We check to see if your planned discharge date was medically appropriate. We will check to see if the decision about when you should leave the hospital was fair and followed all the rules.
- In this situation, we will use the "fast" deadlines rather than the standard deadlines for giving you the answer to this review.

Step 3: Your plan gives you our decision within 72 hours after you ask for a "fast review" ("fast appeal").

- **If we say yes to your fast appeal,** it means we have agreed with you that you still need to be in the hospital after the discharge date, and will keep providing your covered inpatient hospital services for as long as it is medically necessary. It also means that we have agreed to reimburse you for our share of the costs of care you have received since the date when we said your coverage would end. (You must pay your share of the costs and there may be coverage limitations that apply.)
- **If we say no to your fast appeal,** we are saying that your planned discharge date was medically appropriate. Our coverage for your inpatient hospital services ends as of the day we said coverage would end.
  - If you stayed in the hospital *after* your planned discharge date, then **you may have to pay the full cost** of hospital care you received after the planned discharge date.

Step 4: If your plan says *no* to your fast appeal, your case will *automatically* be sent on to the next level of the appeals process.

- To make sure we were following all the rules when we said no to your fast appeal, **your plan is required to send your appeal to the "Independent Review Organization."** When we do this, it means that you are *automatically* going on to Level 2 of the appeals process.

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

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

Legal Terms

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

Step 1: We will automatically forward your case to the Independent Review Organization.

- We are required to send the information for your Level 2 Appeal to the Independent Review Organization within 24 hours of when we tell you that we are saying no to your first appeal. (If you think we are not meeting this deadline or other deadlines, you can make a complaint. The complaint process is different from the appeal process. Section 10 of this chapter tells how to make a complaint.)

Step 2: The Independent Review Organization does a "fast review" of your appeal. The reviewers give you an answer within 72 hours.

- **The Independent Review Organization is an independent organization that is hired by Medicare**. This organization is not connected with your plan and it is not a government agency. This organization is a company chosen by Medicare to handle the job of being the Independent Review Organization. Medicare oversees its work.
- Reviewers at the Independent Review Organization will take a careful look at all of the information related to your appeal of your hospital discharge.
- **If this organization says *yes* to your appeal,** then your plan must reimburse you (pay you back) for our share of the costs of hospital care you have received since the date of your planned discharge. We must also continue the plan's coverage of your inpatient hospital services for as long as it is medically necessary. You must continue to pay your share of the costs. If there are coverage limitations, these could limit how much we would reimburse or how long we would continue to cover your services.
- **If this organization says *no* to your appeal,** it means they agree with your plan that your planned hospital discharge date was medically appropriate.
    - The notice you get from the Independent Review Organization will tell you in writing what you can do if you wish to continue with the review process. It will give you the details about how to go on to a Level 3 Appeal, which is handled by a judge.

Step 3: If the Independent Review Organization turns down your appeal, you choose whether you want to take your appeal further.

- There are three additional levels in the appeals process after Level 2 (for a total of five levels of appeal). If reviewers say no to your Level 2 Appeal, you decide whether to accept their decision or go on to Level 3 and make a third appeal.
- Section 9 in this chapter tells more about Levels 3, 4, and 5 of the appeals process.

SECTION 8 How to ask us to keep covering certain medical services if you think your coverage is ending too soon

Section 8.1 *This section is about three services only:* Home health care, skilled nursing facility care, and Comprehensive Outpatient Rehabilitation Facility (CORF) services

This section is about the following types of care *only*:

- **Home health care services** you are getting.
- **Skilled nursing care** you are getting as a patient in a skilled nursing facility. (To learn about requirements for being considered a "skilled nursing facility," see Chapter 12, Definitions of important words.)
- **Rehabilitation care** you are getting as an outpatient at a Medicare-approved Comprehensive Outpatient Rehabilitation Facility (CORF). Usually, this means you are getting treatment for an illness or accident, or you are recovering from a major operation. (For more information about this type of facility, see Chapter 12, Definitions of important words.)

When you are getting any of these types of care, you have the right to keep getting your covered services for that type of care for as long as the care is needed to diagnose and treat your illness or injury. For more information on your covered services, including your share of the cost and any limitations to coverage that may apply, see the benefit chart located in the front of this booklet and Chapter 4 of this booklet: Medical benefits (what is covered and what you pay).

When your plan decides it is time to stop covering any of the three types of care for you, we are required to tell you in advance. When your coverage for that care ends, your plan will stop paying its share of the cost for your care.

If you think we are ending the coverage of your care too soon, **you can appeal our decision**. This section tells you how to ask for an appeal.

Section 8.2 We will tell you in advance when your coverage will be ending

1. **You will receive a notice in writing.** At least two days before your plan is going to stop covering your care, the agency or facility that is providing your care will give you a notice.
   - The written notice tells you the date when your plan will stop covering the care for you.
   - The written notice also tells what you can do if you want to ask your plan to change this decision about when to end your care, and keep covering it for a longer period of time.

Legal Terms

In telling you what you can do, the written notice is telling how you can request a **"fast-track appeal."** Requesting a fast-track appeal is a formal, legal way to request a change to our coverage decision about when to stop your care. (Section 8.3 below tells how you can request a fast-track appeal.)

Legal Terms

The written notice is called the "**Notice of Medicare Non-Coverage.**" To get a sample copy, call Customer Service (phone numbers are printed on the front cover of this booklet) or 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. (TTY users should call 1-877-486-2048.) Or see a copy online at http://www.cms.hhs.gov/BNI/

2. **You must sign the written notice to show that you received it.**
   - You or someone who is acting on your behalf must sign the notice. (Section 4 tells how you can give written permission to someone else to act as your representative.)
   - Signing the notice shows *only* that you have received the information about when your coverage will stop. **Signing it does <u>not</u> mean you agree** with the plan that it's time to stop getting the care.

Section 8.3 Step-by-step: How to make a Level 1 Appeal to have your plan cover your care for a longer time

If you want to ask us to cover your care for a longer period of time, you will need to use the appeals process to make this request. Before you start, understand what you need to do and what the deadlines are.

- **Follow the process.** Each step in the first two levels of the appeals process is explained below.
- **Meet the deadlines.** The deadlines are important. Be sure that you understand and follow the deadlines that apply to things you must do. There are also deadlines your plan must follow. (If you think we are not meeting our deadlines, you can file a complaint. Section 10 of this chapter tells you how to file a complaint.)
- **Ask for help if you need it**. If you have questions or need help at any time, please call Customer Service (phone numbers are printed on the front cover of this booklet). Or call your State Health Insurance Assistance Program, a government organization that provides personalized assistance (see Section 2 of this chapter).

During a Level 1 Appeal, the Quality Improvement Organization reviews your appeal and decides whether to change the decision made by your plan.

Step 1: Make your Level 1 Appeal: contact the Quality Improvement Organization in your state and ask for a review. You must act quickly.

What is the Quality Improvement Organization?

- This organization is a group of doctors and other health care experts who are paid by the Federal government. These experts are not part of your plan. They check on the quality of care received by people with Medicare and review plan decisions about when it's time to stop covering certain kinds of medical care.

How can you contact this organization?

- The written notice you received tells you how to reach this organization. (Or find the name, address, and phone number of the Quality Improvement Organization for your state in the state-specific agency listing located in Chapter 13.)

What should you ask for?

- Ask this organization to do an independent review of whether it is medically appropriate for your plan to end coverage for your medical services.

Your deadline for contacting this organization

- You must contact the Quality Improvement Organization to start your appeal no later than noon of the day after you receive the written notice telling you when we will stop covering your care.
- If you miss the deadline for contacting the Quality Improvement Organization about your appeal, you can make your appeal directly to your plan instead. For details about this other way to make your appeal, see Section 8.5.

Step 2: The Quality Improvement Organization conducts an independent review of your case.

What happens during this review?

- Health professionals at the Quality Improvement Organization (we will call them "the reviewers") will ask you (or your representative) why you believe coverage for the services should continue. You don't have to prepare anything in writing, but you may do so if you wish.
- The review organization will also look at your medical information, talk with your doctor, and review information that your plan has given to them.
- By the end of the day the reviewers informed your plan of your appeal, and you will also get a written notice from the plan that explains in detail our reasons for ending our coverage for your services.

Legal Terms

This notice explanation is called the "**Detailed Explanation of Non-Coverage.**"

Step 3: Within one full day after they have all the information they need, the reviewers will tell you their decision.

What happens if the reviewers say yes to your appeal?

- If the reviewers say *yes* to your appeal, then **your plan must keep providing your covered services for as long as it is medically necessary.**
- You will have to keep paying your share of the costs (such as deductibles or copayments, if these apply). In addition, there may be limitations on your covered services (see the benefit chart located in the front of this booklet and Chapter 4 of this booklet).

What happens if the reviewers say no to your appeal?

- If the reviewers say *no* to your appeal, then **your coverage will end on the date we have told you.** Your plan will stop paying its share of the costs of this care.
- If you decide to keep getting the home health care, or skilled nursing facility care, or Comprehensive Outpatient Rehabilitation Facility (CORF) services *after* this date when your coverage ends, then **you will have to pay the full cost** of this care yourself.

Step 4: If the answer to your Level 1 Appeal is no, you decide if you want to make another appeal.

- This first appeal you make is "Level 1" of the appeals process. If reviewers say *no* to your Level 1 Appeal–and you choose to continue getting care after your coverage for the care has ended–then you can make another appeal.
- Making another appeal means you are going on to "Level 2" of the appeals process.

Section 8.4 Step-by-step: How to make a Level 2 Appeal to have your plan cover your care for a longer time

If the Quality Improvement Organization has turned down your appeal and you choose to continue getting care after your coverage for the care has ended, then you can make a Level 2 Appeal. During a Level 2 Appeal, you ask the Quality Improvement Organization to take another look at the decision they made on your first appeal. If the Quality Improvement Organization turns down your Level 2 Appeal, you may have to pay the full cost for your home health care, or skilled nursing facility care, or Comprehensive Outpatient Rehabilitation Facility (CORF) services *after* the date when we said your coverage would end.

Here are the steps for Level 2 of the appeal process:

Step 1: You contact the Quality Improvement Organization again and ask for another review.

- You must ask for this review **within 60 days** after the day when the Quality Improvement Organization said *no* to your Level 1 Appeal. You can ask for this review only if you continued getting care after the date that your coverage for the care ended.

Step 2: The Quality Improvement Organization does a second review of your situation.

- Reviewers at the Quality Improvement Organization will take another careful look at all of the information related to your appeal.

Step 3: Within 14 days, the Quality Improvement Organization reviewers will decide on your appeal and tell you their decision.

What happens if the review organization says yes to your appeal?

- **Your plan must reimburse you** for our share of the costs of care you have received since the date when we said your coverage would end. **Your plan must continue providing coverage** for the care for as long as it is medically necessary.
- You must continue to pay your share of the costs and there may be coverage limitations that apply.

What happens if the review organization says no?

- It means they agree with the decision they made to your Level 1 Appeal and will not change it.
- The notice you get will tell you in writing what you can do if you wish to continue with the review process. It will give you the details about how to go on to the next level of appeal, which is handled by a judge.

Step 4: If the answer is no, you will need to decide whether you want to take your appeal further.

- There are three additional levels of appeal after Level 2, for a total of five levels of appeal. If reviewers turn down your Level 2 Appeal, you can choose whether to accept that decision or to go on to Level 3 and make another appeal. At Level 3, your appeal is reviewed by a judge.
- Section 9 in this chapter tells more about Levels 3, 4, and 5 of the appeals process.

Section 8.5 What if you miss the deadline for making your Level 1 Appeal?

You can appeal to your plan instead

As explained above in Section 8.3, you must act quickly to contact the Quality Improvement Organization to start your first appeal (within a day or two, at the most). If you miss the deadline for contacting this organization, there is another way to make your appeal. If you use this other way of making your appeal, *the first two levels of appeal are different.*

Step-by-Step: How to make a Level 1 *Alternate* Appeal

If you miss the deadline for contacting the Quality Improvement Organization, you can make an appeal to your plan, asking for a "fast review." A fast review is an appeal that uses the fast deadlines instead of the standard deadlines.

Here are the steps for a Level 1 Alternate Appeal:

Legal Terms	A "fast" review (or "fast appeal") is also called an **"expedited appeal."**

Step 1: Contact your plan and ask for a "fast review."

- For details on how to contact us, go to Chapter 2, Section 1 and look for the topic called "How to contact your plan when you are making an appeal about your medical care."
- **Be sure to ask for a "fast review**." This means you are asking us to give you an answer using the "fast" deadlines rather than the "standard" deadlines.

Step 2: Your plan does a "fast" review of the decision we made about when to end coverage for your services.

- During this review, we take another look at all of the information about your case. We check to see if we were following all the rules when we set the date for ending the plan's coverage for services you were receiving.
- We will use the "fast" deadlines rather than the standard deadlines for giving you the answer to this review. (Usually, if you make an appeal to your plan and ask for a "fast review," we are allowed to decide whether to agree to your request and give you a "fast review." But in this situation, the rules require us to give you a fast response if you ask for it.)

Step 3: Your plan gives you our decision within 72 hours after you ask for a "fast review" ("fast appeal").

- **If your plan says yes to your fast appeal,** it means we have agreed with you that you need services longer, and will keep providing your covered services for as long as it is medically necessary. It also means that we have agreed to reimburse you for our share of the costs of care you have received since the date when we said your coverage would end. (You must pay your share of the costs and there may be coverage limitations that apply.)
- **If your plan says no to your fast appeal,** then your coverage will end on the date we told you and your plan will not pay any share of the costs after this date.
- If you continued to get home health care, or skilled nursing facility care, or Comprehensive Outpatient Rehabilitation Facility (CORF) services *after* the date when we said your coverage would end, then **you will have to pay the full cost** of this care yourself.

Step 4: If your plan says no to your fast appeal, your case will *automatically* go on to the next level of the appeals process.

- To make sure we were following all the rules when we said no to your fast appeal, **we are required to send your appeal to the "Independent Review Organization."** When we do this, it means that you are *automatically* going on to Level 2 of the appeals process.

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

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

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

Step 1: We will automatically forward your case to the Independent Review Organization.

- We are required to send the information for your Level 2 Appeal to the Independent Review Organization within 24 hours of when we tell you that we are saying no to your first appeal. (If you think we are not meeting this deadline or other deadlines, you can make a complaint. The complaint process is different from the appeal process. (Section 10 of this chapter tells how to make a complaint.)

Step 2: The Independent Review Organization does a "fast review" of your appeal. The reviewers give you an answer within 72 hours.

- **The Independent Review Organization is an independent organization that is hired by Medicare**. This organization is not connected with your plan and it is not a government agency. This organization is a company chosen by Medicare to handle the job of being the Independent Review Organization. Medicare oversees its work.
- Reviewers at the Independent Review Organization will take a careful look at all of the information related to your appeal.
- **If this organization says *yes* to your appeal,** then your plan must reimburse you (pay you back) for our share of the costs of care you have received since the date when we said your coverage would end. We must also continue to cover the care for as long as it is medically necessary. You must continue to pay your share of the costs. If there are coverage limitations, these could limit how much we would reimburse or how long we would continue to cover your services.

- **If this organization says *no* to your appeal,** it means they agree with the decision your plan made to your first appeal and will not change it.
  - The notice you get from the Independent Review Organization will tell you in writing what you can do if you wish to continue with the review process. It will give you the details about how to go on to a Level 3 Appeal.

Step 3: If the Independent Review Organization turns down your appeal, you choose whether you want to take your appeal further.

- There are three additional levels of appeal after Level 2, for a total of five levels of appeal. If reviewers say no to your Level 2 Appeal, you can choose whether to accept that decision or whether to go on to Level 3 and make another appeal. At Level 3, your appeal is reviewed by a judge.
- Section 9 in this chapter tells more about Levels 3, 4, and 5 of the appeals process.

