



# Evidence of Coverage

January 1, 2012 - December 31, 2012

Physicians Health Choice Select (HMO SNP)

H4527-006

**January 1 – December 31, 2012**

## **Evidence of Coverage:**

### **Your Medicare Health Benefits and Services and Prescription Drug Coverage as a Member of our Plan**

This booklet gives you the details about your Medicare health care and prescription drug coverage from January 1 – December 31, 2012. It explains how to get the health care and prescription drugs you need covered. This is an important legal document. Please keep it in a safe place.

This plan, Physicians Health Choice Select (HMO SNP), is offered by PHYSICIANS HEALTH CHOICE OF TEXAS LLC. (When this **Evidence of Coverage** says “we,” “us,” or “our,” it means PHYSICIANS HEALTH CHOICE OF TEXAS LLC. When it says “plan” or “our Plan,” it means Physicians Health Choice Select (HMO SNP).)

UnitedHealthcare® Medicare Advantage plans are insured through UnitedHealthcare Insurance Company and its affiliated companies, a Coordinated Care plan with a Medicare Advantage contract and a contract with the state Medicaid program.

This information is available for free in other languages. Please contact our Customer Service number at toll-free 1-866-550-4736 for additional information. (TTY/TDD users should call 711) Hours are 10/15-3/1: 8:00 am to 8:00 pm Local Time Zone, 7 Days a Week; 3/2-10/14: 8:00 am to 8:00 pm Local Time Zone, Monday - Friday. Customer Service also has free language interpreter services available for non-English speakers.

Esta información está disponible sin costo en otros idiomas. Comuníquese con nuestro Servicio al Cliente al gratuito 1-866-550-4736 para obtener información adicional. (los usuarios de TTY /TDD deben llamar al 711). El horario es del 15/10 al 1/3 de 8:00 a.m. a 8:00 p.m. Huso Horario los 7 días de la semana y del 2/3 al 14/10 de 8:00 a.m. a 8:00 p.m. Huso Horario de lunes a viernes. El Servicio al Cliente también tiene servicios gratuitos de intérpretes de idiomas disponibles para personas que no hablan inglés.

Benefits, formulary, pharmacy network, premium, and/or copayments/coinsurance may change on January 1, 2013.

2012 Evidence of Coverage

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**SECTION 1      Introduction**

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<b>Section 1.1</b>	<b>You are enrolled in Physicians Health Choice Select (HMO SNP), which is a specialized Medicare Advantage Plan (Special Needs Plan)</b>
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You are covered by both Medicare and Medicaid:

- **Medicare** is the Federal health insurance program for people 65 years of age or older, some people under age 65 with certain disabilities, and people with end-stage renal disease (kidney failure).
- **Medicaid** is a joint Federal and state government program that helps with medical costs for certain people with limited incomes and resources. Medicaid coverage varies depending on the state and the type of Medicaid you have. Some people with Medicaid get help paying for their Medicare premiums and other costs. Other people also get coverage for additional services and drugs that are not covered by Medicare.

You have chosen to get your Medicare health care and your prescription drug coverage through our Plan, **Physicians Health Choice Select (HMO SNP)**.

There are different types of Medicare health plans. **Physicians Health Choice Select (HMO SNP)** is a specialized Medicare Advantage plan (a Medicare “Special Needs Plan”), which means its benefits are designed for people with special health care needs. **Physicians Health Choice Select (HMO SNP)** is designed specifically for people who have Medicare and who are also entitled to assistance from Medicaid.

Because you get assistance from Medicaid, you will pay less for some of your Medicare health care services. Medicaid may also provide other benefits to you by covering health care services and prescription drugs that are not usually covered under Medicare. You will also receive Extra Help from Medicare to pay for the costs of your Medicare prescription drugs. **Physicians Health Choice Select (HMO SNP)** will help manage all of these benefits for you, so that you get the health care services and payment assistance that you are entitled to.

**Physicians Health Choice Select (HMO SNP)** is run by a private company. Like all Medicare Advantage plans, this Medicare Special Needs Plan is approved by Medicare. We are pleased to be providing your Medicare health care coverage, including your prescription drug coverage.

<b>Section 1.2</b>	<b>What is the Evidence of Coverage booklet about?</b>
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This **Evidence of Coverage** booklet tells you how to get your Medicare medical care and prescription drugs covered through our Plan. This booklet explains your rights and responsibilities, what is covered, and what you pay as a member of the plan.

This plan, **Physicians Health Choice Select (HMO SNP)**, is offered by PHYSICIANS HEALTH CHOICE OF TEXAS LLC. (When this **Evidence of Coverage** says “we,” “us,” or “our,” it means PHYSICIANS HEALTH CHOICE OF TEXAS LLC. When it says “plan” or “our Plan,” it means **Physicians Health Choice Select (HMO SNP)**.)

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

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<b>Section 1.3</b>	<b>What does this Chapter tell you?</b>
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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?

<b>Section 1.4</b>	<b>What if you are new to the plan?</b>
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If you are a new member, then it’s important for you to learn how the plan operates – what the rules are and what services are available to you. We encourage you to set aside some time to look through this **Evidence of Coverage** booklet.

**If you are confused or concerned or just have a question, please contact our Plan’s Customer Service (contact information is on the back cover of this booklet).**

<b>Section 1.5</b>	<b>Legal information about the Evidence of Coverage</b>
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**It’s part of our contract with you**

This **Evidence of Coverage** is part of our contract with you about how the plan covers your care. Other parts of this contract include your enrollment form, 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 contract is in effect for months in which you are enrolled in the plan between January 1, 2012 and December 31, 2012.

**Medicare must approve our 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 our Plan only as long as we choose to continue to offer the plan for the year in question and the Centers for Medicare & Medicaid Services renews its approval of the plan.

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<b>SECTION 2</b>	<b>What makes you eligible to be a plan member?</b>
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<b>Section 2.1</b>	<b>Your eligibility requirements</b>
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**You are eligible for membership in our Plan as long as:**

- You live in our geographic service area (section 2.4 below describes our service area)

- -- **and** -- you are entitled to Medicare Part A
- -- **and** -- you are enrolled in Medicare Part B
- -- **and** -- you do not have End-Stage Renal Disease (ESRD), 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.
- -- **and** -- you meet the special eligibility requirements described below.

### Special eligibility requirements for our Plan

- Our Plan is designed to meet the needs of people who receive certain Medicaid benefits. (Medicaid is a joint Federal and state government program that helps with medical costs for certain people with limited incomes and resources.) To be eligible for our Plan you must be eligible for Medicare cost-sharing assistance under Medicaid.

<b>Section 2.2</b>	<b>What are Medicare Part A and Medicare Part B?</b>
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When you originally signed up for Medicare, you received information about how to get Medicare Part A and Medicare Part B. Remember:

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

<b>Section 2.3</b>	<b>What is Medicaid?</b>
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Medicaid is a joint Federal and state government program that helps with medical costs for certain people who have limited incomes and resources. Each state decides what counts as income and resources, who is eligible, what services are covered, and the cost for services. States also can decide how to run their program as long as they follow the Federal guidelines.

In addition, there are programs offered through Medicaid that help people with Medicare pay their Medicare costs, such as their Medicare premiums. These 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).

<b>Section 2.4</b>	<b>Here is the plan service area for Physicians Health Choice Select (HMO SNP)</b>
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Although Medicare is a Federal program, our Plan is available only to individuals who live in our Plan service area. To remain a member of our Plan, you must keep living in this service area. The service area is described below.



Our service area includes these counties in Texas: El Paso.

If you plan to move out of the service area, please contact Customer Service. When you move, you will have a Special Enrollment Period that will allow you to switch to Original Medicare or enroll in a Medicare health or drug plan that is available in your new location.

**SECTION 3      What other materials will you get from us?**

**Section 3.1      Your Plan member ID card – Use it to get all covered care and prescription drugs**

While you are a member of our Plan, you must use your member ID card for our Plan whenever you get any services covered by this plan and for prescription drugs you get at network pharmacies. **IMPORTANT** - If you have Medicare and Texas Medicaid Health and Human Services Commission (Medicaid), make sure to show your member ID card and your Texas Medicaid Health and Human Services Commission (Medicaid) identification card whenever you access services. This will help your provider bill correctly. Here's a sample member ID card to show you what yours will look like:

	<b>Physicians Health Choice™</b>	<b>2012 Total HMO</b>
Issuer: 80840		<b>Co-pays</b>
<b>ID #: 123456-01</b>		PCP: \$ 5
<b>Name: Jane Doe</b>		Specialist: \$ 10
PCP: Jones, Frank MD		ER: \$100
PCP Phone: 555 987 6543		Urgent Care: \$ 25
RxBIN: 610097		
RxPCN: 9999		
RxGrp: PHC		
		
	Prescription Drug Coverage	
	Contract: H4527-014	

<b>Customer Service: 1-866-550-4736 (TTY/TDD: 711)</b>	
Monday - Friday, 8am - 8pm	
www.PHCcares.com	
You are responsible for the cost of unauthorized, out-of-network charges. In the event of an emergency, go to the nearest emergency room or call 911 and notify your PCP within 24 hours. You have worldwide emergency coverage.	
Hospital Admission Notification: 1-877-299-7213	
Submit claims to:	Submit pharmacy claims to:
Physicians Health Choice	Prescription Solutions
Attn: Claims	P.O. Box 29045
P.O. Box 29429	Hot Springs, AR 71903
San Antonio, TX 78229	Help Desk: 1-877-889-6481
THIS CARD IS NOT A GUARANTEE OF ELIGIBILITY	

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

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

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

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

Every year that you are a member of our Plan, we will send you either a new **Provider Directory** or an update to your **Provider Directory**. This directory lists our network providers. This directory may also identify which providers participate in Texas Medicaid Health and Human Services Commission (Medicaid). You may see any provider in the directory for plan covered services, even if they do not participate in Texas Medicaid Health and Human Services Commission (Medicaid). Please contact your Texas Medicaid Health and Human Services Commission (Medicaid) for more information on participating Texas Medicaid Health and Human Services Commission (Medicaid) providers.

### What are “network providers”?

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

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

It is important to know which providers are part of our network because, with limited exceptions, while you are a member of our Plan you must use network providers to get your medical care and services. The only exceptions are emergencies, urgently needed care when the network is not available (generally, when you are out of the area), out-of-area dialysis services, and cases in which our Plan authorizes use of out-of-network providers. See Chapter 3 (**Using the plan’s coverage for your medical services**) for more specific information about emergency, out-of-network, and out-of-area coverage.

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

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

Every year that you are a member of our Plan, we will send you either a new Pharmacy Directory or an update to your Pharmacy Directory. This directory lists our network pharmacies.

### What are “network pharmacies”?

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

### Why do you need to know about network pharmacies?

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

If you don’t have the **Pharmacy Directory**, you can get a copy from Customer Service (phone numbers are on the back 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 at [www.PHCcares.com](http://www.PHCcares.com).

### **Section 3.4      The plan’s List of Covered Drugs (Formulary)**

The plan has a **List of Covered Drugs (Formulary)**. We call it the “Drug List” for short. It tells which Part D prescription drugs are covered by our Plan. 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.

In addition to the drugs covered by Part D, some prescription drugs are covered for you under your Medicaid benefits. The Drug List tells you how to find out which drugs are covered under Medicaid.

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. The Drug List we send to you includes information for the covered drugs that are most commonly used by our members. However, we cover additional drugs that are not included in the printed Drug List. If one of your drugs is not listed in the Drug List, you should visit our website or contact Customer Service to find out if we cover it. To get the most complete and current information about which drugs are covered, you can visit the plan's website ([www.PHCcares.com](http://www.PHCcares.com)) or call Customer Service (phone numbers are on the back cover of this booklet).

<b>Section 3.5</b>	<b>The Explanation of Benefits (the "EOB"): Reports with a summary of payments made for your Part D prescription drugs</b>
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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 we have 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.

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**SECTION 4      Your monthly plan premium for the plan**

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<b>Section 4.1</b>	<b>How much is your Plan premium?</b>
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As a member of our Plan, you pay a monthly plan premium unless you qualify for Extra Help with your prescription drug costs. You do not pay a monthly Plan premium (prescription drug plan premium) if you qualify for Extra Help. People with Medicare and Medicaid automatically qualify for Extra Help. For 2012, the monthly premium for our Plan is \$15.50.

**Some members are required to pay other Medicare premiums**

As explained in Section 2 above, in order to be eligible for our Plan, you must maintain your eligibility for Texas Medicaid Health and Human Services Commission (Medicaid) as well as be entitled to Medicare Part A and enrolled in Medicare Part B. For most **Physicians Health Choice Select (HMO SNP)** members, Texas Medicaid Health and Human Services Commission (Medicaid) pays for your Part A premium (if you don't qualify for it automatically) and for your Part B premium. If you receive benefits from Texas Medicaid Health and Human Services Commission (Medicaid), you may not be required to pay any Medicare premiums. If you are not eligible for benefits from Texas Medicaid

Health and Human Services Commission (Medicaid), you may be required to pay Part A and Part B premiums. If Medicaid is not paying your Medicare premiums for you, you must continue to pay your Medicare premiums to remain a member of the plan.

- Your copy of **Medicare & You 2012** gives information about these premiums in the section called “2012 Medicare Costs.” This explains how the Part B premium differs for people with different incomes.
- Everyone with Medicare receives a copy of **Medicare & You** each year in the fall. Those new to Medicare receive it within a month after first signing up. You can also download a copy of **Medicare & You 2012** 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?**

**No.** We are not allowed to change the amount we charge for the plan’s monthly plan premium during the year. If the monthly plan premium changes for next year we will tell you in September and the change will take effect on January 1.

### **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 including your Primary Care Provider.

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

#### **Let us know about these changes:**

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

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

Medicare requires that we collect information from you about any other medical or drug insurance coverage that you have. That's because we must coordinate any other coverage you have with your benefits under our Plan. (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 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 on the back cover of this booklet).

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## **SECTION 6      We protect the privacy of your personal health information**

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<b>Section 6.1      We make sure that your health information is protected</b>
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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.

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## **SECTION 7      How other insurance works with our Plan**

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<b>Section 7.1      Which plan pays first when you have other insurance?</b>
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When you have other insurance (like employer group health coverage), there are rules set by Medicare that decide whether our Plan or your other insurance pays first. 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.

These rules apply for employer or union group health plan coverage:

- If you have retiree coverage, Medicare pays first.
- If your group 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 employer, 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 employer has 100 or more employees or at least one employer in a multiple employer 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 employer has 20 or more employees or at least one employer in a multiple employer plan has more than 20 employees.
- If you have Medicare because of ESRD, your group 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

Texas Medicaid Health and Human Services Commission (Medicaid) and TRICARE never pay first for Medicare-covered services. They only pay after Medicare, employer group 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 on the back 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.

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**SECTION 1      Physicians Health Choice Select (HMO SNP) Contacts**  
(how to contact us, including how to reach Customer Service at the plan)

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**How to contact our Plan's Customer Service**

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

<b>Customer Service</b>	
<b>CALL</b>	1-866-550-4736  Calls to this number are free.  Hours of Operation: 10/15-3/1: 8:00 am to 8:00 pm Local Time Zone, 7 Days a Week; 3/2-10/14: 8:00 am to 8:00 pm Local Time Zone, Monday - Friday  Customer Service also has free language interpreter services available for non-English speakers.
<b>TTY/TDD</b>	711  This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.  Calls to this number are free.  Hours of Operation: 10/15-3/1: 8:00 am to 8:00 pm Local Time Zone, 7 Days a Week; 3/2-10/14: 8:00 am to 8:00 pm Local Time Zone, Monday - Friday
<b>WRITE</b>	PHYSICIANS HEALTH CHOICE OF TEXAS LLC Attn: Customer Service Customer Service Department PO Box 690670 San Antonio, TX 78269-0670
<b>WEBSITE</b>	<a href="http://www.PHCcares.com">www.PHCcares.com</a>

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

A coverage decision is a decision we make about your benefits and coverage or about the amount we

will pay for your medical services. For more information on asking for coverage decisions about your medical care, 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 process.

<b>Coverage Decisions for Medical Care</b>	
<b>CALL</b>	1-866-550-4736  Calls to this number are free.  Hours of Operation: 10/15-3/1: 8:00 am to 8:00 pm Local Time Zone, 7 Days a Week; 3/2-10/14: 8:00 am to 8:00 pm Local Time Zone, Monday - Friday
<b>TTY/TDD</b>	711  This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.  Calls to this number are free.  Hours of Operation: 10/15-3/1: 8:00 am to 8:00 pm Local Time Zone, 7 Days a Week; 3/2-10/14: 8:00 am to 8:00 pm Local Time Zone, Monday - Friday
<b>FAX</b>	1-866-331-4362
<b>WRITE</b>	PHYSICIANS HEALTH CHOICE OF TEXAS LLC Attn: Organization Determinations PO Box 690670 San Antonio, TX 78269-0670
<b>WEBSITE</b>	<a href="http://www.PHCcares.com">www.PHCcares.com</a>

### **How to contact us when you are making an appeal about your medical care**

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

### How to contact us when you are making a complaint about your medical care

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

<b>Appeals and Complaints for Medical Care</b>	
<b>CALL</b>	<p>1-866-550-4736</p> <p>Calls to this number are free.</p> <p>Hours of Operation: 10/15-3/1: 8:00 am to 8:00 pm Local Time Zone, 7 Days a Week; 3/2-10/14: 8:00 am to 8:00 pm Local Time Zone, Monday - Friday</p> <p>For fast/expedited appeals and complaints for medical care: 1-866-974-5188</p> <p>Hours of Operation: 8:00 am to 5:00 pm CST, Monday - Friday</p>
<b>TTY/TDD</b>	<p>711</p> <p>This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.</p> <p>Calls to this number are free.</p> <p>Hours of Operation: 10/15-3/1: 8:00 am to 8:00 pm Local Time Zone, 7 Days a Week; 3/2-10/14: 8:00 am to 8:00 pm Local Time Zone, Monday - Friday</p>
<b>FAX</b>	<p>For fast/expedited appeals and complaints only: 1-877-757-8889</p>
<b>WRITE</b>	<p>PHYSICIANS HEALTH CHOICE OF TEXAS LLC Attn: Appeals Department 5800 Northwest Parkway #125 San Antonio, TX 78249</p>

<b>Appeals and Complaints for Medical Care</b>	
<b>WEBSITE</b>	www.PHCcares.com

**How to contact us when you are asking for a coverage decision about your 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 Part D prescription drugs. For more information on asking for coverage decisions about your Part D prescription drugs, see Chapter 9 (**What to do if you have a problem or complaint (coverage decisions, appeals, complaints)**).

<b>Coverage Decisions for Part D Prescription Drugs</b>	
<b>CALL</b>	1-866-550-4736  Calls to this number are free.  Hours of Operation: 10/15-3/1: 8:00 am to 8:00 pm Local Time Zone, 7 Days a Week; 3/2-10/14: 8:00 am to 8:00 pm Local Time Zone, Monday - Friday
<b>TTY/TDD</b>	711  This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.  Calls to this number are free.  Hours of Operation: 10/15-3/1: 8:00 am to 8:00 pm Local Time Zone, 7 Days a Week; 3/2-10/14: 8:00 am to 8:00 pm Local Time Zone, Monday - Friday
<b>FAX</b>	1-866-331-4362
<b>WRITE</b>	PHYSICIANS HEALTH CHOICE OF TEXAS LLC Attn: Part D Coverage Determinations Department PO Box 690670 San Antonio, TX 78269-0670
<b>WEBSITE</b>	www.PHCcares.com

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

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 Part D prescription drugs, see Chapter 9 (**What to do if you have a problem or complaint (coverage decisions, appeals, complaints)**).

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

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

<b>Appeals and Complaints for Part D Prescription Drugs</b>	
<b>CALL</b>	<p>1-866-550-4736</p> <p>Calls to this number are free.</p> <p>Hours of Operation: 10/15-3/1: 8:00 am to 8:00 pm Local Time Zone, 7 Days a Week; 3/2-10/14: 8:00 am to 8:00 pm Local Time Zone, Monday - Friday</p> <p>For fast/expedited appeals and complaints for Part D prescription drugs:</p> <p>1-866-550-4736</p> <p>Hours of Operation: 10/15-3/1: 8:00 am to 8:00 pm Local Time Zone, 7 Days a Week; 3/2-10/14: 8:00 am to 8:00 pm Local Time Zone, Monday - Friday</p>
<b>TTY/TDD</b>	<p>711</p> <p>This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.</p> <p>Calls to this number are free.</p> <p>Hours of Operation: 10/15-3/1: 8:00 am to 8:00 pm Local Time Zone, 7 Days a Week; 3/2-10/14: 8:00 am to 8:00 pm Local Time Zone, Monday - Friday</p>
<b>FAX</b>	For standard Part D prescription drug appeals and complaints:

<b>Appeals and Complaints for Part D Prescription Drugs</b>	
	1-866-331-4362
<b>WRITE</b>	PHYSICIANS HEALTH CHOICE OF TEXAS LLC Attn: Grievance Coordinator PO Box 690670 San Antonio, TX 78269-0670
<b>WEBSITE</b>	www.PHCcares.com

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

For more information on situations in which you may need to ask us for reimbursement or to pay a bill you have received from a provider, see Chapter 7 (**Asking us to pay 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.

<b>Payment Requests</b>	
<b>CALL</b>	Part D prescription drug payment requests: 1-866-550-4736  Calls to this number are free.  Hours of Operation: 10/15-3/1: 8:00 am to 8:00 pm Local Time Zone, 7 Days a Week; 3/2-10/14: 8:00 am to 8:00 pm Local Time Zone, Monday - Friday  Medical claims requests: 1-866-550-4736  Calls to this number are free.  Hours of Operation: 10/15-3/1: 8:00 am to 8:00 pm Local Time Zone, 7 Days a Week; 3/2-10/14: 8:00 am to 8:00 pm Local Time Zone, Monday - Friday
<b>TTY/TDD</b>	711

<b>Payment Requests</b>	
	<p>This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.</p> <p>Calls to this number are free.</p> <p>Hours of Operation: 10/15-3/1: 8:00 am to 8:00 pm Local Time Zone, 7 Days a Week; 3/2-10/14: 8:00 am to 8:00 pm Local Time Zone, Monday - Friday</p>
<b>WRITE</b>	<p>Part D Prescription drug payment requests:                  Prescription Solutions                  PO Box 29045                  Hot Springs, AR 71903</p> <p>Medical claims payment requests:                  PHYSICIANS HEALTH CHOICE OF TEXAS LLC                  Attn: Claims                  PO Box 29429                  San Antonio, TX 78229-0429</p>
<b>WEBSITE</b>	<a href="http://www.PHCcares.com">www.PHCcares.com</a>

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

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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.

<b>Medicare</b>	
<b>CALL</b>	<p>1-800-MEDICARE, or 1-800-633-4227</p> <p>Calls to this number are free.</p>

<b>Medicare</b>	
	24 hours a day, 7 days a week.
<b>TTY/TDD</b>	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.
<b>WEBSITE</b>	<p><a href="http://www.medicare.gov">http://www.medicare.gov</a></p> <p>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 by selecting “Help and Support” and then clicking on “Useful Phone Numbers and Websites.”</p> <p>The Medicare website also has detailed information about your Medicare eligibility and enrollment options with the following tools:</p> <ul style="list-style-type: none"><li>● <b>Medicare Eligibility Tool:</b> Provides Medicare eligibility status information. Select “Find Out if You’re Eligible.”</li><li>● <b>Medicare Plan Finder:</b> Provides personalized information about available Medicare prescription drug plans, Medicare health plans, and Medigap (Medicare Supplement Insurance) policies in your area. Select “Health &amp; Drug Plans” and then “Compare Drug and Health Plans” or “Compare Medigap Policies.” These tools provide an <b>estimate</b> of what your out-of-pocket costs might be in different Medicare plans.</li></ul> <p>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.</p>

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

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The State Health Insurance Assistance Program (SHIP) is a government program with trained counselors in every state. In your state, the SHIP is called Texas Department of Aging and Disability Services.

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

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

<b>State Health Insurance Assistance Program (SHIP)</b>	
<b>TX</b> <b>Texas Department of Aging and Disability Services</b>	
<b>CALL</b>	1-512-438-3011
<b>TTY/TDD</b>	711  This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.
<b>WRITE</b>	701 W. 51st St. Austin, TX 78751
<b>WEBSITE</b>	<a href="http://www.dads.state.tx.us">www.dads.state.tx.us</a>

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

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There is a Quality Improvement Organization for each state. Your state-specific Quality Improvement Organization is listed below.

Your state's 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. The state's Quality Improvement Organization is an independent organization. It is not connected with our Plan.

You should contact your state's Quality Improvement Organization in any of these situations:

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

<b>Quality Improvement Organization (QIO)</b>	
<b>TX</b>	
<b>TMF Health Quality Institute</b>	
<b>CALL</b>	1-800-725-9216
<b>TTY/TDD</b>	711  This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.
<b>WRITE</b>	5918 West Courtyard Drive, Bridgepoint I Suite 300 Austin, TX 78730-5036
<b>WEBSITE</b>	<a href="http://www.tmf.org">www.tmf.org</a>

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## **SECTION 5      Social Security**

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The Social Security Administration 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.

<b>Social Security Administration</b>	
<b>CALL</b>	1-800-772-1213  Calls to this number are free.  Available 7:00 am to 7:00 pm, Monday through Friday.  You can use Social Security's automated telephone services to get recorded information and conduct some business 24 hours a day.
<b>TTY/TDD</b>	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 am to 7:00 pm, Monday through Friday.
<b>WEBSITE</b>	<a href="http://www.ssa.gov">http://www.ssa.gov</a>

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## **SECTION 6**

### **Medicaid**

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

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Medicaid is a joint Federal and state government program that helps with medical costs for certain people with limited incomes and resources. As a member of this plan, you qualify for Medicare and Medicaid. Depending on your State and eligibility, Medicaid may pay for homemaker, personal care and other services that are not paid for by Medicare.

In addition, there are programs offered through Medicaid that help people with Medicare pay their Medicare costs, such as their Medicare premiums. These 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).
- **Specified Low-Income Medicare Beneficiary (SLMB) and Qualifying 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, contact Texas Medicaid Health and Human Services Commission (Medicaid).

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<b>TX</b> <b>Texas Medicaid Health and Human Services Commission</b>	
<b>CALL</b>	1-800-252-8263
<b>TTY/TDD</b>	711  This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.
<b>WRITE</b>	P.O. Box 200555 Austin, TX 78720
<b>WEBSITE</b>	<a href="http://www.hhsc.state.tx.us/medicaid">www.hhsc.state.tx.us/medicaid</a>

The ombudsman helps people enrolled in Medicaid with service or billing problems. They can help you file a grievance or appeal with our Plan.