SECTION 9 Taking your appeal to Level 3 and beyond

Section 9.1 Levels of Appeal 3, 4, and 5 for Medical Service Appeals

This section may be appropriate for you if you have made a Level 1 Appeal and a Level 2 Appeal, and both of your appeals have been turned down.

If the dollar value of the item or medical service you have appealed meets certain minimum levels, you may be able to go on to additional levels of appeal. If the dollar value is less than the minimum level, you cannot appeal any further. If the dollar value is high enough, the written response you receive to your Level 2 Appeal will explain who to contact and what to do to ask for a Level 3 Appeal.

For most situations that involve appeals, the last three levels of appeal work in much the same way. Here is who handles the review of your appeal at each of these levels.

Level 3 Appeal	**A judge who works for the Federal government** will review your appeal and give you an answer. This judge is called an "Administrative Law Judge."

- **If the Administrative Law Judge says yes to your appeal, the appeals process *may* or *may not* be over**–We will decide whether to appeal this decision to Level 4. Unlike a decision at Level 2 (Independent Review Organization), we have the right to appeal a Level 3 decision that is favorable to you.
  - If we decide *not* to appeal the decision, we must authorize or provide you with the service within 60 calendar days after receiving the judge's decision.

- If we decide to appeal the decision, we will send you a copy of the Level 4 Appeal request with any accompanying documents. We may wait for the Level 4 Appeal decision before authorizing or providing the service in dispute.

- **If the Administrative Law Judge says no to your appeal, the appeals process *may* or *may not* be over**.
  - If you decide to accept this decision that turns down your appeal, the appeals process is over.
  - If you do not want to accept the decision, you can continue to the next level of the review process. If the administrative law judge says no to your appeal, the notice you get will tell you what to do next if you choose to continue with your appeal.

Level 4 Appeal The **Appeals Council** will review your appeal and give you an answer. The Appeals Council works for the Federal government.

- **If the answer is yes, or if the Appeals Council denies our request to review a favorable Level 3 Appeal decision, the appeals process *may* or *may not* be over–** We will decide whether to appeal this decision to Level 5. Unlike a decision at Level 2 (Independent Review Organization), we have the right to appeal a Level 4 decision that is favorable to you.
  - If we decide *not* to appeal the decision, we must authorize or provide you with the service within 60 calendar days after receiving the Appeals Council's decision.
  - If we decide to appeal the decision, we will let you know in writing.
- **If the answer is no or if the Appeals Council denies the review request, the appeals process *may* or *may not* be over**.
  - If you decide to accept this decision that turns down your appeal, the appeals process is over.
  - If you do not want to accept the decision, you might be able to continue to the next level of the review process. If the Appeals Council says no to your appeal, the notice you get will tell you whether the rules allow you to go on to a Level 5 Appeal. If the rules allow you to go on, the written notice will also tell you who to contact and what to do next if you choose to continue with your appeal.

Level 5 Appeal	A judge at the **Federal District Court** will review your appeal.

- This is the last step of the administrative appeals process.

Section 9.2 Levels of Appeal 3, 4, and 5 for Part D Drug Appeals

This section may be appropriate for you if you have made a Level 1 Appeal and a Level 2 Appeal, and both of your appeals have been turned down.

If the value of the drug you have appealed meets a certain dollar amount, you may be able to go on to additional levels of appeal. If the dollar amount is less, you cannot appeal any further. The written response you receive to your Level 2 Appeal will explain who to contact and what to do to ask for a Level 3 Appeal.

For most situations that involve appeals, the last three levels of appeal work in much the same way. Here is who handles the review of your appeal at each of these levels.

Level 3 Appeal	**A judge who works for the Federal government** will review your appeal and give you an answer. This judge is called an "Administrative Law Judge."

- **If the answer is yes, the appeals process is over**. What you asked for in the appeal has been approved. We must **authorize or provide the drug coverage** that was approved by the Administrative Law Judge **within 72 hours (24 hours for expedited appeals) or make payment no later than 30 calendar days** after we receive the decision.
- **If the answer is no, the appeals process *may* or *may not* be over**.
  - If you decide to accept this decision that turns down your appeal, the appeals process is over.
  - If you do not want to accept the decision, you can continue to the next level of the review process. If the administrative law judge says no to your appeal, the notice you will get will tell you what to do next if you choose to continue with your appeal.

Level 4 Appeal — **The Appeals Council** will review your appeal and give you an answer. The Appeals Council works for the Federal government.

- **If the answer is yes, the appeals process is over**. What you asked for in the appeal has been approved. We must **authorize or provide the drug coverage** that was approved by the Appeals Council **within 72 hours (24 hours for expedited appeals) or make payment no later than 30 calendar days** after we receive the decision.
- **If the answer is no, the appeals process *may* or *may not* be over**.
  - If you decide to accept this decision that turns down your appeal, the appeals process is over.
  - If you do not want to accept the decision, you might be able to continue to the next level of the review process. If the Appeals Council says no to your appeal or denies your request to review the appeal, the notice you get will tell you whether the rules allow you to go on to a Level 5 Appeal. If the rules allow you to go on, the written notice will also tell you who to contact and what to do next if you choose to continue with your appeal.

Level 5 Appeal — A judge at the **Federal District Court** will review your appeal.

- This is the last step of the administrative appeals process.

MAKING COMPLAINTS

SECTION 10 How to make a complaint about quality of care, waiting times, customer service, or other concerns

If your problem is about decisions related to benefits, coverage, or payment, then this section *is not for you*. Instead, you need to use the process for coverage decisions and appeals. Go to Section 4 of this chapter.

Section 10.1 What kinds of problems are handled by the complaint process?

This section explains how to use the process for making complaints. The complaint process is used for certain types of problems *only.* This includes problems related to quality of care, waiting times, and the customer service you receive. Here are examples of the kinds of problems handled by the complaint process.

If you have any of these kinds of problems, you can "make a complaint"

Quality of your medical care

- Are you unhappy with the quality of the care you have received (including care in the hospital)?

Respecting your privacy

- Do you believe that someone did not respect your right to privacy or shared information about you that you feel should be confidential?

Disrespect, poor customer service, or other negative behaviors

- Has someone been rude or disrespectful to you?
- Are you unhappy with how our Customer Service has treated you?
- Do you feel you are being encouraged to leave the plan?

Waiting times

- Are you having trouble getting an appointment, or waiting too long to get it?
- Have you been kept waiting too long by doctors, pharmacists, or other health professionals? Or by our Customer Service or other staff at the plan?
  - Examples include waiting too long on the phone, in the waiting room, when getting a prescription, or in the exam room.

Cleanliness

- Are you unhappy with the cleanliness or condition of a clinic, hospital, or doctor's office?

Information you get from us

- Do you believe we have not given you a notice that we are required to give?
- Do you think written information we have given you is hard to understand?

The next page has more examples of possible reasons for making a complaint

Possible complaints
(continued)

These types of complaints are all related to the *timeliness* of our actions related to coverage decisions and appeals

The process of asking for a coverage decision and making appeals is explained in sections 4-9 of this chapter. If you are asking for a decision or making an appeal, you use that process, not the complaint process.

However, if you have already asked us for a coverage decision or made an appeal, and you think that we are not responding quickly enough, you can also make a complaint about our slowness. Here are examples:

- If you have asked us to give you a "fast coverage decision" or a "fast appeal," and we have said we will not, you can make a complaint.
- If you believe we are not meeting the deadlines for giving you a coverage decision or an answer to an appeal you have made, you can make a complaint.
- When a coverage decision we made is reviewed and we are told that we must cover or reimburse you for certain medical services or drugs, there are deadlines that apply. If you think we are not meeting these deadlines, you can make a complaint.
- When we do not give you a decision on time, we are required to forward your case to the Independent Review Organization. If we do not do that within the required deadline, you can make a complaint.

Section 10.2 The formal name for "making a complaint" is "filing a grievance"

Legal Terms

- What this section calls a **"complaint"** is also called a **"grievance."**
- Another term for **"making a complaint"** is **"filing a grievance."**
- Another way to say "**using the process for complaints"** is "**using the process for filing a grievance."**

Section 10.3 Step-by-step: Making a complaint

Step 1: Contact us promptly—either by phone or in writing.

- **Usually, calling Customer Service is the first step.** If there is anything else you need to do, Customer Service will let you know (phone numbers are printed on the front cover of this booklet).
- **If you do not wish to call (or you called and were not satisfied), you can put your complaint in writing and send it to us.** If you put your complaint in writing, we will respond to your complaint in writing.
- 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 Customer Service (phone numbers are printed on the front cover of this booklet).
- A grievance must be filed either verbally or in writing within 60 days of the event or incident. 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.
- A fast grievance can be filed concerning a plan decision not to conduct a fast response to a coverage decision or appeal, or if we take an extension on a coverage decision or appeal. We must respond to your expedited grievance within 24 hours.

- **Whether you call or write, you should contact Customer Service right away.** The complaint must be made within 60 calendar days after you had the problem you want to complain about.
- **If you are making a complaint because we denied your request for a "fast coverage decision" or a "fast appeal," we will automatically give you a "fast" complaint.** If you have a "fast" complaint, it means we will give you **an answer within 24 hours**.

Legal Terms	What this section calls a **"fast complaint"** is also called an **"expedited grievance."**

Step 2: We look into your complaint and give you our answer.

- **If possible, we will answer you right away.** If you call us with a complaint, we may be able to give you an answer on the same phone call. If your health condition requires us to answer quickly, we will do that.
- **Most complaints are answered in 30 calendar days.** If we need more information and the delay is in your best interest or if you ask for more time, we can take up to 14 more calendar days (44 calendar days total) to answer your complaint.
- **If we do not agree** with some or all of your complaint or don't take responsibility for the problem you are complaining about, we will let you know. Our response will include our reasons for this answer. We must respond whether we agree with the complaint or not.

Section 10.4 You can also make complaints about quality of care to the Quality Improvement Organization

You can make your complaint about the quality of care you received to your plan by using the step-by-step process outlined above.

When your complaint is about *quality of care*, you also have two extra options:

- **You can make your complaint to the Quality Improvement Organization**. If you prefer, you can make your complaint about the quality of care you received directly to this organization (*without* making the complaint to us).
  - The Quality Improvement Organization is a group of practicing doctors and other health care experts paid by the Federal government to check and improve the care given to Medicare patients.

- To find the name, address, and phone number of the Quality Improvement Organization for your state, refer to the state-specific agency listing located in Chapter 13. If you make a complaint to this organization, we will work with them to resolve your complaint.

- **Or you can make your complaint to both at the same time**. If you wish, you can make your complaint about quality of care to your plan and also to the Quality Improvement Organization.

Section 10.5 You can also tell Medicare about your complaint

You can submit a complaint about your plan directly to Medicare. To submit a complaint to Medicare, go to www.medicare.gov/MedicareComplaintForm/home.aspx. Medicare takes your complaints seriously and will use this information to help improve the quality of the Medicare program.

If you have any other feedback or concerns, or if you feel the plan is not addressing your issue, please call 1-800-MEDICARE (1-800-633-4227). TTY/TDD users can call 1-877-486-2048.

Chapter

10.

2014 Evidence of Coverage for Medicare Preferred (PPO) with Senior Rx Plus

Ending your membership in your plan

Section		Page
1	**Introduction**	176
1.1	This chapter focuses on ending your membership in your plan	176
2	**When can you end your membership in your plan?**	176
2.1	You can end your membership during the Annual Enrollment Period for Individual (non-group) plans	177
2.2	You may be able to end your membership during the annual Medicare Advantage Disenrollment Period for Individual (non-group) Plans, but your choices are more limited	178
2.3	In certain situations, you can end your membership during a Special Enrollment Period	178
2.4	Where can you get more information about when you can end your membership?	180
3	**How do you end your membership in your plan?**	180
3.1	Usually, you end your membership by enrolling in another plan	180
4	**Until your membership ends, you must keep getting your medical services and drugs through your group sponsored plan**	182
4.1	Until your membership ends, you are still a member of our group sponsored Medicare Advantage plan	182
5	**We must end your membership in the plan in certain situations**	183
5.1	When must we end your membership in the plan?	183
5.2	We cannot ask you to leave your plan for any reason related to your health	184
5.3	You have the right to make a complaint if we end your membership in your plan	184

SECTION 1 Introduction

Section 1.1 This chapter focuses on ending your membership in your plan

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 only certain times during the year, or certain situations, when you may voluntarily end your membership in the plan. Section 2 tells you *when* you can end your membership in the plan.
  - The process for voluntarily ending your membership varies depending on what type of new coverage you are choosing. Section 3 tells you *how* to end your membership in each situation.
- There are also limited situations where you do not choose to leave, but we are required to end your membership. Section 5 tells you about situations when we must end your membership.

If you are leaving your plan, you must continue to get your medical care and prescription drugs through your plan until your membership ends.

SECTION 2 When can you end your membership in your plan?

You may end your membership in your plan only during certain times of the year, known as enrollment periods. All members have the opportunity to leave the plan during the Annual Enrollment Period and during the Medicare Advantage Annual Disenrollment Period. In certain situations, you may also be eligible to leave the plan at other times of the year.

If you do not want to remain enrolled in your group sponsored plan, the key time to make changes is the Medicare fall open enrollment period (also known as the "Annual Election period") for Individual (non-group) plans, which occurs every year from October 15 through December 7. This is the time to review your health care coverage for the following year and make changes to your Medicare health 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.

In addition to the rules above, groups may allow changes to their retiree's enrollment at:

1. The group's open enrollment period, may be any time of the year and does not have to coincide with the individual open enrollment period from 10/15-12/7.
2. Please check with your group for additional enrollment/disenrollment options and the impact of any changes to your group sponsored retiree benefits.

Section 2.1 You can end your membership during the Annual Enrollment Period for Individual (non-group) plans

You can end your membership during the **Annual Enrollment Period for Individual (non-group) Plans (**also known as the "Annual Coordinated Election Period (AEP)"). This is the time when you should review your health and drug coverage and make a decision about your coverage for the upcoming year.

- **When is the Annual Enrollment Period for Individual (non-group plans)?** This happens from October 15 through December 7.
- **What type of plan can you switch to during the Annual Enrollment Period for Individual (non-group) plans?** During this time, you can review your health coverage and your prescription drug coverage. You can choose to keep your current coverage or make changes to your coverage for the upcoming year. If you decide to change to a new plan, you can choose any of the following types of plans:
  - Another Individual (non-group) Medicare health plan. (You can choose a plan that covers prescription drugs or one that does not cover prescription drugs.)
  - Original Medicare *with* a separate Individual (non-group) Medicare prescription drug plan.
  - —*or*— Original Medicare *without* a separate Individual (non-group) Medicare prescription drug plan.
    - **If you receive "Extra Help" from Medicare to pay for your prescription drugs:** If you switch to Original Medicare and do not enroll in a separate Medicare prescription drug plan, Medicare may enroll you in a drug plan, unless you have opted out of automatic enrollment.
  - **Ending your group sponsored Medicare Advantage plan may impact your eligibility for other coverage sponsored by your group or mean that you will not be able to re-enroll in the plan in the future. Before ending your group sponsored Medicare Advantage coverage, please contact your (or your spouse's) group.**
  - **If you end your group Medicare Part D coverage, your Senior Rx Plus supplemental coverage will end on the same date.**
- **Note:** If you disenroll from a Medicare prescription drug coverage and go without creditable prescription drug coverage, you may need to pay a late enrollment penalty if you join a Medicare drug plan later. ("Creditable" coverage means the coverage is expected to pay, on average, at least as much as Medicare's standard prescription drug coverage.) See Chapter 6, Section 10 for more information about the late enrollment penalty.

- **When will your group sponsored plan membership end?** Your membership will end on the first day of the month after we get your request to change plans.

Section 2.2 You may be able to end your membership during the annual Medicare Advantage Disenrollment Period for Individual (non-group) Plans, but your choices are more limited

You have the opportunity to make *one* change to your health coverage during the **Individual (non-group) Medicare Advantage Annual Disenrollment Period**.

- **When is the annual Individual (non-group) Medicare Advantage Disenrollment Period?** This happens every year from January 1 to February 14.
- **What type of plan can you switch to during the annual Individual (non-group) Medicare Disenrollment Period?** During this time, you can cancel your Medicare Advantage Plan enrollment and switch to Original Medicare. If you choose to switch to Original Medicare during this period, you have until February 14 to join a separate Medicare prescription drug plan to add drug coverage.
- **Ending your group sponsored Medicare Advantage plan may impact your eligibility for other coverage sponsored by your group or mean that you will not be able to re-enroll in the plan in the future. Before ending your group sponsored Medicare Advantage coverage, please contact your (or your spouse's) group.**
- **If you end your group Medicare Part D coverage, your Senior Rx Plus supplemental coverage will end on the same date.**
- **When will your group sponsored plan membership end?** Your membership will end on the first day of the month after we get your request to switch to Original Medicare. If you also choose to enroll in a Medicare prescription drug plan, your membership in the drug plan will begin the first day of the month after the drug plan gets your enrollment request.

Section 2.3 In certain situations, you can end your membership during a Special Enrollment Period

Group sponsored plans may allow changes to their retirees' enrollment. This typically occurs during the group's open enrollment period. This may be any time of the year and does not have to coincide with the individual open enrollment period.

Please check with your (or your spouse's) group for additional enrollment and disenrollment options, and the impact of any changes to your group sponsored retiree benefits.

In certain situations, Medicare Advantage members may be eligible to end their membership at other times of the year. This is known as a **Special Enrollment Period**.

- **Who is eligible for a Special Enrollment Period?** If any of the following situations apply to you, you may be eligible to end your membership during a Special Enrollment Period. These are just examples, for the full list you can contact the plan, call Medicare, or visit the Medicare website (http://www.medicare.gov):
  - Usually, when you have moved outside of your plan's service area.
  - If you have Medicaid.
  - If you are eligible for "Extra Help" with paying for your Medicare prescriptions.
  - If we violate our contract with you.
  - If you are getting care in an institution, such as a nursing home or long-term care hospital.
  - If you enroll in the Program of All-inclusive Care for the Elderly (PACE). PACE is not available in all states. If you would like to know if PACE is available in your state, please contact Customer Service (phone numbers are on the front cover of this booklet).
- **When are Special Enrollment Periods?** The enrollment periods vary depending on your situation.
- **What can you do?** To find out if you are eligible for a Special Enrollment Period, please call Medicare at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users call 1-877-486-2048. If you are eligible to end your membership because of a special situation, you can choose to change both your Medicare health coverage and prescription drug coverage. This means you can choose any of the following types of plans:
  - An Individual (non-group) Medicare health plan. (You can choose a plan that covers prescription drugs or one that does not cover prescription drugs.)
  - Original Medicare *with* a separate Individual (non-group) Medicare prescription drug plan.
  - —*or*— Original Medicare *without* a separate Medicare prescription drug plan.
  - **Ending your group sponsored Medicare Advantage plan may impact your eligibility for other coverage sponsored by your group or mean that you will not be able to re-enroll in the plan in the future. Before ending your group sponsored Medicare Advantage coverage, please contact your (or your spouse's) group.**
  - **If you end your group Medicare Part D coverage, your Senior Rx Plus supplemental coverage will end on the same date.**
    - If you **receive "Extra Help" from Medicare to pay for your prescription drugs:** If you switch to Original Medicare and do not

enroll in a separate Medicare prescription drug plan, Medicare may enroll you in a drug plan, unless you have opted out of automatic enrollment.

Note: If you disenroll from Medicare prescription drug coverage and go without creditable prescription drug coverage, you may need to pay a late enrollment penalty if you join a Medicare drug plan later. ("Creditable" coverage means the coverage is expected to pay, on average, at least as much as Medicare's standard prescription drug coverage.) See Chapter 6, Section 10 for more information about the late enrollment penalty.

- **When will your group sponsored plan membership end?** Your membership will usually end on the first day of the month after we receive your request to change your plan.

Section 2.4 Where can you get more information about when you can end your membership?

If you have any questions or would like more information on when you can end your membership:

- Contact your (or your spouse's) current or former employer or union's group benefit administrator to get information on options available to you.
- You can **call Customer Service** (phone numbers are listed on the front cover of this booklet).
- You can find the information in the ***Medicare & You 2014*** Handbook.
  - Everyone with Medicare receives a copy of *Medicare & You* each fall. Those new to Medicare receive it within a month after first signing up.
  - You can also download a copy from the Medicare website (http://www.medicare.gov). Or, you can order a printed copy by calling Medicare at the number below.
- You can contact **Medicare** at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

SECTION 3 How do you end your membership in your group sponsored plan?

Section 3.1 Usually, you end your membership by enrolling in another plan

Usually, to end your membership in your plan, you simply enroll in another Medicare plan during one of the enrollment periods (see Section 2 in this chapter for information about the enrollment periods). However, if you want to switch from your plan to Original

Medicare *without* a Medicare prescription drug plan, you must ask to be disenrolled from your plan. There are two ways you can ask to be disenrolled:

- You can make a request in writing to us. Contact Customer Service if you need more information on how to do this (phone numbers are printed on the front cover of this booklet).
- —*or*—You can contact Medicare at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

  Note: If you disenroll from Medicare prescription drug coverage and go without creditable prescription drug coverage, you may need to pay a late enrollment penalty if you join a Medicare drug plan later. ("Creditable" coverage means the coverage is expected to pay, on average, at least as much as Medicare's standard prescription drug coverage.) See Chapter 6, Section 10 for more information about the late enrollment penalty.

Ending your group sponsored Medicare Advantage plan may impact your eligibility for other coverage sponsored by your group or mean that you will not be able to re-enroll in the plan in the future. Before ending your group sponsored Medicare Advantage coverage, please contact your (or your spouse's) group.

The table below explains how you should end your membership in your plan.

If you would like to switch from your plan to:	This is what you should do:
• An individual (non-group) Medicare health plan.	• Enroll in the new Medicare health plan. You will automatically be disenrolled from your group sponsored plan when your new plan's coverage begins.
• Original Medicare *with* a separate Medicare prescription drug plan.	• Enroll in the new Medicare prescription drug plan. You will automatically be disenrolled from your group sponsored plan when your new plan's coverage begins.

If you would like to switch from your plan to:	This is what you should do:
• Original Medicare *without* a separate Medicare prescription drug plan. **Note:** If you disenroll from a Medicare prescription drug plan and go without creditable prescription drug coverage, you may need to pay a late enrollment penalty if you join a Medicare drug plan later. See Chapter 6, Section 10 for more information about the late enrollment penalty.	• **Send us a written request to disenroll.** Contact Customer Service if you need more information on how to do this (phone numbers are listed on the front cover of this booklet). • You can also contact **Medicare**, at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week, and ask to be disenrolled. TTY users should call 1-877-486-2048. • You will be disenrolled from your group sponsored plan when your coverage in Original Medicare begins.

SECTION 4 Until your membership ends, you must keep getting your medical services and drugs through your plan

Section 4.1 Until your membership ends, you are still a member of your plan

If you leave your plan it may take time before your membership ends and your new Medicare coverage goes into effect. (See Section 2 for information on when your new coverage begins.) During this time, you must continue to get your medical care and prescription drugs through your plan.

- **You should continue to use our network pharmacies to get your prescriptions filled until your membership in our plan ends.** Usually, your prescription drugs are only covered if they are filled at a network pharmacy including through our mail-order pharmacy services.
- **If you are hospitalized on the day that your membership ends, your hospital stay will usually be covered by your plan until you are discharged** (even if you are discharged after your new health coverage begins).

SECTION 5 We must end your membership in the plan in certain situations

Section 5.1 When must we end your membership in the plan?

We must end your membership in the plan if any of the following happen:

- If you do not stay continuously enrolled in Medicare Part B.
- If you move out of our service area.
- If you are away from our service area for more than six months.
  - If you move or take a long trip, you need to call Customer Service to find out if the place you are moving or traveling to is in your plan's area. (Phone numbers for Customer Service are printed on the front cover of this booklet.)
- If you become incarcerated (go to prison).
- If you lie about or withhold information about other insurance you have that provides prescription drug coverage.
- If you intentionally give us incorrect information when you are enrolling in your plan and that information affects your eligibility for your plan. (We cannot make you leave our plan for this reason unless we get permission from Medicare first.)
- If you continuously behave in a way that is disruptive and makes it difficult for us to provide medical care for you and other members of your plan. (We cannot make you leave our plan for this reason unless we get permission from Medicare first.)
- If you let someone else use your membership card to get medical care or prescription drugs. (We cannot make you leave our plan for this reason unless we get permission from Medicare first.)
  - If we end your membership because of this reason, Medicare may have your case investigated by the Inspector General.
- If you are required to pay the extra Part D amount because of your income and you do not pay it, Medicare will disenroll you from our plan and you will lose prescription drug coverage.
- If your group notifies us that they are canceling the group contract for this plan.
- If the premiums paid by your group for this plan are not paid in a timely manner.
- If you pay your plan premium directly to us, and you do not pay the plan premiums for 90 days.
- We must notify you in writing that you have 90 days to pay the plan premium before we end your membership.
- If your group informs this plan of your loss of eligibility for their group coverage.

Where can you get more information?

If you have questions or would like more information on when we can end your membership:

- You can call **Customer Service** for more information (phone numbers are printed on the front cover of this booklet).

Section 5.2 We cannot ask you to leave your plan for any reason related to your health

We are not allowed to ask you to leave our plan for any reason related to your health.

What should you do if this happens?

If you feel that you are being asked to leave your plan because of a health-related reason, you should call Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048. You may call 24 hours a day, 7 days a week.

Section 5.3 You have the right to make a complaint if we end your membership in your plan

If we end your membership in your plan, we must tell you our reasons in writing for ending your membership. We must also explain how you can make a complaint about our decision to end your membership. You can also look in Chapter 9, Section 10 for information about how to make a complaint.

Legal notices

Section | Page

1 **Notice about governing law** 186

2 **Notice about nondiscrimination** 186

3 **Notice about Medicare Secondary Payer subrogation rights** 186

4 **Notice about subrogation and reimbursement** 186

5 **Additional legal notices** 187

SECTION 1 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 Centers for Medicare & Medicaid Services, or CMS. In addition, other Federal laws may apply and, under certain circumstances, the laws of the state you live in.

SECTION 2 Notice about nondiscrimination

We don't discriminate based on a person's race, disability, religion, sex, health, ethnicity, creed, age, or national origin. All organizations that provide Medicare Advantage Plans, like your plan, must obey Federal laws against discrimination, including Title VI of the Civil Rights Act of 1964, the Rehabilitation Act of 1973, the Age Discrimination Act of 1975, the Americans with Disabilities Act, all other laws that apply to organizations that get Federal funding, and any other laws and rules that apply for any other reason.

SECTION 3 Notice about Medicare Secondary Payer subrogation rights

We have the right and responsibility to collect for covered Medicare services for which Medicare is not the primary payer. According to CMS regulations at 42 CFR sections 422.108 and 423.462, your plan, as a Medicare Advantage Organization, will exercise the same rights of recovery that the Secretary exercises under CMS regulations in subparts B through D of part 411 of 42 CFR and the rules established in this section supersede any State laws.

SECTION 4 Notice about subrogation and reimbursement

Subrogation and reimbursement

These provisions apply when we pay benefits as a result of injuries or illness you sustained and you have a right to a recovery or have received a recovery. We have the right to recover payments we make on your behalf from, or take any legal action against, any party responsible for compensating you for your injuries. We also have a right to be repaid from any recovery in the amount of benefits paid on your behalf. The following apply:

- The amount of our recovery will be calculated pursuant to 42 C.F.R. 411.37, and pursuant to 42 C.F.R. 422.108(f), no state laws shall apply to our subrogation and reimbursement rights.

- Our subrogation and reimbursement rights shall have first priority, to be paid before any of your other claims are paid. Our subrogation and reimbursement rights will not be affected, reduced, or eliminated by the "made whole" doctrine or any other equitable doctrine.
- You must notify us promptly of how, when and where an accident or incident resulting in personal injury or illness to you occurred and all information regarding the parties involved, and you must notify us promptly if you retain an attorney related to such an accident or incident. You and your legal representative must cooperate with us, do whatever is necessary to enable us to exercise our rights and do nothing to prejudice our rights.
- If you fail to repay us, we shall be entitled to deduct any of the unsatisfied portion of the amount of benefits we have paid or the amount of your recovery whichever is less, from any future benefit under the plan.

SECTION 5 Additional legal notices

Under certain circumstances, if we pay the health care provider amounts that are your responsibility, such as deductibles, copayments or coinsurance, we may collect such amounts directly from you. You agree that we have the right to collect such amounts from you.

Assignment

The benefits provided under this Evidence of Coverage are for the personal benefit of the member and cannot be transferred or assigned. Any attempt to assign this contract will automatically terminate all rights under this contract.

Notice of claim

In the event that a service is rendered for which you are billed, you have 12 months from the date of service to submit such claim(s) to your plan. According to CMS Pub 100-02 Benefit Policy, Chapter 15, Section 40, physicians and practitioners are required to submit claims on behalf of beneficiaries for all items and services they provide for which Medicare payment may be made under Part B. Also, they are not allowed to charge beneficiaries in excess of the limits on charges that apply to the item or service being furnished. However, a physician or practitioner (as defined in §40.4) may opt out of Medicare. A physician or practitioner who opts out is not required to submit claims on behalf of beneficiaries and also is excluded from limits on charges for Medicare covered services.

You may submit such claims to

Medicare Preferred (PPO) with Senior Rx Plus
P.O. Box 110
Fond du Lac, WI 54936

Entire contract

This Evidence of Coverage and applicable riders attached hereto, and your completed enrollment form, constitute the entire contract between the parties and as of the effective date hereof, supersede all other agreements between the parties.

Waiver by agents

No agent or other person, except an executive officer of your plan, has authority to waive any conditions or restrictions of this Evidence of Coverage or the Medical Benefits Chart in Chapter 4.

No change in this Evidence of Coverage shall be valid unless evidenced by an endorsement signed by an authorized executive officer of the company or by an amendment to it signed by the authorized company officer.

Termination of operation

In the event of the termination of operation or dissolution of your plan in the area in which you reside, this Evidence of Coverage will be terminated. You will receive notice 90 days before the Evidence of Coverage is terminated.

Please note: If the Evidence of Coverage terminates, your coverage will also end.

In that event, your plan will explain your options at that time. For example, there may be other health plans in the area for you to join if you wish. Or, you may wish to return to Original Medicare and possibly obtain supplemental insurance. In the latter situation, your plan would arrange for you to obtain, without health screening or a waiting period, a supplemental health insurance policy to cover Medicare coinsurance and deductibles.

Whether you enroll in another prepaid health plan or not, there would be no gap in coverage.

Refusal to accept treatment

You may, for personal or religious reasons, refuse to accept procedures or treatment recommended as necessary by your primary care physician. Although such refusal is your right, in some situations it may be regarded as a barrier to the continuance of the provider/patient relationship or to the rendering of the appropriate standard of care.

When a member refuses a recommended, necessary treatment or procedure and the primary care physician believes that no professionally acceptable alternative exists, the member will be advised of this belief.

In the event you discharge yourself from a facility against medical advice, your plan will pay for covered services rendered up to the day of self-discharge. Fees pertaining to that

admission will be paid on a per diem basis or appropriate Diagnostic Related Grouping (DRG), whichever is applicable.

Limitation of actions

No legal action may be taken to recover benefits within 60 days after the service is rendered. No such action may be taken later than 3 years after the service upon which the legal action is based was provided.