<b>State Medicaid Ombudsman Programs</b>		
<p><b>AL</b>                      Alabama Department of Senior Services                      1-877-425-2243;                      1-800-AGELINE                      (1-800-243-5463)                      770 Washington Avenue                      RSA Plaza Suite 570                      Montgomery, AL 36130</p>	<p><b>AZ</b>                      Client Advocate, Arizona                      Health Care Cost Containment System (AHCCCS)                      602-417-4230                      801 E. Jefferson Street, MD                      3400                      Phoenix, AZ 85034  <a href="http://www.azahcccs.gov/grievancesappeals/Default.aspx">http://www.azahcccs.gov/grievancesappeals/Default.aspx</a></p>	<p><b>CA</b>                      California Office of the Patient Advocate Help Center                      1-888-466-2219                      980 9th Street, Suite 500                      Sacramento, CA 95814-2725  <a href="http://www.opa.ca.gov">http://www.opa.ca.gov</a></p>
<p><b>CO</b>                      Ombudsman for Medicaid Managed Care                      303-830-3560                      1-877 435-7123                      303 E. 17th Ave., Suite 105                      Denver, CO 80203  <a href="mailto:help123@Maximus.com">help123@Maximus.com</a></p>	<p><b>CT</b>                      Connecticut Office of the Healthcare Advocate                      1-866-466-4446                      P.O. Box 1543                      Harford, CT 06144  <a href="http://www.ct.gov/oha">http://www.ct.gov/oha</a></p>	<p><b>DC</b>                      Office of the Health Care Ombudsman and Bill of Rights                      Department of Health Care Finance                      1-877-685-6391  <a href="mailto:healthcareombudsman@dc.gov">healthcareombudsman@dc.gov</a>                      899 North Capitol Street, NE,                      6th Floor, Room 6101                      Washington, DC 20002</p>
<p><b>FL</b>                      Florida Department of Financial Services                      Division of Consumer Services                      1-877-693-5236                      200 East Gaines Street                      Tallahassee, FL 32399-0321  <a href="http://www.myfloridacfo.com/consumers/">http://www.myfloridacfo.com/consumers/</a></p>	<p><b>GA</b>                      DHS Division of Aging Services                      2 Peachtree St NW                      Suite 9-385                      Atlanta, GA 30303-3142                      1-866-552-4464</p>	<p><b>HI</b>                      Hilopa's Family to Family Health Information Center                      1-808-791-3467                      1319 Punahou St. Room 742                      Honolulu, HI 96826  <a href="http://hilopaa.org/default.aspx">http://hilopaa.org/default.aspx</a></p>

<b>State Medicaid Ombudsman Programs</b>		
<p><b>IA</b>                      Iowa Citizen's Aide                      515-281-3592                      1-888-426-6283                      TTY/TDD 515-242-5065                      ombudsman@legis.state.ia.us                      Ola Babcock Miller Building                      1112 East Grand                      Des Moines, Iowa 50319  <a href="http://www.legis.iowa.gov/Ombudsman/index.html">http://www.legis.iowa.gov/Ombudsman/index.html</a></p>	<p><b>IL</b>                      Office of Consumer Health Insurance                      Illinois Department of Insurance                      1-866-455-5364                      320 W. Washington Street                      Springfield, IL 62767  <a href="http://www.insurance.illinois.gov/OCHI/office_consumer_health_ins.asp">http://www.insurance.illinois.gov/OCHI/office_consumer_health_ins.asp</a></p>	<p><b>IN</b>                      Consumer Services Department                      Indiana Department of Insurance                      1-800-622-4461                      311 W. Washington Street, Suite 300                      Indianapolis, IN 46204-2787  <a href="http://www.in.gov/idoi/2526.htm">http://www.in.gov/idoi/2526.htm</a></p>
<p><b>MA</b>                      Office of Patient Protection                      Massachusetts Health and Human Services                      1-800-436-7757                      99 Chauncy Street                      Boston, MA 02111  <a href="http://www.mass.gov/dph/opp">http://www.mass.gov/dph/opp</a></p>	<p><b>MI</b>                      Office of Health Insurance Consumer Assistance                      Michigan Office of Financial and Insurance Regulations                      1-877-999-6442                      P.O. Box 30220                      Lansing, MI 48909-7720  <a href="http://www.michigan.gov/ofir">www.michigan.gov/ofir</a></p>	<p><b>MO</b>                      Missouri DIFP                      Attn: Consumer Affairs                      1-800-726-7390                      P.O. Box 690                      Jefferson City, MO 65102-0690  <a href="http://www.insurance.mo.gov">www.insurance.mo.gov</a></p>
<p><b>NC</b>                      Consumer Services Division                      North Carolina Department of Insurance                      1-800-546-5664                      430 N. Salisbury St.                      Raleigh, NC 27603-5926  <a href="http://www.ncdoi.com/Consumer/consumer_health.asp">http://www.ncdoi.com/Consumer/consumer_health.asp</a></p>	<p><b>NE</b>                      Consumer Affairs Division,                      Nebraska Department of Insurance                      1-877-564-7323                      TTY/TDD 1-800-833-7352                      Terminal Building                      941 O Street, Suite 400                      Lincoln, Nebraska 68508-3690  <a href="http://www.doi.ne.gov/consumer.htm">http://www.doi.ne.gov/consumer.htm</a></p>	<p><b>NJ</b>                      The Office of Insurance Claims Ombudsman                      New Jersey Department of Banking and Insurance                      1-800-446-7467                      P.O. Box 471                      Trenton, NJ 08625-0472  <a href="http://www.state.nj.us/dobi/division_insurance/index.htm">http://www.state.nj.us/dobi/division_insurance/index.htm</a></p>

<b>State Medicaid Ombudsman Programs</b>		
<p><b>NM</b>                      NM Human Services                      Department's Medical                      Assistance Division                      505-827-3100                      1-888-997-2583                      MADInfo.HSD@state.nm.us                      P.O. Box 2348                      Santa Fe, NM 87504-2348</p>	<p><b>NY</b>                      Department of Health                      Medicaid Helpline:                      1-800-541-2831                      Corning Tower                      Empire State Plaza                      Albany, NY 12237  <a href="http://www.health.state.ny.us/health_care/medicaid/">http://www.health.state.ny.us/health_care/medicaid/</a></p>	<p><b>OH</b>                      Medicaid Consumer Hotline 1-800-324-8680                      TDD 1-800-292-3572  <a href="http://www.jfs.ohio.gov/ohp">www.jfs.ohio.gov/ohp</a></p>
<p><b>PA</b>                      Pennsylvania Insurance                      Department                      Bureau of Consumer Services                      1-877-881-6388                      Room 1209, Strawberry Square                      Harrisburg, PA 17120  <a href="http://www.insurance.pa.gov">http://www.insurance.pa.gov</a></p>	<p><b>TN</b>                      Family Assistance Services                      Center (a part of Department of                      Human Services)                      1-866-311-4287                      In Nashville, please dial                      743-2000  <a href="http://www.tn.gov/humanserv/adfam/afs_fasc.html">http://www.tn.gov/humanserv/adfam/afs_fasc.html</a></p>	<p><b>TX</b>                      Texas Health and Human                      Services Commission                      Office of the Ombudsman,                      MC H-700                      1-877-787-8999                      TDD: 1-888-425-6889                      P.O. Box 13247                      Austin, Texas 78711-3247  <a href="http://www.hhs.state.tx.us/OMB/contact.shtml">http://www.hhs.state.tx.us/OMB/contact.shtml</a></p>
<p><b>VA</b>                      Virginia Department of Social                      Services                      1-800-552-8627                      801 E. Main Street                      Richmond, VA 23219-2901  <a href="http://www.dss.virginia.gov/index.html">http://www.dss.virginia.gov/index.html</a></p>	<p><b>WA</b>                      Washington State Office of the                      Insurance Commissioner                      1-800-562-6900                      P.O. Box 40256                      Olympia, WA 98504-0256  <a href="http://www.insurance.wa.gov">www.insurance.wa.gov</a></p>	<p><b>WI</b>                      Managed Care Ombudsman                      1-800-760-0001                      P.O. Box 6470                      Madison, WI 53716-0470  <a href="http://www.dhs.wisconsin.gov/medicaid/">http://www.dhs.wisconsin.gov/medicaid/</a></p>

The long-term care ombudsman helps people get information about nursing homes and resolve problems between nursing homes and residents or their families.

<b>State Long-Term Care Ombudsman Programs</b>		
<p><b>AL</b>                      Alabama Department of Senior Services                      1-877-425-2243;                      1-800-AGELINE                      (1-800-243-5463)                      770 Washington Avenue                      RSA Plaza Suite 570                      Montgomery, AL 36130</p>	<p><b>AZ</b>                      Client Advocate, Arizona Health Care Cost Containment System (AHCCCS)                      602-417-4230                      801 E. Jefferson Street, MD 3400                      Phoenix, AZ 85034  <a href="http://www.azahcccs.gov/grievancesappeals/Default.aspx">http://www.azahcccs.gov/grievancesappeals/Default.aspx</a></p>	<p><b>CA</b>                      Long Term Care Ombudsman of California                      1-800-231-4024                      TTY/TDD 1-800-735-2929                      1300 National Drive, Suite 200                      Sacramento, CA 95834-1992  <a href="http://www.aging.ca.gov/">http://www.aging.ca.gov/</a></p>
<p><b>CO</b>                      Legal Center for People with Disabilities and Older People of Colorado                      1-800-288-1376                      455 Sherman St. #130                      Denver, CO 80203  <a href="http://www.thelegalcenter.org">http://www.thelegalcenter.org</a></p>	<p><b>CT</b>                      Long Term Care Ombudsman of Connecticut                      1-866-388-1888                      TTY/TDD 1-800-842-4524                      25 Sigourney Street, Hartford, CT 06106  <a href="http://www.ltcop.state.ct.us">http://www.ltcop.state.ct.us</a></p>	<p><b>DC</b>                      DC Long-Term Care Ombudsman Program                      AARP Legal Counsel for the Elderly                      202-434-2140                      601 E Street NW, T3-232                      Washington, DC 20049</p>
<p><b>FL</b>                      Long Term Care Ombudsman of Florida                      1-888-831-0404                      4040 Esplanade Way, Ste 280                      Tallahassee, FL 32399-7000  <a href="http://www.ombudsman.myflorida.com">http://www.ombudsman.myflorida.com</a></p>	<p><b>GA</b>                      Office of the State Long-Term Care Ombudsman                      1-888-454-LTCO (5826)                      TTY/TDD 404-657-1929                      2 Peachtree St, NW, 9th Floor (mailing address)                      2 Peachtree St, NW, 8th Floor (actual address)                      Atlanta, GA 30303-3142</p>	<p><b>HI</b>                      State LTC Ombudsman Executive Office on Aging                      1-808-586-0100                      No. 1 Capitol District                      250 South Hotel St, Suite 406                      Honolulu, HI 96813-2831  <a href="http://www.hawaiiadrc.org/site/438/">http://www.hawaiiadrc.org/site/438/</a>  <a href="http://www.hawaiiadrc.org/site/438/long_term_care_ombudsman.aspx">long_term_care_ombudsman.aspx</a></p>

**State Long-Term Care Ombudsman Programs**

<p><b>IA</b>                      Iowa Department on Aging                      Long-Term Care Ombudsman                      1-800-532-3213                      TTY/TDD 515-725-3302                      510 E 12th Street                      Jessie Parker Building, Ste 2                      Des Moines, IA 50319-9025  <a href="http://www.aging.iowa.gov/advocacy/ombudsman.html">http://www.aging.iowa.gov/advocacy/ombudsman.html</a></p>	<p><b>IL</b>                      State LTC Ombudsman                      Department of Aging of Illinois                      217-785-3143                      421 East Capitol Avenue                      Suite 100                      Springfield, IL 62702-1789  <a href="http://www.state.il.us/aging/">http://www.state.il.us/aging/</a></p>	<p><b>IN</b>                      Division of Aging                      1-800-622-4484                      402 W. Washington Street                      P.O. Box 7083, MS21 Room                      W-454 Indianapolis, IN 46204  <a href="http://www.in.gov/fssa/da">http://www.in.gov/fssa/da</a></p>
<p><b>MA</b>                      Executive Office of Elder                      Affairs of Massachusetts                      1-800- 243-4636                      TTY/TDD 1-800-872-0166                      One Ashburton Place                      Boston, MA 02108  <a href="http://www.800ageinfo.com">http://www.800ageinfo.com</a></p>	<p><b>MI</b>                      Michigan Office of Services to                      the Aging                      1-866-485-9393                      PO Box 30676                      Lansing, MI 48909-8176  <a href="http://www.michigan.gov/miseniors">http://www.michigan.gov/miseniors</a></p>	<p><b>MO</b>                      State Office of Long-Term                      Care Ombudsman Program                      Missouri Department of Health                      and Senior Services                      1-800-309-3282                      PO Box 570                      Jefferson City, MO 65102-0570  <a href="http://health.mo.gov/seniors/ombudsman/">http://health.mo.gov/seniors/ombudsman/</a></p>
<p><b>NC</b>                      North Carolina Division of                      Aging and Adult Services                      Long Term Care Ombudsman                      Program                      919-733-8395                      2101 Mail Service Center                      Raleigh, NC 27699-2101  <a href="http://www.ncdhhs.gov/aging/ombud.htm">http://www.ncdhhs.gov/aging/ombud.htm</a></p>	<p><b>NE</b>                      Office of the Long-Term Care                      Ombudsman                      Dept of Health and Human                      Services of Nebraska - State                      Unit on Aging                      1-800-942-7830                      P.O. Box 95026                      Lincoln, NE 68509-5026  <a href="http://www.dhhs.ne.gov/ags/ltcombud.htm">http://www.dhhs.ne.gov/ags/ltcombud.htm</a></p>	<p><b>NJ</b>                      State of New Jersey                      Office of the Ombudsman for                      the Institutionalized Elderly                      1-877-582-6995                      P.O. Box 852                      Trenton, NJ 08625-0852  <a href="http://www.state.nj.us/publicadvocate/seniors/elder/">http://www.state.nj.us/publicadvocate/seniors/elder/</a></p>

<b>State Long-Term Care Ombudsman Programs</b>		
<p><b>NM</b>                      New Mexico Aging &amp; Long Term Services Department                      1-800-432-2080                      2550 Cerrillos Road                      Santa Fe, NM 87505-3260  <a href="http://www.nmaging.state.nm.us">http://www.nmaging.state.nm.us</a></p>	<p><b>NY</b>                      New York State                      Office of Long Term Care Ombudsman                      1-800-342-9871                      2 Empire State Plaza                      Albany, NY 12223  <a href="http://www.ltcombudsman.ny.gov/">http://www.ltcombudsman.ny.gov/</a></p>	<p><b>OH</b>                      Region 1 - Cincinnati Area                      Serving Butler, Hamilton &amp; Warren counties                      Pro-Seniors LTCOP                      1-800-488-6070                      7162 Reading Road, Ste 1150                      Cincinnati, OH 45237  <a href="http://www.proseniors.org">www.proseniors.org</a></p>
<p><b>OH</b>                      Region 2 - Dayton Area                      Serving Clark, Greene &amp; Montgomery, counties                      1-800-395-8267                      15 E. Fourth St., Suite 208                      Dayton, OH 45402  <a href="http://www.dayton-ombudsman.org">www.dayton-ombudsman.org</a></p>	<p><b>OH</b>                      Region 6 - Columbus Area                      Serving Franklin &amp; Madison counties                      1-800-536-5891                      197 E. Gay St.                      Columbus, OH 43215  <a href="http://www.colscss.org">www.colscss.org</a></p>	<p><b>OH</b>                      Region 10a - Cleveland Area                      Serving Cuyahoga county                      LTCOP                      1-800-365-3112                      2800 Euclid Ave., Suite 200                      Cleveland, OH 44115  <a href="http://www.ltco.org">www.ltco.org</a></p>
<p><b>OH</b>                      Region 10b - Akron Area                      Serving Stark &amp; Summit counties                      LTCOP                      1-800-421-7277                      1550 Corporate Woods Pkwy.                      Uniontown, OH 44685</p>	<p><b>OH</b>                      Region 11 - Youngstown Area                      Serving Mahoning county                      5555 Youngstown Warren, Ste 2685                      Youngstown, OH 44503                      1-800-589-5826  <a href="http://www.aaa11.org/ombudsman.asp">www.aaa11.org/ombudsman.asp</a></p>	<p><b>PA</b>                      Office of the State Long-Term Care Ombudsman                      Department of Aging of Pennsylvania                      717-783-8975                      555 Walnut Street, 5th floor                      Harrisburg, PA 17101-1919  <a href="http://www.aging.state.pa.us/">http://www.aging.state.pa.us/</a></p>
<p><b>TN</b>                      State Long-Term Care Ombudsman                      Commission on Aging and Disability of Tennessee                      1-877-236-0013                      TTY/TDD 615-532-3893                      500 Deaderick St Suite 825                      Nashville, TN 37243-0860  <a href="http://www.state.tn.us/comaging">http://www.state.tn.us/comaging</a></p>	<p><b>TX</b>                      Texas Long-Term Care Ombudsman Program                      Texas Department of Aging and Disability Services                      1-800-252-2412                      P. O. Box 149030                      MC-W250                      Austin, TX 78714-9030</p>	<p><b>VA</b>                      Virginia Department for the Aging                      Office of the State Long-Term Care Ombudsman                      1-800-552-3402                      24 E. Cary St, Suite 100                      Richmond, VA 23219  <a href="http://www.elderrightsva.org/default.aspx">http://www.elderrightsva.org/default.aspx</a></p>

**State Long-Term Care Ombudsman Programs**

<p><b>WA</b>                  Long Term Care Ombudsman                  of Washington                  1-800-562-6028                  1200 South 336th Street                  P.O. Box 23699                  Federal Way, WA 98093  <a href="http://www.ltcop.org">http://www.ltcop.org</a></p>	<p><b>WI</b>                  Board of Aging and Long Term                  Care of Wisconsin                  1-800-815-0015                  1402 Pankratz Street                  Madison, WI 53704-4001  <a href="http://www.longtermcare.wi.gov/">www.longtermcare.wi.gov/</a>  <a href="mailto:BOALTC@Wisconsin.Gov">BOALTC@Wisconsin.Gov</a></p>	
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**SECTION 7 Information about programs to help people pay for their prescription drugs**

**Medicare’s “Extra Help” Program**

Because you are eligible for Texas Medicaid Health and Human Services Commission (Medicaid), you qualify for and are getting “Extra Help” from Medicare for your prescription drug plan costs. You do not need to do anything further to get this Extra Help.

If you have questions about Extra Help, call:

- 1-800-MEDICARE (1-800-633-4227). TTY/TDD 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 am to 7 pm, Monday through Friday. TTY/TDD users should call 1-800-325-0778; or
- Your State Medicaid Office. (See Section 6 of this chapter for contact information)

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

- Please call the customer service number in Chapter 2 Section 1. Our customer service representatives can help get your copayment amount corrected.
- 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.

**Medicare Coverage Gap Discount Program**

Because you get “Extra Help” from Medicare to pay for your prescription drug plan costs, the

Medicare Coverage Gap Discount Program does not apply to you. You already have coverage for your prescription drugs during the coverage gap through the Extra Help program.

For people who don't get Extra Help, the Medicare Coverage Gap Discount Program provides manufacturer discounts on brand name drugs to Part D enrollees who have reached the coverage gap. These enrollees also receive some coverage for generic drugs. If you have any questions about the Medicare Coverage Gap Discount Program, please contact Customer Service (phone numbers are on the back 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?**

Most of our members get "Extra Help" from Medicare to pay for their prescription drug plan costs. If you get "Extra Help," the Medicare Coverage Gap Discount Program does not apply to you. 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 in Section 3 of this Chapter) or by calling **1-800-MEDICARE (1-800-633-4227)**, 24 hours a day, 7 days a week. TTY/TDD 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 seniors and individuals with disabilities financial help for prescription drugs. In your state, the State Pharmaceutical Assistance Program is Texas Department of State Health Services, Texas Kidney Health Care (KHC).

#### **State Pharmaceutical Assistance Programs**

**TX**

**Texas Department of State Health Services, Texas Kidney Health Care (KHC)**

**CALL**

**1-800-222-3986**

<b>State Pharmaceutical Assistance Programs</b>	
<b>TX</b> <b>Texas Department of State Health Services, Texas Kidney Health Care (KHC)</b>	
<b>TTY/TDD</b>	1-800-735-2989  This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.
<b>WRITE</b>	Department of State Health Services, MC 1938, PO Box 149347 Austin, TX 78714
<b>WEBSITE</b>	<a href="http://www.dshs.state.tx.us/kidney">www.dshs.state.tx.us/kidney</a>

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## **SECTION 8      How to contact the Railroad Retirement Board**

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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.

<b>Railroad Retirement Board</b>	
<b>CALL</b>	1-877-772-5772  Calls to this number are free.  Available 9:00 am to 3:30 pm, 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.
<b>TTY/TDD</b>	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 <b>not</b> free.

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<b>Railroad Retirement Board</b>	
<b>WEBSITE</b>	<a href="http://www.rrb.gov">http://www.rrb.gov</a>

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**SECTION 9      Do you have “group insurance” or other health insurance from an employer?**

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If you (or your spouse) get benefits from your (or your spouse’s) employer or retiree group, call the employer/union benefits administrator or Customer Service if you have any questions. You can ask about your (or your spouse’s) employer or retiree health benefits, premiums, or the enrollment period.

If you have other prescription drug coverage through your (or your spouse’s) employer or retiree group, please contact **that group’s benefits administrator**. The benefits administrator can help you determine how your current prescription drug coverage will work with our Plan.

### CHAPTER 3: Using the plan's coverage for your medical services

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

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

For the details on what medical care is covered by our Plan and how much you pay as your share of the cost when you get this care, use the benefits chart in the next chapter, Chapter 4 (**Medical Benefits Chart (what is covered and what you pay)**).

<b>Section 1.1      What are “network providers” and “covered services”?</b>
--

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

- **“Providers”** are doctors and other health care professionals licensed by the state to provide medical services and care. The term “providers” also includes hospitals and other health care facilities.
- **“Network providers”** are the doctors and other health care professionals, medical groups, hospitals, and other health care facilities that have an agreement with us to accept our payment and your cost-sharing amount as payment in full. We have arranged for these providers to deliver covered services to members in our Plan. The providers in our network generally bill us directly for care they give you. When you see a network provider, you usually pay only your share of the cost for their services.
- **“Covered services”** include all the medical care, health care services, supplies, and equipment that are covered by our Plan. Your covered services for medical care are listed in the benefits chart in Chapter 4.

<b>Section 1.2      Basic rules for getting your medical care covered by the plan</b>
---

As a Medicare health plan, **Physicians Health Choice Select (HMO SNP)** must cover all services covered by Original Medicare and must follow Original Medicare's coverage rules.

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

- **The care you receive is included in the plan's Medical Benefits Chart** (this chart is in Chapter 4 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 have a network primary care physician (a PCP) who is providing and overseeing your care.** As a member of our Plan, you must choose a network PCP (for more information about this, see Section 2.1 in this chapter).

- In most situations, your network PCP must give you approval in advance before you can use other providers in the plan's network, such as specialists, hospitals, skilled nursing facilities, or home health care agencies. This is called giving you a "referral." For more information about this, see Section 2.2 of this chapter.
- Referrals from your PCP are not required for emergency care or urgently needed care. There are also some other kinds of care you can get without having approval in advance from your PCP (for more information about this, see Section 2.3 of this chapter).
- **You must receive your care from a network provider** (for more information about this, see Section 2 in this chapter). In most cases, care you receive from an out-of-network provider (a provider who is not part of our Plan's network) will not be covered. **Here are three exceptions:**
  - The plan covers emergency care or urgently needed care that you get from an out-of-network provider. For more information about this, and to see what emergency or urgently needed care means, see Section 3 in this chapter.
  - If you need medical care that Medicare requires our Plan to cover and the providers in our network cannot provide this care, you can get this care from an out-of-network provider. In this situation, we will cover these services as if you got the care from a network provider. For information about getting approval to see an out-of-network doctor, see Section 2.4 in this chapter.
  - Kidney dialysis services that you get at a Medicare-certified dialysis facility when you are temporarily outside the plan's service area.

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## SECTION 2      Use providers in the plan's network to get your medical care

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<b>Section 2.1</b>	<b>You must choose a Primary Care Physician (PCP) to provide and oversee your medical care</b>
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### What is a "PCP" and what does the PCP do for you?

#### What is a PCP?

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

#### What types of providers may act as a PCP?

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

#### What is the role of my PCP?

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

#### How do you choose your PCP?

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

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

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

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

### **Changing your PCP**

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

If you want to change your PCP, call Customer Service. If the PCP is accepting additional plan members, and your request is received on or before the 5th of the month, the transfer will become effective on the first day of the following month. If your request is received after the 5th of the month, the transfer will become effective the first day of the second month following your request. For example, if we receive your change request on July 5, your change is effective on August 1. If we receive your change request on July 6, your change is effective on September 1. You will receive a new member ID card that shows this change.

<b>Section 2.2</b>	<b>What kinds of medical care can you get without getting approval in advance from your PCP?</b>
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You can get the services listed below without getting approval in advance from your PCP.

- Routine women's health care, which includes breast exams, screening mammograms (x-rays of the breast), Pap tests, and pelvic exams as long as you get them from a network provider.
- Flu shots.
- Emergency services from network providers or from out-of-network providers.
- Urgently needed care from in-network providers or from out-of-network providers when network providers are temporarily unavailable or inaccessible, e.g., when you are temporarily outside of the plan's service area.
- Kidney dialysis services that you get at a Medicare-certified dialysis facility when you are temporarily outside the plan's service area. (If possible, please call Customer Service before you leave the service area so we can help arrange for you to have maintenance dialysis while you are away.)

<b>Section 2.3</b>	<b>How to get care from specialists and other network providers</b>
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A specialist is a doctor who provides health care services for a specific disease or part of the body. There are many kinds of specialists. Here are a few examples:

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

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

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

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

Please refer to Chapter 4, Section 2.1 for more information about which services require prior authorization.

Please refer to the Provider Directory for a listing of Plan specialists available through your network or you may consult the Provider Directory online at the website listed in Chapter 2 of this booklet.

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

### **What if a specialist or another network provider leaves our Plan?**

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

#### **Section 2.4      How to get care from out-of-network providers**

Care that you receive from out-of-network providers will not be covered unless the care meets one of the three exceptions described in Section 1.2 of this chapter. For information about getting out-of-network care when you have a medical emergency or urgent need for care, please see Section 3 in this chapter.

### **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, hospital, or urgent care center. Call for an ambulance if you need it. You do **not** need to get approval or a referral first from your PCP.
- **As soon as possible, make sure that our Plan has been told about your emergency.** We need to follow up on your emergency care. You or someone else should call to tell us about your emergency care, usually within 48 hours by calling the Customer Service number located in Chapter 2 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 world. Our Plan covers ambulance services in situations where getting to the emergency room in any other way could endanger your health. For more information, see the Medical Benefits Chart in Chapter 4 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 our Plan. If your emergency care is provided by out-of-network providers, we will try to arrange for network providers to take over your care as soon as your medical condition and the circumstances allow.

### What if it wasn't a medical emergency?

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

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

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

<b>Section 3.2</b> <b>Getting care when you have an urgent need for care</b>
--

### What is “urgently needed care”?

“Urgently needed care” is a non-emergency, unforeseen medical illness, injury, or condition, that requires immediate medical care, but the plan's network of providers is temporarily unavailable or inaccessible. The unforeseen condition could, for example, be an unforeseen flare-up of a known condition that you have (for example, a flare-up of a chronic skin condition).

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

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

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

When you are outside the service area and cannot get care from a network provider, our Plan will cover urgently needed care that you get from any provider.

Our Plan does not cover urgently needed care or any other non-emergency care if you receive the care outside of the United States.

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

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**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 us to pay our share of a bill you have received for covered medical services or drugs**) for information about what to do.

**Section 4.2      What should you do if services are not covered by our Plan?**

Our Plan covers all medical services that are medically necessary, are listed in the plan's Medical Benefits Chart (this chart is in Chapter 4 of this booklet), and are obtained consistent with plan rules. Generally, you are responsible for paying the full cost of services that aren't covered by our Plan, either because they are not plan covered services, or they were obtained out-of-network where not authorized. However, before paying for the cost of the service, contact Texas Medicaid Health and Human Services Commission (Medicaid) to find out if the service is covered.

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 at the number on the back cover of this booklet to get more information about how to do this.

For covered services that have a benefit limitation, you pay the full cost of any services you get after you have used up your benefit for that type of covered service. For example, if your Plan covers one routine physical exam per year and you receive that routine physical but choose to have a second routine physical within the same year, you pay the full cost of the second routine physical. Any amounts that you pay after you have reached the benefit limitation do not count toward your annual out-of-pocket maximum. (See Chapter 4 for more information on your Plan's out-of-pocket maximum.) You can call Customer Service when you want to know how much of your benefit limit you have already used.

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

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<b>Section 5.1      What is a “clinical research study”?</b>
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A clinical research study is a way that doctors and scientists test new types of medical care, like how well a new cancer drug works. They test new medical care procedures or drugs by asking for volunteers to help with the study. This kind of study is one of the final stages of a research process that helps doctors and scientists see if a new approach works and if it is safe.

Not all clinical research studies are open to members of our Plan. Medicare first needs to approve the research study. If you participate in a study that Medicare has **not** approved, **you will be responsible for paying all costs for your participation in the study.**

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

If you participate in a Medicare-approved study, Original Medicare pays most of the costs for the covered services you receive as part of the study. When you are in a clinical research study, you may stay enrolled in our Plan and continue to get the rest of your care (the care that is not related to the study) through our Plan.

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

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

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

If you plan on participating in a clinical research study, contact Customer Service (see Chapter 2, Section 1 of this **Evidence of Coverage**).

<b>Section 5.2      When you participate in a clinical research study, who pays for what?</b>
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Once you join a Medicare-approved clinical research study, you are covered for routine items and services you receive as part of the study, including:

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

Original Medicare pays most of the cost of the covered services you receive as part of the study. After

Medicare has paid its share of the cost for these services, our Plan will also pay for part of the costs. We will pay the difference between the cost-sharing in Original Medicare and your cost-sharing as a member of our Plan. This means 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 our 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 would be only \$10 under our 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 our 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 our Plan will pay for any of the following:**

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

### **Do you want to know more?**

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.

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

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<b>Section 6.1      What is a religious non-medical health care institution?</b>
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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.

<b>Section 6.2</b>	<b>What care from a religious non-medical health care institution is covered by our Plan?</b>
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To get care from a religious non-medical health care institution, you must sign a legal document that says you are conscientiously opposed to getting medical treatment that is “non-excepted.”

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

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

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

The coverage limits are described under **Inpatient Hospital Care** in the Medical Benefits Chart in Chapter 4.

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**SECTION 7**      **Rules for ownership of durable medical equipment**

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<b>Section 7.1</b>	<b>Will you own your durable medical equipment after making a certain number of payments under our Plan?</b>
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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 enrollee. In this section, we discuss other types of durable medical equipment that must be rented.

In Original Medicare, people who rent certain types of durable medical equipment own the equipment after paying co-payments for the item for 13 months. As a member of our Plan, however, you usually will not acquire ownership of rented durable medical equipment items no matter how many copayments you make for the item while a member of our Plan. Under certain limited circumstances

we will transfer ownership of the durable medical equipment item. Call Customer Service (phone numbers are on the back cover of this booklet) to find out about the requirements you must meet and the documentation you need to provide.

**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 our Plan: If you did not acquire ownership of the durable medical equipment item while in our Plan, you will have to make 13 new consecutive payments for the item while in Original Medicare in order to acquire ownership of the item. Your previous payments while in our 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 new 13 consecutive payments. You will have to make 13 new 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.

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**CHAPTER 4: Medical Benefits Chart (what is covered and what you pay)**

**SECTION 1 Understanding your out-of-pocket costs for covered services..... 2**  
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will pay..... 3**  
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**SECTION 3 What benefits are not covered by the plan?..... 32**  
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## SECTION 1      Understanding your out-of-pocket costs for covered services

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This chapter focuses on your covered services and what you pay for your medical benefits. It includes a Medical Benefits Chart that gives a list of your covered services and tells how much you will pay for each covered service as a member of Physicians Health Choice Select (HMO SNP). Later in this chapter, you can find information about medical services that are not covered. It also tells about limitations on certain services.

<b>Section 1.1      Types of out-of-pocket costs you may pay for your covered services</b>
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To understand the payment information we give you in this chapter, you need to know about the types of out-of-pocket costs you may pay for your covered services.

- A **“copayment”** is the fixed amount you pay each time you receive certain medical services. You pay a copayment at the time you get the medical services. (The Medical Benefits Chart in Section 2 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 Benefits Chart in Section 2 tells you more about your coinsurance.)

QMB members - you do not have any costs, except your prescription copayments if you are enrolled in Medicare as a Qualified Medicare Beneficiary (QMB) and Texas Medicaid Health and Human Services Commission (Medicaid). Your coinsurance, deductibles and copayments (except for Part D prescription drugs) are paid by Texas Medicaid Health and Human Services Commission (Medicaid).

Show your plan member ID card and Texas Medicaid Health and Human Services Commission (Medicaid) member identification cards when getting health care services. These cards will help your health care providers coordinate payment.