Circumstances beyond plan control

If there is an epidemic, catastrophe, general emergency or other circumstance beyond the company's control, neither your plan nor any provider shall have any liability or obligation except the following, as a result of reasonable delay in providing services:

- Because of the occurrence, you may have to obtain covered services from a out-of-network provider instead of an in-network provider. Your plan will reimburse you up to the amount that would have been covered under this Evidence of Coverage.
- Your plan may require written statements from you and the medical personnel who attended you confirming your illness or injury and the necessity for the treatment you received.

Plan's sole discretion

The plan may, at its sole discretion, cover services and supplies not specifically covered by the Evidence of Coverage.

This applies if the plan determines such services and supplies are in lieu of more expensive services and supplies that would otherwise be required for the care and treatment of a member.

Disclosure

You are entitled to ask for the following information from your plan:

- Information on your plan's physician incentive plans.
- Information on the procedures your plan uses to control utilization of services and expenditures.
- Information on the financial condition of the company.
- General coverage and comparative plan information.

To obtain this information, call Customer Service (the phone number and hours of availability are located on the front of this booklet). The plan will send this information to you within 30 days of your request.

Information about advance directives

(Information about using a legal form such as a "living will" or "power of attorney" to give directions in advance about your health care in case you become unable to make your own health care decisions)

You have the right to make your own health care decisions. *But what if you had an accident or illness so serious that you became unable to make these decisions for yourself?*

If this were to happen:

- You might want a particular person you trust to make these decisions for you.
- You might want to let health care providers know the types of medical care you would *want* and *not want* if you were not able to make decisions for yourself.
- You might want to do both–to appoint someone else to make decisions for you, and to let this person and your health care providers know the kinds of medical care you would want if you were unable to make these decisions for yourself.

If you wish, you can fill out and sign a special form that lets others know what you want done if you cannot make health care decisions for yourself. This form is a legal document. It is sometimes called an "advance directive," because it lets you give directions in advance about what you want to happen if you ever become unable to make your own health care decisions.

There are different types of advance directives and different names for them depending on your state or local area. For example, documents called "living will" and "power of attorney for health care" are examples of advance directives.

It's your choice whether you want to fill out an advance directive. The law forbids any discrimination against you in your medical care based on whether or not you have an advance directive.

How can you use a legal form to give your instructions in advance?

If you decide that you want to have an advance directive, there are several ways to get this type of legal form. You can get a form from your lawyer, from a social worker and from some office supply stores. You can sometimes get advance directive forms from organizations that give people information about Medicare, such as your SHIP (which stands for State Health Insurance Assistance Program). Chapter 13 of this booklet tells how to contact your SHIP. (SHIPs have different names depending on which state you are in.)

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, take a copy with you.

If you are hospitalized, they will ask you about an advance directive

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.

It is your choice whether to sign or not. If you decide not to sign an advance directive form, you will not be denied care or be discriminated against in the care you are given.

What if providers don't follow the instructions you have given?

If you believe that a doctor or hospital has not followed the instructions in your advance directive, you may file a complaint with your state Department of Health.

Continuity and coordination of care

Your plan has policies and procedures in place to promote the coordination and continuity of medical care for our members. This includes the confidential exchange of information between primary care physicians and specialists, as well as behavioral health providers. In addition, your plan helps coordinate care with a practitioner when the practitioner's contract has been discontinued and works to enable a smooth transition to a new practitioner.

Allowed amount – The allowed amount is either:

1) The rate negotiated with in-network providers;
2) The Medicare-allowable amount for out-of-network providers who accept Medicare assignment;
3) The limiting charge for providers who do not accept assignment but who are subject to the limiting amount; or
4) The provider's actual charge when the provider does not accept assignment and is not subject to the limiting amount.

Ambulatory Surgical Center – An Ambulatory Surgical Center is an entity that operates exclusively for the purpose of furnishing outpatient surgical services to patients not requiring hospitalization and whose expected stay in the center does not exceed 24 hours.

Annual Enrollment Period – A set time each fall when members can change their health or drugs plans or switch to Original Medicare. The Annual Enrollment Period is from October 15 until December 7.

Appeal – An appeal is something you do if you disagree with our decision to deny a request for coverage of health care services or prescription drugs or payment for services or drugs you already received. You may also make an appeal if you disagree with our decision to stop services that you are receiving. For example, you may ask for an appeal if your plan doesn't pay for a drug, item or service you think you should be able to receive. Chapter 9 explains appeals, including the process involved in making an appeal.

Balance Billing – When a provider (such as a doctor or hospital) bills a patient more than the plan's allowed cost-sharing amount. As a member of our plan, you only have to pay our plan's cost-sharing amounts when you get services covered by our plan. We do not allow providers to "balance bill" or otherwise charge you more than the amount of cost-sharing your plan says you must pay.

Benefit Period – The way that both our plan and Original Medicare measures your use of hospital and skilled nursing facility (SNF) services. A benefit period begins the day you go into a hospital or skilled nursing facility. The benefit period ends when you haven't received any inpatient hospital care (or skilled care in a SNF) for 60 days in a row. If you go into a hospital or a skilled nursing facility after one benefit period has ended, a new benefit period begins. There is no limit to the number of benefit periods.

Brand-Name Drug – A prescription drug that is manufactured and sold by the pharmaceutical company that originally researched and developed the drug. Brand-name drugs have the same active-ingredient

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formula as the generic version of the drug. However, generic drugs are manufactured and sold by other drug manufacturers and are generally not available until after the patent on the brand-name drug has expired.

Calendar Year - The period beginning January 1 of any year through December 31 of the same year.

Catastrophic Coverage Stage – The stage in the Part D Drug Benefit where you pay a low copayment or coinsurance for your drugs after you or other qualified parties on your behalf have paid your True Out of Pocket cost for covered drugs during the covered year. You can find this amount listed on the benefit chart in the front of this booklet.

Centers for Medicare & Medicaid Services (CMS) – The Federal agency that administers Medicare. Chapter 2 explains how to contact CMS.

Coinsurance – An amount you may be required to pay as your share of the cost for services or prescription drugs after you pay any deductibles. Coinsurance is usually a percentage (for example, 20%).

Combined Maximum Out-of-Pocket Amount – This is the amount you will pay in a year for all Part A and Part B services from both in-network (preferred) providers and out-of-network (non-preferred) providers. In addition to the maximum out-of-pocket amount for covered Part A and Part B medical services, we also have a maximum out-of-pocket amount for certain types of services. See Chapter 4, Section 1 for information about your combined maximum out-of-pocket amount.

Comprehensive Outpatient Rehabilitation Facility (CORF) – A facility that mainly provides rehabilitation services after an illness or injury, and provides a variety of services including physical therapy, social or psychological services, respiratory therapy, occupational therapy, speech-language pathology services, and home environment evaluation services.

Copayment – An amount you may be required to pay as your share of the cost for a medical service or supply, like a doctor's visit, hospital visit, or a prescription drug. A copayment is usually a set amount, rather than a percentage. For example, you might pay $10 or $20 for a doctor's visit or prescription drug.

Cost-Sharing – Cost-sharing refers to amounts that a member has to pay when services or drugs are received. It includes any combination of the following three types of payments: (1) any deductible amount a plan may impose before drugs or services are covered; (2) any fixed "copayment" amount that a plan requires when a specific service or drug is received; or (3) any "coinsurance" amount a percentage of the total amount paid for a service or drug, that a plan requires when a specific service or drug is received. A "daily cost-sharing rate" may apply when your doctor prescribes less than a full month's supply of certain drugs for you and you are required to pay a copay.

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Cost-Sharing Tier – Every drug on the list of covered drugs is in one of the cost-sharing tiers. In general, the higher the cost-sharing tier, the higher your cost for the drug.

Coverage Determination – A decision about whether a drug prescribed for you is covered by the plan and the amount, if any, you are required to pay for the prescription. In general, if you bring your prescription to a pharmacy and the pharmacy tells you the prescription isn't covered under your plan, that isn't a coverage determination. You need to call or write to us to ask for a formal decision about the coverage. Coverage determinations are called "coverage decisions" in this booklet. Chapter 9 explains how to ask us for a coverage decision.

Covered Drugs – The term we use to mean all of the prescription drugs covered by your plan.

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

Creditable Prescription Drug Coverage – Prescription drug coverage (for example, from a group, employer or union) that is expected to pay, on average, at least as much as Medicare's standard prescription drug coverage. People who have this kind of coverage when they become eligible for Medicare can generally keep that coverage without paying a penalty, if they decide to enroll in Medicare prescription drug coverage later.

Custodial Care – Custodial care is personal care provided in a nursing home, hospice, or other facility setting when you do not need skilled medical care or skilled nursing care. Custodial care is personal care that can be provided by people who don't have professional skills or training, such as help with activities of daily living like bathing, dressing, eating, getting in or out of a bed or chair, moving around, and using the bathroom. It may also include the kind of health-related care that most people do themselves, like using eye drops. Medicare doesn't pay for custodial care.

Customer Service – A department within your plan responsible for answering your questions about your membership, benefits, grievances and appeals. See Chapter 2 for information about how to contact Customer Service.

Daily Cost-Sharing Rate – A "daily cost-sharing rate" may apply when your doctor prescribes less than a full month's supply of certain drugs for you and you are required to pay a copay. A daily cost-sharing rate is the copay divided by the number of days in a month's supply. Here is an example: If your copay for a one-month supply of a drug is $30, and a one-month's supply in your plan is 30 days, then your "daily cost-sharing rate" is $1 per day. This means you pay $1 for each day's supply when you fill your prescription.

Deductible – The amount you must pay for health care or prescriptions before our plan begins to pay.

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DESI - Drug Efficacy Study Implementation (DESI) review. Drugs entering the market between 1938 and 1962 that were approved for safety but not effectiveness are referred to as "DESI drugs."

Diagnostic testing – Testing performed to detect disease when clinical indications of active disease are present.

Disenroll or Disenrollment – The process of ending your membership in your plan. Disenrollment may be voluntary (your own choice) or involuntary (not your own choice).

Dispensing Fee – A fee charged each time a covered drug is dispensed to pay for the cost of filling a prescription. The dispensing fee covers costs such as the pharmacist's time to prepare and package the prescription.

Durable Medical Equipment (DME) – Certain medical equipment that is ordered by your doctor for medical reasons. Examples are walkers, wheelchairs, or hospital beds.

Emergency – A medical emergency is when you, or any other prudent layperson with an average knowledge of health and medicine, believe that you have medical symptoms that require immediate medical attention to prevent loss of life, loss of a limb, or loss of function of a limb. The medical symptoms may be an illness, injury, severe pain, or a medical condition that is quickly getting worse.

Emergency Care – Covered services that are: 1) rendered by a provider qualified to furnish emergency services; and 2) needed to treat, 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 your plan.

Exception – A type of coverage determination that, if approved, allows you to get a drug that is not on your plan sponsor's formulary (a formulary exception), or get a non-preferred drug at the preferred cost-sharing level (a tiering exception). You may also request an exception if your plan sponsor requires you to try another drug before receiving the drug you are requesting, or the plan limits the quantity or dosage of the drug you are requesting (a formulary exception).

Extra Covered Drugs – Is used to describe coverage of drugs which are excluded by law from coverage by Medicare Part D, but are included in some group sponsored retiree drug plans. If your plan covers drugs under the "Extra Covered Drug" benefit, these will be listed in the benefit chart located in the front of this booklet.

"Extra Help" – A Medicare program to help people with limited income and resources pay Medicare prescription drug program costs, such as premiums, deductibles, and coinsurance.

Formulary – A list of covered drugs provided by the plan.

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Generic Drug – A prescription drug that is approved by the Food and Drug Administration (FDA) as having the same active ingredient(s) as the brand-name drug. Generally, a "generic" drug works the same as a brand-name drug and usually costs less.

Grievance - A type of complaint you make about us or one of our network providers or pharmacies, including a complaint concerning the quality of your care. This type of complaint does not involve coverage or payment disputes.

Home Health Aide – A home health aide provides services that don't need the skills of a licensed nurse or therapist, such as help with personal care (e.g., bathing, using the toilet, dressing, or carrying out the prescribed exercises). Home health aides do not have a nursing license or provide therapy.

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. Note: refer to your benefit chart for Hospice benefit information.

Hospital Inpatient Stay – A hospital stay when you have been formally admitted to the hospital for skilled medical services. Even if you stay in the hospital overnight, you might still be considered an "outpatient" under observation. Be sure to ask the hospital if you are an inpatient status or outpatient observation status when staying overnight as the plan benefits are different for each category.

Hospital Observation Stay – Hospital outpatient services given to help the doctor decide if you need to be admitted as an inpatient or can be discharged. Observation services may be given in the Emergency Department (ED) or another area of the hospital and may include an overnight stay up to 48 hours.

Initial Coverage Limit – The maximum limit of coverage under the Initial Coverage Stage.

Initial Coverage Stage – This is the stage after you have met your deductible (if you have one) and before your total drug expenses, have reached your initial coverage limit, including amounts you've paid and what we have paid on your behalf. To find out if your plan includes an initial coverage limit, refer to the benefit chart located in the front of this booklet.

Initial Enrollment Period – When you are first eligible for Medicare, the period of time when you can sign up for Medicare Part B. For example, if you're eligible for Medicare

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when you turn 65, your Initial Enrollment Period is the 7-month period that begins 3 months before the month you turn 65, includes the month you turn 65, and ends 3 months after the month you turn 65.

In-Network Maximum Out-of-Pocket Amount – The most you will pay for covered Part A and Part B services received from in-network (preferred) providers. After you have reached this limit, you will not have to pay anything when you get covered services from in-network providers for the rest of the contract year. However, until you reach your combined out-of-pocket amount, you must continue to pay your share of the costs when you seek care from an out-of-network (non-preferred) provider. In addition to the maximum out-of-pocket amount for covered medical services from an in-network provider, you may also have a maximum out-of-pocket amount for certain types of services. Please refer to the benefit chart at the front of this booklet for information about your in-network maximum out-of-pocket amount and to see if you have separate maximum out-of-pocket amounts for specific medical services.

In-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 **"in-network providers"** when they have an agreement with your plan to accept our payment as payment in full, and in some cases to coordinate as well as provide covered services to members of your plan. Your plan pays in-network providers based on the agreements it has with the providers or if the providers agree to provide you with plan-covered services. In-network providers may also be referred to as "plan providers" or "network providers."

Institutional Special Needs Plan (SNP) – A Special Needs Plan that enrolls eligible individuals who continuously reside or are expected to continuously reside for 90 days or longer in a long-term care (LTC) facility. These LTC facilities may include a skilled nursing facility (SNF); nursing facility (NF); (SNF/NF); an intermediate care facility for the mentally retarded (ICF/MR); and/or an inpatient psychiatric facility. An institutional Special Needs Plan to serve Medicare residents of LTC facilities must have a contractual arrangement with (or own and operate) the specific LTC facility(ies).

Institutional Equivalent Special Needs Plan (SNP) – An institutional Special Needs Plan that enrolls eligible individuals living in the community but requiring an institutional level of care based on the State assessment. The assessment must be performed using the same respective State level of care assessment tool and administered by an entity other than the organization offering the plan. This type of Special Needs Plan may restrict enrollment to individuals that reside in a contracted assisted living facility (ALF) if necessary to ensure uniform delivery of specialized care.

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Late Enrollment Penalty – An amount added to your monthly premium for Medicare drug coverage if you go without creditable coverage (coverage that is expected to pay, on average, at least as much as standard Medicare prescription drug coverage) for a continuous period of 63 days or more. You pay this higher amount as long as you have a Medicare drug plan. There are some exceptions. For example, if you receive "Extra Help" from Medicare to pay your prescription drug plan costs, the late enrollment penalty rules do not apply to you. If you receive "Extra Help," you do not pay a penalty, even if you go without "creditable" prescription drug coverage.

List of Covered Drugs (Formulary or "Drug List") – A list of prescription drugs covered by your plan. The drugs on this list are selected by us with the help of doctors and pharmacists. The list includes both brand-name and generic drugs.

Low Income Subsidy (LIS) – See "Extra Help."

Medicaid (or Medical Assistance) – A joint Federal and State Program that helps with medical costs for some people with low incomes and limited resources. Medicaid programs vary from state to state, but most health care costs are covered if you qualify for both Medicare and Medicaid. See Chapter 2, Section 6 for information about how to contact Medicaid in your state.

Medically Accepted Indication – A use of a drug that is either approved by the Food and Drug Administration or supported by certain reference books. See Chapter 5, Section 4 for more information about a medically accepted indication.

Medically Necessary – Services, supplies, or drugs that are needed for the prevention, diagnosis or treatment of your medical condition and meet accepted standards of medical practice.

Medicare – The Federal health insurance program for people 65 years of age or older, some people under age 65 with certain disabilities, and people with End-Stage Renal Disease (generally those with permanent kidney failure who need dialysis or a kidney transplant). People with Medicare can get their Medicare health coverage through Original Medicare, a Medicare Cost Plan, a PACE plan, or a Medicare Advantage Plan.

Medicare Advantage Disenrollment Period – A set time each year when members in a Medicare Advantage plan can cancel their plan enrollment and switch to Original Medicare. The Medicare Advantage Disenrollment Period is from January 1 until February 14, 2014.

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 and Part B benefits. A Medicare Advantage Plan can be an HMO, a PPO, a Private Fee-for-Service (PFFS) plan, or a Medicare Medical Savings Account (MSA) plan. When you are enrolled in a Medicare Advantage Plan, Medicare services are covered through the plan, and are not paid for under Original Medicare. In

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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 Cost Plan – A Medicare Cost Plan is a plan operated by a Health Maintenance Organization (HMO) or Competitive Medical Plan (CMP) in accordance with a cost-reimbursed contract under section 1876(h) of the Act.

Medicare Coverage Gap Discount Program – A program that provides discounts on most covered Part D brand-name drugs to Part D enrollees who have reached the Coverage Gap Stage and who are not already receiving "Extra Help." Discounts are based on agreements between the Federal government and certain drug manufacturers. For this reason, most, but not all, brand-name drugs are discounted.

Medicare-Covered Services – Services covered by Medicare Part A and Part B. All Medicare health plans, including our plan, must cover all of the services that are covered by Medicare Part A and B. For Part B only members, your plan, rather than Medicare, will cover services normally covered by Medicare Part A.

Medicare Health Plan – A Medicare health plan is offered by a private company that contracts with Medicare to provide Part A and Part B benefits to people with Medicare who enroll in the plan. This term includes all Medicare Advantage Plans, Medicare Cost Plans, Demonstration/Pilot Programs, and Programs of All-inclusive Care for the Elderly (PACE).

Medicare Prescription Drug Coverage (Medicare Part D) – Insurance to help pay for outpatient prescription drugs, vaccines, biologicals, and some supplies not covered by Medicare Part A or Part B.

"Medigap" (Medicare Supplement Insurance) Policy – Medicare supplement insurance sold by private insurance companies to fill "gaps" in Original Medicare. Medigap policies only work with Original Medicare. (A Medicare Advantage Plan is not a Medigap policy.)

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

Multi Source Drug – A prescription drug that is manufactured and sold by more than one pharmaceutical company. Multi source drugs include both brand and generic drug options.

Network Pharmacy – A network pharmacy is a pharmacy where members of this plan can get their prescription drug benefits. We call them "network pharmacies" because they contract with us. In most cases, your prescriptions are covered only if they are filled at one of our network pharmacies.

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Non-Formulary Drugs - Drugs that are not included in the list of preferred medications that a committee of pharmacists and doctors have deemed to be the safest, most effective and most economical. Non-formulary drugs may not be included in the Plan's formulary ("Drug List"); therefore, they would not be covered under the plan unless you request and receive approval for coverage from us. You can find if non-formulary drugs are covered on your drug plan by referencing the benefit chart located in the front of this booklet.

Non-Preferred Brand Drug – While these drugs meet your Part D plans safety requirements, a committee of independent practicing doctors and pharmacists which recommends drugs for our Drug List did not determine that these drugs provided the same overall value that preferred brand drugs can offer. If your plan covers both preferred and non-preferred brand drugs, the non-preferred brand drugs usually cost you more. If your plan does not cover non-preferred brand drugs, and your physician feels that you should take the non-preferred brand drug, you may request an exception. Please see Chapter 3, Section 5.2 for how to request an exception.

Non-Preferred Generic Drug – These are generic drugs that cost more than preferred generic drugs. If your plan includes separate preferred and non-preferred generic drug tiers, the non-preferred generic drugs usually cost you more.

Organization Determination – The Medicare Advantage plan has made an organization determination when it makes a decision about whether items or services are covered or how much you have to pay for covered items or services. The Medicare Advantage plan's network provider or facility has also made an organization determination when it provides you with an item or service, or refers you to an out-of-network provider for an item or service. Organization determinations are called "coverage decisions" in this booklet. Chapter 9 explains how to ask us for a coverage decision.

Original Medicare ("Traditional Medicare" or "Fee-for-service" Medicare) – Original Medicare is offered by the government, and not a private health plan such as Medicare Advantage plans and prescription drug plans. Under Original Medicare, Medicare services are covered by paying doctors, hospitals and other health care providers payment amounts established by Congress. You can see any doctor, hospital, or other health care provider that accepts Medicare. You must pay the deductible. Medicare pays its share of the Medicare-approved amount, and you pay your share. Original Medicare has two parts: Part A (Hospital Insurance) and Part B (Medical Insurance) and is available everywhere in the United States.

Out-of-Network Pharmacy – A pharmacy that doesn't have a contract with our plan to coordinate or provide covered drugs to members of our plan. As explained in this Evidence of Coverage, most drugs you get

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from out-of-network pharmacies are not covered by our plan unless certain conditions apply.

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 your 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 booklet in Chapter 3.

Out-of-Pocket Costs – See the definition for "cost-sharing" above. A member's cost-sharing requirement to pay for a portion of services or drugs received is also referred to as the member's "out-of-pocket" cost requirement.

PACE Plan – A PACE (Program of All-Inclusive Care for the Elderly) plan combines medical, social, and long-term care services for frail people to help people stay independent and living in their community (instead of moving to a nursing home) as long as possible, while getting the high-quality care they need. People enrolled in PACE plans receive both their Medicare and Medicaid benefits through the plan.

Part C – See "Medicare Advantage (MA) Plan."

Part D – The voluntary Medicare Prescription Drug Benefit Program. (For ease of reference, we will refer to the prescription drug benefit program as Part D.)

Part D Drugs – Drugs that can be covered under Part D. We may or may not offer all Part D drugs. (See your formulary for a specific list of covered drugs.) Certain categories of drugs were specifically excluded by Congress from being covered as Part D drugs.

Plan 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 "plan providers" when they have an agreement with this plan to accept our payment as payment in full, and in some cases to coordinate as well as provide covered services to members of this plan. This plan pays plan providers based on the agreements it has with the providers or if the providers agree to provide you with plan-covered services.

Preferred Brand Drug – These are brand drugs that have been identified as excellent values both clinically and financially. Before a drug can be designated as a preferred brand drug, a committee of independent practicing doctors and pharmacists evaluates the drug to be sure it meets standards for safety, effectiveness, and cost. On most plans, selecting a preferred brand or generic drug will save you money.

Preferred Generic Drug – These are generic drugs that have been identified as excellent values both clinically and financially. If your plan includes separate preferred generic and non-preferred generic drug tiers, then your cost will usually be lower when you choose a preferred generic drug.

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Preferred Provider Organization (PPO) Plan – A Preferred Provider Organization plan is a Medicare Advantage Plan that has a network of contracted providers that have agreed to treat plan members for a specified payment amount. A PPO plan must cover all plan benefits whether they are received from in-network or out-of-network providers. Member cost-sharing will generally be higher when plan benefits are received from out-of-network providers. PPO plans have an annual limit on your out-of-pocket costs for services received from in-network (preferred) providers and a higher limit on your total combined out-of-pocket costs for services from both in-network (preferred) and out-of-network (non-preferred) providers.

Premium – The periodic payment to Medicare, an insurance company, or a health care plan for health or prescription drug coverage.

Prior Authorization – Approval in advance to get services or certain drugs that may or may not be on our formulary. In the network portion of a PPO, some in-network medical services are covered only if your doctor or other in-network provider gets "prior authorization" from your plan. In a PPO, you do not need prior authorization to obtain out-of-network services. However, you may want to check with the plan before obtaining services from out-of-network providers to confirm that the service is covered by your plan and what your cost-sharing responsibility is. Covered services that need prior authorization are marked in the benefit chart located in the front of this booklet. Some drugs are covered only if your doctor or other in-network provider gets "prior authorization" from us. Covered drugs that need prior authorization are marked in the formulary.

Quality Improvement Organization (QIO) – A group of practicing doctors and other health care experts paid by the Federal government to check and improve the care given to Medicare patients. For contact information, please refer to the state-specific agency listing located in Chapter 13.

Quantity Limits – A management tool that is designed to limit the use of selected drugs for quality, safety, or utilization reasons. Limits may be on the amount of the drug that we cover per prescription or for a defined period of time.

Rehabilitation Services – These services include physical therapy, speech and language therapy, and occupational therapy.

Screening Exam – A routine exam to detect evidence of unsuspected disease.

Select Generics – A specific list of generic drugs that have been on the market long enough to have a proven track record for effectiveness and value. A complete list of these drugs is included in your Drug List (Formulary) that accompanies this Evidence of Coverage. Some plans have reduced copayments for Select Generics. If your plan includes a reduced copayment, you can find this information listed on the benefit chart located in the front of this booklet.

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Service Area – A geographic area where a health plan accepts members if it limits membership based on where people live. For plans that limit which doctors and hospitals you may use, it's also generally the area where you can get routine (non-emergency) services. The plan may disenroll you if you permanently move out of the plan's service area.

Single Source Drug – A prescription brand drug that is manufactured and sold only by the pharmaceutical company that originally researched and developed the drug. Single source drugs are always brand drugs.

Skilled Nursing Facility (SNF) Care – Skilled nursing care and rehabilitation services provided on a continuous, daily basis, in a skilled nursing facility. Examples of skilled nursing facility care include physical therapy or intravenous injections that can only be given by a registered nurse or doctor.

Special Enrollment Period – A set time when members can change their health or drugs plans or return to Original Medicare. Situations in which you may be eligible for a Special Enrollment Period include: if you move outside the service area, if you are getting "Extra Help" with your prescription drug costs, if you move into a nursing home, or if we violate our contract with you.

Specialty Drugs – The Centers for Medicare & Medicaid Services (CMS) defines specialty drugs as any drug that costs $600 or more per unit.

Special Needs Plan – A special type of Medicare Advantage Plan that provides more focused health care for specific groups of people, such as those who have both Medicare and Medicaid, who reside in a nursing home, or who have certain chronic medical conditions.

Step Therapy – A utilization tool that requires you to first try another drug to treat your medical condition before we will cover the drug your physician may have initially prescribed.

Supplemental Security Income (SSI) – A monthly benefit paid by Social Security 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 – Urgently needed care is care provided to treat a non-emergency, unforeseen medical illness, injury, or condition that requires immediate medical care. Urgently needed care may be furnished by in-network providers or by out-of-network providers when in-network providers are temporarily unavailable or inaccessible.

State organization contact information

Section		Page
1	**State Health Insurance Assistance (SHIP)**	205
2	**Quality Improvement Organizations (QIO)**	212
3	**State Medicaid Offices**	219
4	**State Medicare Offices**	226
5	**State Pharmacy Assistance Program (SPAP)**	227
6	**Civil Rights Commission**	231

SECTION 1 State Health Insurance Assistance (SHIP)

ALABAMA

State Health Insurance Assistance Program (SHIP)

770 Washington Avenue, Suite 570
Montgomery, AL 36130

1-800-243-5463, TTY/TDD: 711
Fax: 1-334-242-5594
Email: ageline@adss.alabama.gov
www.alabamaageline.gov/healthcare/

ALASKA

Alaska State Health Insurance Assistance Program (SHIP)

550 W 8th Avenue
Anchorage, AK 99501

1-800-478-6065, TTY/TDD: 711
www.hss.state.ak.us/dsds/medicare/

ARIZONA

Arizona State Health Insurance Assistance Program

1789 W Jefferson Street, #950a
Phoenix, AZ 85007

1-800-432-4040, TTY/TDD: 711
Fax: 1-602-542-6575
www.azdes.gov/daas/ship/

ARKANSAS

Senior Health Insurance Information Program (SHIIP)

1200 W 3rd Street
Little Rock, AR 72201-1904

1-800-224-6330, TTY/TDD: 711
Fax: 1-501-371-2781
Email: insurance.shiip@arkansas.gov
http://insurance.arkansas.gov/shiip.htm

CALIFORNIA

California Health Insurance Counseling & Advocacy Program (HICAP)

1300 National Drive, Suite 200
Sacramento, CA 95834-1992

1-800-434-0222, TTY/TDD: 1-800-735-2929
Email: hicap@aging.ca.gov
www.aging.ca.gov/HICAP

COLORADO

Senior Health Insurance Assistance Program (SHIP)

1560 Broadway, Suite 850
Denver, CO 80202

1-888-696-7213, TTY/TDD: 1-303-894-7880
Fax: 1-303-894-7455
Email: ship@dora.state.co.us
www.dora.state.co.us/insurance/senior/senior.htm

CONNECTICUT

CHOICES

25 Sigourney Street
10th Floor
Hartford, CT 06106

1-800-994-9422, TTY/TDD: 1-860-424-5274
Email: agingservices.dss@ct.gov
www.ct.gov/agingservices

DELAWARE

ELDERinfo

841 Silver Lake Boulevard
Dover, DE 19904

1-800-336-9500, TTY/TDD: 711
Fax: 1-302-739-6278
Email: elderinfo@state.de.us
http://delawareinsurance.gov/services/elderinfo.shtml

SECTION 1 State Health Insurance Assistance (SHIP) (con't)

DISTRICT OF COLUMBIA

Health Insurance Counseling Project (HICP)

2136 Pennsylvania Avenue NW
Washington, DC 20052

1-202-994-6272, TTY/TDD: 1-202-973-1079
Fax: 1-202-293-4043
www.dcoa.dc.gov/

FLORIDA

Serving Health Insurance Needs of Elders (SHINE)

4040 Esplanade Way, Suite 270
Tallahassee, FL 32399-7000

1-800-963-5337, TTY/TDD: 711
Fax: 1-850-414-2150
Email: information@elderaffairs.org
www.floridashine.org

GEORGIA

GeorgiaCares

2 Peachtree Street NW
33 Floor
Atlanta, GA 30303-3142

1-800-669-8387, TTY/TDD: 1-404-657-1929
www.mygeorgiacares.org

HAWAII

Sage PLUS Program - Executive Office on Aging

250 S Hotel Street , Suite 406
Honolulu, HI 96813

1-888-875-9229, TTY/TDD: 1-866-810-4379
Fax: 1-808-586-0185
Email: help@hawaiiship.org
http://www.hawaiiship.org/site/1/home.aspx

IDAHO

Senior Health Insurance Benefits Advisors (SHIBA)

700 W State Street
P.O. Box 83720
Boise, ID 83702-0043

1-800-247-4422, TTY/TDD: 711
Fax: 1-208-334-4389
http://www.doi.idaho.gov/Shiba/Vol/login.aspx

ILLINOIS

Senior Health Insurance Program (SHIP)

One Natural Resources Way, #100
Springfield, IL 62702-1271

1-800-548-9034, TTY/TDD: 711
Fax: 1-217-782-4105
Email: aging.ship@illinois.gov
http://www.state.il.us/aging/SHIP/default.htm

INDIANA

State Health Insurance Assistance Program (SHIP)

714 W 53rd Street
Anderson, IN 46013

1-800-452-4800, TTY/TDD: 1-866-846-0139
Email: cstclair@idoi.in.gov
www.medicare.in.gov

IOWA

Senior Health Insurance Information Program (SHIIP)

330 Maple Street
Des Moines, IA 50319-0065

1-800-351-4664, TTY/TDD: 1-800-735-2942
Email: shiip@iid.iowa.gov
www.shiip.state.ia.us

SECTION 1 State Health Insurance Assistance (SHIP) (con't)

KANSAS

Senior Health Insurance Counseling for Kansas (SHICK)

503 S Kansas Avenue, New England Building
Topeka, KS 66603

1-800-860-5260, TTY/TDD: 711
Fax: 1-785-296-0256
Email: wwwmail@aging.ks.gov
www.kdads.ks.gov/SHICK/shick_index.html

KENTUCKY

State Health Insurance Assistance Program (SHIP)

275 E Main Street, 3W-F
Frankfort, KY 40621

1-877-293-7447, TTY/TDD: 711
Fax: 1-502-564-4595
www.chfs.ky.gov/dail/ship.htm

LOUISIANA

Senior Health Insurance Information Program (SHIIP)

P.O. Box 94214
Baton Rouge, LA 70802

1-800-259-5300, TTY/TDD: 711
Fax: 1-225-342-5352
Email: vdufrene@Idi.state.la.us
www.ldi.state.la.us

MAINE

Maine State Health Insurance Assistance Program (SHIP)

11 State House Station, 32 Blossom Lane
Augusta, ME 04333

1-800-262-2232, TTY/TDD: 711
Fax: 1-207-287-9229
Email: BEAS.Webmaster@maine.gov
www.maine.gov/dhhs/oads/aging/community/ship.shtml

MARYLAND

Senior Health Insurance Assistance Program (SHIP)

301 W Preston Street, Room 1007
Baltimore, MD 21201

1-410-333-7943, TTY/TDD: 711
Fax: 1-410-333-7943
Email: webmail@ooa.state.md.us
www.mdoa.state.md.us

MASSACHUSETTS

Serving Health Information Needs of Elders (SHINE)

1 Ashburton Place, 5th Floor
Boston, MA 02108

1-800-243-4636, TTY/TDD: 1-800-872-0166
www.800ageinfo.com

MICHIGAN

MMAP, Inc.