Call Customer Service at the telephone number listed in Chapter 2 of this booklet if:

- you are asked to pay for covered services,
- your provider will not see you or
- you have other questions

If you receive notice that your Texas Medicaid Health and Human Services Commission (Medicaid) coverage has expired, please call your Medicaid office right away to reapply for assistance. Your Medicaid Agency phone number is listed in Chapter 2 of this booklet. Please call Customer Service at the number listed in Chapter 2 of this booklet if you have questions.

### Grace Period

QMB members - if you lose your Texas Medicaid Health and Human Services Commission (Medicaid) eligibility, you can remain enrolled in this Medicare plan for up to 6 months. You must re-enroll in Medicaid before the end of the 6 month period to keep your Medicare benefits with this plan. During the 6 month period, you do not have any cost-sharing responsibilities, except your prescription drug copayments or premiums.

During this 6 month period, if you receive bills from your provider, call Customer Service at the telephone number listed in Chapter 2 of this booklet. You should not pay these bills. You should only pay your prescription drug copayment. If you have paid copayments, deductibles or coinsurance during this 6 month period, please call Customer Service to get your money back.

Keep the following information for any care you get during the 6 month period:

- copies of your bills and receipts
- letter or documentation about your loss of Texas Medicaid Health and Human Services Commission (Medicaid) eligibility

If you do not re-enroll in Texas Medicaid Health and Human Services Commission (Medicaid) during the 6 month period, you will be disenrolled from our Plan. You will be enrolled in Original Medicare.

<b>Section 1.2</b>	<b>What is the most you will pay for Medicare Part A and Part B covered medical services?</b>
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**Note:** Because our members also get assistance from Texas Medicaid Health and Human Services Commission (Medicaid), very few members ever reach this out-of-pocket maximum.

Because you are enrolled in a Medicare Advantage Plan, there is a limit to how much you have to pay out-of-pocket each year for in-network medical services that are covered under Part A and Part B (see the Medical Benefits Chart in Section 2, below). This limit is called the maximum out-of-pocket amount for medical services.

As a member of Physicians Health Choice Select (HMO SNP), the most you will have to pay out-of-pocket for in-network covered Part A and Part B services in 2012 is \$3,350. The amounts you pay for your copayments, and coinsurance for in-network covered services count toward this out-of-pocket amount. (The amounts you pay for your Plan premium and for your prescription drugs do not count toward your maximum out-of-pocket amount. In addition, amounts you pay for some services do not count toward your maximum out-of-pocket amount. These services are marked with an asterisk in the Medical Benefits Chart.) If you reach the maximum out-of-pocket amount of \$3,350, you will not have to pay any out-of-pocket costs for the rest of the year for in-network 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 Texas Medicaid Health and Human Services Commission (Medicaid) or another third party.)

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<b>SECTION 2</b>	<b>Use the Medical Benefits Chart to find out what is covered for you and how much you will pay</b>
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<b>Section 2.1</b>	<b>Your medical benefits and costs as a member of the plan</b>
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The Medical Benefits Chart on the following pages lists the services Physicians Health Choice Select (HMO SNP) covers and what you pay out-of-pocket for each service. The services listed in the Medical Benefits Chart are covered only when the following coverage requirements are met:

- Your Medicare and Medicaid covered services must be provided according to the coverage guidelines established by Medicare and Medicaid.
- 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 accepted standards of medical practice.
- You receive your care from a network provider. In most cases, care you receive from an out-of-network provider will not be covered. Chapter 3 provides more information about requirements for using network providers and the situations when we will cover services from an out-of-network provider.
- You have a primary care provider (a PCP) who is providing and overseeing your care. In most situations, your PCP must give you approval in advance before you can see other providers in the plan’s network. This is called giving you a “referral.” Chapter 3 provides more information about getting a referral and the situations when you do not need a referral.
- 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.

**Medical Benefits Chart**

Services that are covered for you	What you must pay when you get these services
<b>Inpatient Care</b>	
<p><b>Inpatient Hospital Care</b></p> <p>Covered services include:</p> <ul style="list-style-type: none"> <li>● Semi-private room (or a private room if medically necessary)</li> <li>● Meals including special diets</li> <li>● Regular nursing services</li> <li>● Costs of special care units (such as intensive care or coronary care units)</li> <li>● Drugs and medications</li> <li>● Lab tests</li> <li>● X-rays and other radiology services</li> <li>● Necessary surgical and medical supplies</li> <li>● Use of appliances, such as wheelchairs</li> <li>● Operating and recovery room costs</li> <li>● Physical therapy, speech language therapy, and occupational therapy</li> <li>● Under certain conditions, the following types of transplants are covered: corneal, kidney, kidney-pancreatic, heart, liver, lung, heart/lung, bone marrow, stem cell, and intestinal/multivisceral. If you need a transplant, we will arrange to have your case reviewed by a Medicare-approved transplant center that will decide whether you are a candidate for a transplant. If Physicians Health Choice Select (HMO SNP) provides transplant services at a distant location (farther away than the normal community patterns of care) 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.</li> <li>● Blood - including storage and administration. Coverage begins with the first pint of blood that you need.</li> <li>● Physician services</li> </ul>	<p>\$0 copayment each day for Medicare-covered hospital care.</p> <p>Medicare hospital benefit periods do not apply. (See definition of benefit periods in the chapter titled Definitions of important words.) For inpatient hospital care, the cost sharing described above applies each time you are admitted to the hospital. For each inpatient hospital stay, you are covered for unlimited days as long as the hospital stay is covered in accordance with plan rules.</p>

<p><b>Services that are covered for you</b></p>	<p><b>What you must pay</b> when you get these services</p>
<p><b>Note:</b> To be an inpatient, your provider must write an order to admit you to 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.</p> <p>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 <a href="http://www.medicare.gov/Publications/Pubs/pdf/11435.pdf">http://www.medicare.gov/Publications/Pubs/pdf/11435.pdf</a> 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.</p>	
<p><b>Inpatient Mental Health Care</b></p> <p>Covered services include:</p> <ul style="list-style-type: none"> <li>● Mental health care services that require a hospital stay. There is a 190 day lifetime limit for inpatient services in a psychiatric hospital. The 190-day limit does not apply to Mental Health services provided in a psychiatric unit of a general hospital.</li> <li>● Inpatient substance abuse services</li> </ul>	<p>\$0 copayment for each Medicare-covered network hospital stay, up to 90 days.</p> <p>You pay these amounts until you reach the out-of-pocket maximum.</p> <p>Medicare hospital benefit periods are used to determine the total number of days covered for inpatient mental health care. (See definition of benefit periods in the chapter titled Definitions of important words.) However, the cost sharing described above applies each time you are admitted to the hospital, even if you are admitted multiple times</p>

<p><b>Services that are covered for you</b></p>	<p><b>What you must pay</b> when you get these services</p>
	<p>within a benefit period.</p>
<p><b>Skilled Nursing Facility (SNF) Care</b></p> <p>(For a definition of “skilled nursing facility care”, see Chapter 12 of this booklet. Skilled nursing facilities are sometimes called “SNFs”.)</p> <p>Covered services include:</p> <ul style="list-style-type: none"> <li>● Semiprivate room (or a private room if medically necessary)</li> <li>● Meals, including special diets</li> <li>● Regular nursing services</li> <li>● Physical therapy, occupational therapy, and speech therapy</li> <li>● 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)</li> <li>● Blood - including storage and administration. Coverage begins with the first pint of blood that you need.</li> <li>● Medical and surgical supplies ordinarily provided by SNFs</li> <li>● Laboratory tests ordinarily provided by SNFs</li> <li>● X-rays and other radiology services ordinarily provided by SNFs</li> <li>● Use of appliances such as wheelchairs ordinarily provided by SNFs</li> <li>● Physician services</li> </ul> <p>A 3-day prior hospital stay is not required.</p> <p>Generally, you will get your SNF care from plan facilities. However, under certain conditions listed below, you may be able to get your care from a facility that isn’t a plan provider, if the facility accepts our Plan’s amounts for payment.</p>	<p>\$0 copayment each day for days 1 to 20; \$0 copayment each day for days 21 to 87; \$0 copayment for additional Medicare-covered days, up to 100 days.</p> <p>You pay these amounts until you reach the out-of-pocket maximum.</p> <p>You are covered for up to 100 days each benefit period for inpatient services in a SNF, in accordance with Medicare guidelines.</p> <p>A benefit period begins on the first day you go to a Medicare-covered inpatient hospital or a skilled nursing facility. The benefit period ends when you haven’t been an inpatient at any hospital or SNF for 60 days in a row. If you go to the hospital (or SNF) after one benefit period has ended, a new benefit period begins. There is no limit to the number of benefit periods you can have.</p>

<p><b>Services that are covered for you</b></p>	<p><b>What you must pay</b> when you get these services</p>
<ul style="list-style-type: none"> <li>● 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).</li> <li>● A SNF where your spouse is living at the time you leave the hospital.</li> </ul>	
<p><b>Inpatient Services Covered During a Non-Covered Inpatient Stay</b></p> <p>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:</p> <ul style="list-style-type: none"> <li>● Physician services</li> <li>● Diagnostic tests (like lab tests)</li> <li>● X-ray, radium, and isotope therapy including technician materials and services</li> <li>● Surgical dressings</li> <li>● Splints, casts and other devices used to reduce fractures and dislocations</li> </ul>	<p>When your stay is no longer covered, these services will be covered as described in the following sections:</p> <p>Please refer below to Physician services, Including Doctor’s Office Visits.</p> <p>Please refer below to Outpatient Diagnostic Tests and Therapeutic Services and Supplies.</p> <p>Please refer below to Outpatient Diagnostic Tests and Therapeutic Services and Supplies.</p> <p>Please refer below to Outpatient Diagnostic Tests and Therapeutic Services and Supplies.</p>

<b>Services that are covered for you</b>	<b>What you must pay</b> when you get these services
<ul style="list-style-type: none"> <li>● Prosthetics and orthotics devices (other than dental) that replace all or part of an internal body organ (including contiguous tissue), or all or part of the function of a permanently inoperative or malfunctioning internal body organ, including replacement or repairs of such devices</li> <li>● 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</li> <li>● Physical therapy, speech language therapy, and occupational therapy</li> </ul>	<p>Please refer below to Prosthetic Devices and Related Supplies.</p> <p>Please refer below to Prosthetic Devices and Related Supplies.</p> <p>Please refer below to Outpatient Rehabilitation Services.</p>
<p><b>Home Health Agency Care</b></p> <p>Covered services include:</p> <ul style="list-style-type: none"> <li>● 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)</li> <li>● Physical therapy, occupational therapy, and speech therapy</li> <li>● Medical and social services</li> <li>● Medical equipment and supplies</li> </ul>	<p>\$0 copayment for all home health visits provided by a network home health agency when Medicare criteria are met.</p> <p>Other copayments or coinsurance may apply (Please see Durable Medical Equipment and Related Supplies for applicable copayments or coinsurance).</p>
<p><b>Hospice Care</b></p> <p>You may receive care from any Medicare-certified hospice program. Your hospice doctor can be a network provider or an out-of-network provider.</p>	<p>When you enroll in a Medicare-certified hospice program, your hospice services and your Part A and Part B services related to your terminal condition are paid for by Original Medicare, not</p>

<p><b>Services that are covered for you</b></p>	<p><b>What you must pay</b> when you get these services</p>
<p>Original Medicare (rather than our Plan) will pay for your hospice services and any Part A and Part B services related to your terminal condition. While you are in the hospice program, your hospice provider will bill Original Medicare for the services that Original Medicare pays for.</p> <p>Covered services include:</p> <ul style="list-style-type: none"> <li>● Drugs for symptom control and pain relief</li> <li>● Short-term respite care</li> <li>● Home care</li> </ul> <p>You are still a member of our plan. If you need non-hospice care (care that is not related to your terminal condition), you have two options:</p> <ul style="list-style-type: none"> <li>● You can obtain your non-hospice care from plan providers. In this case, you only pay plan allowed cost sharing</li> <li>● --or-- You can get your care covered by Original Medicare. In this case, you must pay the cost-sharing amounts under Original Medicare, except for emergency or urgently needed care. However, after payment, you can ask us to pay you back for the difference between the cost sharing in our plan and the cost sharing under Original Medicare.</li> </ul> <p><b>Note:</b> 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 network providers will lower your share of the costs for the services.</p> <p>Our Plan covers hospice consultation services (one time only) for a terminally ill person who hasn't elected the hospice benefit.</p>	<p>Physicians Health Choice Select (HMO SNP).</p>
<p><b>Outpatient Services</b></p>	

<p><b>Services that are covered for you</b></p>	<p><b>What you must pay</b> when you get these services</p>
<p><b>Physician Services, Including Doctor Office Visits</b></p> <p>Covered services include:</p> <ul style="list-style-type: none"> <li>● Medically-necessary medical or surgical services furnished in a physician’s office</li>   <li>● Medically-necessary medical or surgical services furnished in a certified ambulatory surgical center or hospital outpatient department</li>   <li>● Other health care professionals</li> <li>● Consultation, diagnosis, and treatment by a specialist</li>   <li>● Basic hearing and balance exams performed by your specialist, if your doctor orders it to see if you need medical treatment.</li>   <li>● Telehealth office visits including consultation, diagnosis and treatment by a specialist</li> </ul>	<p>\$0 copayment for services obtained from a primary care physician or under certain circumstances, treatment by a nurse practitioner or physician’s assistant or other non-physician health care professionals in a primary care physician’s office (as permitted under Medicare rules).</p> <p>See “Outpatient surgery” later in this chart for any applicable copayments or coinsurance amounts for ambulatory surgical center visits or in a hospital outpatient setting.</p> <p>\$0 copayment for services obtained from a specialist, or under certain circumstances, treatment by a nurse practitioner or physician’s assistant or other non-physician health care professionals in a specialist’s office (as permitted under Medicare rules).</p> <p>\$0 copayment for each Medicare-covered exam.</p> <p>\$0 copayment for each visit.</p>

<p><b>Services that are covered for you</b></p>	<p><b>What you must pay</b> when you get these services</p>
<ul style="list-style-type: none"> <li>● Second opinion by another network provider prior to surgery</li> <li>● 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)</li> <li>● Monitoring services if you are taking anticoagulation medications, such as Coumadin, Heparin or Warfarin (these services may also be referred to as ‘Coumadin Clinic’ services)</li> </ul>	<p>\$0 copayment for each Medicare-covered visit.</p> <p>\$0 copayment for services obtained from a primary care physician.</p> <p>\$0 copayment for services obtained from a specialist.</p>
<p><b>Outpatient Hospital Services</b></p> <p>We cover medically-necessary services you get in the outpatient department of a hospital for diagnosis or treatment of an illness or injury.</p> <p>Covered services include:</p> <ul style="list-style-type: none"> <li>● Services in an emergency department or outpatient clinic, including same-day surgery</li> <li>● Laboratory tests billed by the hospital</li> </ul>	<p>Please refer to Emergency Care or Outpatient Surgery, Including Services Provided at Hospital Outpatient Facilities and Ambulatory Surgical Centers</p> <p>Please refer to Outpatient Diagnostic Tests and Therapeutic Services and</p>

<p><b>Services that are covered for you</b></p>	<p><b>What you must pay</b> when you get these services</p>
<ul style="list-style-type: none"> <li>● Mental health care, including care in a partial-hospitalization program, if a doctor certifies that inpatient treatment would be required without it</li> <li>● X-rays and other radiology services billed by the hospital</li> <li>● Medical supplies such as splints and casts</li> <li>● Certain screenings and preventive services</li> <li>● Certain drugs and biologicals that you can't give yourself</li> </ul> <p><b>Note:</b> 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.</p> <p>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 <a href="http://www.medicare.gov/Publications/Pubs/pdf/11435.pdf">http://www.medicare.gov/Publications/Pubs/pdf/11435.pdf</a> or by calling 1-800-MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048. You can call these numbers for free,</p>	<p>Supplies</p> <p>Please refer to Outpatient Mental Health Care</p> <p>Please refer to Outpatient Diagnostic Tests and Therapeutic Services and Supplies</p> <p>Please refer to Outpatient Diagnostic Tests and Therapeutic Services and Supplies</p> <p>Please refer to Preventive Services</p> <p>Please refer to Medicare Part B Prescription Drugs</p>

<b>Services that are covered for you</b>	<b>What you must pay</b> when you get these services
24 hours a day, 7 days a week.	
<p><b>Chiropractic Services</b></p> <p>Covered services include:</p> <ul style="list-style-type: none"> <li>• We cover only manual manipulation of the spine to correct subluxation</li> </ul>	\$0 copayment for each Medicare-covered visit.
<p><b>Podiatry Services</b></p> <p>Covered services include:</p> <ul style="list-style-type: none"> <li>• Treatment of injuries and diseases of the feet (such as hammer toe or heel spurs).</li> <li>• Routine foot care for members with certain medical conditions affecting the lower limbs.</li> </ul>	\$0 copayment for each Medicare-covered visit.
<p><b>Outpatient Mental Health Care</b></p> <p>Covered services include:</p> <p>Mental health services provided by a doctor, clinical psychologist, clinical social worker, clinical nurse specialist, nurse practitioner, physician assistant, or other Medicare-qualified mental health care professional as allowed under applicable state laws.</p>	<p>\$0 copayment for each Medicare-covered individual therapy session.</p> <p>\$0 copayment for each Medicare-covered group therapy session.</p>
<p><b>Partial Hospitalization Services</b></p> <p>“Partial hospitalization” is a structured program of active psychiatric treatment provided in a hospital outpatient setting or by a community mental health center, that is more intense than the care received in your doctor’s or therapist’s office and is an alternative to inpatient hospitalization.</p>	\$0 copayment each day for Medicare-covered benefits.

<b>Services that are covered for you</b>	<b>What you must pay</b> when you get these services
<p><b>Outpatient Substance Abuse Services</b></p>	<p>\$0 copayment for each Medicare-covered individual therapy session.</p> <p>\$0 copayment for each Medicare-covered group therapy session.</p>
<p><b>Outpatient Surgery, Including Services Provided at Hospital Outpatient Facilities and Ambulatory Surgical Centers</b></p> <p><b>Note:</b> 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.”</p>	<p>\$0 copayment for Medicare-covered services provided to you at an outpatient hospital, including but not limited to hospital or other facility charges, physician or surgical charges, and tests.</p> <p>\$0 copayment for Medicare-covered services provided to you at an ambulatory surgical center, including but not limited to hospital or other facility charges, physician or surgical charges, and tests.</p>
<p><b>Ambulance Services</b></p> <ul style="list-style-type: none"> <li>• Covered ambulance services include fixed wing, rotary wing, and ground ambulance services, to the nearest appropriate facility that can provide care only if they are furnished to a member whose medical condition is such that other means of transportation are contraindicated (could endanger the person’s health) or if authorized by the plan. The member’s condition must require both the ambulance transportation itself and the level of service provided in order for the billed service to be considered</li> </ul>	<p>\$0 copayment for each one-way Medicare-covered trip.</p> <p>You pay these amounts until you reach the out-of-pocket maximum.</p>

<p><b>Services that are covered for you</b></p>	<p><b>What you must pay</b> when you get these services</p>
<p>medically necessary.</p> <ul style="list-style-type: none"> <li>• 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.</li> </ul>	
<p><b>Emergency Care</b></p> <p>Emergency care is care that is needed to evaluate or stabilize an emergency medical condition.</p> <p>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.</p> <p>Worldwide coverage for emergency department services.</p>	<p>\$0 copayment for each emergency room visit.</p> <p>You do not pay this amount if you are admitted to the hospital within 24 hours for the same condition.</p> <p>\$65 copayment for Worldwide coverage of emergency department services.</p> <p>If you receive emergency care at an out-of-network hospital and need inpatient care after your emergency condition is stabilized, you must return to a network hospital in order for your care to continue to be covered or you must have your inpatient care at the out-of-network hospital authorized by the plan and your cost is the cost sharing you would pay at a network hospital.</p> <p>You pay these amounts until you reach the out-of-pocket maximum.</p>

<b>Services that are covered for you</b>	<b>What you must pay</b> when you get these services
<p><b>Urgently Needed Care</b></p> <p>Urgently needed care is care provided to treat a non-emergency, unforeseen medical illness, injury, or condition, that requires immediate medical care, but the plan's network of providers is temporarily unavailable or inaccessible.</p> <p>Urgently needed care is provided within the United States according to Medicare coverage guidelines.</p>	<p>\$0 copayment for each visit in a network Urgent Care Center.</p> <p>\$0 copayment for each visit in a non-network or an out-of-area facility.</p> <p>You pay these amounts until you reach the out-of-pocket maximum.</p>
<p><b>Outpatient Rehabilitation Services</b></p> <p>Covered services include: physical therapy, occupational therapy, and speech language therapy.</p> <p>Outpatient rehabilitation services are provided in various outpatient settings, such as hospital outpatient departments, independent therapist offices, and Comprehensive Outpatient Rehabilitation Facilities (CORFs).</p>	<p>\$0 copayment for each Medicare-covered physical therapy and speech-language therapy visit.</p> <p>\$0 copayment for each Medicare-covered occupational therapy visit.</p>
<p><b>Cardiac Rehabilitation Services</b></p> <p>Comprehensive programs that include exercise, education, and counseling are covered for members who meet certain conditions with a doctor's referral. The plan also covers intensive cardiac rehabilitation programs that are typically more rigorous or more intense than cardiac rehabilitation programs.</p>	<p>\$0 copayment for each Medicare-covered cardiac rehabilitative visit.</p>
<p><b>Pulmonary Rehabilitation Services</b></p> <p>Comprehensive programs of pulmonary rehabilitation are</p>	<p>\$0 copayment for each Medicare-covered pulmonary rehabilitative visit.</p>

<b>Services that are covered for you</b>	<b>What you must pay</b> when you get these services
<p>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.</p>	
<p><b>Durable Medical Equipment and Related Supplies</b></p> <p>(For a definition of “durable medical equipment,” see Chapter 12 of this booklet.)</p> <p>Covered items include, but are not limited to: wheelchairs, crutches, hospital bed, IV infusion pump, oxygen equipment, nebulizer, and walker.</p>	<p>\$0 copayment for Medicare-covered benefits.</p> <p>You pay these amounts until you reach the out-of-pocket maximum.</p>
<p><b>Prosthetic Devices and Related Supplies</b></p> <p>Devices (other than dental) that replace a body part or function. These include, but are not limited to: colostomy bags and supplies directly related to colostomy care, pacemakers, braces, prosthetic shoes, artificial limbs, and breast prostheses (including a surgical brassiere after a mastectomy). Includes certain supplies related to prosthetic devices, and repair and/or replacement of prosthetic devices. Also includes some coverage following cataract removal or cataract surgery – see “Vision Care” later in this section for more detail.</p> <p>There is no separate charge for medical supplies routinely used in the course of an office visit and included in the provider’s charges for that visit (such as bandages, cotton swabs, and other routine supplies.) However, supplies for which an appropriate separate charge is made by providers (such as, chemical agents used in certain diagnostic procedures) are subject to cost sharing as shown.</p>	<p>\$0 copayment for each Medicare-covered prosthetic or orthotic device, including replacement or repairs of such devices.</p> <p>\$0 copayment for Medicare-covered supplies.</p> <p>You pay these amounts until you reach the out-of-pocket maximum.</p>
<p><b>Diabetes Self-Management Training, Diabetic Services and</b></p>	

<b>Services that are covered for you</b>	<b>What you must pay</b> when you get these services
<p><b>Supplies</b></p> <p>For all people who have diabetes (insulin and non-insulin users). Covered services include:</p> <ul style="list-style-type: none"> <li>● Blood glucose monitor, blood glucose test strips, lancet devices and lancets, and glucose-control solutions for checking the accuracy of test strips and monitors</li>   <li>● For people with diabetes who have severe diabetic foot disease: One pair per calendar 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). Coverage includes fitting.</li>   <li>● Diabetes self-management training is covered under certain conditions</li> </ul>	<p>\$0 copayment for each Medicare-covered diabetes monitoring supply.</p> <p>For cost sharing applicable to insulin and syringes, see Chapter 6 - What you pay for your Part D prescription drugs.</p> <p>\$0 copayment for each pair of Medicare-covered therapeutic shoes.</p> <p>You pay these amounts until you reach the out-of-pocket maximum.</p> <p>\$0 copayment for Medicare-covered benefits.</p>
<p><b>Outpatient Diagnostic Tests and Therapeutic Services and Supplies</b></p> <p>Covered Services Include:</p> <ul style="list-style-type: none"> <li>● X-rays</li>   <li>● Radiation (radium and isotope) therapy including</li> </ul>	<p>\$0 copayment for each Medicare-covered standard X-ray service.</p> <p>\$0 copayment for each</p>

<p><b>Services that are covered for you</b></p>	<p><b>What you must pay</b> when you get these services</p>
<p>technician materials and supplies</p> <ul style="list-style-type: none"> <li>● Surgical supplies, such as dressings</li> <li>● Splints, casts and other devices used to reduce fractures and dislocations</li>   <li>● Laboratory tests</li>   <li>● Blood - Coverage begins with the first pint of blood that you need.</li>   <li>● Other outpatient diagnostic tests                      Non-radiological diagnostic services                      Radiological diagnostic services, not including x-rays.</li> </ul>	<p>Medicare-covered radiation therapy service.</p> <p>\$0 copayment for each Medicare-covered medical supply.</p> <p>You pay these amounts until you reach the out-of-pocket maximum.</p> <p>\$0 copayment for Medicare-covered lab services.</p> <p>\$0 copayment for Medicare-covered blood services.</p> <p>\$0 copayment for Medicare-covered non-radiological diagnostic services.</p> <p>Examples include, but are not limited to EKG's, pulmonary function tests, sleep studies and treadmill stress tests.</p> <p>\$0 copayment for each Medicare-covered radiological diagnostic service, not including X-rays, performed in a physician's office or at a free-standing facility (such as a</p>

<p><b>Services that are covered for you</b></p>	<p><b>What you must pay</b> when you get these services</p>
	<p>radiology center or medical clinic).</p> <p>The diagnostic radiology services require specialized equipment beyond standard X-ray equipment and must be performed by specially trained or certified personnel. Examples include, but are not limited to, specialized scans, CT, SPECT, PET, MRI, MRA, nuclear studies, ultrasounds, diagnostic mammograms and interventional radiological procedures (myelogram, cystogram, angiogram, and barium studies).</p> <p>See “Outpatient Surgery, Including Services Provided at Hospital Outpatient Facilities and Ambulatory Surgical Centers” earlier in this chart for any applicable copayments or coinsurance amounts for diagnostic radiology services performed at an outpatient facility.</p>
<p><b>Vision Care</b></p> <p>Covered services include:</p> <ul style="list-style-type: none"> <li>• Outpatient physician services for the diagnosis and</li> </ul>	<p>\$0 copayment for each</p>

<b>Services that are covered for you</b>	<b>What you must pay</b> when you get these services
<p>treatment of diseases and conditions of the eye. Original Medicare doesn't cover routine eye exams (eye refractions) for eyeglasses/contacts.</p> <ul style="list-style-type: none"> <li>• 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.</li> <li>• 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.</li> </ul> <p>See 'Additional Benefits' section for Non-Medicare Covered Vision Care.</p>	<p>Medicare-covered visit.</p> <p>\$0 copayment for Medicare-covered glaucoma screening.</p> <p>\$0 copayment for one pair of Medicare-covered standard glasses or contact lenses after cataract surgery.</p>
<b>Preventive Services</b>	
<b>Note:</b> 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.	
<p><b>Abdominal Aortic Aneurysm Screening</b></p> <p>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" physical exam.</p>	<p>\$0 copayment for each Medicare-covered screening.</p>
<p><b>Bone Mass Measurement</b></p> <p>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</p>	<p>\$0 copayment for each Medicare-covered screening.</p>

<b>Services that are covered for you</b>	<b>What you must pay</b> when you get these services
bone loss, or determine bone quality, including a physician's interpretation of the results.	
<p><b>Colorectal Cancer Screening</b></p> <p>For people 50 and older, the following are covered:</p> <ul style="list-style-type: none"> <li>● Flexible sigmoidoscopy (or screening barium enema as an alternative) every 48 months</li> <li>● Fecal occult blood test, every 12 months</li> </ul> <p>For people at high risk of colorectal cancer, we cover:</p> <ul style="list-style-type: none"> <li>● Screening colonoscopy (or screening barium enema as an alternative) every 24 months</li> </ul> <p>For people not at high risk of colorectal cancer, we cover:</p> <ul style="list-style-type: none"> <li>● Screening colonoscopy every 10 years (120 months), but not within 48 months of a screening sigmoidoscopy</li> </ul>	<p>\$0 copayment for each Medicare-covered screening</p> <p>A screening colonoscopy or screening sigmoidoscopy does not include polyp removal or biopsy procedures. A colonoscopy or sigmoidoscopy that includes polyp removal or biopsy is a surgical procedure subject to the Outpatient Surgery cost sharing described earlier in this chart.</p>
<p><b>HIV Screening</b></p> <p>For people who ask for an HIV screening test or who are at increased risk for HIV infection, we cover:</p> <ul style="list-style-type: none"> <li>● One screening test every 12 months</li> </ul> <p>For women who are pregnant, we cover:</p> <ul style="list-style-type: none"> <li>● Up to three screening tests during a pregnancy</li> </ul>	<p>\$0 copayment for each Medicare-covered screening.</p>
<p><b>Immunizations</b></p> <p>Covered Medicare Part B services include:</p> <ul style="list-style-type: none"> <li>● Pneumonia vaccine</li> <li>● Flu shots, once a year in the fall or winter</li> <li>● Hepatitis B vaccine if you are at high or intermediate risk of getting Hepatitis B</li> <li>● Other vaccines if you are at risk and they meet Medicare</li> </ul>	<p>\$0 copayment for each Medicare-covered pneumonia vaccine and flu vaccine.</p> <p>\$0 copayment for Hepatitis B vaccine.</p> <p>\$0 copayment for all other</p>