6105 W Street Joseph, Suite 204
Lansing, MI 48917

1-800-803-7174, TTY/TDD: 711
www.mmapinc.org

MINNESOTA

Minnesota State Health Insurance Assistance Program/Senior LinkAge Line

P.O. Box 64976
St. Paul, MN 55164-0976

1-800-333-2433, TTY/TDD: 1-800-627-3529
Fax: 1-651-431-7453
Email: senior_linkage@mail.state.mn.us
www.mnaging.org

SECTION 1 State Health Insurance Assistance (SHIP) (con't)

MISSISSIPPI

MS State Health Insurance Assistance Program (SHIP)

750 N State Street
Jackson, MS 39202

1-800-948-3090, TTY/TDD: 711
Fax: 1-601-359-9664
www.mdhs.state.ms.us/aas_info.html

MISSOURI

CLAIM

200 N Keene Street, Suite 101
Columbia, MO 65109

1-800-390-3330, TTY/TDD: 711
Fax: 1-573-817-8341
Email: claim@primaris.org
www.missouriclaim.org

MONTANA

Montana State Health Insurance Assistance Program (SHIP)

2030 11th Avenue
Helena, MT 59604-4210

1-800-551-3191, TTY/TDD: 711
Fax: 1-406-444-7743
www.dphhs.mt.gov/sltc/services/aging

NEBRASKA

Nebraska Senior Health Insurance Information Program (SHIIP)

941 O Street, Suite 400
Lincoln, NE 68508

1-800-234-7119, TTY/TDD: 711
Fax: 1-402-471-6559
Email: DOI.SHIIP@nebraska.gov
www.doi.ne.gov/shiip

NEVADA

State Health Insurance Assistance Program (SHIP)

1860 E Sahara
Las Vegas, NV 89104

1-800-307-4444, TTY/TDD: 711
Fax: 1-702-486-3572
www.nvaging.net/ship/ship_main.htm

NEW HAMPSHIRE

NH SHIP - ServiceLink Resource Center

129 Pleasant Street
Gallen State Office Park
Concord, NH 03301-3857

1-866-634-9412, TTY/TDD: 711
Fax: 1-603-271-4643
www.servicelink.org

NEW JERSEY

State Health Insurance Assistance Program (SHIP)

12B Quakerbridge Plaza
PO Box 715
Mercerville, NJ 08625-0715

1-800-792-8820, TTY/TDD: 711
www.state.nj.us/humanservices/doas/services/ship/

NEW MEXICO

Benefits Counseling Program

2550 Cerrillos Road
Santa Fe, NM 87505

1-800-432-2080, TTY/TDD: 711
www.nmaging.state.nm.us

SECTION 1 State Health Insurance Assistance (SHIP) (con't)

NEW YORK

Health Insurance Information Counseling and Assistance Program (HIICAP)

2 Empire State Plaza
Albany, NY 12223-1251

1-800-701-0501, TTY/TDD: 711
Email: NYSOFA@ofa.state.ny.us
www.aging.ny.gov

NORTH CAROLINA

Seniors' Health Insurance Information Program (SHIIP)

11 S Boylan Avenue
Raleigh, NC 27603

1-800-443-9354, TTY/TDD: 711
Fax: 1-919-807-6901
Email: ncshiip@ncdoi.gov
www.ncdoi.com/SHIIP/Default.aspx

NORTH DAKOTA

Senior Health Insurance Counseling (SHIC)

State Capitol
600 East Boulevard, 5th Floor
Bismarck, ND 58505-0320

1-800-247-0560, TTY/TDD: 1-800-366-6888
Fax: 1-701-328-9610
Email: ndshic@nd.gov
www.state.nd.us/ndins/

OHIO

Ohio Senior Health Insurance Information Program (OSHIIP)

50 W Town Street
3rd Floor
Columbus, OH 43215

1-800-686-1578, TTY/TDD: 1-614-644-3745
Fax: 1-614-752-0740
Email: oshiipmail@insurance.ohio.gov
www.ohioinsurance.gov

OKLAHOMA

Senior Health Insurance Counseling Program (SHIP)

Five Corporate Plaza
3625 NW 56th, Ste 100
Oklahoma City, OK 73112

1-800-763-2828, TTY/TDD: 711
Fax: 1-405-522-4492
www.ok.gov/oid/Consumers/

OREGON

Senior Health Insurance Benefits Assistance Program (SHIBA)

350 Winter Street NE, Suite 330, P.O. Box 14480
Salem, OR 97309-0405

1-800-722-4134, TTY/TDD: 1-800-735-2900
Fax: 1-503-378-8365
Email: shiba.oregon@state.or.us
http://oregonshiba.org

PENNSYLVANIA

APPRISE

555 Walnut Street
5th Floor
Harrisburg, PA 17101

1-800-783-7067, TTY/TDD: 711
Fax: 1-717-772-6842
Email: Aging@pa.gov
www.portal.state.pa.us/portal/server.pt?ope

RHODE ISLAND

Senior Health Insurance Program (SHIP)

Hazard Building
74 West Road
Cranston, RI 02920

1-401-462-4444, TTY/TDD: 1-401-462-0445
Fax: 1-401-462-0503
http://adrc.ohhs.ri.gov

SECTION 1 State Health Insurance Assistance (SHIP) (con't)

SOUTH CAROLINA

(I-CARE) Insurance Counseling Assistance and Referrals for Elders

1301 Gervais Street, Suite 350
Columbia, SC 29201

1-800-868-9095, TTY/TDD: 711
Fax: 1-803-734-9887
Email: askus@aging.sc.gov
www.aging.sc.gov

SOUTH DAKOTA

Senior Health Information & Insurance Education (SHIINE)

700 Governors Drive
Pierre, SD 57101

1-800-536-8197, TTY/TDD: 711
Fax: 1-605-336-7471
www.shiine.net

TENNESSEE

TN SHIP

500 Deaderick Street
Suite 825
Nashville, TN 37243-0860

1-877-801-0044, TTY/TDD: 711
Fax: 1-615-741-3309
http://www.state.tn.us/comaging/ship.html

TEXAS

Health Information Counseling and Advocacy Program (HICAP)

701 W 51st Street
Austin, TX 78751

1-800-252-9240, TTY/TDD: 711
Fax: 1-512-438-3538
Email: ConsumerProtection@tdi.texas.gov
www.dads.state.tx.us

UTAH

Senior Health Insurance Information Program (SHIP)

195 North 1950 W
Salt Lake City, UT 84116

1-800-541-7735, TTY/TDD: 711
Fax: 1-801-538-4395
Email: DAAS@utah.gov
www.hsdaas.utah.gov/index.htm

VERMONT

State Health Insurance Assistance Program

481 Summer Street
Suite 101
St. Johnsbury, VT 05819

1-800-642-5119, TTY/TDD: 711
Fax: 1-802-748-6622
www.medicarehelpvt.net

VIRGINIA

Virginia Insurance Counseling and Assistance Program (VICAP)

1610 Forest Avenue, Suite 100
Richmond, VA 23229

1-800-552-3402, TTY/TDD: 711
Fax: 1-804-662-9354
Email: aging@vda.virginia.gov
www.vda.virginia.gov

WASHINGTON

Statewide Health Insurance Benefits Advisors (SHIBA) Helpline

P.O. Box 40255
Olympia, WA 98504-0255

1-800-562-6900, TTY/TDD: 711
Email: SHIBAHelpLine@oic.wa.gov
www.insurance.wa.gov

SECTION 1 State Health Insurance Assistance (SHIP) (con't)

WEST VIRGINIA

West Virginia State Health Insurance Assistance Program (WV SHIP)

1900 Kanawha Boulevard E
Charleston, WV 25305

1-877-987-4463, TTY/TDD: 711
Fax: 1-304-558-0004
www.wvship.org

WISCONSIN

Wisconsin SHIP (SHIP)

One W Wilson Street
Madison, WI 53707-7850

1-800-242-1060, TTY/TDD: 711
Email: DHFSDLTCAging@dhfs.state.wi.us
www.dhs.wisconsin.gov/aging/EBS/ship.htm

WYOMING

Wyoming State Health Insurance Information Program (WSHIIP)

106 W Adams
P.O. Box BD
Riverton, WY 82501

1-800-856-4398, TTY/TDD: 711
Fax: 1-307-856-4466
Email: wshiipmgr@wyoming.com
www.wyomingseniors.com

SECTION 2 Quality Improvement Organizations (QIO)

ALABAMA

Alabama Quality Assurance Foundation

2 Perimeter Park South, Suite 200 West
Birmingham, AL 35243

1-205-970-1600, TTY/TDD: 711
Fax: 1-205-970-1616
www.aqaf.com

ALASKA

Mountain-Pacific Quality Health Foundation

4241 B Street, Suite 101
Ankorage, AK 99503

1-877-561-3202, TTY/TDD: 1-800-497-8232
Fax: 1-907-561-3204
http://www.mpqhf.com/alaska/index.php

ARIZONA

Health Services Advisory Group

3133 E Camelback Road, #300
Phoenix, AZ 85016

1-800-359-9909, TTY/TDD: 711
Fax: 1-866-800-8767
www.hsag.com

ARKANSAS

Arkansas Foundation for Medical Care

P.O. Box 180001
Fort Smith, AR 72918-0001

1-888-987-1200, TTY/TDD: 711
Fax: 1-501-244-2101
www.afmc.org

CALIFORNIA

Health Services Advisory Group

C/O FMQAI
5201 W Kennedy Blvd.
Suite 900
Tampa, FL 33609-1822

1-866-800-8750, TTY/TDD: 1-800-881-5980
Fax: 1-818-409-0835
www.hsag.com

COLORADO

Colorado Foundation for Medical Care

23 Inverness Way East, Suite 100
Englewood, CO 80112-5708

1-800-727-7086, TTY/TDD: 711
Fax: 1-303-695-3343
www.cfmc.org

CONNECTICUT

Qualidigm

1111 Cromwell Avenue
Suite 201
Rocky Hill, CT 06067-3454

1-800-553-7590, TTY/TDD: 711
Fax: 1-860-632-5865
Email: info@qualidigm.org
www.qualidigm.org

DELAWARE

Quality Insights of Delaware

3411 Silverside Road
Baynard Building, Suite 100
Wilmington, DE 19810-4812

1-866-475-9669, TTY/TDD: 711
Fax: 1-302-478-3873
www.qide.org/Home.aspx

SECTION 2 Quality Improvement Organizations (QIO) (con't)

DISTRICT OF COLUMBIA

Delmarva Foundation

2175 K Street, NW, Suite 250
Washington, DC 20037

1-800-937-3362, TTY/TDD: 711
Fax: 1-202-293-3253
www.delmarvafoundation.org

FLORIDA

Florida Medical Quality Assurance, Inc.

5201 W Kennedy Boulevard, Suite 900
Tampa, FL 33609-1822

1-800-844-0795, TTY/TDD: 1-866-800-8751
Fax: 1-813-354-0737
www.fmqai.com

GEORGIA

Alliant GMCF

1455 Lincoln Parkway, Suite 800
Atlanta, GA 30346

1-800-979-7217, TTY/TDD: 711
Fax: 1-678-527-3427
www.gmcf.org

HAWAII

Mountain-Pacific Quality Health - Hawaii

1360 S Beretania Street, Suite 501
Honolulu, HI 96814

1-800-524-6550, TTY/TDD: 1-800-497-8232
Fax: 1-808-440-6030
http://www.mpqhf.com/hawaii/inner.php?PageID=131

IDAHO

Qualis Health

720 Park Boulevard, Suite 120
Boise, ID 83712

1-800-488-1118, TTY/TDD: 1-877-486-2048
Fax: 1-208-343-4705
Email: info@qualishealth.org
www.qualishealthmedicare.org

ILLINOIS

Telligen

711 Jorie Boulevard
Oak Brook, IL 60523-2238

1-800-647-8089, TTY/TDD: 711
Fax: 1-630-571-5611
http://www.telligenqio.org/

INDIANA

Health Care Excel, Incorporated

2901 Ohio Blvd., Suite 112
Terre Haute, IN 47803

1-800-288-1499, TTY/TDD: 711
Fax: 1-812-235-4991
www.hce.org

IOWA

Telligen

1776 West Lakes Parkway
West Des Moines, IA 50266

1-800-752-7014, TTY/TDD: 711
Fax: 1-515-222-2407
http://www.telligenqio.org/

SECTION 2 Quality Improvement Organizations (QIO) (con't)

KANSAS

Kansas Foundation for Medical Care

2947 SW Wanamaker Drive
Topeka, KS 66614-4193

1-800-432-0770, TTY/TDD: 711
Fax: 1-785-273-5130
www.kfmc.org

KENTUCKY

Health Care Excel, Inc.

2901 Ohio Boulevard, Suite 112
Terre Haute, IN 47803-0713

1-800-288-1499, TTY/TDD: 711
Fax: 1-812-235-4991
www.hce.org

LOUISIANA

eQHealth Solutions

8591 United Plaza Boulevard, Suite 270
Baton Rouge, LA 70809

1-800-433-4958, TTY/TDD: 1-800-618-4781
Fax: 1-225-923-0957
louisianaqio.eqhs.org/

MAINE

Northeast Health Care Quality Foundation

15 Old Rollinsford Road, Suite 302
Dover, NH 03820-2830

1-800-772-0151, TTY/TDD: 711
Fax: 1-603-749-1195
Email: Info@nhcqf.org
www.nhcqf.org

MARYLAND

Delmarva Foundation for Medical Care, Inc.