<b>Services that are covered for you</b>	<b>What you must pay</b> when you get these services
<p>Part B coverage rules</p> <p>We also cover some vaccines under our Part D prescription drug benefit. See Chapter 6 for more information about coverage and applicable cost sharing.</p>	<p>Medicare-covered Immunizations.</p>
<p><b>Breast Cancer Screening (Mammograms)</b></p> <p>Covered services include:</p> <ul style="list-style-type: none"> <li>● One baseline mammogram between the ages of 35 and 39</li> <li>● One screening mammogram every 12 months for women age 40 and older</li> <li>● Clinical breast exam once every 24 months</li> </ul>	<p>\$0 copayment for each Medicare-covered screening.</p>
<p><b>Cervical and Vaginal Cancer Screening</b></p> <p>Covered services include:</p> <ul style="list-style-type: none"> <li>● For all women: Pap tests and pelvic exams are covered once every 24 months</li> <li>● If you are at high risk of cervical cancer or have had an abnormal Pap test and are of childbearing age: one Pap test every 12 months</li> </ul>	<p>\$0 copayment for each Medicare-covered test or exam.</p>
<p><b>Prostate Cancer Screening Exams</b></p> <p>For men age 50 and older, covered services include the following – once every 12 months:</p> <ul style="list-style-type: none"> <li>● Digital rectal exam</li> <li>● Prostate Specific Antigen (PSA) test</li> </ul>	<p>\$0 copayment for each Medicare-covered digital rectal exam.</p> <p>\$0 copayment for each Medicare-covered PSA test.</p>
<p><b>Cardiovascular Disease Testing</b></p>	<p>\$0 copayment for each Medicare-covered test.</p>

<p><b>Services that are covered for you</b></p>	<p><b>What you must pay</b> when you get these services</p>
<p>Blood tests for the detection of cardiovascular disease (or abnormalities associated with an elevated risk of cardiovascular disease) covered once every 5 years (60 months).</p>	
<p><b>“Welcome to Medicare” Physical Exam</b></p> <p>The plan covers a one-time “Welcome to Medicare” physical exam, which includes a review of your health, as well as education and counseling about the preventive services you need (including certain screenings and shots), and referrals for other care if needed.</p> <p><b>Important:</b> You must have the physical exam 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” physical exam.</p>	<p>There is no coinsurance, copayment, or deductible for the Welcome to Medicare exam.</p>
<p><b>Annual Wellness Visit</b></p> <p>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.</p> <p><b>Note:</b> Your first annual wellness visit can’t take place within 12 months of your “Welcome to Medicare” exam. However, you don’t need to have had a “Welcome to Medicare” exam to be covered for annual wellness visit after you’ve had Part B for 12 months.</p>	<p>There is no coinsurance, copayment, or deductible for the annual wellness visit.</p>
<p><b>Diabetes Screening</b></p> <p>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</p>	<p>\$0 copayment for each Medicare-covered screening.</p>

<b>Services that are covered for you</b>	<b>What you must pay</b> when you get these services
<p>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.</p> <p>Based on the results of these tests, you may be eligible for up to two diabetes screenings every 12 months.</p>	
<p><b>Medical Nutrition Therapy</b></p> <p>This benefit is for people with diabetes, renal (kidney) disease (but not on dialysis), or after a transplant when referred by your doctor.</p> <p>We cover 3 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 2 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 calendar year.</p>	<p>\$0 copayment for Medicare-covered benefits.</p>
<p><b>Smoking and Tobacco Use Cessation (Counseling to Stop Smoking)</b></p> <p>If you use tobacco, but do not have signs or symptoms of tobacco-related disease: we cover two counseling quit attempts within a 12-month period. Each counseling attempt includes up to four face-to-face visits.</p> <p>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 two</p>	<p>\$0 copayment if you haven’t been diagnosed with an illness caused or complicated by tobacco use.</p> <p>\$0 copayment if you have been diagnosed with an illness caused or complicated by tobacco use, or you take a medicine that is affected by tobacco use.</p>

<b>Services that are covered for you</b>	<b>What you must pay</b> when you get these services
<p>counseling quit attempts within a 12-month period. Each counseling attempt includes up to four face-to-face visits, however, you will pay the applicable inpatient or outpatient cost sharing.</p>	
<b>Other Services</b>	
<p><b>Services to Treat Kidney Disease and Conditions</b></p> <p>Covered services include:</p> <ul style="list-style-type: none"> <li>● 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.</li> <li>● Outpatient dialysis treatments (including dialysis treatments when temporarily out of the service area, as explained in Chapter 3)</li> <li>● Inpatient dialysis treatments (if you are admitted as an inpatient to a hospital for special care)</li> <li>● Self-dialysis training (includes training for you and anyone helping you with your home dialysis treatments)</li> <li>● Home dialysis equipment and supplies</li> <li>● Certain home support services (such as, when necessary, visits by trained dialysis workers to check on your home</li> </ul>	<p>\$0 copayment for Medicare-covered benefits.</p> <p>\$0 copayment for Medicare-covered benefits.</p> <p>These services will be covered as described in the following sections:                      Please refer to Inpatient Hospital Care.</p> <p>Please refer to Home Health Agency Care.</p> <p>Please refer to Durable Medical Equipment and Related Supplies.</p> <p>Please refer to Home Health Agency Care.</p>

<p><b>Services that are covered for you</b></p>	<p><b>What you must pay</b> when you get these services</p>
<p>dialysis, to help in emergencies, and check your dialysis equipment and water supply)</p> <p>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.”</p>	
<p><b>Medicare Part B Prescription Drugs</b></p> <p>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:</p> <ul style="list-style-type: none"> <li>● Drugs that usually aren’t self-administered by the patient and are injected or infused while you are getting physician, hospital outpatient, or ambulatory surgical center services</li> <li>● Drugs you take using durable medical equipment (such as nebulizers) that was authorized by the plan</li> <li>● Clotting factors you give yourself by injection if you have hemophilia</li> <li>● Immunosuppressive Drugs, if you were enrolled in Medicare Part A at the time of the organ transplant</li> <li>● 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</li> <li>● Antigens</li> <li>● Certain oral anti-cancer drugs and anti-nausea drugs</li> <li>● Certain drugs for home dialysis, including heparin, the antidote for heparin when medically necessary, topical anesthetics, and erythropoiesis-stimulating agents (such as Epogen<sup>®</sup>, Procrit<sup>®</sup>, Epoetin Alfa, Aranesp<sup>®</sup>, or Darbepoetin Alfa)</li> <li>● Intravenous Immune Globulin for the home treatment of</li> </ul>	<p>\$0 copayment for each Medicare-covered Part B drug.</p> <p>You pay these amounts until you reach the out-of-pocket maximum.</p> <p>\$0 copayment for each Medicare-covered chemotherapy drugs and the administration of that drug.</p> <p>You pay these amounts until you reach the out-of-pocket maximum.</p>

<b>Services that are covered for you</b>	<b>What you must pay</b> when you get these services
<p>primary immune deficiency diseases</p> <ul style="list-style-type: none"> <li>• Chemotherapy Drugs, and the Administration of chemotherapy drugs</li> </ul> <p>Chapter 5 explains the Part D prescription drug benefit, including rules you must follow to have prescriptions covered. What you pay for your Part D prescription drugs through our plan is listed in Chapter 6.</p>	
<b>Additional Benefits</b>	
<p><b>Dental Services</b></p> <p>In general, preventive dental services (such as cleaning, routine dental exams, and dental x-rays) are not covered by Original Medicare. We cover:</p> <p><b>Preventive Dental Services:</b></p> <ul style="list-style-type: none"> <li>• Oral exams once every year</li> <li>• Routine cleanings once every 6 months</li> <li>• Topical Application of Fluoride once a year</li> <li>• Routine xrays, to include Bitewing - 2 films, or Bitewing - 4 films or 1 Panoramic Film once every calendar year</li> </ul> <p>Please refer to the “Additional Benefits Contact List” in your Provider Directory for contracted provider information.</p>	<p>\$0 copayment</p>
<p><b>Hearing Services</b></p> <p>Basic hearing evaluations performed by your provider are covered as outpatient care when furnished by a physician, audiologist, or other qualified provider.</p> <p><b>Routine Hearing Exams</b></p> <ul style="list-style-type: none"> <li>• Limited to 1 exam(s) every year.</li> </ul>	<p><b>Hearing Exam:</b>                  Provided by: EPIC Hearing Healthcare                  \$0 copayment</p> <p><b>Hearing Aids:</b>                  Provided by: EPIC Hearing Healthcare</p>

<b>Services that are covered for you</b>	<b>What you must pay</b> when you get these services
<p><b>Hearing Aids:</b></p> <p>Hearing Aids are covered every 2 years.</p> <p>Please refer to the “Additional Benefits Contact List” in your Provider Directory for contracted provider information.</p>	<p>Hearing aid credit is \$300</p>
<p><b>Vision Care</b></p> <p><b>Routine Eye Exam:</b></p> <ul style="list-style-type: none"> <li>• Limited to 1 exam(s) every year.</li> </ul> <p><b>Routine Eye Wear:</b></p> <ul style="list-style-type: none"> <li>• Standard lenses/frames and contact lenses every 2 years.</li> </ul>	<p><b>Routine Eye Exam:</b></p> <ul style="list-style-type: none"> <li>• \$0 copayment</li> </ul> <p><b>Routine Eye Wear:</b></p> <ul style="list-style-type: none"> <li>• \$10 copayment for standard lenses/frames and unlimited contact lenses up to \$200*</li> </ul>
<p><b>Health and Wellness Education Program</b></p> <p><b>Health Products Benefit</b></p> <p>You will receive a quarterly credit (January, April, July and October) that will allow you to purchase personal health care items from the FieldTex Products, Inc. catalog. This catalog contains many daily use over the counter products which will be delivered to you. The quarterly credit expires at the end of each quarter (March 31, June 30th, September 30th and December 31st) and can not be added to the next quarter.</p>	<ul style="list-style-type: none"> <li>• Quarterly Credit is \$50</li> </ul>
<p><b>Health and Wellness Education Program</b></p> <p><b>Fitness Program:</b></p> <p>Membership for SilverSneakers® Fitness Program through</p>	<p>Provided by: SilverSneakers® Fitness Program                  \$0 copayment</p>

<b>Services that are covered for you</b>	<b>What you must pay</b> when you get these services
<p>network fitness centers. There is no visit or use fee for basic membership when you use network service providers.</p> <p>Please refer to the “Additional Benefits Contact List” in your Provider Directory for contracted provider information.</p>	
<p><b>Routine Physical Exam</b></p> <p>Includes comprehensive physical examination and evaluation of status of chronic diseases. Doesn’t include lab tests.</p>	<p>\$0 copayment for a routine physical exam each year.</p>
<p><b>Routine Transportation</b></p> <p>Routine transportation for up to 30 one-way transportation trips per calendar year.                      (limited to ground transportation only)</p> <ul style="list-style-type: none"> <li>● Pick-up to or from plan approved locations such as network physicians, medical facilities and pharmacies.</li> </ul> <p>Transportation services must be requested 48 hours prior to a scheduled appointment.</p> <p>Note: Transportation is only provided within the service area. Transportation by stretcher (for members who require a stretcher) is not a covered benefit. Drivers do not have medical training. In case of an emergency, call 911.</p>	<p>\$0 copayment</p>
<p>* Covered services that do not count toward your maximum out-of-pocket amount.</p>	

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## SECTION 3      What benefits are not covered by the plan?

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<b>Section 3.1      Benefits we do not cover (exclusions)</b>
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This section tells you what kinds of benefits are “excluded.” Excluded means that plan doesn’t cover these benefits. In some cases, we cover items or services that are excluded by Medicare under our Plan’s Medicaid benefits. For more information about Texas Medicaid Health and Human Services Commission (Medicaid) benefits, call Customer Service (phone numbers are on the back cover of this booklet).

The list below describes some services and items that aren’t covered by the plan under any conditions and some that are excluded by Medicare only under specific conditions.

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 6.3 in this booklet.)

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

- Services considered not reasonable and necessary, according to the standards of Original Medicare, unless these services are listed by our Plan as covered services.
- Experimental medical and surgical procedures, equipment and medications, unless covered by Original Medicare or under a Medicare-approved clinical research study. (See Chapter 3, Section 5 for more information on clinical research studies.) Experimental procedures and items are those items and procedures determined by our plan and Original Medicare to not be generally accepted by the medical community.
- Surgical treatment for morbid obesity, except when it is considered medically necessary and covered under Original Medicare.
- Private room in a hospital, except when it is considered medically necessary.
- Private duty nurses.
- Personal items in your room at a hospital or a skilled nursing facility, such as a telephone or a television.
- Full-time nursing care in your home.
- Custodial care, unless it is provided with covered skilled nursing care and/or skilled rehabilitation services. Custodial care, or non-skilled care, is care that helps you with activities of daily living, such as bathing or dressing.
- Homemaker services include basic household assistance, including light housekeeping or light meal preparation.
- Fees charged by your immediate relatives or members of your household.
- Meals delivered to your home.

- Elective or voluntary enhancement procedures or services (including weight loss, hair growth, sexual performance, athletic performance, cosmetic purposes, anti-aging and mental performance), except when medically necessary.
- Cosmetic surgery or procedures, unless because of an accidental injury or to improve a malformed part of the body. However, all stages of reconstruction are covered for a breast after a mastectomy, as well as for the unaffected breast to produce a symmetrical appearance.
- Routine dental care, such as cleanings, fillings or dentures, except as specifically described in the Medical Benefits Chart in this chapter. However, non-routine dental care required to treat illness or injury may be covered as inpatient or outpatient care.
- Chiropractic care, other than manual manipulation of the spine consistent with Medicare coverage guidelines, except as specifically described in the Medical Benefits Chart in this chapter.
- Routine foot care, except for the limited coverage provided according to Medicare guidelines, except as specifically described in the Medical Benefits Chart in this chapter.
- Orthopedic shoes, unless the shoes are part of a leg brace and are included in the cost of the brace or the shoes are for a person with diabetic foot disease, except as specifically described in the Medical Benefits Chart in this chapter.
- Supportive devices for the feet, except for orthopedic or therapeutic shoes for people with diabetic foot disease.
- Routine hearing exams, hearing aids, or exams to fit hearing aids, except as specifically described in the Medical Benefits Chart in this chapter.
- Eyeglasses, routine eye examinations (except as specifically described in the Medical Benefits Chart in this chapter), radial keratotomy, LASIK surgery, vision therapy and other low vision aids. However, eyeglasses are covered for people after cataract surgery.
- Outpatient prescription drugs including drugs for treatment of sexual dysfunction, including erectile dysfunction, impotence, and anorgasmia or hyporgasmia, except as described in Chapter 6.
- Reversal of sterilization procedures, sex change operations, and non-prescription contraceptive supplies.
- Acupuncture, except as specifically described in the Medical Benefits Chart in this chapter.
- Naturopath services (uses natural or alternative treatments), except as specifically described in the Medical Benefits Chart in this chapter.
- Services provided to veterans in Veterans Affairs (VA) facilities. However, when emergency services are received at VA hospital and the VA cost-sharing is more than the cost-sharing under our Plan, we will reimburse veterans for the difference. Members are still responsible for our cost-sharing amounts.
- Paramedic intercept service (advanced life support provided by an emergency service entity, such as a paramedic services unit, which do not provide ambulance transport), except when Medicare criteria are met.
- Optional, additional, or deluxe features or accessories to durable medical equipment, corrective appliances or prosthetics which are primarily for the comfort or convenience of the Member, or for ambulation primarily in the community, including home and car remodeling or modification.
- Immunizations for foreign travel purposes.

- Substance abuse detoxification and rehabilitation, except as covered in accordance with Medicare guidelines.
- If you are asking the plan to pay its share of the costs for covered drugs, you must send us your request for payment within 90 days of getting your prescription filled.

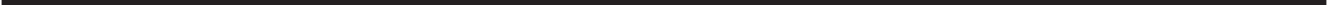
We regularly review new procedures, devices and drugs to determine whether or not they are safe and efficacious for Members. New procedures and technology that are safe and efficacious are eligible to become Covered Services. If the technology becomes a Covered Service, it will be subject to all other terms and conditions of the plan, including medical necessity and any applicable Member Copayments, Coinsurance, deductibles or other payment contributions.

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

The plan will not cover the excluded services listed above. Even if you receive the services at an emergency facility, the excluded services are still not covered.

**CHAPTER 5: Using the plan's coverage for your Part D prescription drugs**

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### How can you get information about your drug costs?

Because you are eligible for Texas Medicaid Health and Human Services Commission (Medicaid), you qualify for and are getting “Extra Help” from Medicare to pay for your prescription drug plan costs. Because you are in the Extra Help program, **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 the “Evidence of Coverage Rider for People Who Get Extra Help Paying for Prescription Drugs” (LIS Rider), which tells you about your drug coverage. If you don't have this insert, please call Customer Service and ask for the “Evidence of Coverage Rider for People Who Get Extra Help Paying for Prescription Drugs” (LIS Rider). Phone numbers for Customer Service are on the back cover of this booklet.

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## SECTION 1 Introduction

Section 1.1 This chapter describes your coverage for Part D drugs
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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. Chapter 4 (**Medical Benefits Chart, what is covered and what you pay**) 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, certain drug injections you are given during an office visit, and drugs you are given at a dialysis facility. Chapter 4 (**Medical Benefits Chart, what is covered and what you pay**) tells about your benefits and costs for Part B drugs.

In addition to the drugs covered by Medicare, some prescription drugs are covered for you under your Texas Medicaid Health and Human Services Commission (Medicaid) benefits. The Texas Medicaid Health and Human Services Commission (Medicaid) Drug List tells you how to find out about your Texas Medicaid Health and Human Services Commission (Medicaid) drug coverage. **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**).

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<b>Section 1.2</b>	<b>Basic rules for the plan's Part D drug coverage</b>
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The plan will generally cover your drugs as long as you follow these basic rules:

- You must have a network provider (a doctor or other prescriber) write your prescription.
- You must use a network pharmacy to fill your prescription. (See Section 2, **Fill your prescriptions at a network pharmacy or through the plan's mail-order service.**)
- Your drug must be on the plan's **List of Covered Drugs (Formulary)** (we call it the "Drug List" for short). (See Section 3, **Your drugs need to be on the plan's Drug List.**)
- Your 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 Section 3 for more information about a medically accepted indication.)

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<b>SECTION 2</b>	<b>Fill your prescription at a network pharmacy or through the plan's mail-order service</b>
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<b>Section 2.1</b>	<b>To have your prescription covered, use a network pharmacy</b>
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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 all of the Part D prescription drugs that are covered on the plan's Drug List.

<b>Section 2.2</b>	<b>Finding network pharmacies</b>
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**How do you find a network pharmacy in your area?**

To find a network pharmacy, you can look in your **Pharmacy Directory**, visit our website ([www.PHCcares.com](http://www.PHCcares.com)) or call Customer Service (phone numbers are on the back cover of this booklet). Choose whatever is easiest for you.

You may go to any of our network pharmacies. If you switch from one network pharmacy to another, and you need a refill of a drug you have been taking, you can ask 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 on the back 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.
- 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.

### Section 2.3 Using the plan's mail-order services

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

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

To get order forms and information about filling your prescriptions by mail, please reference your **Pharmacy Directory** to find the mail service pharmacies in our network. If you use a mail-order pharmacy not in the plan's network, your prescription will not be covered.

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

If your prescription is on file at your local pharmacy, go to your pharmacy to fill the prescription. If your delayed prescription is not on file at your local pharmacy, then please ask your doctor to call in a new prescription to your pharmacist. Or, your pharmacist can call the doctor's office for you to request the prescription. Your pharmacist can call the Pharmacy help desk at 1-877-889-6481, (TTY/TDD) 711, 24 hours a day, 7 days a week if he/she has any problems, questions, concerns, or needs a claim override for a delayed prescription.

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

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

drugs. Some of these retail pharmacies may agree to accept the mail-order cost-sharing amount for a long-term supply of mail-order drugs. Other retail pharmacies may not agree to accept the mail-order cost-sharing amounts for a long-term supply of mail-order drugs. In this case you will be responsible for the difference in price. Your **Pharmacy Directory** tells you which pharmacies in our network can give you a long-term supply of mail-order drugs. You can also call Customer Service for more information.

2. For certain kinds of drugs, you can use the plan's network **mail-order services**. Our Plan's mail-order service requires you to order up to a 90-day supply. See Section 2.3 for more information about using our mail-order services.

<b>Section 2.5</b>	<b>When can you use a pharmacy that is not in the plan's network?</b>
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### Your prescription may be covered in certain situations

We have network pharmacies outside of our service area where you can get your prescriptions filled as a member of our Plan. Generally, we cover drugs filled at an out-of-network pharmacy **only** when you are not able to use a network pharmacy. Here are the circumstances when we would cover prescriptions filled at an out-of-network pharmacy:

- If you go to a pharmacy that is not part of our Plan's network, that pharmacy is considered an out-of-network pharmacy.

- **Prescriptions for a Medical Emergency**

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

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

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

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

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

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

### How do you ask for reimbursement from the plan?

If you must use an out-of-network pharmacy, you will generally have to pay the full cost (rather than 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.)

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## SECTION 3 Your drugs need to be on the plan's "Drug List"

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<b>Section 3.1 The "Drug List" tells which Part D drugs are covered</b>
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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.

### **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.
- Texas Medicaid Health and Human Services Commission (Medicaid)-covered drugs may not be included on this plan's Drug list. If this plan does not cover a specific drug, please check your Texas Medicaid Health and Human Services Commission (Medicaid) Drug list to see if the drug is covered.

<b>Section 3.2 How can you find out if a specific drug is on the Drug List?</b>
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You have three ways to find out:

1. Check the most recent Drug List we sent you in the mail. (Please note: The Drug List we send includes information for the covered drugs that are most commonly used by our members. However, we cover additional drugs that are not included in the printed Drug List. If one of your drugs is not listed in the Drug List, you should visit our website or contact Customer Service to find out if we cover it.)

2. Visit the plan's website (www.PHCcares.com). The Drug List on the website is always the most current.
3. Call Customer Service to find out if a particular drug is on the plan's Drug List or to ask for a copy of the list. Phone numbers for Customer Service are on the back cover of this booklet.

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## SECTION 4      **There are restrictions on coverage for some drugs**

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<b>Section 4.1      Why do some drugs have restrictions?</b>
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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 medically just as well 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 formal appeals process and ask us to make an exception. We may or may not agree to waive the restriction for you. (See Chapter 9, Section 6.4 for information about asking for exceptions.)

<b>Section 4.2      What kinds of restrictions?</b>
---

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

### **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.** We usually will not cover the brand name drug when a generic version is available. However, if your provider has told us the medical reason that the generic drug will not work for you OR has written "No substitutions" on your prescription for a brand name drug OR has told us the medical reason that neither the generic drug nor other covered drugs that treat the same condition will 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.

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<b>Section 4.3</b>	<b>Do any of these restrictions apply to your drugs?</b>
--------------------	--

The plan's Drug List includes information about the restrictions described above. To find out if any of these restrictions apply to a drug you take or want to take, check the Drug List. For the most up-to-date information, call Customer Service (phone numbers are on the back cover of this booklet) or check our website ([www.PHCcares.com](http://www.PHCcares.com)).

**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 formal appeals process and ask us to make an exception. We may or may not agree to waive the restriction for you. (See Chapter 9, Section 7.4 for information about asking for exceptions.)

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<b>SECTION 5</b>	<b>What if one of your drugs is not covered in the way you'd like it to be covered?</b>
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<b>Section 5.1</b>	<b>There are things you can do if your drug is not covered in the way you'd like it to be covered</b>
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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, you might be required to try a different drug first, to see if it will work, before the drug you want to take will be covered for you. Or there might be limits on what amount of the drug (number of pills, etc.) is covered during a particular time period. 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.

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

- If your drug is not on the Drug List or if your drug is restricted, go to the Section 5.2 to learn what you can do.

<b>Section 5.2</b>	<b>What can you do if your drug is not on the Drug List or if the drug is restricted in some way?</b>
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If your drug is not on the Drug List or is restricted, here are things you can do:

- You may be able to get a temporary supply of the drug (only members in certain situations can get a temporary supply). 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:**
  - The drug you have been taking is **no longer on the plan's Drug List**.
  - -- or -- the drug you have been taking is **now restricted in some way** (Section 4 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 calendar year**. This temporary supply will be for a maximum of a 31-day supply, or less if your prescription is written for fewer days. The prescription must be filled at a network pharmacy.
  - **For those members who are new to the plan and aren't in a long-term care facility:**  
We will cover a temporary supply of your drug **one time only during the first 90 days of your membership** in the plan. This temporary supply will be for a maximum of a 31-day supply, or less if your prescription is written for fewer days. 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 the plan. The first supply will be for a maximum of a 31-day supply, or less if your prescription is written for fewer days. If needed, we will cover additional refills during your first 90 days in the plan.
  - **For those 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.

- **For those current members with level of care changes:**

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

To ask for a temporary supply, call Customer Service (phone numbers are on the back 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 to find a covered drug that might work for you.

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

If you and your provider want to ask for an exception, Chapter 9, Section 7.4 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.

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

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

## 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 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.

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

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<b>Section 7.1      Types of drugs we do not cover</b>
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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 by both Medicare and Texas Medicaid Health and Human Services Commission (Medicaid), you must pay for them yourself. We won't pay for the drugs that are listed in this section. The only exception: If the requested drug is found upon appeal to be a drug that is not excluded under Part D and we should have paid for or covered it because of your specific situation. (For information about appealing a decision we have made to not cover a drug, go to Chapter 9, Section 7.5 in this booklet.)

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

- Our Plan's Part D drug coverage cannot cover a drug that would be covered under Medicare Part A or Part B
- Our Plan cannot cover a drug purchased outside the United States and its territories.
- Our 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.
  - Generally, coverage for “off-label use” is allowed only when the use is supported by certain reference books. These reference books are the American Hospital Formulary Service Drug Information, the DRUGDEX Information System, and the USPDI or its successor. If the use is not supported by any of these reference books, then our Plan cannot cover its “off-label use.”

Also, by law, these categories of drugs are not covered by Medicare drug plans. However, some of these drugs may be covered for you under your Texas Medicaid Health and Human Services Commission (Medicaid) drug coverage. Please check your Texas Medicaid Health and Human Services Commission (Medicaid) Drug list to see if any of the drugs listed below are covered:

- Non-prescription drugs (also called over-the-counter drugs)
- Drugs when used to promote fertility
- Drugs when used for the relief of cough or cold symptoms
- Drugs when used for cosmetic purposes or to promote hair growth

- Prescription vitamins and mineral products, except prenatal vitamins and fluoride preparations
- Drugs when used for the treatment of sexual or erectile dysfunction, such as Viagra, Cialis, Levitra, and Caverject
- Drugs when used for treatment of anorexia, weight loss, or weight gain
- Outpatient drugs for which the manufacturer seeks to require that associated tests or monitoring services be purchased exclusively from the manufacturer as a condition of sale
- Barbiturates and Benzodiazepines

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

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<b>Section 8.1</b>	<b>Show your member ID card</b>
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To fill your prescription, show your Plan member ID card at the network pharmacy you choose. When you show your Plan member ID card, the network pharmacy will automatically bill the plan for **our** share of your covered prescription drug cost. You will need to pay the pharmacy **your** share of the cost when you pick up your prescription.

<b>Section 8.2</b>	<b>What if you don't have your member ID card with you?</b>
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If you don't have your Plan member ID card with you when you fill your prescription, ask the pharmacy to call the plan to get the necessary information.

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

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## SECTION 9      Part D drug coverage in special situations

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

<b>Section 9.2</b>	<b>What if you're a resident in a long-term care facility?</b>
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Usually, a long-term care facility (such as a nursing home) has its own pharmacy, or a pharmacy that supplies drugs for all of its residents. If you are a resident of a long-term care facility, you may get

your prescription drugs through the facility's pharmacy as long as it is part of our network.

Check your **Pharmacy Directory** to find out if your long-term care facility's pharmacy is part of our network. If it isn't, or if you need more information, please contact Customer Service.

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

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

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

During the time when you are getting a temporary supply of a drug, you should talk with your 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 7.4 tells what to do.

<b>Section 9.3</b>	<b>What if you're also getting drug coverage from an employer or retiree group plan?</b>
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Do you currently have other prescription drug coverage through your (or your spouse's) employer or 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 our Plan.

In general, if you are currently employed, the prescription drug coverage you get from us will be **secondary** to your employer or retiree group coverage. That means your group coverage would pay first. **Special note about 'creditable coverage':**

Each year your employer or retiree group should send you a notice that tells if your prescription drug coverage for the next calendar year is "**creditable**" and the choices you have for drug coverage.

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

**Keep these notices about creditable coverage**, because you may need them later. If you enroll in a Medicare plan that includes Part D drug coverage, you may need these notices to show that you have maintained creditable coverage. If you didn't get a notice about creditable coverage from your employer or retiree group plan, you can get a copy from the employer or retiree group's benefits administrator or the employer or union.

### **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.

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 on the back cover of this booklet).

**CHAPTER 6: What you pay for your Part D prescription drugs**

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### How can you get information about your drug costs?

Because you are eligible for Texas Medicaid Health and Human Services Commission (Medicaid), you qualify for and are getting “Extra Help” from Medicare to pay for your prescription drug plan costs. Because you are in the Extra Help program, **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 the “Evidence of Coverage Rider for People Who Get Extra Help Paying for Prescription Drugs” (LIS Rider), which tells you about your drug coverage. If you don’t have this insert, please call Customer Service and ask for the “Evidence of Coverage Rider for People Who Get Extra Help Paying for Prescription Drugs” (LIS Rider). Phone numbers for Customer Service are on the back cover of this booklet.

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## SECTION 1 Introduction

<b>Section 1.1</b>	<b>Use this chapter together with other materials that explain your drug coverage</b>
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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 or under Texas Medicaid Health and Human Services Commission (Medicaid) and other drugs are excluded from Medicare coverage by law.

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

- **The plan’s List of Covered Drugs (Formulary).** To keep things simple, we call this the “Drug List”.
  - This Drug List tells which drugs are covered for you.
  - If you need a copy of the Drug List, call Customer Service (phone numbers are on the back cover of this booklet). You can also find the Drug List on our website at [www.PHCcares.com](http://www.PHCcares.com). The Drug List on the website is always the most current.
- **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 our Plan.
- **The 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

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pharmacies in the plan's network. It also explains how you can get a long-term supply of a drug (such as filling a prescription for a three-month's supply).