6940 Columbia Gateway Drive, Suite 420
Columbia, MD 21046-2877

1-800-492-5811, TTY/TDD: 1-877-486-2048
www.dfmc.org

MASSACHUSETTS

MassPRO

245 Winter Street
Waltham, MA 02451

1-800-252-5533, TTY/TDD: 1-781-419-2502
Fax: 1-781-487-0083
www.masspro.org

MICHIGAN

Michigan Peer Review Organization

22670 Haggerty Road, Suite 100
Farmington Hills, MI 48335-2611

1-800-365-5899, TTY/TDD: 711
Fax: 1-248-465-7428
www.mpro.org

MINNESOTA

Stratis Health

2901 Metro Drive, Suite 400
Bloomington, MN 55425-1525

1-877-787-2847, TTY/TDD: 1-800-627-3529
Fax: 1-952-853-8503
www.stratishealth.org

SECTION 2 Quality Improvement Organizations (QIO) (con't)

MISSISSIPPI

Information and Quality Healthcare

385B Highland Colony Parkway, Suite 504
Ridgeland, MS 39157

1-800-844-0500, TTY/TDD: 711
Fax: 1-601-956-1713
http://www.msqio.org/index.php

MISSOURI

Primaris

200 North Keene Street, Suite 101
Columbia, MO 65201

1-800-735-6776, TTY/TDD: 1-800-735-2966
Fax: 1-573-777-9039
www.primaris.org

MONTANA

Mountain-Pacific Quality Health Foundation

3404 Cooney Drive
Helena, MT 59602

1-800-497-8232, TTY/TDD: 1-800-497-8232
Fax: 1-406-513-1920
http://www.mpqhf.com/montana/

NEBRASKA

Cimro of Nebraska

1230 O Street, Suite 120
Lincoln, NE 68508

1-800-458-4262, TTY/TDD: 1-800-325-0778
Fax: 1-402-476-1335
www.cimronebraska.org

NEVADA

HealthInsight

6830 W Oquendo Road, Suite 102
Las Vegas, NV 89118

1-702-385-9933, TTY/TDD: 1-877-486-2048
Fax: 1-702-385-4586
www.healthinsight.org

NEW HAMPSHIRE

Northeast Health Care Quality Foundation

15 Old Rollinsford Road, Suite 302
Dover, NH 03820-2830

1-800-772-0151, TTY/TDD: 711
Fax: 1-603-749-1195
Email: Info@nhcqf.org
www.nhcqf.org

NEW JERSEY

Health Care Quality Strategies

557 Cranbury Road, Suite 21
East Brunswick, NJ 08816-4026

1-800-624-4557, TTY/TDD: 1-800-752-8420
Fax: 1-732-238-7766
www.hqsi.org

NEW MEXICO

HealthInsight

5801 Osuna Road NE, Suite 200
Albuquerque, NM 87109

1-800-663-6351, TTY/TDD: 1-877-486-2048
Fax: 1-505-998-9899
www.nmmra.org

SECTION 2 Quality Improvement Organizations (QIO) (con't)

NEW YORK

Island Peer Review Organization - IPRO

1979 Marcus Avenue
Lake Success, NY 11042-1002

1-800-331-7767, TTY/TDD: 1-516-326-6182
Fax: 1-516-328-2310
Email: support@ipro.us
www.ipro.org

NORTH CAROLINA

Medical Review of North Carolina, Inc.

100 Regency Forest Drive, Suite 200
Cary, NC 27518-8598

1-800-682-2650, TTY/TDD: 1-800-735-2962
Fax: 1-919-461-5700
http://www.ccmemedicare.org/default.aspx?pid=1

NORTH DAKOTA

North Dakota Health Care Review, Inc.

3520 North Broadway
Minot, ND 58701

1-888-472-4231, TTY/TDD: 711
Fax: 1-701-838-6009
www.ndhcri.org

OHIO

Ohio KePRO, Inc.

5700 Lombardo Center Drive, Rock Run Center, Suite 100
Seven Hills, OH 44131

1-800-589-7337, TTY/TDD: 711
Fax: 1-216-447-7925
www.ohiokepro.com

OKLAHOMA

Oklahoma Foundation for Medical Quality, Inc.

14000 Quail Springs Parkway, Suite 400
Oklahoma City, OK 73134-2600

1-800-522-3414, TTY/TDD: 1-877-486-2048
Fax: 1-405-858-9097
Email: ofmqhit@ofmq.com
www.ofmq.com

OREGON

Acumentra Health

2020 SW 4th Avenue, Suite 520
Portland, OR 97201-4960

1-800-344-4354, TTY/TDD: 711
Fax: 1-503-279-0190
www.acumentra.org

PENNSYLVANIA

Quality Insights of Pennsylvania

2601 Market Place Street, Suite 320
Harrisburg, PA 17110

1-800-322-1914, TTY/TDD: 711
Fax: 1-717-671-5970
www.qipa.org

RHODE ISLAND

Healthcentric Advisors

235 Promenade Street, Suite 500, Box 18
Providence, RI 02908

1-800-662-5028, TTY/TDD: 711
Fax: 1-401-528-3210
http://healthcentricadvisors.org/

SECTION 2 Quality Improvement Organizations (QIO) (con't)

SOUTH CAROLINA

The Carolinas Center for Medical Excellence

246 Stoneridge Drive, Suite 200
Columbia, SC 29210

1-800-922-3089, TTY/TDD: 1-800-735-8583
Fax: 1-803-212-7600
http://www.ccmemedicare.org/default.aspx?pid=1

SOUTH DAKOTA

South Dakota Foundation for Medical Care, Inc.

2600 West 49th Street, Suite 300
Sioux Falls, SD 57105

1-800-658-2285, TTY/TDD: 1-800-325-0778
Fax: 1-605-373-0580
www.sdfmc.org

TENNESSEE

Qsource

3340 Players Club Parkway
Memphis, TN 38215

1-800-528-2655, TTY/TDD: 1-800-848-0298
Fax: 1-901-761-3786
www.qsource.org

TEXAS

TMF Health Quality Institute

5918 West Courtyard Drive
Bridgepoint I, Suite 300
Austin, TX 78730-5036

1-800-725-9216, TTY/TDD: 1-877-486-2048
Fax: 1-512-327-7159
www.tmf.org

UTAH

HealthInsight

756 E Winchester Street, Suite 200
Salt Lake City, UT 84107

1-801-892-0155, TTY/TDD: 711
Fax: 1-801-892-0160
www.healthinsight.org

VERMONT

Northeast Health Care Quality Foundation

15 Old Rollinsford Road, Suite 302
Dover, NH 03820-2830

1-800-772-0151, TTY/TDD: 711
Fax: 1-603-749-1195
Email: Info@nhcqf.org
www.nhcqf.org

VIRGINIA

Virginia Health Quality Center

9830 Mayland Drive, Suite J
Richmond, VA 23233

1-866-263-8402, TTY/TDD: 1-877-486-2048
Fax: 1-804-289-5324
www.vhqc.org

WASHINGTON

Qualis Health

P.O. Box 33400
Seattle, WA 98133-0400

1-800-949-7536, TTY/TDD: 1-877-486-2048
Fax: 1-206-368-2419
Email: info@qualishealth.org
www.qualishealthmedicare.org

SECTION 2 Quality Improvement Organizations (QIO) (con't)

WEST VIRGINIA

West Virginia Medical Institute, Inc.

3001 Chesterfield Avenue
Charleston, WV 25304

1-800-642-8686, TTY/TDD: 711

http://www.qiwv.org/Home.aspx

WISCONSIN

MetaStar, Inc.

2909 Landmark Place
Madison, WI 53713

1-800-362-2320, TTY/TDD: 711
Fax: 1-608-274-5008

www.metastar.com

WYOMING

Mountain-Pacific Quality Health Foundation

145 S Durbin, Suite 105
Casper, WY 82601

1-877-810-6248, TTY/TDD: 1-800-497-8232
Fax: 1-307-472-1791

http://www.mpqhf.com/wyoming/index.php

SECTION 3 State Medicaid Offices

ALABAMA

Alabama Medicaid Agency

P.O. Box 5624
Montgomery, AL 36103-5624

1-800-362-1504, TTY/TDD: 1-800-253-0799
Fax:1-334-242-0566
www.medicaid.alabama.gov

ALASKA

State of Alaska Health & Social Services

350 Main Street, Room 404
P.O. Box 110601
Juneau, AK 99811-0601

1-800-780-9972, TTY/TDD: 1-907-644-6800
1-907-465-3068
http://dhss.alaska.gov/dhcs/Pages/medicaid_medicare/default.aspx

ARIZONA

AHCCCS-Arizona's Medicaid Agency

801 E Jefferson, MD 4100
Phoenix, AZ 85034

1-602-417-4000, TTY/TDD: 1-800-826-5140
Fax:1-602-252-6536
www.azahcccs.gov

ARKANSAS

Arkansas Medicaid

P.O. Box 1437, Slot S401
Donaghey Plaza South
Little Rock, AR 72203-1437

1-800-482-8988, TTY/TDD: 711
Fax:1-501-682-8978
www.medicaid.state.ar.us

CALIFORNIA

California Department of Health Care Services

P.O. Box 997417, MS 4607
Sacramento, CA 95899-7413

1-916-552-9200, TTY/TDD: 711
www.medi-cal.ca.gov

COLORADO

Department of Health Care Policy and Financing of Colorado

1570 Grant Street
Denver, CO 80203

1-303-866-3513, TTY/TDD: 1-800-659-2656
Fax:1-303-866-4411
Email: customer.service@hcpf.state.co.us
www.chcpf.state.co.us

CONNECTICUT

State of Connecticut Department of Social Services

25 Sigourney Street
Hartford, CT 06106-5033

1-800-842-1508, TTY/TDD: 1-877-284-8759
www.ct.gov/dss

DELAWARE

Delaware Health and Social Services

Herman Holloway Sr. Campus
1901 N DuPont Highway
New Castle, DE 19720

1-800-372-2022, TTY/TDD: 711
Fax:1-302-255-4454
www.dhss.delaware.gov/dhss/dmma/medicaid.html

SECTION 3 State Medicaid Offices (con't)

DISTRICT OF COLUMBIA

District of Columbia Department of Health Care Finance

899 North Capitol Street NE, Suite 6036
Washington, DC 20002

1-202-442-5988, TTY/TDD: 711
Fax:1-202-442-4790
Email: dhcf@dc.gov
http://dhcf.dc.gov/

FLORIDA

Florida Agency for Health Care Administration

2727 Mahan Drive
Tallahassee, FL 32308

1-888-419-3456, TTY/TDD: 711
www.ahca.myflorida.com/Medicaid/index.shtml/about

GEORGIA

Georgia Department of Community Health

2 Peachtree Street, NW
Atlanta, GA 30303

1-866-211-0950, TTY/TDD: 711
www.dch.georgia.gov

HAWAII

State of Hawaii Department of Human Services Med-QUEST Division

601 Kamokila Blvd., Room 518
Kapolei, HI 96707

1-800-316-8005, TTY/TDD: 711
Email: dhs@dhs.hawaii.gov
www.med-quest.us

IDAHO

Idaho Dept. of Health and Welfare

1720 West Gate Drive
Boise, ID 83705

1-800-926-2588, TTY/TDD: 711
Fax:1-208-334-6912
Email: apsportal@dhw.idaho.gov
http://healthandwelfare.idaho.gov

ILLINOIS

Illinois Department of Healthcare and Family Services

201 S Grand Avenue E
Springfield, IL 62762

1-800-226-0768, TTY/TDD: 711
Email: hfswebmaster@illinois.gov
http://www2.illinois.gov/hfs/Pages/default.aspx

INDIANA

Family and Social Services Administration

402 W Washington Street, Room E 414
Indianapolis, IN 46204

1-800-446-1993, TTY/TDD: 711
Fax:1-317-234-2244
http://member.indianamedicaid.com/

IOWA

Iowa Department of Human Services

Hoover State Office Building, 5th Floor
Des Moines, IA 50319

1-800-338-8366, TTY/TDD: 711
Fax:1-515-281-4597
Email: contactdhs@dhs.state.ia.us
www.dhs.state.ia.us

SECTION 3 State Medicaid Offices (con't)

KANSAS

KanCare

900 SW Jackson, Suite 900 N
Topeka, KS 66612-1220

1-866-305-5147, TTY/TDD: 1-800-766-3777

www.kancare.ks.gov/index.htm

KENTUCKY

Kentucky Cabinet for Health and Family Services

275 E Main Street
Frankfort, KY 40621

1-800-635-2570, TTY/TDD: 1-800-627-4702

www.chfs.ky.gov

LOUISIANA

Louisiana Department of Health & Hospitals

P.O. Box 91278
Baton Rouge, LA 70821-9278

1-888-342-6207, TTY/TDD: 1-800-220-5404
Fax:1-877-523-2987
Email: bayouhealth@la.gov

new.dhh.louisiana.gov/index.cfm/subhome/1

MAINE

MaineCare Services

11 State House Station
Augusta, ME 04333

1-800-977-6740, TTY/TDD: 1-800-606-0215

www.maine.gov/dhhs/oms/index.shtml

MARYLAND

Department of Health and Mental Hygiene

201 W Preston Street
Baltimore, MD 21201-2301

1-800-492-5231, TTY/TDD: 711
Fax:1-410-767-6489
Email: dhrhelp@dhr.state.md.us

https://mmcp.dhmh.maryland.gov/SitePages/Home.aspx

MASSACHUSETTS

Office of Health and Human Services (EOHHS)

One Ashburton Place, 11th Floor
Boston, MA 02108

1-800-841-2900, TTY/TDD: 711
Email: mainquiries@unisys.com

www.mass.gov/eohhs/gov/departments/masshealth/

MICHIGAN

Michigan Department of Community Health

Capital View Building
201 Townsend St
Lansing, MI 48913

1-800-642-3195, TTY/TDD: 711

www.michigan.gov/mdch

MINNESOTA

Minnesota Department of Human Services

P.O. Box 64838
St. Paul, MN 55164

1-800-657-3739, TTY/TDD: 711
Fax:1-651-282-5100

www.dhs.state.mn.us

SECTION 3 State Medicaid Offices (con't)

MISSISSIPPI

Mississippi Division of Medicaid

550 High Street, Suite 1000
Sillers Building
Jackson, MS 39201-1399

1-800-421-2408, TTY/TDD: 711
Fax:1-601-359-6048
www.medicaid.ms.gov

MISSOURI

Missouri Department of Social Services

P.O. Box 6500, 615 Howerton Ct
Jefferson City, MO 65102

1-800-392-2161, TTY/TDD: 1-800-735-2966
www.dss.mo.gov/fsd/index.htm

MONTANA

Montana Department of Public Health & Human Services

1400 Broadway, Cogswell Building
P.O. Box 202951
Helena, MT 59620

1-800-362-8312, TTY/TDD: 711
Fax:1-406-444-1861
Email: dphhstech@state.mt.us
www.dphhs.mt.gov

NEBRASKA

Nebraska Department of Health & Human Services

P.O. Box 95026
Lincoln, NE 68509-5026

1-800-430-3244, TTY/TDD: 711
Fax:1-402-471-9092
www.dhhs.ne.gov/medicaid/Pages/medicaid.aspx

NEVADA

Nevada Deparment of Health and Human Services

1100 East William Street, Suite 101
Carson City, NV 89701

1-775-684-3600, TTY/TDD: 711
http://dhcfp.state.nv.us

NEW HAMPSHIRE

New Hampshire Department of Health and Human Services

129 Pleasant Street
Concord, NH 03301-3857

1-800-852-3345, TTY/TDD: 1-800-735-2964
www.dhhs.state.nh.us

NEW JERSEY

State of New Jersey Department of Human Services

P.O. Box 712, Quakerbridge Plaza, Building 7
Trenton, NJ 08625-0712

1-800-356-1561, TTY/TDD: 711
Fax:1-609-588-2557
Email: mahs.response@dhs.state.nj.us
www.state.nj.us/humanservices/dmahs

NEW MEXICO

New Mexico Human Services Department

P.O. Box 2348
Sante Fe, NM 87504-2348

1-888-997-2583, TTY/TDD: 711
Fax:1-505-827-3185
www.state.nm.us/hsd/mad/Index.html