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

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<b>Section 2.1      What are the drug payment stages for our Plan members?</b>
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As shown in the table below, there are “drug payment stages” for your prescription drug coverage under our Plan. 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.

**If you get extra help paying for drugs, you will not pay the amounts shown below. Please see your Evidence of Coverage Rider for People Who Get Extra Help for more information about your actual drug costs.**

STAGE 1	STAGE 2	STAGE 3	STAGE 4
<b>Yearly Deductible Stage</b>	<b>Initial Coverage Stage</b>	<b>Coverage Gap Stage</b>	<b>Catastrophic Coverage Stage</b>
<p>You begin in this payment stage when you fill your first prescription of the year.</p> <p>During this stage <b>you pay the full cost</b> of your drugs.</p> <p>You stay in this stage until you have paid \$320 for your drugs (\$320 is the amount of your deductible).</p> <p>(Details are in Section 4 of this chapter.)</p>	<p>During this stage, the plan pays its share of the cost of your drugs and <b>you pay your share of the cost.</b></p> <p>You stay in this stage until your year-to-date <b>“total drug costs”</b> (your payments plus any Part D plan’s payments) total \$2,930.</p> <p>(Details are in Section 5 of this chapter.)</p>	<p>During this stage, you pay 50% of the price (plus the dispensing fee) for brand name drugs and 86% of the price for generic drugs.</p> <p>You stay in this stage until your year-to-date <b>“out-of-pocket costs”</b> (your payments) reach a total of \$4,700. This amount and rules for counting costs toward this amount have been set by Medicare.</p> <p>(Details are in Section 6 of this chapter.)</p>	<p>During this stage, <b>the plan will pay most of the cost</b> of your drugs for the rest of the calendar year (through December 31, 2012).</p> <p>(Details are in Section 7 of this chapter.)</p>

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

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

Our 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 payment stage to the next. In particular, there are two types of costs we keep track of:

- We keep track of how much you have paid. This is called your **“out-of-pocket”** cost.

- We keep track of your “**total drug costs.**” This is the amount you pay out-of-pocket or others pay on your behalf plus the amount paid by the plan.

Our 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 drug costs, what the plan paid, and what you and others on your behalf paid.
- **Totals for the year since January 1.** This is called “year-to-date” information. It shows you the total drug costs and total payments for your drugs since the year began.

<b>Section 3.2</b>	<b>Help us keep our information about your drug payments up to date</b>
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To keep track of your drug costs and the payments you make for drugs, we use records we get from pharmacies. Here is how you can help us keep your information correct and up to date:

- **Show your member ID card when you get a prescription filled.** To make sure we know about the prescriptions you are filling and what you are paying, show your Plan member ID card every time you get a prescription filled.
- **Make sure we have the information we need.** There are times you may pay for prescription drugs when we will not automatically get the information we need to 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 our Plan to pay our share of the cost of the drug. 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 our Plan’s benefit.
  - When you made a copayment for drugs that are provided under a drug manufacturer patient assistance program.
  - Any time you have purchased covered drugs at out-of-network pharmacies or other times you have paid the full price for a covered drug under special circumstances.
- **Send us information about the payments others have made for you.** Payments made by certain other individuals and organizations also count toward your out of pocket costs and help qualify you for catastrophic coverage. For example, payments made by a State Pharmaceutical Assistance Program, an AIDS drug assistance program, the Indian Health Service, and most charities count toward your out-of-pocket costs. You should keep a record of these payments and send them to us so we can track your costs.
- **Check the written report we send you.** When you receive an **Explanation of Benefits** (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 us at Customer Service (phone numbers are on the back cover of this booklet). Be sure to keep these reports. They are an important record of your drug expenses.

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

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**Section 4.1      You stay in the Deductible Stage until you have paid \$320 for your drugs**

Because most of our members get Extra Help with their prescription drug costs, the Deductible Stage does not apply to most members. If you receive Extra Help, this payment stage does not apply to you.

If you do not receive Extra Help, the Deductible Stage is the first payment stage for your drug coverage. This stage begins when you fill your first prescription in the year. When you are in this payment stage, **you must pay the full cost of your drugs** until you reach the plan's deductible amount, which is \$320 for 2012.

- Your **“full cost”** is usually lower than the normal full price of the drug, since our 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.

Once you have paid \$320 for your drugs, you leave the Deductible Stage and move on to the next drug payment stage, which is the Initial Coverage Stage.

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

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

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

**Your pharmacy choices**

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

- A retail pharmacy that is in our Plan's network
- A pharmacy that is not in the plan's network
- The plan's 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**.

<b>Section 5.2</b>	<b>A table that shows your costs for a one-month supply of a drug</b>
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During the Initial Coverage Stage, your share of the cost of a covered drug will be either a copayment or coinsurance.

- **“Copayment”** means that you pay a fixed amount each time you fill a prescription.
- **“Coinsurance”** means that you pay a percent of the total cost of the drug each time you fill a prescription.
- We cover prescriptions filled at out-of-network pharmacies in only limited situations. Please see Chapter 5, Section 2.5 for information about when we will cover a prescription filled at an out-of-network pharmacy.

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

**For Members that Qualify for “Extra Help”:**

For generic drugs (including drugs treated as generic) either:

- \$0
- \$1.10
- \$2.60
- 15%

For all other drugs

- \$0
- \$3.30
- \$6.50
- 15%

**You will pay the following for your covered prescription drugs if you DO NOT qualify for “Extra Help” from Medicare to help pay for your prescription drug costs:**

<b>Your share of the cost when you get a one-month (31-day) supply (or less) of a covered Part D prescription drug from:</b>		
	<b>Network Pharmacy</b>	<b>The Plan’s Mail-Order Service</b>
<b>Cost-Sharing for Covered Drugs</b>	25% coinsurance	25% coinsurance

**Section 5.3 A table that shows your costs for a long-term (up to a 90-day) supply of a drug**

For some drugs, you can get a long-term supply (also called an “extended supply”) when you fill your prescription. A long-term supply is up to a 90-day supply. (For details on where and how to get a long-term supply of a drug, see Chapter 5.)

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

**For Members that Qualify for “Extra Help”:**

For generic drugs (including drugs treated as generic) either:

- \$0
- \$1.10
- \$2.60
- 15%

For all other drugs

- \$0
- \$3.30
- \$6.50
- 15%

**You will pay the following for your covered prescription drugs if you DO NOT qualify for “Extra Help” from Medicare to help pay for your prescription drug costs:**

<b>Your share of the cost when you get a long-term supply of a covered Part D prescription drug from:</b>		
	<b>Network Pharmacy (up to a 90-day supply)</b>	<b>The Plan’s Mail-Order Service (up to a 90-day supply)</b>
<b>Cost-Sharing for Covered Drugs</b>	25% coinsurance	25% coinsurance

**Section 5.4 You stay in the Initial Coverage Stage until your total drug costs for the year reach \$2,930**

You stay in the Initial Coverage Stage until the total amount for the prescription drugs you have filled and refilled reaches the \$2,930 **limit for the Initial Coverage Stage**. 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 year. (See Section 6.2 for more information about how Medicare calculates your out-of-pocket costs) This includes:

- The \$320 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 2012, the amount that plan paid during the Initial Coverage Stage also counts toward your total drug costs.)

The **Explanation of Benefits** (EOB) that we send to you will help you keep track of how much you and the plan have spent for your drugs during the year. Many people do not reach the \$2,930 limit in a year.

We will let you know if you reach this \$2,930 amount. If you do reach this amount, you will leave the Initial Coverage Stage and move on to the Coverage Gap Stage.

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**SECTION 6      During the Coverage Gap Stage, you receive a discount on brand name drugs and pay no more than 86% of the costs for generic drugs**

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<b>Section 6.1      You stay in the Coverage Gap Stage until your out-of-pocket costs reach \$4,700</b>
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When you are in the Coverage Gap Stage, the Medicare Coverage Gap Discount Program provides manufacturer discounts on brand name drugs. You pay 50% of the negotiated price (excluding the dispensing fee and vaccine administration fee, if any) for brand name drugs. 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.

You also receive some coverage for generic drugs. You pay no more than 86% of the cost for generic drugs and the plan pays the rest. For generic drugs, the amount paid by the plan (14%) does not count toward your out-of-pocket costs. Only the amount you pay counts and moves you through the coverage gap.

You continue paying the discounted price for brand name drugs and no more than 86% of the costs of generic drugs until your yearly out-of-pocket payments reach a maximum amount that Medicare has set. In 2012, that amount is \$4,700.

Medicare has rules about what counts and what does not count as your out-of-pocket costs. When you reach an out-of-pocket limit of \$4,700, you leave the Coverage Gap Stage and move on to the Catastrophic Coverage Stage.

<b>Section 6.2      How Medicare calculates your out-of-pocket costs for prescription drugs</b>
---

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 payment stages:
  - The Deductible Stage.
  - The Initial Coverage Stage.
  - The Coverage Gap Stage.
- Any payments you made during this calendar year as a member of a different Medicare prescription drug plan before you joined our Plan.

**It matters who pays:**

- If you make these payments **yourself**, they are included in your out-of-pocket costs.
- These payments are **also included** if they are made on your behalf by **certain other individuals or organizations**. This includes payments for your drugs made by a friend or relative, by most charities, or 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.
- Some of the payments made by the Medicare Coverage Gap Discount Program are included. The amount the manufacturer pays for your brand name drugs is included. But the amount the plan pays for your generic drugs is not included.

**Moving on to the Catastrophic Coverage Stage:**

When you (or those paying on your behalf) have spent a total of \$4,700 in out-of-pocket costs within the calendar year, you will move from the Coverage Gap Stage to the Catastrophic Coverage Stage.

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

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

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

**Reminder:** If any other organization such as the ones listed above pays part or all of your out-of-pocket costs for drugs, you are required to tell our Plan. Call Customer Service to let us know (phone numbers are on the back 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). When you reach a total of \$4,700 in out-of-pocket costs for the year, this report will tell you that you have left the Coverage Gap Stage and have moved on to the Catastrophic Coverage Stage.
- **Make sure we have the information we need.** Section 3.2 tells what you can do to help make sure that our records of what you have spent are complete and up to date.

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## SECTION 7

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

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<b>Section 7.1</b>	<b>Once you are in the Catastrophic Coverage Stage, you will stay in this stage for the rest of the year</b>
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You qualify for the Catastrophic Coverage Stage when your out-of-pocket costs have reached the \$4,700 limit for the calendar year. Once you are in the Catastrophic Coverage Stage, you will stay in this payment stage until the end of the calendar year.

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

- **Your share** of the cost for a covered drug will be either coinsurance or a copayment, whichever is the **larger** amount:
  - **–either** – coinsurance of 5% of the cost of the drug
  - **–or** – \$2.60 copayment for a generic drug or a drug that is treated like a generic. Or a \$6.50 copayment for all other drugs.
- **Our Plan pays the rest** of the cost.

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**SECTION 8**      **Additional benefits information**

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<b>Section 8.1</b>	<b>Our Plan has benefit limitations</b>
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This part of Chapter 6 talks about limitations of our Plan.

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

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

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<b>Section 9.1</b>	<b>Our Plan has separate coverage for the Part D vaccine medication itself and for the cost of giving you the vaccination shot</b>
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Our Plan provides coverage of 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 Benefits Chart in Chapter 4, Section 2.1.

There are two parts to our 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 Chapter 4, **Medical Benefits Chart (what is covered and what you pay)**.
  - Other vaccines are considered Part D drugs. You can find these vaccines listed in the plan’s **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 our Plan to pay you back for our share of the cost.
- Other times, when you get the vaccine medication or the vaccination shot, you will pay only your share of the cost.

To show how this works, here are three common ways you might get a Part D vaccination shot. Remember you are responsible for all of the costs associated with vaccines (including their administration) during the Deductible and Coverage Gap Stage 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 and/or coinsurance for the vaccine itself.
- Our 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 our Plan to pay our share of the cost by using the procedures that are described in Chapter 7 of this booklet (**Asking the 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 and/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 and/or coinsurance for the vaccine itself.
- When your doctor gives you the vaccination shot, you will pay the entire cost for this service. You can then ask our Plan to pay our share of the cost by using the procedures described in Chapter 7 of this booklet.
- You will be reimbursed the amount charged by the doctor for administering the vaccine 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.)

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

<b>Section 9.2</b>	<b>You may want to call us at Customer Service before you get a vaccination</b>
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The rules for coverage of vaccinations are complicated. We are here to help. We recommend that you call us first at Customer Service whenever you are planning to get a vaccination (phone numbers are on the back cover of this booklet).

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

**CHAPTER 7: Asking us to pay our share of a bill you have  
received for covered medical services or drugs**

**SECTION 1 Situations in which you should ask us to pay for your covered services or drugs..... 2**  
Section 1.1 If you pay for your covered services or drugs, or if you receive a bill, you can ask us for  
payment .....2

**SECTION 2 How to ask us to pay you back or to pay a bill you have received.....4**  
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**SECTION 1      Situations in which you should ask us to pay for your covered services or drugs**

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<b>Section 1.1      If you pay for your covered services or drugs, or if you receive a bill, you can ask us for payment</b>
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Our network providers bill the plan directly for your covered services and drugs. If you get a bill for medical care or drugs you have received, you should send this bill to us so that we can pay it. When you send us the bill, 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.

If you have already paid for services or drugs covered by the plan, you can ask our Plan to pay you back (paying you back is often called “reimbursing” you). It is your right to be paid back by our Plan whenever you’ve paid for medical services or drugs that are covered by our Plan. When you send us a bill you have already paid, we will look at the bill and decide whether the services or drugs should be covered. If we decide they should be covered, we will pay you back for the services or drugs.

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

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

You can receive emergency services from any provider, whether or not the provider is a part of our network. When you receive emergency or urgently needed care from a provider who is not part of our network, you should ask the provider to bill the plan.

- 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 for the service, we will determine how much you owed and pay you back for our share of the cost.

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

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

- 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. You should ask us to pay you back for the difference between the amount you paid and the amount you owed under the plan.

### **3. If you are retroactively enrolled in our Plan.**

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

If you were retroactively enrolled in our 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 contact Customer Service for additional information about how to ask us to pay you back and deadlines for making your request.

### **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 member ID card to fill a prescription, the pharmacy may not be able to submit the claim directly to us. When that happens, you will have to pay the full cost of your prescription. (We cover prescriptions filled at out-of-network pharmacies only in a few special situations. Please go to Chapter 5, Sec. 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 member ID card with you**

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

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

### **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 of the cost of the drug.

When you send us a request for payment, we will review your request and decide whether the service or drug should be covered. This is called making a "coverage decision." If we decide it should be covered, we will pay for our share of the cost for the service or drug. 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.

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

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

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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:

Part D Prescription drug payment requests  
Prescription Solutions  
PO Box 29045  
Hot Springs, AR 71903

Medical Claims payment requests  
PHYSICIANS HEALTH CHOICE OF TEXAS LLC  
PO Box 29429  
San Antonio, TX 78229-0429

**You must submit your Part C (medical) claim to us within 12 months** of the date you received the service, item, or Part B drug.

**You must submit your Part D (prescription drug) claim to us within 90 days** of the date you received the service, item, or drug.

Please be sure to contact Customer Service if you have any questions. If you don't know what you should have paid, 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.

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

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

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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 for the service. If you have already paid for the service or drug, we will mail your reimbursement of our share of the cost to you. If you have not paid for the service or drug yet, we will mail the payment directly to the provider. (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 drugs covered.)

- 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 of the care or drug. 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.

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

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 5 of Chapter 9. Section 5 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 5, 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 6.3 in Chapter 9.
- If you want to make an appeal about getting paid back for a drug, go to Section 7.5 of Chapter 9.

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**SECTION 4**      **Other situations in which you should save your receipts and send copies to us**

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<b>Section 4.1</b> <b>In some cases, you should send copies of your receipts to us to help us track your out-of-pocket drug costs</b>
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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.

Below is an example of a situation when you should send us copies of receipts to let us know about payments you have made for your drugs:

**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 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 case described above, this situation is not considered a coverage decision. Therefore, you cannot make an appeal if you disagree with our decision.

## **CHAPTER 8: Your rights and responsibilities**

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Sección 1.1 Usted tiene derecho a recibir información sobre la organización, sus servicios, sus practicantes y proveedores, y sobre los derechos y las responsabilidades de los miembros. Debemos proveer la información de una forma que sea adecuada para usted (en idiomas diferentes al inglés, en formato de letras grandes o en otros formatos alternativos).....	2
Section 1.2 You have a right to be treated with respect and recognition of your dignity and right to privacy. We must treat you with fairness and respect at all times.....	2
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**SECTION 1      Our Plan must honor your rights as a member of the plan**


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<b>Section 1.1</b>	<b>You have a right to receive information about the organization, its services, its practitioners and providers and member rights and responsibilities. We must provide information in a way that works for you (in languages other than English, in large print or other alternate formats)</b>
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To get information from us in a way that works for you, please call Customer Service (phone numbers are on the back cover of this booklet).

Our Plan has people and free language interpreter services available to answer questions from non-English speaking members. This information is available for free in other languages. We can also give you information in large print or other alternate formats if you need it. If you are eligible for Medicare because of 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 our Plan because of problems related to language or a 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.

<b>Sección 1.1</b>	<b>Usted tiene derecho a recibir información sobre la organización, sus servicios, sus practicantes y proveedores, y sobre los derechos y las responsabilidades de los miembros. Debemos proveer la información de una forma que sea adecuada para usted (en idiomas diferentes al inglés, en formato de letras grandes o en otros formatos alternativos)</b>
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Para obtener información de nosotros de una forma adecuada para usted, sírvase llamar a Servicio al Cliente (los números de teléfono se encuentran en la portada posterior de este libro).

Nuestro Plan tiene personal y servicios de traducción disponibles para responder a las preguntas de los miembros que no hablan inglés. Esta información está disponible gratuitamente en otros idiomas. También podemos brindarle la información en formato de letras grandes o en otros formatos alternativos si lo necesita. Si usted es elegible para Medicare debido a una discapacidad, se nos exige que le brindemos la información con respecto a los beneficios del plan de forma accesible y apropiada para usted.

Si tiene algún problema para obtener la información de nuestro Plan debido a problemas relacionados con idioma o discapacidad, sírvase llamar a Medicare al 1-800-MEDICARE (1-800-633-4227), las 24 horas del día, los 7 días de la semana, y dígales que quiere presentar una queja. Los usuarios de TTY deben llamar al 1-877-486-2048.

<b>Section 1.2</b>	<b>You have a right to be treated with respect and recognition of your dignity and right to privacy. We must treat you with fairness and respect at all times</b>
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Our 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 disability, 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/TDD 1-800-537-7697) or your local Office for Civil Rights.

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

<b>Section 1.3</b>	<b>We must ensure that you get timely access to your covered services and drugs</b>
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As a member of our Plan, you have the right to choose a primary care provider (PCP) in the plan's network to provide and arrange for your covered services (Chapter 3 explains more about this). Call Customer Service to learn which doctors are accepting new patients (phone numbers are on the back cover of this booklet). You also have the right to go to a women's health specialist (such as a gynecologist) without a referral.

As a plan member, you have the right to get appointments and covered services from the plan's network of providers, without interference **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.

### **How to Receive Care After Hours**

If you need to talk or see your Primary Care Physician after the office has closed for the day, call your Primary Care Physician's office. When the on call physician returns your call he or she will advise you on how to proceed.

If you think that you are not getting your medical care or Part D drugs within a reasonable amount of time, Chapter 9, Section 11, 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 5 tells what you can do.)

<b>Section 1.4</b>	<b>We must protect the privacy of your personal health information</b>
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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 our Plan through Medicare, we are required to give Medicare your health information including information about your Part D prescription drugs. If Medicare releases your information for research or other uses, this will be done according to Federal statutes and regulations.

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

You have the right to look at your medical records held at the plan, and to get a copy of your records. We are allowed to charge you a fee for making copies. You also have the right to ask us to make additions or corrections to your medical records. If you ask us to do this, we will work with your healthcare 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 on the back cover of this booklet).

**Medical Information Privacy Notice**

**THIS SAYS HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND SHARED. IT SAYS HOW YOU CAN GET ACCESS TO THIS INFORMATION. READ IT CAREFULLY.**

Effective January 1, 2011

We<sup>4</sup> must by law protect the privacy of your health information (“HI”). We must send you this notice. It tells you:

- How we may use your HI.
- When we can share your HI with others.
- What rights you have to your HI.

We must by law follow the terms of this notice.

“Health information” (or HI) in this notice means information that can be used to identify you. And it must relate to your health or health care.

We have the right to change our privacy practices. If we change them, we will mail you a notice or we may provide you with a notice by e-mail, if permitted by law. We will post the new notice on your health plan website (You can find our website and contact information in Chapter 2 of this booklet). We have the right to make changes apply to HI that we have and future information.

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<sup>4</sup> This Medical Information Notice of Privacy Practices applies to the following health plans that are affiliated with UnitedHealth Group: All Savers Insurance Company; All Savers Life Insurance Company of California; American Medical Security Life Insurance Company; AmeriChoice of Connecticut, Inc.; AmeriChoice of Georgia, Inc.; AmeriChoice of New Jersey, Inc.; AmeriChoice of Pennsylvania, Inc.; Arizona Physicians IPA, Inc.; Citrus Health Care, Inc.; Dental Benefit Providers of California, Inc.; Dental Benefit Providers of Illinois, Inc.; Evercare of Arizona, Inc.; Evercare of New Mexico, Inc.; Evercare of Texas, LLC; Golden Rule Insurance Company; Health Plan of Nevada, Inc.; MAMSI Life and Health Insurance Company; MD - Individual Practice Association, Inc.; Midwest Security Life Insurance Company; National Pacific Dental, Inc.; Neighborhood Health Partnership, Inc.; Nevada Pacific Dental; Optimum Choice, Inc.; Oxford Health Insurance, Inc.; Oxford Health Plans (CT), Inc.; Oxford Health Plans (NJ), Inc.; Oxford Health Plans (NY), Inc.; PacifiCare Dental; PacifiCare Dental of Colorado, Inc.; PacifiCare Life and Health Insurance Company; PacifiCare Life Assurance Company; PacifiCare of Arizona, Inc.; PacifiCare of Colorado, Inc.; PacifiCare of Nevada, Inc.; Physicians Health Choice of Texas, LLC.; Sierra

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## How We Use or Share Information

We **must** use and share your HI if asked for by:

- You or your legal representative.
- The Secretary of the Department of Health and Human Services to make sure your privacy is protected.

We **have the right to** use and share HI. This must be for your treatment, to pay for care and to run our business. For example, we may use and share it:

- **To Pay** premiums, determine coverage, and process claims. This also may include coordinating benefits. For example, we may tell a doctor you have coverage. We may tell a doctor how much of the bill may be covered.
- **For Treatment** or managing care. For example, we may share your HI with providers to help them give you care.
- **For Health Care Operations** related to your care. For example, we may suggest a disease management or wellness program. We may study data to see how we can improve our services.
- **To tell you about Health Programs or Products.** This may be other treatments or products and services. These activities may be limited by law.
- **For Plan Sponsors.** We may give enrollment and summary HI to an employer plan sponsor. We may give them other HI if they agree to limit its use per federal law.
- **For Reminders** on benefits or care. Such as appointment reminders.

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Health & Life Insurance Co., Inc.; UHC of California; U.S. Behavioral Health Plan, California; Unimerica Insurance Company; Unimerica Life Insurance Company of New York; Unison Family Health Plan of Pennsylvania, Inc.; Unison Health Plan of Delaware, Inc.; Unison Health Plan of Tennessee, Inc.; Unison Health Plan of the Capital Area, Inc.; United Behavioral Health; UnitedHealthcare Community Plan of OH, Inc.; UnitedHealthcare Insurance Company; UnitedHealthcare Insurance Company of Illinois; UnitedHealthcare Insurance Company of New York; UnitedHealthcare Insurance Company of the River Valley; UnitedHealthcare Insurance Company of Ohio; UnitedHealthcare of Alabama, Inc.; UnitedHealthcare of Arizona, Inc.; UnitedHealthcare of Arkansas, Inc.; UnitedHealthcare Benefits of Texas, Inc.; UnitedHealthcare of Colorado, Inc.; UnitedHealthcare of Florida, Inc.; UnitedHealthcare of Georgia, Inc.; UnitedHealthcare of the Great Lakes Health Plan, Inc.; UnitedHealthcare of Illinois, Inc.; UnitedHealthcare of Kentucky, Ltd.; UnitedHealthcare of Louisiana, Inc.; UnitedHealthcare of Mid-Atlantic, Inc.; UnitedHealthcare of the Midlands, Inc.; UnitedHealthcare of the Midwest, Inc.; United HealthCare of Mississippi, Inc.; UnitedHealthcare of New England, Inc.; UnitedHealthcare of New York, Inc.; UnitedHealthcare of North Carolina, Inc.; UnitedHealthcare of Ohio, Inc.; UnitedHealthcare of Oklahoma, Inc.; UnitedHealthcare of Oregon, Inc.; UnitedHealthcare of Pennsylvania, Inc.; UnitedHealthcare of South Carolina, Inc.; UnitedHealthcare of Tennessee, Inc.; UnitedHealthcare of Texas, Inc.; UnitedHealthcare of Utah, Inc.; UnitedHealthcare of Washington, Inc.; UnitedHealthcare of Wisconsin, Inc.; UnitedHealthcare Plan of the River Valley, Inc.

We may use or share your HI as follows:

- **As Stated by Law.**
- **To Persons Involved With Your Care.** This may be to a family member. This may happen if you are unable to agree or object. Such as in an emergency or when you agree or fail to object when asked. If you are not able to object, we will use our best judgment.
- **For Public Health Activities.** This may be to prevent disease outbreaks.
- **For Reporting Abuse, Neglect or Domestic Violence.** We may only share with entities allowed by law to get this HI. This may be a social or protective service agency.
- **For Health Oversight Activities** to an agency allowed by the law to get the HI. This may be for licensure, audits and fraud and abuse investigations.
- **For Judicial or Administrative Proceedings.** Such as to answer a court order or subpoena.
- **For Law Enforcement.** Such as to find a missing person or report a crime.
- **For Threats to Health or Safety.** This may be to public health agencies or law enforcement. Such as in an emergency or disaster.
- **For Government Functions.** This may be for military and veteran use, national security, or the protective services.
- **For Workers' Compensation.** To comply with labor laws.
- **For Research.** Such as to study disease or disability, as allowed by law.
- **To Give Information on Decedents.** This may be to a coroner or medical examiner. Such as to identify the deceased, find a cause of death or as stated by law. We may give HI to funeral directors.
- **For Organ Transplant.** To help get, bank or transplant organs, eyes or tissue.
- **To Correctional Institutions or Law Enforcement.** For persons in custody: (1) To give health care. (2) To protect your health and the health of others. (3) For the security of the institution.
- **To Our Business Associates** if needed to give you services. Our associates agree to protect your HI. They are not allowed to use HI other than as per our contract with them.
- **To Notify of a Data Breach.** To give notice of unauthorized access to your HI. We may send notice to you or to your Plan sponsor.
- **Other Restrictions.** Federal and state laws may limit the use and sharing of highly confidential HI. This may include state laws on:
  1. HIV/AIDS
  2. Mental health
  3. Genetic tests
  4. Alcohol and drug abuse
  5. Sexually transmitted diseases and reproductive health
  6. Child or adult abuse or neglect or sexual assault

If stricter laws apply, we try to meet those laws. Attached is a Summary of Federal and State Laws.

Except as stated in this notice, we use your HI only with your written consent. If you allow us to share your HI, we do not promise that the person who gets it will not share it. You may take back your consent, unless we have acted on it. To find out how, call the phone number on the back of your ID card.

## Your Rights

You have a right:

- **To ask us to limit** use or sharing for treatment, payment, or health care operations. You can ask to limit sharing with family members or others involved in your care or payment for it. We may allow your dependents to ask for limits. **We will try to honor your request, but we do not have to do so.**
- **To ask to get confidential communications** in a different way or place. (For example, at a P.O. Box instead of your home.) We will agree to your request when a disclosure could endanger you. We take verbal requests. You can change your request. This must be in writing. Mail it to the address below.
- **To see or get a copy** of HI that we use to make decisions about you. You must ask in writing. Mail it to the address below. We may send you a summary. We may charge for copies. We may deny your request. If we deny your request, you may have the denial reviewed. If we keep an electronic record, if and when we are required by law, you will have the right to ask for an electronic copy to be sent to you or a third party. We may charge a fee for this.
- **To ask to amend.** If you think your HI is wrong or incomplete you can ask to change it. You must ask in writing. You must give the reasons for the change. Mail this to the address below. If we deny your request, you may add your disagreement to your HI.
- **To get an accounting** of HI shared in the six years prior to your request. This will not include any HI shared: (i) Prior to April 14, 2003. (ii) For treatment, payment, and health care operations. (iii) With you or with your consent. (iv) With correctional institutions or law enforcement. This will not list disclosures if federal law does not make us keep track of them.
- **To get a paper copy of this notice.** You may ask for a copy at any time. Even if you agreed to get this notice electronically, you have a right to a paper copy. You may also get a copy at our website, (You can find our website and contact information in Chapter 2 of this booklet).

### Using Your Rights

- **To Contact your Health Plan. Call the phone number on the back of your ID card.** Or you may contact the UnitedHealth Group Call Center at 866-633-2446.
- **To Submit a Written Request.** Mail to:  
UnitedHealth Group  
PSMG Privacy Office  
MN006-W800  
P.O. Box 1459  
Minneapolis, MN 55440
- **To File a Complaint.** If you think your privacy rights have been violated, you may send a complaint at the address above.

**You may also notify the Secretary of the U.S. Department of Health and Human Services.** We will not take any action against you for filing a complaint.

### Financial Information Privacy Notice

**THIS NOTICE SAYS HOW YOUR FINANCIAL INFORMATION MAY BE USED AND SHARED. IT SAYS HOW YOU CAN GET ACCESS TO THIS INFORMATION. REVIEW IT CAREFULLY.**

Effective January 1, 2011

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We<sup>5</sup> protect your “personal financial information” (“FI”). This means non-health information about an enrollee or an applicant obtained to provide coverage. It is information that identifies the person and is not public.

### **Information We Collect**

We get FI about you from:

- Applications or forms. This may be name, address, age and social security number.
- Your transactions with us or others. This may be premium payment data.

### **Sharing of FI**

We do not share FI about our enrollees or former enrollees, except as required or permitted by law.

To run our business, we may share FI without your consent to our affiliates. This is to tell them about your transactions, such as premium payment.

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<sup>5</sup> For purposes of this Financial Information Privacy Notice, “we” or “us” refers to the entities listed in footnote 1, beginning on the first page of the Health Plan Notices of Privacy Practices, plus the following UnitedHealthcare affiliates: ACN Group IPA of New York, Inc.; ACN Group, Inc.; AmeriChoice Health Services, Inc.; DBP Services of New York IPA, Inc.; DCG Resource Options, LLC; Dental Benefit Providers, Inc.; Disability Consulting Group, LLC; HealthAllies, Inc.; MAMSI Insurance Resources, LLC; Managed Physical Network, Inc.; Mid Atlantic Medical Services, LLC; OneNet PPO, LLC; OptumHealth Bank, Inc.; Oxford Benefit Management, Inc.; Oxford Health Plans LLC; PacifiCare Health Plan Administrators, Inc.; PacificDental Benefits, Inc.; ProcessWorks, Inc.; Spectera of New York, IPA, Inc.; UMR, Inc.; Unison Administrative Services, LLC; United Behavioral Health of New York I.P.A., Inc.; United HealthCare Services, Inc.; UnitedHealth Advisors, LLC; United Healthcare Service LLC; UnitedHealthcare Services Company of the River Valley, Inc.; UnitedHealthOne Agency, Inc. This Financial Information Privacy Notice only applies where required by law. Specifically, it does not apply to (1) health care insurance products offered in Nevada by Health Plan of Nevada, Inc. and Sierra Health and Life Insurance Company, Inc.; or (2) other UnitedHealth Group health plans in states that provide exceptions for HIPAA covered entities or health insurance products.

## **Confidentiality and Security**

We limit access to your FI to our employees and providers who manage your coverage and provide services. We have physical, electronic and procedural safeguards per federal standards to guard your FI. We do regular audits to ensure secure handling.

## **Your Right to Access and Correct FI**

In some States<sup>6</sup>, you may have a right to ask for access to your FI. You can ask:

- For the source of the FI.
- For a list of disclosures made in the two years before your request.
- To view and copy your FI in person.
- For a copy to be sent. (We may charge a fee.)
- For corrections, amendments or deletions.

Follow these directions:

To access your FI: Send a request in writing with your name, address, social security number, phone, and the FI you want to access. State if you want access in person or a copy sent. When we get your request, we will contact you within 30 business days.

To correct, amend, or delete any of your FI: Send a request in writing with your name, address, social security number, phone, the FI in dispute, and the identity of the document or record. Upon receipt of your request, we will contact you within 30 business days. We will tell you if we have made the correction, amendment or deletion. Or we will tell you we refuse to do so and the reasons why. You may challenge this.

### **Send requests:**

UnitedHealth Group  
PSMG Privacy Office  
MN006-W800  
P.O. Box 1459  
Minneapolis, MN 55440

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<sup>6</sup> California and Massachusetts.

**UNITEDHEALTH GROUP  
 HEALTH PLAN NOTICE OF PRIVACY PRACTICES:  
 FEDERAL AND STATE AMENDMENTS**

**Revised: January 1, 2011**

The first part of this Notice says how we may use and share your health information (“HI”) under federal privacy rules. Other laws may limit these rights. The charts below:

1. Show the categories subject to more restrictive laws.
2. Give you a summary of when we can use and share your HI without your consent.

Your written consent, if needed, must meet the rules of the federal or state law.

**Summary of Federal Laws**

<b>Alcohol &amp; Drug Abuse Information</b>	
We may use and share alcohol and drug information protected by federal law only (1) in limited cases, and/or (2) with certain recipients.	
<b>Genetic Information</b>	
We may not use genetic information for underwriting.	

**Summary of State Laws**

<b>General Health Information</b>	
We may share general HI only (1) in limited cases, and /or (2) with certain recipients.	CA, NE, RI, VT, WA, WI
HMOs must let enrollees approve or refuse disclosures, with some exceptions.	KY
You may be able to limit some electronic disclosures.	NV
We may not use HI for certain purposes.	CA, NH
<b>Prescriptions</b>	
We may share prescription information only (1) in limited cases, and /or (2) with certain recipients.	ID, NV
<b>Communicable Diseases</b>	
We may share communicable disease information only (1) in limited cases, and /or (2) with certain recipients.	AZ, IN, MI, OK
You may be able to restrict disclosure of electronic information.	NV
<b>Sexually Transmitted Diseases and Reproductive Health</b>	
You may be able to restrict disclosures of electronic health information.	NV
We may share sexually transmitted disease and/or reproductive health information only (1) in limited cases and/or (2) with certain recipients.	MT, NJ, WA
<b>Alcohol and Drug Abuse</b>	

### Summary of State Laws

We may use and share alcohol and drug information (1) in limited cases, and/or (2) with certain recipients.	CT, HI, KY, IL, IN, IA, LA, MD, MA, NH, NV, WA, WI
Sharing of alcohol and drug information may be limited by the person who is the subject.	WA
<b>Genetic Information</b>	
We may not share genetic information without your written consent.	CA, CO, HI, IL, KY, NY, TN
We may share genetic information only (1) in limited cases and/or (2) with certain recipients.	GA, MD, MA, MO, NV, NH, NM, SC, RI, TX, UT, VT
Limits apply to (1) the use, and/or (2) the keeping of genetic information.	FL, GA, LA, MD, OH, SC, SD, UT, VT
<b>HIV / AIDS</b>	
We may share HIV/AIDS information only (1) in limited cases and/or (2) with certain recipients.	AZ, AR, CA, CT, DE, FL, HI, IL, IN, MI, MT, NY, NC, PA, PR, RI, TX, VT, WV
Some limits apply to oral disclosures of HIV/AIDS information.	CT
You may be able to restrict disclosure of electronic health information.	NV
<b>Mental Health</b>	
We may share mental health information only (1) in limited cases and/or (2) with certain recipients.	CA, CT, DC, HI, IL, IN, KY, MA, MI, PR, WA, WI
Sharing may be limited by the person who is the subject of the information.	WA
Some limits apply to oral disclosures of mental health information.	CT
Some limits apply to the use of mental health information.	ME
<b>Child or Adult Abuse</b>	
We may use and share child and/or adult abuse information only (1) in limited cases, and/or (2) with certain recipients.	AL, CO, IL, LA, NE, NJ, NM, RI, TN, TX, UT, WI
You may be able to restrict disclosure of electronic health information.	NV

<b>Section 1.5</b>	<b>We must give you information about the plan, its network of providers, and your covered services</b>
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As a member of our 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 languages other than English and large print or other alternate formats.)

If you want any of the following kinds of information, please call Customer Service (phone numbers

are on the back cover of this booklet):

- **Information about our Plan.** This includes, for example, information about the plan's financial condition. It also includes information about the number of appeals made by members and the plan's performance ratings, including how it has been rated by plan members and how it compares to other Medicare health plans.
- **Information about our network providers including our network pharmacies.**
  - For example, you have the right to get information from us about the qualifications of the providers and pharmacies in our network and how we pay the providers in our network.
  - For a list of the providers in the plan's network, see the **Provider Directory**.
  - For a list of the pharmacies in the plan's network, see the **Pharmacy Directory**.
  - For more detailed information about our providers or pharmacies, you can call Customer Service (phone numbers are on the back cover of this booklet) or visit our website [www.PHCcares.com](http://www.PHCcares.com).
- **Information about your coverage and rules you must follow in using your coverage.**
  - In Chapters 3 and 4 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 on the back 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 medical service or drug from an out-of-network provider or pharmacy.
  - If you are not happy or if you disagree with a decision we make about what medical care or Part D drug is covered for you, you have the right to ask us to change the decision. 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 our 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**

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

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

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**care**

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

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

- **To know about all of your choices.** This means that you have the right to be told about all of the treatment options that are recommended for your condition, no matter what they cost or whether they are covered by our Plan. It also includes being told about programs our Plan offers to help members manage their medications and use drugs safely.
- **To know about the risks.** You have the right to be told about any risks involved in your care. You must be told in advance if any proposed medical care or treatment is part of a research experiment. You always have the choice to refuse any experimental treatments.
- **The right to say “no.”** You have the right to refuse any recommended treatment. This includes the right to leave a hospital or other medical facility, even if your doctor advises you not to leave. You also have the right to stop taking your medication. Of course, if you refuse treatment or stop taking medication, you accept full responsibility for what happens to your body as a result.
- **To receive an explanation if you are denied 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 one of these situations. 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. You can also contact Customer Service to ask for the forms (phone numbers are on the back cover of this booklet).

- **Fill it out and sign it.** Regardless of where you get this form, keep in mind that it is a legal document. You should consider having a lawyer help you prepare it.
- **Give copies to appropriate people.** You should give a copy of the form to your doctor and to the person you name on the form as the one to make decisions for you if you can't. You may want to give copies to close friends or family members as well. Be sure to keep a copy at home.

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

- If you are admitted to the hospital, they will ask you whether you have signed an advance directive form and whether you have it with you.
- If you have not signed an advance directive form, the hospital has forms available and will ask if you want to sign one.

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

### **What if your instructions are not followed?**

If you have signed an advance directive, and you believe that a doctor or hospital hasn't followed the instructions in it, you may file a complaint with the appropriate state-specific agency, for example, your State Department of Health. See Chapter 2, Section 3 for contact information regarding your state-specific agency.

**Section 1.7      You have a right to voice complaints or appeals about the organization or the care it provides. You have the right to make complaints and to ask us to reconsider decisions we have made**

If you have any problems or concerns about your covered services or care, 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 our Plan to make a coverage decision for you, make an appeal to us to change a coverage decision, or make a complaint. Whatever you do – ask for a coverage decision, make an appeal, or make a complaint – **we are required to treat you fairly.**

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

**Section 1.8      What can you do if you think you are being treated unfairly or your rights are not being respected?**

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

If you think you have been treated unfairly or your rights have not been respected due to your race, disability, religion, sex, health, ethnicity, creed (beliefs), age, or national origin, you should call the

Department of Health and Human Services' **Office for Civil Rights** at 1-800-368-1019 or TTY 1-800-537-7697, or call your local Office for Civil Rights.

### Is it about something else?

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

- You can **call Customer Service** (phone numbers are on the back 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.
- 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      You have a right to make recommendations regarding the organization's member rights and responsibilities policy. How to get more information about your rights**

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

- You can **call Customer Service** (phone numbers are on the back 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.
- You can contact **Medicare**.
  - You can visit the Medicare website 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 on the back 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.
  - 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.
  - 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 our Plan, you are required to tell us.** Please call Customer Service to let us know.
  - We are required to follow rules set by Medicare and Medicaid to make sure that you are

using all of your coverage in combination when you get your covered services from our Plan. This is called “**coordination of benefits**” because it involves coordinating the health and drug benefits you get from our Plan with any other health and drug benefits available to you. We’ll help you 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 our Plan.** Show your Plan member ID card and Medicaid card whenever you get your medical care or Part D prescription drugs.
- **Help your doctors and other providers help you by giving them information, asking questions, and following through on your care.**
  - To help your doctors and other health providers give you the best care, learn as much as you are able to about your health problems and give them the information they need about you and your health. Follow the treatment plans and instructions that you and your doctors agree upon.
  - 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:
  - In order to be eligible for our Plan, you must be entitled to Medicare Part A and enrolled in Medicare Part B. For most Plan members, Medicaid pays for your Part A premium (if you don’t qualify for it automatically) and for your Part B premium. If Medicaid is not paying your Medicare premiums for you, you must continue to pay your Medicare premiums 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). Chapter 4 tells what you must pay for your medical services. Chapter 6 tells what you must pay for your Part D prescription drugs.
  - If you get any medical services or drugs that are not covered by our Plan or by other insurance you may have, you must pay the full cost.
    - 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.
- **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 on the back cover of this booklet).
  - **If you move outside of our 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, we can let you know if we have a plan in your new area.
  - **If you move within our service area, we still need to know** so we can keep your

membership record up to date and know how to contact you.

- **Call Customer Service for help if you have questions or concerns.** We also welcome any suggestions you may have for improving our Plan.
  - Phone numbers and calling hours for Customer Service are on the back cover of this booklet.
  - For more information on how to reach us, including our mailing address, please see Chapter 2.

**CHAPTER 9: What to do if you have a problem or complaint (coverage decisions, appeals, complaints)**

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**BACKGROUND**

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**SECTION 1 Introduction**

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**Section 1.1 What to do if you have a problem or concern**

This chapter explains the processes for handling problems and concerns. The process you use to handle your problem depends on two things:

1. Whether your problem is about benefits covered by **Medicare** or **Medicaid**. If you would like help deciding whether to use the Medicare process or the Medicaid process, or both, please contact Customer Service. (Telephone numbers are on the back cover of this booklet.)
2. The type of problem you are having:
  - For some types of problems, you need to use the **process for coverage decisions and making appeals**.
  - For other types of problems you need to use the **process for making complaints**.

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? 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.

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

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**Section 2.1 Where to get more information and personalized assistance**

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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 our Plan or with any insurance company or health plan. The counselors at this program can help you understand which process you should use to handle a problem you are having. They can also answer your questions, give you more information, and offer guidance on what to do.

The services of SHIP counselors are free. You will find phone numbers in Chapter 2, Section 3 of this booklet.

### **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>).

### **You can get help and information from Texas Medicaid Health and Human Services Commission (Medicaid)**

For more information and help in handling a problem, you can also contact Texas Medicaid Health and Human Services Commission (Medicaid). Here are two ways to get information directly from Texas Medicaid Health and Human Services Commission (Medicaid):

- You can call 1-800-252-8263. TTY users should call 711.
- You can visit the Texas Medicaid Health and Human Services Commission (Medicaid) website ([www.hhsc.state.tx.us/medicaid](http://www.hhsc.state.tx.us/medicaid)).

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

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<b>Section 3.1</b>	<b>Should you use the process for Medicare benefits or Medicaid benefits?</b>
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Because you have Medicare and get assistance from Medicaid, you have different processes that you can use to handle your problem or complaint. Which process you use depends on whether the problem is about Medicare benefits or Medicaid benefits. If your problem is about a benefit covered by Medicare, then you should use the Medicare process. If your problem is about a benefit covered by Medicaid, then you should use the Medicaid process. If you would like help deciding whether to use the Medicare process or the Medicaid process, please contact Customer Service. (Telephone numbers are on the back cover of this booklet.)

The Medicare process and Medicaid process are described in different parts of this chapter. To find out which part you should read, use the chart below.

To figure out which part of this chapter will help with your specific problem or concern, <b>START HERE</b>	
<b>Is your problem about Medicare benefits or Medicaid benefits?</b> (If you would like help deciding whether your problem is about Medicare benefits or Medicaid benefits, please contact Customer Service.)	
My problem is about <b>Medicare</b> benefits.  Go to the next section of this chapter, <b>Section 4, “Handling problems about Medicare your benefits.”</b>	My problem is about <b>Medicaid</b> benefits.  Skip ahead to <b>Section 12</b> of this chapter, <b>“Handling problems about your Medicaid benefits.”</b>

**PROBLEMS ABOUT YOUR MEDICARE BENEFITS**

**SECTION 4 Handling problems about your Medicare benefits**

<b>Section 4.1</b>	<b>Should you use the process for coverage decisions and appeals? Or should you use the process for making complaints?</b>
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If you have a problem or concern, you only need to read the parts of this chapter that apply to your situation. The chart below will help you find the right section of this chapter for problems or complaints about **benefits covered by Medicare**.

To figure out which part of this chapter will help with your problem or concern about your **Medicare** benefits, use this chart:

**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.**

My problem is about benefits or coverage.

Go on to the next section of this chapter, **Section 5, “A guide to the basics of coverage decisions and making appeals.”**

**No.**

My problem is not about **benefits or coverage.**

Skip ahead to **Section 11** at the end of this chapter: **“How to make a complaint about quality of care, waiting times, customer service or other concerns.”**

**SECTION 5      A guide to the basics of coverage decisions and appeals**

**Section 5.1      Asking for coverage decisions and making appeals: the big picture**

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

**Asking for coverage decisions**

A coverage decision is a decision we make about your benefits and coverage or about the amount we will pay for your medical services or drugs. We are making a coverage decision whenever we decide what is covered for you and how much we pay. For example, your Plan 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 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.

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 our Plan. (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 several more levels of appeal.

<b>Section 5.2</b> <b>How to get help when you are asking for a coverage decision or making an appeal</b>
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Would you like some help? Here are resources you may wish to use if you decide to ask for any kind of coverage decision or appeal a decision:

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

<b>Section 5.3</b> <b>Which section of this chapter gives the details of your situation?</b>
--

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 6** of this chapter: “Your medical care: How to ask for a coverage decision or make an appeal”
- **Section 7** of this chapter: “Your Part D prescription drugs: How to ask for a coverage decision or make an appeal”
- **Section 8** 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 9** 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 on the back cover of this booklet). You can also get help or information from government organizations such as your State Health Insurance Assistance Program (Chapter 2, Section 3, of this booklet has the phone numbers for this program).

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## SECTION 6      Your medical care: How to ask for a coverage decision or make an appeal

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Have you read Section 5 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.

<b>Section 6.1</b>	<b>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</b>
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This section is about your benefits for medical care and services. These benefits are described in Chapter 4 of this booklet: **Medical Benefits Chart (what is covered and what you pay)**. To keep things simple, we generally refer to “medical care coverage” or “medical care” in the rest of this section, instead of repeating “medical care or treatment or services” every time.

This section 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 our Plan.
2. Our Plan will not approve the medical care your doctor or other medical provider wants to give you, and you believe that this care is covered by the plan.
3. You have received medical care or services that you believe should be covered by the plan, but we have said we will not pay for this care.
4. You have received and paid for medical care or services that you believe should be covered by the plan, and you want to ask our Plan to reimburse you for this care.
5. You are being told that coverage for certain medical care you have been getting 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 8: **How to ask us to cover a longer inpatient hospital stay if you think the doctor is discharging you too soon.**
  - Chapter 9, Section 9: **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 6) as your guide for what to do.

<b>Which of these situations are you in?</b>	
<b>If you are in this situation:</b>	<b>This is what you can do:</b>
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, <b>Section 6.2</b> .
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 <b>appeal</b> . (This means you are asking us to reconsider.)  Skip ahead to <b>Section 6.3</b> 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 <b>Section 6.5</b> of this chapter.

<b>Section 6.2</b>	<b>Step-by-step: How to ask for a coverage decision (how to ask our Plan to authorize or provide the medical care coverage you want)</b>
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<b>Legal Terms</b>	When a coverage decision involves your medical care, it is called an <b>“organization determination.”</b>
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<b>Step 1:</b>	<b>You ask our Plan to make a coverage decision on the medical care you are requesting.</b> If your health requires a quick response, you should ask us to make a <b>“fast decision.”</b>
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**Legal Terms** A “fast decision” is called an **“expedited determination.”**

### How to request coverage for the medical care you want

- Start by calling, writing, or faxing our Plan to make your request for us to provide coverage for the medical care you want. You, or your doctor, or your representative can do this.
- For the details on how to contact us, go to Chapter 2, 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 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) 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 11 of this chapter.)

### If your health requires it, ask us to give you a “fast decision”

- **A fast decision means we will answer within 72 hours.**
  - **However, we can take up to 14 more calendar days** if we find that some information that may benefit you is missing, 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 11 of this chapter.) We will call you as soon as we make the decision.
- **To get a fast decision, you must meet two requirements:**
  - You can get a fast decision only if you are asking for coverage for medical care **you have not yet received.** (You cannot get a fast decision if your request is about payment for medical care you have already received.)
  - You can get a fast decision **only** if using the standard deadlines **could cause serious harm to your health or hurt your ability to function.**
- **If your doctor tells us that your health requires a “fast decision,” we will automatically agree to give you a fast decision.**

- If you ask for a fast decision on your own, without your doctor’s support, our Plan will decide whether your health requires that we give you a fast decision.
  - If we decide that your medical condition does not meet the requirements for a fast decision, we will send you a letter that says so (and we will use the standard deadlines instead).
  - This letter will tell you that if your doctor asks for the fast decision, we will automatically give a fast decision.
  - The letter will also tell how you can file a “fast complaint” about our decision to give you a standard decision instead of the fast decision you requested. (For more information about the process for making complaints, including fast complaints, see Section 11 of this chapter.)

<b>Step 2:</b>	<b>Our Plan considers your request for medical care coverage and we give you our answer.</b>
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#### Deadlines for a “fast” coverage decision

- Generally, for a fast 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 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 11 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 6.3 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 decision, we will provide the coverage by the end of that extended period.
- **If our answer is no to part or all of what you requested**, we will send you a written statement that explains why we said no.

#### Deadlines for a “standard” coverage decision

- Generally, for a standard decision, we will give you our answer within **14 days of receiving your request**.
  - We can take up to 14 more calendar days (“an extended time period”) under certain circumstances. If we decide to take extra days to make the decision, we will tell you in writing.
  - If 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 11 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 6.3 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 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.

<b>Step 3:</b>	<b>If we say no to your request for coverage for medical care, you decide if you want to make an appeal.</b>
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- If our Plan says no, you have the right to ask us to reconsider – and perhaps change – this decision by making an appeal. Making an appeal means making another try to get the medical care coverage you want.
- If you decide to make an appeal, it means you are going on to Level 1 of the appeals process (see Section 6.3 below).

<b>Section 6.3</b>	<b>Step-by-step: How to make a Level 1 Appeal (how to ask for a review of a medical care coverage decision made by our Plan)</b>
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<b>Legal Terms</b>	An appeal to the plan about a medical care coverage decision is called a plan <b>“reconsideration.”</b>
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<b>Step 1:</b>	<b>You contact our Plan and make your appeal.</b> If your health requires a quick response, you must ask for a <b>“fast appeal.”</b>
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### What to do

- **To start your appeal, you, your doctor, or your representative, must contact our Plan.** For details on how to reach us for any purpose related to your appeal, go to Chapter 2, Section 1 look for section called, **How to contact us when you are making an appeal or complaint about your medical care.**
- **If you are asking for a standard appeal, make your standard appeal in writing by submitting a signed request.**
  - If you 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 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, Section 1 (**How to contact us when you are making an appeal or complaint 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 our Plan made about coverage for care you have not yet received, you and/or your doctor will need to decide if you need a “fast appeal.”
- The requirements and procedures for getting a “fast appeal” are the same as those for getting a “fast decision.” To ask for a fast appeal, follow the instructions for asking for a fast decision. (These instructions are given earlier in this section.)
- If your doctor tells us that your health requires a “fast appeal,” we will give you a fast appeal.

**Step 2:**

**Our Plan considers your appeal and we give you our answer.**

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

**Deadlines for a “fast” appeal**

- When we are using the fast deadlines, we must give you our answer **within 72 hours after we receive your appeal**. We will give you our answer sooner if your health requires us to do so.
  - However, if you ask for more time, or if we need to gather more information that may benefit you, we **can take up to 14 more 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 11 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 tell about this review organization and explain what happens at Level 2 of the appeals process.
- **If our answer is yes to part or all of what you requested**, we must authorize or provide the coverage we have agreed to provide within 30 days after we receive your appeal.
- **If our answer is no to part or all of what you requested**, we will send you a written denial notice informing you that we have automatically sent your appeal to the Independent Review Organization for a Level 2 Appeal.

<b>Step 3:</b>	<b>If our 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.</b>
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- To make sure we were following all the rules when we said no to your appeal, **our Plan is required to send your appeal to the “Independent Review Organization.”** When we do this, it means that your appeal is going on to the next level of the appeals process, which is Level 2.

<b>Section 6.4</b>	<b>Step-by-step: How to make a Level 2 Appeal</b>
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If our Plan says no to your Level 1 Appeal, your case will **automatically** be sent on to the next level of the appeals process. During the Level 2 Appeal, the **Independent Review Organization** reviews the decision our Plan made when we said no to your first appeal. This organization decides whether the decision we made should be changed.

<b>Legal Terms</b> The formal name for the “Independent Review Organization” is the “ <b>Independent Review Entity.</b> ” It is sometimes called the “ <b>IRE.</b> ”
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<b>Step 1:</b>	<b>The Independent Review Organization reviews your appeal.</b>
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- **The Independent Review Organization is an independent organization that is hired by Medicare.** This organization is not connected with our Plan and it is not a government agency. This organization is a company chosen by Medicare to handle the job of being the Independent Review Organization. Medicare oversees its work.
- We will send the information about your appeal to this organization. This information is called your “case file.” **You have the right to ask us for a copy of your case file.**
- You have a right to give the Independent Review Organization additional information to support your appeal.
- Reviewers at the Independent Review Organization will take a careful look at all of the information related to your appeal.

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

- If you had a fast appeal to our Plan at Level 1, you will automatically receive a fast appeal at Level 2. The review organization must give you an answer to your Level 2 Appeal **within 72 hours** of when it receives your appeal.
- However, if the Independent Review Organization needs to gather more information that may benefit you, **it can take up to 14 more 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 our Plan at Level 1, you will automatically receive a standard appeal at Level 2. The review organization must give you an answer to your Level 2 Appeal **within 30 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.**

<b>Step 2:</b>	<b>The Independent Review Organization gives you their answer.</b>
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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 our Plan that your request (or part of your request) for coverage for medical care should not be approved. (This is called “upholding the decision.” It is also called “turning down your appeal.”)
  - The notice you get from the Independent Review Organization will tell you in writing if your case meets the requirements for continuing with the appeals process. For example, to continue and make another appeal at Level 3, the dollar value of the medical care coverage you are requesting must meet a certain minimum. If the dollar value of the coverage you are requesting is too low, you cannot make another appeal, which means that the decision at Level 2 is final.

<b>Step 3:</b>	<b>If your case meets the requirements, you choose whether you want to take your appeal further.</b>
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- 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 10 in this chapter tells more about Levels 3, 4, and 5 of the appeals process.

<b>Section 6.5</b>	<b>What if you are asking our Plan to pay you back for our share of a bill you have received for medical care?</b>
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If you want to ask our Plan 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 our Plan**

If you send us the paperwork that asks for reimbursement, you are asking us to make a coverage decision (for more information about coverage decisions, see Section 5.1 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 Chapter 4: **Medical Benefits Chart (what is covered and what you pay)**). We will also check to see if you followed all the rules for using your coverage for medical care (these rules are given in 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. (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 6.3 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.

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## SECTION 7      **Your Part D prescription drugs: How to ask for a coverage decision or make an appeal**

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Have you read Section 5 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.

<b>Section 7.1</b>	<b>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</b>
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Your benefits as a member of our Plan include coverage for many outpatient prescription drugs. Medicare calls these outpatient prescription drugs “Part D drugs.” You can get these drugs as long as they are included in our Plan’s **List of Covered Drugs (Formulary)** 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 or supported by certain reference books. See Chapter 5, Section 4 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 the 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 5 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.

<b>Legal</b> An initial coverage decision about your Part D drugs is called <b>Terms</b> a “ <b>coverage determination.</b> ”
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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 meet the requirements for coverage. (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:

<b>Which of these situations are you in?</b>			
<p>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?</p> <p>You can ask us to make an exception. (This is a type of coverage decision.)</p> <p>Start with <b>Section 7.2</b> of this chapter.</p>	<p>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?</p> <p>You can ask us for a coverage decision.</p> <p>Skip ahead to <b>Section 7.4</b> of this chapter.</p>	<p>Do you want to ask us to pay you back for a drug you have already received and paid for?:</p> <p>You can ask us to pay you back. (This is a type of coverage decision.)</p> <p>Skip ahead to <b>Section 7.4</b> of this chapter.</p>	<p>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?</p> <p>You can make an appeal. (This means you are asking us to reconsider.)</p> <p>Skip ahead to <b>Section 7.5</b> of this chapter.</p>

**Section 7.2      What is an exception?**

If a drug is not covered in the way you would like it to be covered, you can ask the plan to make an

“exception.” An exception is a type of coverage decision. Similar to other types of coverage decisions, if we turn down your request for an exception, you can appeal our decision.

When you ask for an exception, your doctor or other prescriber will need to explain the medical reasons why you need the exception approved. We will then consider your request. Here are two examples of exceptions that you or your doctor or other prescriber can ask us to make:

**1. Covering a Part D drug for you that is not on our Plan’s List of Covered Drugs (formulary).** (We call it the “Drug List” for short.)

**Legal** Asking for coverage of a drug that is not on the Drug List is  
**Terms** 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 drugs in Tier Four. You cannot ask for an exception to the copayment or coinsurance amount we require you to pay for the drug.
- You cannot ask for coverage of any “excluded drugs” or other non-Part D drugs which Medicare does not cover. (For more information about excluded drugs, see Chapter 5.)

**2. Removing a restriction on the plan’s coverage for a covered drug.** There are extra rules or restrictions that apply to certain drugs on the plan’s **List of Covered Drugs (Formulary)** (for more information, go to Chapter 5 and look for Section 5).

**Legal** Asking for removal of a restriction on coverage for a drug is  
**Terms** sometimes called asking for a “**formulary exception.**”

- The extra rules and restrictions on coverage for certain drugs include:
  - **Being required to use the generic version** of a drug instead of the brand-name drug.
  - **Getting plan approval in advance** before we will agree to cover the drug for you. (This is sometimes called “prior authorization.”)
  - **Being required to try a different drug first** before we will agree to cover the drug you are asking for. (This is sometimes called “step therapy.”)
  - **Quantity limits.** For some drugs, there are restrictions on the amount of the drug you can have.
- If our Plan agrees to make an exception and waive a restriction for you, you can ask for an exception to the copayment or coinsurance amount we require you to pay for the drug.