SECTION 3 State Medicaid Offices (con't)

NEW YORK

New York State Department of Health

Corning Tower, Empire State Plaza
Albany, NY 12237

1-800-541-2831, TTY/TDD: 711
Email: medicaid@health.state.ny.us
www.health.state.ny.us

NORTH CAROLINA

North Carolina Department of Health and Human Services

Division of Medical Assistance
2501 Mail Service Center
Raleigh, NC 27699-2012

1-800-662-7030, TTY/TDD: 711
www.dhhs.state.nc.us/dma/mqb.html

NORTH DAKOTA

North Dakota Department of Human Services

600 E Boulevard Avenue, Dept. 325
Bismarck, ND 58505-0250

1-800-755-2604, TTY/TDD: 711
Fax:1-701-328-1544
Email: sogaph@state.nd.us
www.nd.gov/dhs/services/medicalserv/medicaid/

OHIO

Ohio Department of Job and Family Services

P.O. Box 182709
Columbus, OH 43218-2709

1-800-324-8680, TTY/TDD: 1-800-292-3572
jfs.ohio.gov/ohp/

OKLAHOMA

The Oklahoma State Department of Health

2401 NW 23rd Street, Suite 1A
Oklahoma City, OK 73107

1-800-522-0310, TTY/TDD: 711
Fax:1-405-522-7100
www.okhca.org

OREGON

Oregon Department of Human Services

500 Summer Street NE
Salem, OR 97301-1079

1-800-359-9517, TTY/TDD: 711
www.oregon.gov/dhs/index.shtml

PENNSYLVANIA

Pennsylvania Department of Public Welfare

Health and Welfare Building, Room 515
P.O. Box 2675
Harrisburg, PA 17105

1-800-692-7462, TTY/TDD: 711
https://www.compass.state.pa.us/compass.web/CMHOM.aspx

RHODE ISLAND

Rhode Island Department of Human Services

Louis Pasteur Building
600 New London Avenue
Cranston, RI 02920

1-401-462-5300, TTY/TDD: 711
www.dhs.ri.gov/

SECTION 3 State Medicaid Offices (con't)

SOUTH CAROLINA

South Carolina Department of Health and Human Services

P.O. Box 8206
Columbia, SC 29202

1-888-549-0820, TTY/TDD: 711
Email: info@dhhs.state.sc.us
https://www.scdhhs.gov/

SOUTH DAKOTA

South Dakota Department of Social Services

700 Governors Drive,
Richard F Kneip Building
Pierre, SD 57501

1-800-597-1603, TTY/TDD: 711
Email: medical@state.sd.us
www.state.sd.us/social/medical

TENNESSEE

TennCare

310 Great Circle Road
Nashville, TN 37243

1-866-311-4287, TTY/TDD: 711
http://state.tn.us/tenncare

TEXAS

Texas Health and Human Services Commission

4900 N Lamar Boulevard, 4th Floor
Austin, TX 78751-2316

1-877-541-7905, TTY/TDD: 711
Email: medicaid@hhsc.state.tx.us
www.hhsc.state.tx.us

UTAH

Utah Department of Health

P.O. Box 143106
Salt Lake City, UT 84114

1-801-538-6155, TTY/TDD: 711
Fax:1-801-538-6805
www.health.utah.gov/medicaid

VERMONT

Office of Vermont Health Access-Agency of Human Services

103 S Main Street
Waterbury, VT 05676

1-800-250-8427, TTY/TDD: 711
Fax:1-802-241-1244
http://www.greenmountaincare.org/vermont-health-insurance-plans/medicaid

VIRGINIA

DMAS-Department of Medical Assistance Services

600 E Broad Street, Suite 1300
Richmond, VA 23219

1-804-786-7933, TTY/TDD: 1-800-343-0634
Email: dmas-info@dmas.virginia.gov
http://dmasva.dmas.virginia.gov/

WASHINGTON

Washington State Department of Social and Health Services

P.O. Box 45505
Olympia, WA 98504-5502

1-800-562-3022, TTY/TDD: 711
www.adsa.dshs.wa.gov/pubinfo/benefits/medicaid.htm

SECTION 3 State Medicaid Offices (con't)

WEST VIRGINIA

West Virginia Department of Health & Human Resources

350 Capital Street, Room 251
Office of Administration
Charleston, WV 25301-3709

1-888-483-0797, TTY/TDD: 711
Email: medman@wvdhhr.org
www.dhhr.wv.gov/bms/Pages/default.aspx

WISCONSIN

Department of Health Services

1 W Wilson Street
Madison, WI 53702

1-800-362-3002, TTY/TDD: 711
Fax:1-608-221-8815
Email: dhswebmaildhcf@wisconsin.gov
www.dhfs.state.wi.us/medicaid/index.htm

WYOMING

Wyoming Department of Health

6101 Yellowstone Road, Suite 201
Cheyenne, WY 82002

1-800-251-1269, TTY/TDD: 1-307-777-5648
Fax:1-307-777-7439
health.wyo.gov

SECTION 4 State Medicare Offices

Medicare

1-800-MEDICARE

(1-800-633-4227)

TTY/TDD: 1-877-486-2048

Seven days a week, 24 hours a day

www.medicare.gov

CALIFORNIA

San Francisco Regional Office
90 - 7th Street, Suite 5-300
San Francisco, CA 94103-6706

COLORADO

Denver Regional Office
1600 Broadway, Suite 700
Denver, CO 80202-4367

GEORGIA

Atlanta Regional Office
61 Forsyth Street, SW, Suite 4T20
Atlanta, GA 30303-8909

ILLINOIS

Chicago Regional Office
233 North Michigan Avenue, Suite 600
Chicago, IL 60601

MASSACHUSETTS

Boston Regional Office
JFK Federal Building, Suite 2325
Boston, MA 02203-0003

MISSOURI

Kansas City Regional Office
601 E. 12th Street, Suite 235
Kansas City, MO 64106

NEW YORK

New York Regional Office
26 Federal Plaza, Room 3811
New York, NY 10278-0063

PENNSYLVANIA

Philadelphia Regional Office
150 S. Independence Mall West
Suite 216
Philadelphia, PA 19106

TEXAS

Dallas Regional Office
1301 Young Street, Room 714
Dallas, TX 75202

WASHINGTON

Seattle Regional Office
2201 6th Avenue, MS/Rx-44
Seattle, WA 98121

SECTION 5 State Pharmacy Assistance Program (SPAP)

ALABAMA

SeniorRx/Wellness

Alabama Department of Senior Services
770 Washington Avenue
RSA Plaza, Suite 570
Montgomery, AL 36130

1-800-AGE-LINE
TTY/TDD: 711
Email: ageline@adss.alabama.gov
www.alabamaageline.gov/seniorx.cfm

COLORADO

Bridging The Gap, Colorado

4300 Cherry Creek Drive South
DCEED-STD-A3
Denver, CO 80246-1530

1-303-692-2700
TTY/TDD: 711
www.chd.dphe.state.co.us/Resources/cms/dc/HIVandSTD/RyanWhite/medicared.html

CONNECTICUT

ConnPace

P.O. Box 5011
Hartford, CT 06102-5011

1-800-423-5026, 1-860-269-2029
TTY/TDD: 711
www.connpace.com/

DELAWARE

Delaware Prescription Assistance Program

P.O. Box 950
New Castle, DE 19720

1-800-996-9969
TTY/TDD: 711
www.dhss.delaware.gov/dhss/dmma/dpap.html

DISTRICT OF COLUMBIA

DC AIDS Drug Assistance Program

889 North Capitol Street NE
Washington, DC 20002

1-202-442-5955
TTY/TDD: 711
Email: doh@dc.gov
http://doh.dc.gov/service/dc-aids-drug-assistance-program

IDAHO

Idaho HIV State Prescription Assistance Program (IDAGAP)

P. O. Box 83720
Boise, ID 83720

1-800-926-2588
TTY/TDD: 711
http://healthandwelfare.idaho.gov/Health/FamilyPlanningSTDHIV/HIVCareandTreatment/tabid/391/Default.aspx

SECTION 5 State Pharmacy Assistance Program (SPAP) (con't)

INDIANA

HoosiersRX

P.O. Box 6224
Indianapolis, IN 46206

1-866-267-4679
TTY/TDD: 711
www.in.gov/fssa/elderly/hoosierrx/

MAINE

Maine Low Cost Drugs for the Elderly or Disabled Program

#11 State House Station
442 Civic Center Drive
Augusta, ME 04333

1-866-796-2463
TTY/TDD: 711
www.maine.gov/dhhs/beas/resource/lc_drugs.htm

MARYLAND

Maryland Senior Prescription Drug Assistance Program SPDAP

c/o Pool Administrators
628 Hebron Ave, Suite 212
Glastonbury, CT 06033

1-800-551-5995
TTY/TDD: 1-800-877-5156
Fax: 1-800-847-8217
www.marylandspdap.com

MASSACHUSETTS

Massachusetts Prescription Advantage

P.O. Box 15153
Worcester, MA 01615

1-800-243-4636
TTY/TDD: 1-877-610-0241
www.mass.gov/elders/healthcare/prescription-advantage/

MISSOURI

Missouri Rx Plan

P.O. Box 6500
205 Jefferson Street, 14th Floor
Jefferson City, MO 65102

1-800-375-1406
TTY/TDD: 711
Fax: 1-573-751-6564
Email: clinical.services@dss.mo.gov
www.morx.mo.gov

MONTANA

Montana Big Sky Rx Program

P.O. Box 202915
Helena, MT 59620-2915

1-866-369-1233
TTY/TDD: 711
Fax: 1-406-444-3846
Email: Bigskyrx@mt.gov
www.dphhs.mt.gov/prescriptiondrug/bigsky.shtml

SECTION 5 State Pharmacy Assistance Program (SPAP) (con't)

NEVADA

Senior Rx and Disability Rx

Aging and Disability Services Division
3416 Goni Road, Suite B-113
Carson City, NV 89706

1-866-303-6323
TTY/TDD: 711
Fax: 1-775-687-3499
http://dhhs.nv.gov/SeniorRx.htm

NEW JERSEY

New Jersey Pharmaceutical Assistance to the Aged and Disabled Program (PAAD)

PAAD-HAAAD
P.O. Box 715
Trenton, NJ 08625-0715

1-800-792-9745
TTY/TDD: 711
http://www.state.nj.us/humanservices/doas/home/pbp.html

New Jersey Senior Gold Prescription Discount Program

P.O. Box 715
Trenton, NJ 08625

1-800-792-9745
TTY/TDD: 711
http://www.state.nj.us/humanservices/doas/services/seniorgold/index.html

NEW YORK

New York State Elderly Pharmaceutical Insurance Coverage (EPIC)

P.O. Box 15018
Albany, NY 12212

1-800-332-3742
TTY/TDD: 1-800-290-9138
Email: epic@health.state.ny.us
www.health.ny.gov/health_care/epic/

NORTH CAROLINA

North Carolina Department of Health and Human Services - AIDS Drug Assistant Program (ADAP)

2001 Mail Service Center
Raleigh, NC 27699-2001

1-877-466-2232
TTY/TDD: 711
http://epi.publichealth.nc.gov/cd/hiv/adap.html

PENNSYLVANIA

Pennsylvania Department of Aging Bureau of Pharmaceutical Assistance

1st Health Services
555 Walnut Street
Harrisburg, PA 17101

1-800-225-7223
TTY/TDD: 711
Fax: 1-717-651-3608
Email: aging@state.pa.us
www.aging.state.pa.us/portal/server.pt/community/pace_and_affordable_medications/17942

SECTION 5 State Pharmacy Assistance Program (SPAP) (con't)

RHODE ISLAND

Rhode Island Department of Elderly Affairs (RIPAE)

74 West Road, Hazard Building
Second Floor
Cranston, RI 02920

1-401-462-3000

TTY/TDD: 1-401-462-0740

www.dea.state.ri.us/RIPAE/index.php

VERMONT

Vermont V Pharm

312 Hurricane Lane, Suite 201
Willston, VT 05495

1-800-250-8427

TTY/TDD: 1-888-834-7898

www.greenmountaincare.org/vermont-health-insurance-plans/prescription-assistance

VIRGINIA

Virginia AIDS Drug Assistance Program

P.O. Box 5930
Midlothian, VA 23112

1-800-366-7741

TTY/TDD: 711

www.vdh.virginia.gov/epidemiology/DiseasePrevention/Programs/ADAP/index.htm

WISCONSIN

SeniorCare

P.O. Box 6710
Madison, WI 53716

1-800-657-2038

TTY/TDD: 711

www.dhfs.state.wi.us/seniorcare/index.htm

SECTION 6 Civil Rights Commission Contact Information

REGION I
Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island, and Vermont

Office for Civil Rights

JFK Federal Building, Room 1875
Boston, MA 02203

1-800-368-1019, 1-617-565-3809
TTY/TDD: 1-800-537-7697
www.hhs.gov/ocr

REGION II
New Jersey, New York, Puerto Rico, and Virgin Islands

Office for Civil Rights

26 Federal Plaza, Suite 3312
New York, NY 10278

1-800-368-1019, 1-212-264-3039
TTY/TDD: 1-800-537-7697
www.hhs.gov/ocr

REGION III
Delaware, District of Columbia, Maryland, Pennsylvania, Virginia, and West Virginia

Office for Civil Rights

Public Ledger Building
150 S Independence Mall W
Suite 372
Philadelphia, PA 19106

1-800-368-1019, 1-215-861-4431
TTY/TDD: 1-800-537-7697
www.hhs.gov/ocr

REGION IV
Alabama, Florida, Georgia, Kentucky, Mississippi, North Carolina, South Carolina, and Tennessee

Office for Civil Rights

61 Forsyth Street, Suite 16T70
Atlanta, GA 30303

1-800-368-1019, 1-404-562-7881
TTY/TDD: 1-800-537-7697
www.hhs.gov/ocr

REGION V
Illinois, Indiana, Michigan, Minnesota, Ohio, and Wisconsin

Office for Civil Rights

233 N Michigan Ave, Suite 240
Chicago, IL 60601

1-800-368-1019, 1-312-886-1807
TTY/TDD: 1-800-537-7697
www.hhs.gov/ocr

REGION VI
Arkansas, Louisiana, New Mexico, Oklahoma, and Texas

Office for Civil Rights

1301 Young Street, Suite 1169
Dallas, TX 75202

1-800-368-1019, 1-214-767-0432
TTY/TDD: 1-800-537-7697
www.hhs.gov/ocr/

SECTION 6 Civil Rights Commission Contact Information (con't)

REGION VII
Iowa, Kansas, Missouri, and Nebraska

Office for Civil Rights

601 E 12th Street, Room 353
Kansas, MO 64106

1-800-368-1019, 1-816-426-3686
TTY/TDD: 1-800-537-7697
www.hhs.gov/ocr

REGION VIII
Colorado, Montana, North Dakota, South Dakota, Utah, and Wyoming

Office for Civil Rights

999 18th Street, Suite 417
Denver, CO 80202

1-800-368-1019, 1-303-844-2025
TTY/TDD: 1-800-537-7697
www.hhs.gov/ocr

REGION IX
American Samoa, Arizona, California, Guam, Hawaii, and Nevada

Office for Civil Rights

90 7th Street, Suite 4-100
San Francisco, CA 94103

1-800-368-1019, 1-415-437-8329
TTY/TDD: 1-800-537-7697
www.hhs.gov/ocr

REGION X
Alaska, Idaho, Oregon, and Washington

Office for Civil Rights

2201 6th Avenue, M/S Rx 11
Seattle, WA 98121

1-800-368-1019, 1-206-615-2297
TTY/TDD: 1-800-537-7697
www.hhs.gov/ocr

BlueCross BlueShield of Georgia

SHBP State Health Benefit Plan

P.O. Box 110
Fond du Lac, WI 54936

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