**Section 7.3 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.

### Our Plan can say yes or no to your request

- If we approve your request for an exception, our approval usually is valid until the end of the plan year. This is true as long as your doctor continues to prescribe the drug for you and that drug continues to be safe and effective for treating your condition.
- If we say no to your request for an exception, you can ask for a review of our decision by making an appeal. Section 7.5 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.

<b>Section 7.4</b>	<b>Step-by-step: How to ask for a coverage decision, including an exception</b>
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<b>Step 1:</b>	<b>You ask our Plan to make a coverage decision about the drug(s) or payment you need.</b> If your health requires a quick response, you must ask us to make a “ <b>fast decision.</b> ” <b>You cannot ask for a fast decision if you are asking us to pay you back for a drug you already bought.</b>
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### What to do

- **Request the type of coverage decision you want.** Start by calling, writing, or faxing our Plan to make your request. You, your representative, or your doctor (or other prescriber) can do this. For the details, go to Chapter 2, Section 1 and look for the section called, **How to contact us when you are asking for a coverage decision about your Part D prescription drugs.** Or if you are asking us to pay you back for a drug, go to the section 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 our Plan 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 “doctor’s statement.”** Your doctor or other prescriber must give us the medical reasons for the drug exception you are requesting. (We call this the “doctor’s statement.”) Your doctor or other prescriber can fax or mail the statement to our Plan. Or your doctor or other prescriber can tell us on the phone and follow up by faxing or mailing the signed statement. See Sections 7.2 and 7.3 for more information about exception requests.

## If your health requires it, ask us to give you a “fast decision”

**Legal** A “fast decision” is called an “**expedited coverage Terms determination.**”

- When we give you our decision, we will use the “standard” deadlines unless we have agreed to use the “fast” deadlines. A standard decision means we will give you an answer within 72 hours after we receive your doctor’s statement. A fast decision means we will answer within 24 hours.
- **To get a fast decision, you must meet two requirements:**
  - You can get a fast decision only if you are asking for a **drug you have not yet received.** (You cannot get a fast decision if you are asking us to pay you back for a drug you are already bought.)
  - You can get a fast decision **only** if using the standard deadlines could **cause serious harm to your health or hurt your ability to function.**
- **If your doctor or other prescriber tells us that your health requires a “fast decision,” we will automatically agree to give you a fast decision.**
- If you ask for a fast decision on your own (without your doctor’s or other prescriber’s support), our Plan will decide whether your health requires that we give you a fast decision.
  - If we decide that your medical condition does not meet the requirements for a fast decision, we will send you a letter that says so (and we will use the standard deadlines instead).
  - This letter will tell you that if your doctor or other prescriber asks for the fast decision, we will automatically give a fast decision.
  - The letter will also tell how you can file a complaint about our decision to give you a standard decision instead of the fast decision you requested. It 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 11 of this chapter.)

### **Step 2:**

**Our Plan considers your request and we give you our answer.**

### **Deadlines for a “fast” coverage decision**

- If we are using the fast deadlines, we must give you our answer **within 24 hours.**
  - Generally, this means within 24 hours after we receive your request. If you are requesting an exception, we will give you our answer within 24 hours after we receive your doctor’s statement supporting your request. We will give you our answer sooner if your health requires us to.
  - If we do not meet this deadline, we are required to send your request on to Level 2 of the appeals process, where it will be reviewed by an independent outside organization. Later in this section, we tell about this review organization and explain what happens at Appeal Level 2.
- **If our answer is yes to part or all of what you requested,** we must provide the coverage we have agreed to provide within 24 hours after we receive your request or doctor’s statement supporting

your request.

- **If our answer is no to part or all of what you requested**, we will send you a written statement that explains why we said no.

#### **Deadlines for a “standard” coverage decision about a drug you have not yet received**

- If we are using the standard deadlines, we must give you our answer **within 72 hours**.
  - Generally, this means within 72 hours after we receive your request. If you are requesting an exception, we will give you our answer within 72 hours after we receive your doctor’s statement supporting your request. We will give you our answer sooner if your health requires us to.
  - If we do not meet this deadline, we are required to send your request on to Level 2 of the appeals process, where it will be reviewed by an independent organization. Later in this section, we tell about this review organization and explain what happens at Appeal Level 2.
- **If our answer is yes to part or all of what you requested –**
  - If we approve your request for coverage, we must **provide the coverage** we have agreed to provide **within 72 hours** after we receive your request or doctor’s statement supporting your request.
- **If our answer is no to part or all of what you requested**, we will send you a written statement that explains why we said no.

#### **Deadlines for a “standard” coverage decision about 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 tell about this review organization and explain what happens at Appeal Level 2.
- **If our answer is yes to part or all of what you requested**, we are also required to make payment to you within 30 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.

<b>Step 3:</b>	<b>If we say no to your coverage request, you decide if you want to make an appeal.</b>
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- If our Plan says no, you have the right to request an appeal. Requesting an appeal means asking us to reconsider – and possibly change – the decision we made.

<b>Section 7.5</b>	<b>Step-by-step: How to make a Level 1 Appeal</b> (how to ask for a review of a coverage decision made by our Plan)
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<b>Legal Terms</b>	An appeal to the plan about a Part D drug coverage decision is called a plan “ <b>redetermination.</b> ”
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<b>Step 1:</b>	<b>You contact our Plan and make your Level 1 Appeal.</b> If your health requires a quick response, you must ask for a <b>“fast appeal.”</b>
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**What to do**

- **To start your appeal, you (or your representative or your doctor or other prescriber) must contact our Plan.**
  - For details on how to reach us by phone, fax, or mail for any purpose related to your appeal, go to Chapter 2, Section 1, and look for the section called, **How to contact us when you are making an appeal or a complaint about your Part D prescription drugs.**
- **If you are asking for a standard appeal, make your appeal 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 us when you are making an appeal about your Part D prescription drugs).
- **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”**

<b>Legal Terms</b>	A “fast appeal” is also called an <b>“expedited redetermination.”</b>
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- If you are appealing a decision our Plan made about a drug you have not yet received, you and your doctor or other prescriber will need to decide if you need a “fast appeal.”
- The requirements for getting a “fast appeal” are the same as those for getting a “fast decision” in Section 7.4 of this chapter.

<b>Step 2:</b>	<b>Our Plan considers your appeal and we give you our answer.</b>
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- When our Plan is reviewing your appeal, we take another careful look at all of the information about your coverage request. We check to see if we were following all the rules when we said no to your request. We may contact you or your doctor or other prescriber to get more information.

**Deadlines for a “fast” appeal**

- If we are using the fast deadlines, we must give you our answer **within 72 hours after we receive your appeal.** We will give you our answer sooner if your health requires it.
  - If we do not give you an answer within 72 hours, we are required to send your request on to

Level 2 of the appeals process, where it will be reviewed by an Independent Review Organization. Later in this section, we tell about this review organization and explain what happens at Level 2 of the appeals process.

- **If our answer is yes to part or all of what you requested**, we must provide the coverage we have agreed to provide within 72 hours after we receive your appeal.
- **If our answer is no to part or all of what you requested**, we will send you a written statement that explains why we said no and how to appeal our decision.

### Deadlines for a “standard” appeal

- If we are using the standard deadlines, we must give you our answer **within 7 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.

<b><u>Step 3:</u></b>	<b>If we say no to your appeal, you decide if you want to continue with the appeals process and make another appeal.</b>
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- If our Plan says no to your appeal, you then choose whether to accept this decision or continue by making another appeal.
- If you decide to make another appeal, it means your appeal is going on to Level 2 of the appeals process (see below).

<b>Section 7.6</b>	<b>Step-by-step: How to make a Level 2 Appeal</b>
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If our Plan says no to your appeal, you then choose whether to accept this decision or continue by making another appeal. If you decide to go on to a Level 2 Appeal, the **Independent Review Organization** reviews the decision our Plan made when we said no to your first appeal. This organization decides whether the decision we made should be changed.

**Legal Terms** The formal name for the “Independent Review Organization” is the “**Independent Review Entity**.” It is sometimes called the “**IRE**.”

**Step 1:**

**To make a Level 2 Appeal, you must contact the Independent Review Organization and ask for a review of your case.**

- If our Plan says no to your Level 1 Appeal, the written notice we send you will include **instructions on how to make a Level 2 Appeal** with the Independent Review Organization. These instructions will tell who can make this Level 2 Appeal, what deadlines you must follow, and how to reach the review organization.
- When you make an appeal to the Independent Review Organization, we will send the information we have about your appeal to this organization. This information is called your “case file.” **You have the right to ask us for a copy of your case file.**
- You have a right to give the Independent Review Organization additional information to support your appeal.

**Step 2:**

**The Independent Review Organization does a review of your appeal and gives you an answer.**

- **The Independent Review Organization is an independent organization that is hired by Medicare.** This organization is not connected with our Plan and it is not a government agency. This organization is a company chosen by Medicare to review our decisions about your Part D benefits with our Plan.
- Reviewers at the Independent Review Organization will take a careful look at all of the information related to your appeal. The organization will tell you its decision in writing and explain the reasons for it.

**Deadlines for a “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 a “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.

<b>Step 3:</b>	<b>If the dollar value of the coverage you are requesting meets the requirement, you choose whether you want to take your appeal further.</b>
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- 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 10 in this chapter tells more about Levels 3, 4, and 5 of the appeals process.

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## SECTION 8      How to ask us to cover a longer inpatient hospital stay if you think the doctor is discharging you too soon

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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 our coverage for your hospital care, including any limitations on this coverage, see Chapter 4 of this booklet: **Medical Benefits Chart (what is covered and what you pay)**.

During your hospital stay, your doctor and the hospital staff will be working with you to prepare for the day when you will leave the hospital. They will also help arrange for care you may need after you leave.

- The day you leave the hospital is called your “**discharge date.**” Our Plan’s coverage of your hospital stay ends on this date.

- When your discharge date has been decided, your doctor or the hospital staff will let you know.
- 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.

<b>Section 8.1</b>	<b>During your inpatient hospital stay, you will get a written notice from Medicare that tells about your rights</b>
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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. 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.

<p><b>Legal Terms</b> The written notice from Medicare tells you how you can <b>“request an immediate review.”</b> 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 8.2 below tells you how you can request an immediate review.)</p>
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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 5 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 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](http://www.cms.gov/BNI/12_HospitalDischargeAppealNotices.asp).

<b>Section 8.2</b>	<b>Step-by-step: How to make a Level 1 Appeal to change your hospital discharge date</b>
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If you want to ask for your hospital services to be covered by our Plan for a longer time, you will need to use the appeals process to make this request. Before you start, understand what you need to do and what the deadlines are.

- **Follow the process.** Each step in the first two levels of the appeals process is explained below.
- **Meet the deadlines.** The deadlines are important. Be sure that you understand and follow the deadlines that apply to things you must do.
- **Ask for help if you need it.** If you have questions or need help at any time, please call Customer Service (phone numbers are on the back 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.** It checks to see if your planned discharge date is medically appropriate for you.

<b>Step 1:</b>	<b>Contact the Quality Improvement Organization in your state and ask for a “fast review” of your hospital discharge. You must act quickly.</b>
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<b>Legal Terms</b>
A “fast review” is also called an <b>“immediate review.”</b>

### What is the Quality Improvement Organization?

- This organization is a group of doctors and other health care professionals who are paid by the Federal government. These experts are not part of our Plan. This organization is paid by Medicare to check on and help improve the quality of care for people with Medicare. This includes reviewing hospital discharge dates for people with Medicare.

### How can you contact this organization?

- The written notice you received (**An Important Message from Medicare 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 Chapter 2, Section 4, of this booklet.)

### Act quickly:

- To make your appeal, you must contact the Quality Improvement Organization **before** you leave the hospital and **no later than your planned discharge date**. (Your “planned discharge date” is the date that has been set for you to leave the hospital.)
  - If you meet this deadline, you are allowed to stay in the hospital **after** your discharge date

**without paying for it** while you wait to get the decision on your appeal from the Quality Improvement Organization.

- If you do **not** meet this deadline, and you decide to stay in the hospital after your planned discharge date, **you may have to pay all of the costs** for hospital care you receive after your planned discharge date.
- If you miss the deadline for contacting the Quality Improvement Organization about your appeal, you can make your appeal directly to our Plan instead. For details about this other way to make your appeal, see Section 8.4.

#### 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” for short) will ask you (or your representative) why you believe coverage for the services should continue. You don’t have to prepare anything in writing, but you may do so if you wish.
- The reviewers will also look at your medical information, talk with your doctor, and review information that the hospital and our Plan has given to them.
- By noon of the day after the reviewers informed our Plan of your appeal, you will also get a written notice that gives your planned discharge date and explains the reasons why your doctor, the hospital, and our Plan think it is right (medically appropriate) for you to be discharged on that date.

**Legal Terms** This written explanation is called the “**Detailed Notice of Discharge**.” You can get a sample of this notice by calling Customer Service or 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. (TTY users should call 1-877-486-2048.) Or you can see a sample notice online at <http://www.cms.hhs.gov/BNI/>

#### Step 3:

**Within one full day after it has all the needed information, the Quality Improvement Organization will give you its answer to your appeal.**

#### What happens if the answer is yes?

- If the review organization says **yes** to your appeal, **our Plan must keep providing your covered**

**hospital services for as long as these services are medically necessary.**

- You will have to keep paying your share of the costs (such as deductibles or copayments, if these apply). In addition, there may be limitations on your covered hospital services. (See 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, **our Plan's coverage for your hospital services will end** at noon on the day **after** the Quality Improvement Organization gives you its answer to your appeal.
- If the review organization says **no** to your appeal and you decide to stay in the hospital, then **you may have to pay the full** cost of hospital care you receive after noon on the day after the Quality Improvement Organization gives you its answer to your appeal.

#### **Step 4:**

**If the answer to your Level 1 Appeal is no, you decide if you want to make another appeal.**

- If the Quality Improvement Organization has turned down your appeal, **and** you stay in the hospital after your planned discharge date, then you can make another appeal. Making another appeal means you are going on to "Level 2" of the appeals process.

#### **Section 8.3**

#### **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 we turn 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:**

- **Our Plan must reimburse you** for our share of the costs of hospital care you have received since noon on the day after the date your first appeal was turned down by the Quality Improvement Organization. **Our Plan must continue providing coverage for your hospital care for as long as it is medically necessary.**
- You must continue to pay your share of the costs and coverage limitations may apply.

**If the review organization says no:**

- It means they agree with the decision they made 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 10 in this chapter tells more about Levels 3, 4, and 5 of the appeals process.

**Section 8.4****What if you miss the deadline for making your Level 1 Appeal?****You can appeal to our Plan instead**

As explained above in Section 8.2, you must act quickly to contact the Quality Improvement Organization to start your first appeal of your hospital discharge. (“Quickly” means before you leave the hospital and no later than your planned discharge date). If you miss the deadline for contacting this organization, there is another way to make your appeal.

If you use this other way of making your appeal, **the first two levels of appeal are different.**

**Step-by-Step: How to make a Level 1 Alternate Appeal**

If you miss the deadline for contacting the Quality Improvement Organization, you can make an appeal to our Plan, asking for a “fast review.” A fast review is an appeal that uses the fast deadlines instead of the standard deadlines.

**Legal** A “fast” review (or “fast appeal”) is also called an “**expedited Terms appeal**”.

**Step 1:**

**Contact our Plan and ask for a “fast review.”**

- For details on how to contact our Plan, go to Chapter 2, Section 1 and look for the section called, **How to contact us when you are making an appeal or complaint about your medical care.**
- **Be sure to ask for a “fast review.”** This means you are asking us to give you an answer using the “fast” deadlines rather than the “standard” deadlines.

<b>Step 2:</b>	<b>Our Plan does a “fast” review of your planned discharge date, checking to see if it was medically appropriate.</b>
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- During this review, our Plan takes a look at all of the information about your hospital stay. We check to see if your planned discharge date was medically appropriate. We will check to see if the decision about when you should leave the hospital was fair and followed all the rules.
- In this situation, we will use the “fast” deadlines rather than the standard deadlines for giving you the answer to this review.

<b>Step 3:</b>	<b>Our Plan gives you our decision within 72 hours after you ask for a “fast review” (“fast appeal”).</b>
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- **If our Plan says yes to your fast appeal,** it means we have agreed with you that you still need to be in the hospital after the discharge date, and will keep providing your covered services for as long as it is medically necessary. It also means that we have agreed to reimburse you for our share of the costs of care you have received since the date when we said your coverage would end. (You must pay your share of the costs and there may be coverage limitations that apply.)
- **If our Plan says no to your fast appeal,** we are saying that your planned discharge date was medically appropriate. Our coverage for your hospital services ends as of the day we said coverage would end.
  - If you stayed in the hospital **after** your planned discharge date, then **you may have to pay the full cost** of hospital care you received after the planned discharge date.

<b>Step 4:</b>	<b>If our Plan says no to your fast appeal, your case will automatically be sent on to the next level of the appeals process.</b>
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- To make sure we were following all the rules when we said no to your fast appeal, **our Plan is required to send your appeal to the “Independent Review Organization.”** When we do this, it means that you are **automatically** going on to Level 2 of the appeals process.

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

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

<p><b>Legal Terms</b> The formal name for the “Independent Review Organization” is the <b>“Independent Review Entity.”</b> It is sometimes called the <b>“IRE.”</b></p>
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<b>Step 1:</b>	<b>We will automatically forward your case to the Independent Review Organization.</b>
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- 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 11 of this chapter tells how to make a complaint.)

<b>Step 2:</b>	<b>The Independent Review Organization does a “fast review” of your appeal. The reviewers give you an answer within 72 hours.</b>
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- **The Independent Review Organization is an independent organization that is hired by Medicare.** This organization is not connected with our Plan and it is not a government agency. This organization is a company chosen by Medicare to handle the job of being the Independent Review Organization. Medicare oversees its work.
- Reviewers at the Independent Review Organization will take a careful look at all of the information related to your appeal of your hospital discharge.
- **If this organization says yes to your appeal,** then our Plan must reimburse you (pay you back) for our share of the costs of hospital care you have received since the date of your planned discharge. We must also continue the plan’s coverage of your hospital services for as long as it is medically necessary. You must continue to pay your share of the costs. If there are coverage limitations, these could limit how much we would reimburse or how long we would continue to cover your services.
- **If this organization says no to your appeal,** it means they agree with our Plan that your planned hospital discharge date was medically appropriate.
  - 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.

<b>Step 3:</b>	<b>If the Independent Review Organization turns down your appeal, you choose whether you want to take your appeal further.</b>
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- 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 10 in this chapter tells more about Levels 3, 4, and 5 of the appeals process.

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**SECTION 9      How to ask us to keep covering certain medical services if you think your coverage is ending too soon**

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<b>Section 9.1</b>	<b>This section is about three services <u>only</u>: Home health care, skilled nursing facility care, and Comprehensive Outpatient Rehabilitation Facility (CORF) services</b>
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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 Chapter 4 of this booklet: **Medical Benefits Chart (what is covered and what you pay)**.

When our Plan decides it is time to stop covering any of the three types of care for you, we are required to tell you in advance. When your coverage for that care ends, **our Plan will stop paying its share of the cost for your care**.

If you think we are ending the coverage of your care too soon, **you can appeal our decision**. This section tells you how to ask for an appeal.

## Section 9.2 We will tell you in advance when your coverage will be ending

1. **You receive a notice in writing.** At least two days before our Plan is going to stop covering your care, the agency or facility that is providing your care will give you a notice.
  - The written notice tells you the date when our Plan will stop covering the care for you.
  - The written notice also tells what you can do if you want to ask our Plan to change this decision about when to end your care, and keep covering it for a longer period of time.

**Legal Terms** In telling what you can do, the written notice is telling how you can 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 9.3 below tells how you can request a fast-track appeal.)

**Legal Terms Coverage.** The written notice is called the “**Notice of Medicare Non-Coverage**.” To get a sample copy, call Customer Service or 1-800-MEDICARE (1-800-633-4227, 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.). Or see a copy online at <http://www.cms.hhs.gov/BNI/>

2. **You must sign the written notice to show that you received it.**

- You or someone who is acting on your behalf must sign the notice. (Section 5 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 not mean you agree** with the plan that it's time to stop getting the care.

<b>Section 9.3</b>	<b>Step-by-step: How to make a Level 1 Appeal to have our Plan cover your care for a longer time</b>
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If you want to ask us to cover your care for a longer period of time, you will need to use the appeals process to make this request. Before you start, understand what you need to do and what the deadlines are.

- **Follow the process.** Each step in the first two levels of the appeals process is explained below.
- **Meet the deadlines.** The deadlines are important. Be sure that you understand and follow the deadlines that apply to things you must do. There are also deadlines our Plan must follow. (If you think we are not meeting our deadlines, you can file a complaint. Section 11 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 on the back 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 our Plan.**

<b>Step 1:</b>	<b>Make your Level 1 Appeal: contact the Quality Improvement Organization in your state and ask for a review. You must act quickly.</b>
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#### **What is the Quality Improvement Organization?**

- This organization is a group of doctors and other health care experts who are paid by the Federal government. These experts are not part of our Plan. They check on the quality of care received by people with Medicare and review plan decisions about when it's time to stop covering certain kinds of medical care.

#### **How can you contact this organization?**

- The written notice you received tells you how to reach this organization. (Or find the name, address, and phone number of the Quality Improvement Organization for your state in Chapter 2, Section 4, of this booklet.)

#### **What should you ask for?**

- Ask this organization to do an independent review of whether it is medically appropriate for our Plan to end coverage for your medical services.

#### **Your deadline for contacting this organization.**

- You must contact the Quality Improvement Organization to start your appeal **no later than noon of the day after you receive the written notice telling you when we will stop covering your care.**
- If you miss the deadline for contacting the Quality Improvement Organization about your appeal, you can make your appeal directly to our Plan instead. For details about this other way to make your appeal, see Section 9.5.

<b>Step 2:</b>	<b>The Quality Improvement Organization conducts an independent review of your case.</b>
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#### What happens during this review?

- Health professionals at the Quality Improvement Organization (we will call them “the reviewers” for short) will ask you (or your representative) why you believe coverage for the services should continue. You don’t have to prepare anything in writing, but you may do so if you wish.
- The review organization will also look at your medical information, talk with your doctor, and review information that our Plan has given to them.
- By the end of the day the reviewers informed our Plan of your appeal, and you will also get a written notice from the plan that gives our reasons for ending the plan’s coverage for your services.

**Legal** This notice explanation is called the “**Detailed Explanation Terms of Non-Coverage.**”

<b>Step 3:</b>	<b>Within one full day after they have all the information they need, the reviewers will tell you their decision.</b>
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#### What happens if the reviewers say yes to your appeal?

- If the reviewers say **yes** to your appeal, then **our Plan must keep providing your covered services for as long as it is medically necessary.**
- You will have to keep paying your share of the costs (such as deductibles or copayments, if these apply). In addition, there may be limitations on your covered services (see 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.** Our Plan will stop paying its share of the costs of this care.
- If you decide to keep getting the home health care, or skilled nursing facility care, or Comprehensive Outpatient Rehabilitation Facility (CORF) services **after** this date when your coverage ends, then **you will have to pay the full cost** of this care yourself.

<b>Step 4:</b>	<b>If the answer to your Level 1 Appeal is no, you decide if you want to make another appeal.</b>
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- 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.

<b>Section 9.4</b>	<b>Step-by-step: How to make a Level 2 Appeal to have our Plan cover your care for a longer time</b>
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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 we turn 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:

<b><u>Step 1:</u></b>	<b>You contact the Quality Improvement Organization again and ask for another review.</b>
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- 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.

<b><u>Step 2:</u></b>	<b>The Quality Improvement Organization does a second review of your situation.</b>
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- Reviewers at the Quality Improvement Organization will take another careful look at all of the information related to your appeal.

<b><u>Step 3:</u></b>	<b>Within 14 days, the Quality Improvement Organization reviewers will decide on your appeal and tell you their decision.</b>
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**What happens if the review organization says yes to your appeal?**

- **Our Plan must reimburse you** for our share of the costs of care you have received since the date when we said your coverage would end. **Our Plan must continue providing coverage** for the care for as long as it is medically necessary.
- You must continue to pay your share of the costs and there may be coverage limitations that apply.

**What happens if the review organization says no?**

- It means they agree with the decision they made to your Level 1 Appeal and will not change it.
- 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.

<b><u>Step 4:</u></b>	<b>If the answer is no, you will need to decide whether you want to take your appeal further.</b>
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- 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 10 in this chapter tells more about Levels 3, 4, and 5 of the appeals process.

<b>Section 9.5</b>	<b>What if you miss the deadline for making your Level 1 Appeal?</b>
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### You can appeal to our Plan instead

As explained above in Section 9.3, you must act quickly to contact the Quality Improvement Organization to start your first appeal (within a day or two, at the most). If you miss the deadline for contacting this organization, there is another way to make your appeal. If you use this other way of making your appeal, **the first two levels of appeal are different.**

### Step-by-Step: How to make a Level 1 Alternate Appeal

If you miss the deadline for contacting the Quality Improvement Organization, you can make an appeal to our Plan, asking for a “fast review.” A fast review is an appeal that uses the fast deadlines instead of the standard deadlines.

Here are the steps for a Level 1 Alternate Appeal:

<b>Legal</b> A “fast” review (or “fast appeal”) is also called an <b>“expedited Terms appeal”</b> .
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<b>Step 1:</b>	<b>Contact our Plan and ask for a “fast review.”</b>
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- For details on how to contact our Plan, go to Chapter 2, Section 1 and look for the section called, **How to contact us when you are making an appeal or complaint about your medical care.**
- **Be sure to ask for a “fast review.”** This means you are asking us to give you an answer using the “fast” deadlines rather than the “standard” deadlines.

<b>Step 2:</b>	<b>Our Plan does a “fast” review of the decision we made about when to end coverage for your services.</b>
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- During this review, our Plan takes another look at all of the information about your case. We check to see if we were following all the rules when we set the date for ending the plan’s coverage for services you were receiving.
- We will use the “fast” deadlines rather than the standard deadlines for giving you the answer to this review. (Usually, if you make an appeal to our Plan and ask for a “fast review,” we are allowed to decide whether to agree to your request and give you a “fast review.” But in this situation, the rules require us to give you a fast response if you ask for it.)

<b>Step 3:</b>	<b>Our Plan gives you our decision within 72 hours after you ask for a “fast review” (“fast appeal”).</b>
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- **If our Plan says yes to your fast appeal**, it means we have agreed with you that you need services longer, and will keep providing your covered services for as long as it is medically necessary. It also means that we have agreed to reimburse you for our share of the costs of care you have received since the date when we said your coverage would end. (You must pay your share of the costs and there may be coverage limitations that apply.)
- **If our Plan says no to your fast appeal**, then your coverage will end on the date we have told you and our Plan will not pay after this date. Our Plan will stop paying its share of the costs of this care.
- If you continued to get home health care, or skilled nursing facility care, or Comprehensive Outpatient Rehabilitation Facility (CORF) services **after** the date when we said your coverage ends, then **you will have to pay the full cost** of this care yourself.

<b>Step 4:</b>	<b>If our Plan says no to your fast appeal, your case will automatically go on to the next level of the appeals process.</b>
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- To make sure we were following all the rules when we said no to your fast appeal, **our Plan is required to send your appeal to the “Independent Review Organization.”** When we do this, it means that you are **automatically** going on to Level 2 of the appeals process.

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

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

**Legal Terms** The formal name for the “Independent Review Organization” is the “**Independent Review Entity**.” It is sometimes called the “**IRE**.”

<b>Step 1:</b>	<b>We will automatically forward your case to the Independent Review Organization.</b>
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- 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 11 of this chapter tells how to make a complaint.)

<b>Step 2:</b>	<b>The Independent Review Organization does a “fast review” of your appeal. The reviewers give you an answer within 72 hours.</b>
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- **The Independent Review Organization is an independent organization that is hired by Medicare.** This organization is not connected with our Plan and it is not a government agency. This organization is a company chosen by Medicare to handle the job of being the Independent Review Organization. Medicare oversees its work.

- Reviewers at the Independent Review Organization will take a careful look at all of the information related to your appeal.
- **If this organization says yes to your appeal**, then our Plan must reimburse you (pay you back) for our share of the costs of care you have received since the date when we said your coverage would end. We must also continue to cover the care for as long as it is medically necessary. You must continue to pay your share of the costs. If there are coverage limitations, these could limit how much we would reimburse or how long we would continue to cover your services.
- **If this organization says no to your appeal**, it means they agree with the decision our Plan made to your first appeal and will not change it.
  - 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.

<b>Step 3:</b>	<b>If the Independent Review Organization turns down your appeal, you choose whether you want to take your appeal further.</b>
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- 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 10 in this chapter tells more about Levels 3, 4, and 5 of the appeals process.

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## SECTION 10 Taking your appeal to Level 3 and beyond

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### Section 10.1 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.

<b>Level 3 Appeal</b>	<b>A judge who works for the Federal government</b> will review your appeal and give you an answer. This judge is called an “Administrative Law Judge.”
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- **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 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.

<b>Level 4 Appeal</b>	The <b>Medicare Appeals Council</b> will review your appeal and give you an answer. The Medicare Appeals Council works for the Federal government.
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- **If the answer is yes, or if the Medicare Appeals Council denies our request to review a favorable Level 3 Appeal decision, the appeals process may or may not be over** - We will decide whether to appeal this decision to Level 5. Unlike a decision at Level 2 (Independent Review Organization), we have the right to appeal a Level 4 decision that is favorable to you.
  - If we decide **not** to appeal the decision, we must authorize or provide you with the service within 60 days after receiving the Medicare Appeals Council's decision.
  - If we decide to appeal the decision, we will let you know in writing.
- **If the answer is no or if the Medicare Appeals Council denies the review request, the appeals process may or may not be over.**
  - If you decide to accept this decision that turns down your appeal, the appeals process is over.
  - If you do not want to accept the decision, you might be able to continue to the next level of the review process. If the Medicare Appeals Council says no to your appeal, the notice you get will tell you whether the rules allow you to go on to a Level 5 Appeal. If the rules allow you to go on, the written notice will also tell you who to contact and what to do next if you choose to continue with your appeal.

<b>Level 5 Appeal</b>	A judge at the <b>Federal District Court</b> will review your appeal.
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- This is the last step of the administrative appeals process.

<b>Section 10.2</b>	<b>Levels of Appeal 3, 4, and 5 for Part D Drug Appeals</b>
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This section may be appropriate for you if you have made a Level 1 Appeal and a Level 2 Appeal, and both of your appeals have been turned down.

If the dollar value of the drug you have appealed meets certain minimum levels, you may be able to go on to additional levels of appeal. If the dollar value is less than the minimum level, you cannot appeal any further. If the dollar value is high enough, the written response you receive to your Level 2 Appeal will explain who to contact and what to do to ask for a Level 3 Appeal.

For most situations that involve appeals, the last three levels of appeal work in much the same way. Here is who handles the review of your appeal at each of these levels.

<b>Level 3 Appeal</b>	<b>A judge who works for the Federal government</b> will review your appeal and give you an answer. This judge is called an “Administrative Law Judge.”
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- **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 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 get will tell you what to do next if you choose to continue with your appeal.

<b>Level 4 Appeal</b>	The <b>Medicare Appeals Council</b> will review your appeal and give you an answer. The Medicare Appeals Council works for the Federal government.
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- **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 Medicare Appeals Council **within 72 hours (24 hours for expedited appeals) or make payment no later than 30 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 Medicare Appeals Council says no to your appeal, the notice you get will tell you whether the rules allow you to go on to a Level 5 Appeal. If the rules allow you to go on, the written notice will also tell you who to contact and what to do next if you choose to continue with your appeal.

<b>Level 5 Appeal</b>	A judge at the <b>Federal District Court</b> will review your appeal.
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- This is the last step of the appeals process.

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**SECTION 11      How to make a complaint about quality of care, waiting times, customer service, or other concerns**

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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 5 of this chapter.

**Section 11.1      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 Customer Service or other staff at our 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 5-10 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 response” for a coverage decision or 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 11.2      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 11.3      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. 1-866-550-4736, 711, 10/15-3/1: 8:00 am to 8:00 pm Local Time Zone, 7 Days a Week; 3/2-10/14: 8:00 am to 8:00 pm Local Time Zone, Monday - Friday.

- **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.
- The complaint must be submitted within 60 days of the event or incident. The address for filing complaints is located in Chapter 2 under **How to contact us when you are making a complaint about your medical care** or Part D complaints **How to contact us when you are making a complaint about your Part D prescription drugs**. We must address your grievance as quickly as your case requires based on your health status, but no later than 30 days after receiving your complaint. We may extend the time frame by up to 14 days if you ask for the extension, or if we justify a need for additional information and the delay is in your best interest. If we deny your grievance in whole or in part, our written decision will explain why we denied it, and will tell you about any dispute resolution options you may have.
- **Whether you call or write, you should contact Customer Service right away.** The complaint must be made within 60 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 response” to a coverage decision or appeal, we will automatically give you a “fast” complaint.** If you have a “fast” complaint, it means we will give you **an answer within 24 hours**.

**Legal** What this section calls a “fast complaint” is also called an **Terms “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 11.4****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 our Plan by using the step-by-step process outlined above.

When your complaint is about **quality of care**, you also have two extra options:

- **You can make your complaint to the Quality Improvement Organization.** If you prefer, you can make your complaint about the quality of care you received directly to this organization (**without** making the complaint to our Plan).
  - 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, look in Chapter 2, Section 4, of this booklet. 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 our Plan and also to the Quality Improvement Organization.

## PROBLEMS ABOUT YOUR MEDICAID BENEFITS

### Section 12 Handling problems about your Medicaid benefits

#### **You can get help and information from Texas Medicaid Health and Human Services Commission (Medicaid)**

For more information and help in handling a problem, you can also contact Texas Medicaid Health and Human Services Commission (Medicaid).

If you have Medicare and Medicaid, some of your Plan services may also be covered by your State Texas Medicaid Health and Human Services Commission (Medicaid) program. Therefore, if you believe that we improperly denied you a service or payment for a service, you may also have the right to ask your State Texas Medicaid Health and Human Services Commission (Medicaid) program to pay for the service. You may also have appeals and grievances related to Medicaid-covered services. Please see your Medicaid Handbook for more information, or contact your State Texas Medicaid Health and Human Services Commission (Medicaid) agency at the contact information listed in Chapter 2, Section 6 of this booklet.

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**CHAPTER 10: Ending your membership in the plan**

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## SECTION 1 Introduction

If you are in an institution, receive Medicaid, or if you qualify for a Medicare Savings Program such as Qualified Medicare Beneficiary, Special Low Income Medicare Beneficiary, Qualified Disabled Working Individual or a Qualified Individual, you may disenroll from your Plan at any time, for any reason.

### Section 1.1 This chapter focuses on ending your membership in our Plan

Ending your membership in the plan may be **voluntary** (your own choice) or **involuntary** (not your own choice):

- You might leave our Plan because you have decided that you **want** to leave.
  - You can end your membership in the plan at any time. Section 2 tells you about the types of plans you can enroll in and when your enrollment in your new coverage will begin.
  - 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 our Plan, you must continue to get your medical care through our Plan until your membership ends.

## SECTION 2 When can you end your membership in our Plan?

### Section 2.1 You can end your membership at any time

You can end your membership in our Plan at any time.

- **When can you end your membership?** Most people with Medicare can end their membership only during certain times of the year. However, because you get assistance from Medicaid, **you can end your membership in our Plan at any time.**
- **What type of plan can you switch to?** If you decide to change to a new plan, you can choose any of the following types of Medicare plans.
  - Another 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 Medicare prescription drug plan.
    - 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.
  - – **or** – Original Medicare **without** a separate Medicare prescription drug plan.

Contact your State Texas Medicaid Health and Human Services Commission (Medicaid) Office to learn about your Medicaid plan options (telephone numbers are in Chapter 2, Section 6 of this booklet).

- **When will your membership end?** Your membership will usually end on the first day of the month after we receive your request to change your Plans. Your enrollment in your new plan will also begin on this day.

<b>Section 2.2</b>	<b>Where can you get more information about when you can end your membership?</b>
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If you have any questions or would like more information on when you can end your membership:

- You can **call Customer Service** (phone numbers are on the back cover of this booklet)
- You can find the information in the **Medicare & You 2012** 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.

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<b>SECTION 3</b>	<b>How do you end your membership in our Plan?</b>
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<b>Section 3.1</b>	<b>Usually, you end your membership by enrolling in another plan</b>
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Usually, to end your membership in our Plan, you simply enroll in another Medicare plan. However, if you want to switch from our Plan to Original Medicare but you have not selected a separate Medicare prescription drug plan, you must ask to be disenrolled from our 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.)
- --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.

The table below explains how you should end your membership in our Plan.

If you would like to switch from our Plan to:	This is what you should do:
<ul style="list-style-type: none"> <li>● Another Medicare health plan.</li> </ul>	<ul style="list-style-type: none"> <li>● Enroll in the new Medicare health plan. You will automatically be disenrolled from our Plan when your new plan's coverage begins.</li> </ul>
<ul style="list-style-type: none"> <li>● Original Medicare <b>with</b> a separate Medicare prescription drug plan.</li> </ul>	<ul style="list-style-type: none"> <li>● Enroll in the new Medicare prescription drug plan. You will automatically be disenrolled from our Plan when your new plan's coverage begins.</li> </ul>
<ul style="list-style-type: none"> <li>● Original Medicare <b>without</b> a separate Medicare prescription drug plan. <ul style="list-style-type: none"> <li>○ 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.</li> </ul> </li> </ul>	<ul style="list-style-type: none"> <li>● <b>Send us a written request to disenroll.</b> Contact Customer Service if you need more information on how to do this (phone numbers are on the back cover of this booklet).</li> <li>● You can also contact <b>Medicare</b>, 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.</li> <li>● You will be disenrolled from our Plan when your coverage in Original Medicare begins.</li> </ul>

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**SECTION 4      Until your membership ends, you must keep getting your medical services and drugs through our Plan**

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**Section 4.1      Until your membership ends, you are still a member of our Plan**

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If you leave our Plan it may take time before your membership ends and your new Medicare coverage goes into effect. (See Section 2 for information on when your new coverage begins.) During this time, you must continue to get your medical care and prescription drugs through our Plan.

- **You should continue to use our network pharmacies to get your prescriptions filled until your membership in our Plan ends.** Usually, your prescription drugs are only covered if they are filled at a network pharmacy including through our mail-order pharmacy services.
- **If you are hospitalized on the day that your membership ends, your hospital stay will usually be covered by our Plan until you are discharged** (even if you are discharged after your new health coverage begins).

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**SECTION 5      We must end your membership in the plan in certain situations**

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**Section 5.1      When must we end your membership in the plan?****We must end your membership in the plan if any of the following happen:**

- If you do not stay continuously enrolled in Medicare Part A and Part B.
- If you are no longer eligible for Medicaid. As stated in Chapter 1, section 2.1, our Plan is for people who are eligible for both Medicare and Medicaid. We must notify you in writing that you have a 6 month grace period to regain eligibility before you are disenrolled. For more information on the grace period and how it may affect your costs under this plan, please see Chapter 4.
- If you do not pay your medical spenddown, if applicable.
- If you move out of our service area for more than six months.
  - If you move or take a long trip, you need to call Customer Service to find out if the place you are moving or traveling to is in our Plan's area.
- If you become incarcerated (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 our Plan and that information affects your eligibility for our Plan.
- If you continuously behave in a way that is disruptive and makes it difficult for us to provide medical care for you and other members of our Plan.
  - We cannot make you leave our Plan for this reason unless we get permission from Medicare first.
- If you let someone else use your member ID card to get medical care.
  - If we end your membership because of this reason, Medicare may have your case investigated by the Inspector General.

**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 on the back cover of this booklet).

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**Section 5.2      We cannot ask you to leave our Plan for any reason related to your health**

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**What should you do if this happens?**

If you feel that you are being asked to leave our Plan because of a health-related reason, you should call Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048. You may call 24 hours a day, 7 days a week.

<b>Section 5.3</b>	<b>You have the right to make a complaint if we end your membership in our Plan</b>
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If we end your membership in our Plan, we must tell you our reasons in writing for ending your membership. We must also explain how you can make a complaint about our decision to end your membership. You can also look in Chapter 9, Section 11 for information about how to make a complaint.

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**CHAPTER 11: Legal notices**

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**SECTION 1      Notice about governing law**

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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.

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**SECTION 2      Notice about nondiscrimination**

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We don't discriminate based on a person's race, disability, religion, sex, health, ethnicity, creed, age, or national origin. All organizations that provide Medicare Advantage Plans, like our Plan, must obey Federal laws against discrimination, including Title VI of the Civil Rights Act of 1964, the Rehabilitation Act of 1973, the Age Discrimination Act of 1975, the Americans with Disabilities Act, all other laws that apply to organizations that get Federal funding, and any other laws and rules that apply for any other reason.

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**SECTION 3      Member liability**

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In the event we fail to reimburse network provider's charges for covered services, you will not be liable for any sums owed by us. Neither the plan nor Medicare will pay for those services except for the following eligible expenses:

- Emergency services
- Urgently needed services Out-of-area and routine travel dialysis (must be received in a Medicare Certified Dialysis Facility within the United States)
- Post-stabilization services

If you enter into a private contract with a non-network provider, neither the plan nor Medicare will pay for those services.

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**SECTION 4      Medicare-covered services must meet requirement of reasonable and necessary**

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In determining coverage, services must meet the reasonable and necessary requirements under Medicare in order to be covered under your Plan, unless otherwise listed as a covered service. A service is "reasonable and necessary" if the service is:

- Safe and effective;
- Not experimental or investigational; and

- Appropriate, including the duration and frequency that is considered appropriate for the service, in terms of whether it is:
  1. Furnished in accordance with accepted standards of medical practice for the diagnosis or treatment of the patient's condition or to improve the function of a malformed body member;
  2. Furnished in a setting appropriate to the patient's medical needs and condition;
  3. Ordered and furnished by qualified personnel;
  4. One that meets, but does not exceed, the patient's medical need; and
  5. At least as beneficial as an existing and available medically appropriate alternative.

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## SECTION 5      **Third party liability and subrogation**

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If you suffer an injury or illness for which any third party is liable or responsible due to any negligent or intentional act or omission causing illness or injury to you, you must promptly notify us of the injury or illness. We will send you a statement of the amounts we paid for services provided in connection with the injury or illness. If you recover any sums from any third party, we shall be reimbursed out of any such recovery from any third party for the payments we made on your behalf, subject to the limitations in the following paragraphs.

- 1)      **Our payments are less than the recovery amount.** If our payments are less than the total recovery amount from any third party (the "recovery amount"), then our reimbursement is computed as follows:
  - a) **First:** Determine the ratio of the procurement costs to the recovery amount (the term "procurement costs" means the attorney fees and expenses incurred in obtaining a settlement or judgment).
  - b) **Second:** Apply the ratio calculated above to our payment. The result is our share of procurement costs.
  - c) **Third:** Subtract our share of procurement costs from our payments. The remainder is our reimbursement amount.
- 2)      **Our payments equal or exceed the recovery amount.** If our payments equal or exceed the recovery amount, our reimbursement amount is the total recovery amount minus the total procurement costs.
- 3)      **We incur procurement costs because of opposition to our reimbursement.** If we must bring suit against the party that received the recovery amount because that party opposes our reimbursement, our reimbursement amount is the lower of the following:
  - a) our payments made on your behalf for services; or
  - b) the recovery amount, minus the party's total procurement cost.

Subject to the limitations stated above, you agree to grant us an assignment of, and a claim and a lien against, any amounts recovered through settlement, judgment or verdict. You may be required by us and you agree to execute documents and to provide information necessary to establish the assignment, claim, or lien to ascertain our right to reimbursement.

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**SECTION 6      Non duplication of benefits with automobile, accident or liability coverage**

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If you are receiving benefits as a result of other automobile, accident or liability coverage, we will not duplicate those benefits. It is your responsibility to take whatever action is necessary to receive payment under automobile, accident, or liability coverage when such payments may reasonably be expected, and to notify us of such coverage when available. If we happen to duplicate benefits to which you are entitled under other automobile, accident or liability coverage, we may seek reimbursement of the reasonable value of those benefits from you, your insurance carrier, or your health care provider to the extent permitted under State and/or federal law. We will provide benefits over and above your other automobile, accident or liability coverage, if the cost of your health care services exceeds such coverage. **You are required to cooperate with us in obtaining payment from your automobile, accident or liability coverage carrier. Your failure to do so may result in termination of your Plan membership.**

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**SECTION 7      Acts beyond our control**

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If, due to a natural disaster, war, riot, civil insurrection, complete or partial destruction of a facility, ordinance, law or decree of any government or quasi-governmental agency, labor dispute (when said dispute is not within our control), or any other emergency or similar event not within the control of us, network providers may become unavailable to arrange or provide health services pursuant to this Evidence of Coverage and Disclosure Information, then we shall attempt to arrange for covered services insofar as practical and according to our best judgment. Neither we nor any network provider shall have any liability or obligation for delay or failure to provide or arrange for covered services if such delay is the result of any of the circumstances described above.

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**SECTION 8      Contracting medical providers and network hospitals are independent contractors**

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The relationships between us and our network providers and network hospitals are independent contractor relationships. None of the network providers or network hospitals or their physicians or employees are employees or agents of UnitedHealthcare. An agent would be anyone authorized to act on our behalf. Neither we nor any employee of UnitedHealthcare is an employee or agent of the network providers or network hospitals.

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**SECTION 9      Our contracting arrangements**

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In order to obtain quality service in an efficient manner, we pay providers using various payment methods, including capitation, per diem, incentive and discounted Fee-for-Service arrangements. Capitation means paying an agreed upon dollar amount per month for each member assigned to the provider. Per diem means paying a fixed dollar amount per day for all services rendered, such as

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inpatient hospital and skilled nursing facility stays. Incentive means a payment that is based on appropriate medical management by the provider. Discounted Fee-for-Service means paying an agreed upon fee schedule which is a reduction from their usual and customary charges.

You are entitled to ask if we have special financial arrangements with the network providers that may affect the use of referrals and other services that you might need. To obtain this information, call Customer Service and request information about the network provider's payment arrangements.

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## **SECTION 10      How our network providers are compensated**

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The following is a brief description of how we pay our network providers:

We typically contract with individual physicians and medical groups, often referred to as Independent Practitioner Associations ("IPAs"), to provide medical services and with hospitals to provide services to members. The contracting medical groups/IPAs in turn, employ or contract with individual physicians.

Most of the individual physicians are paid on a Fee-for-Service arrangement. In addition, some physicians receive an agreed-upon monthly payment from us to provide services to members. The monthly payment may be either a fixed dollar amount for each member, or a percentage of the monthly plan premium received by us. The monthly payment typically covers professional services directly provided by individual physicians and may also cover certain referral services.

Most of the contracted medical groups/IPAs receive an agreed upon monthly payment from us to provide services to members. The monthly payment may be either a fixed dollar amount for each member or a percentage of the monthly plan premium received by us. The monthly payment typically covers professional services directly provided by the contracted medical group/IPA, and may also cover certain referral services. Some of our network hospitals receive similar monthly payments in return for arranging hospital services for members. Other hospitals are paid on a discounted Fee-for-Service or fixed charge per day of hospitalization.

Each year, we and the contracted medical group/IPA agree on a budget for the cost of services covered under the program for all plan members treated by the contracted medical group/IPA. At the end of the year, the actual cost of services for the year is compared to the agreed-upon budget. If the actual cost of services is less than the agreed-upon budget, the contracted medical group/IPA shares in the savings. The network hospital and the contracted medical group/IPA typically participate in programs for hospital services similar to that described above.

Stop-loss insurance protects the contracted medical groups/IPAs and network hospitals from large financial losses and helps the providers with resources to cover necessary treatment. We provide stop-loss protection to the contracted medical groups/IPAs and network hospitals that receive capitation payments. If any capitated providers do not obtain stop-loss protection from us, they must obtain stop-loss insurance from an insurance carrier acceptable to us. You may obtain additional information on compensation arrangements by contacting Customer Service or your contracted medical group/IPA, however, specific compensation terms and rates are confidential and will not be disclosed.

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**SECTION 11      Technology assessment**

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We regularly review new procedures, devices and drugs to determine whether or not they are safe and efficacious for Members. New procedures and technology that are safe and efficacious are eligible to become Covered Services. If the technology becomes a Covered Service, it will be subject to all other terms and conditions of the plan, including medical necessity and any applicable Member Copayments, Coinsurance, deductibles or other payment contributions.

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

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**SECTION 12      Member statements**

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In the absence of fraud, all statements made by you will be deemed representations and not warranties. No such representation will void coverage or reduce covered services under this Evidence of Coverage or be used in defense of a legal action unless it is contained in a written application.

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**SECTION 13      Information upon request**

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As a plan member, you have the right to request information on the following:

- General coverage and comparative plan information
- Utilization control procedures
- Quality improvement programs
- Statistical data on grievances and appeals
- The financial condition of UnitedHealthcare

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**SECTION 14      Internal protection of information within UnitedHealth Group**

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UnitedHealth Group collects and maintains oral, written and electronic information to administer our business and to provide products, services and information of importance to our enrollees. We provide physical, electronic and procedural security safeguards in the handling and maintenance of our enrollees' information to protect against risks such as loss, destruction or misuse. We conduct regular audits to guarantee appropriate and secure handling and processing of our enrollees' information.

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**SECTION 15      2012 Enrollee Fraud & Abuse Communication**

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### 2012 Enrollee Fraud & Abuse Communication

#### **How you can fight healthcare fraud**

Our company is committed to preventing fraud, waste, and abuse in Medicare benefit programs and we're asking for your help. If you identify a potential case of fraud, please report it to us immediately. Here are some examples of potential Medicare fraud cases:

- A health care provider – such as a physician, pharmacy, or medical device company – bills for services you never got,
- A supplier bills for equipment different from what you got
- Someone uses another person's Medicare card to get medical care, prescriptions, supplies or equipment
- Someone bills for home medical equipment after it has been returned.
- A company offers a Medicare drug or health plan that hasn't been approved by Medicare.
- A company uses false information to mislead you into joining a Medicare drug or health plan.

To report a potential case of fraud in a Medicare benefit program, call United HealthCare Insurance Company's dedicated fraud hotline at 1-877-637-5595, 24 hours a day, 7 days a week. TTY/TDD users may call 1-877-730-4203.

This hotline allows you to report cases anonymously and confidentially. We will make every effort to maintain your confidentiality. However, if law enforcement needs to get involved, we may not be able to guarantee your confidentiality. Please know that our organization will not take any action against you for reporting a potential fraud case in good faith.

You may also report potential prescription drug program fraud cases to the Medicare program directly at 1-877-7SafeRx (1-877-772-3379). For potential medical or non-prescription fraud cases, you may report to the Medicare program directly at 1-800-Medicare (1-800-633-4227). The Medicare fax number is 1-717-975-4442 and the Web site is [www.medicare.gov](http://www.medicare.gov).

For more information, request the guide titled "Protecting Medicare and You from Fraud" by calling 1-800-Medicare (1-800-633-4227). TTY/TDD users should call 1-877-486-2048. A customer service representative can answer your questions 24 hours a day, 7 days a week.

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## **CHAPTER 12: Definitions of important words**

**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.

**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 we don'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.

**Benefit period** – The way that 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. You must pay the inpatient hospital deductible for each benefit period. There is no limit to the number of benefit periods. For Inpatient Hospital Care, Medicare-defined hospital benefit periods do not apply. For inpatient hospital care, the cost sharing described in the Medical Benefits Chart in Chapter 4 applies each time you are admitted to the hospital. For each inpatient hospital stay, you are covered for unlimited days as long as the hospital stay is covered in accordance with plan rules.

**Brand Name Drug** – A prescription drug that is manufactured and sold by the pharmaceutical company that originally researched and developed the drug. Brand name drugs have the same active-ingredient formula as the generic version of the drug. However, generic drugs are manufactured and sold by other drug manufacturers and are generally not available until after the patent on the brand name drug has expired.

**Catastrophic Coverage Stage** – The stage in the Part D Drug Benefit where you pay no copayment or coinsurance for your drugs after you or other qualified parties on your behalf have spent \$4,700 in covered drugs during the covered year.

**Centers for Medicare & Medicaid Services (CMS)** – The Federal agency that administers Medicare. Chapter 2 explains how to contact CMS.

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

**Coinsurance** – An amount you may be required to pay as your share of the cost for services or prescription drugs. Coinsurance is usually a percentage (for example, 20%). Coinsurance for in-network services is based upon contractually negotiated rates (when available for the specific covered service to which the coinsurance applies) or Medicare Allowable Cost, depending on our contractual arrangements for the service.

**Comprehensive Outpatient Rehabilitation Facility (CORF)** – A facility that mainly provides rehabilitation services after an illness or injury, and provides a variety of services including physical therapy, social or psychological services, respiratory therapy, occupational therapy and speech-language pathology services, and home environment evaluation services.

**Co-Payment, Copayment, Copay** – 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 outpatient 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. Cost sharing includes any combination of the following three types of payments: (1) any deductible amount a plan may impose before services or drugs 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.

**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 your Plan 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 our Plan.

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

**Creditable Prescription Drug Coverage** – Prescription drug coverage (for example, from an employer or union) that is expected to 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 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 our Plan responsible for answering your questions about your membership, benefits, grievances, and appeals. See Chapter 2 for information about how to contact Customer Service.

**Disenroll or Disenrollment** – The process of ending your membership in our Plan. Disenrollment may be voluntary (your own choice) or involuntary (not your own choice).

**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.

**Dual Eligible Individual** – A person who qualifies for Medicare and Medicaid coverage.

**Durable Medical Equipment** – Certain medical equipment that is ordered by your doctor for use at home. Examples are walkers, wheelchairs, or hospital beds.

**Emergency Care** – Covered services that are: 1) rendered by a provider qualified to furnish emergency services; and 2) needed to evaluate or stabilize an emergency medical condition.

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

**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 Help** – A Medicare program to help people with limited income and resources pay Medicare prescription drug program costs, such as premiums, deductibles, and coinsurance.

**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.

**Home Health Care** – Skilled nursing care and certain other health care services that you get in your home for the treatment of an illness or injury. Covered services are listed in the Benefits Chart in Chapter 4, Section 2.1 under the heading “Home health care.” If you need home health care services, our Plan will cover these services for you provided the Medicare coverage requirements are met. Home health care can include services from a **home health aide** if the services are part of the home health plan of care for your illness or injury. They aren’t covered unless you are also getting a covered skilled service. Home health services don’t include the services of housekeepers, food service arrangements, or full time nursing care at home.

**Hospice Care** – A special way of caring for people who are terminally ill and providing counseling for their families. Hospice care is physical care and counseling that is given by a team of people who are part of a Medicare-certified public agency or private company. Depending on the situation, this care may be given in the home, a hospice facility, a hospital, or a nursing home. Care from a hospice is meant to help patients in the last months of life by giving comfort and relief from pain. The focus is on care, not cure. For more information on hospice care visit [www.medicare.gov](http://www.medicare.gov) and under “Search Tools” choose “Find a Medicare Publication” to view or download the publication “Medicare Hospice

Benefits.” Or, call **1-800-MEDICARE (1-800-633-4227)**. **TTY/TDD** users should call **1-877-486-2048**. You may call 24 hours a day/7 days a week.

**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 and before your total drug expenses have reached \$2,930 including amounts you’ve paid and what our Plan has paid on your behalf.

**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 Part B 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.

**Independent Practitioner Associations (IPAs)** – Individual physicians and medical groups contracted by the plan to provide medical services and with hospitals to provide services to members. The contracting medical groups/IPAs in turn, employ or contract with individual physicians. (See Chapter 11, Section 10)

**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.

**List of Covered Drugs (Formulary, or “Drug List”)** – A list of prescription drugs covered by the plan. The drugs on this list are selected by the plan with the help of doctors and pharmacists. The list includes both brand name and generic drugs.

**Low Income Subsidy** – See “Extra Help.”

**Maximum Out-of-Pocket Amount** – The most that you pay out-of-pocket during the calendar year for in-network covered Part A and Part B services. Amounts you pay for your Plan premiums, Medicare Part A and Part B premiums, and prescription drugs do not count toward the maximum out-of-pocket amount. (Note: Because our members also get assistance from Medicaid, very few members ever reach this out-of-pocket maximum.) See Chapter 4, Section 1.2 for information about your maximum out-of-pocket amount.

**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.

**Medical 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.

**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 PACE plan, or a Medicare Advantage Plan.

**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, PPO, POS, 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 most cases, Medicare Advantage Plans also offer Medicare Part D (prescription drug coverage). These plans are called **Medicare Advantage Plans with Prescription Drug Coverage**. Everyone who has Medicare Part A and Part B is eligible to join any Medicare health plan that is offered in their area, except people with End-Stage Renal Disease (unless certain exceptions apply).

**Medicare Allowable Cost** – The maximum price of a service for reimbursement purposes under Original Medicare.

**Medicare Coverage Gap Discount Program** – A program that provides discounts on most covered Part D brand name drugs to Part D enrollees who have reached the Coverage Gap Stage and who are not already receiving “Extra Help.” Discounts are based on agreements between the Federal government and certain drug manufacturers. For this reason, most, but not all, brand name drugs are discounted.

**Medicare 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 our Plan, or “Plan Member”)** – A person with Medicare who is eligible to get

covered services, who has enrolled in our Plan and whose enrollment has been confirmed by the Centers for Medicare & Medicaid Services (CMS).

**Network** – The doctors and other health care professionals, medical groups, hospitals, and other health care facilities or providers that have an agreement with us provide covered services to our members and to accept our payment and any plan cost-sharing as payment in full. (See Chapter 1, Section 3.2)

**Network Pharmacy** – A network pharmacy is a pharmacy where members of our Plan can get their prescription drug benefits. We call them “network pharmacies” because they contract with our Plan. In most cases, your prescriptions are covered only if they are filled at one of our network pharmacies.

**Network Provider** – “Provider” is the general term we use for doctors, other health care professionals, hospitals, and other health care facilities that are licensed or certified by Medicare and by the State to provide health care services. We call them “**network providers**” when they have an agreement with our Plan to accept our payment as payment in full, and in some cases to coordinate as well as provide covered services to members of our Plan. Our Plan pays network providers based on the agreements it has with the providers or if the providers agree to provide you with plan-covered services. Network providers may also be referred to as “plan providers.”

**Organization Determination** – The Medicare Advantage organization has made an organization determination when it, or one of its providers, makes a decision about whether services are covered or how much you have to pay for covered services. 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 like 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 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 our Plan. Out-of-network providers are providers that are not employed, owned, or operated by our Plan or are not under contract to deliver covered services to you. Using out-of-network providers or facilities is explained in this 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.

**Premium** – The periodic payment to Medicare, an insurance company, or a health care plan for health or prescription drug coverage.

**Primary Care Physician (PCP)** – Your primary care physician is the doctor or other provider you see first for most health problems. He or she makes sure you get the care you need to keep you healthy. He or she also may talk with other doctors and health care providers about your care and refer you to them. In many Medicare health plans, you must see your primary care physician before you see any other health care provider. See Chapter 3, Section 2.1 for information about Primary Care Physicians.

**Providers** – Doctors and other health care professionals that the state licenses to provide medical services and care. The term “providers” also includes hospitals and other health care facilities.

**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. See Chapter 2, Section 4 for information about how to contact the QIO for your state.

**Quantity Limits** – A management tool that is designed to limit the use of selected drugs for quality, safety, or utilization reasons. Limits may be on the amount of the drug that we cover per prescription or for a defined period of time.

**Referral** – A formal recommendation by your PCP for you to receive care from a specialist or network provider.

**Rehabilitation Services** – These services include physical therapy, speech and language therapy, and occupational therapy.

**Service Area** – 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 move out of the plan’s service area.

**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 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 the Social Security Administration to people with limited income and resources who are disabled, blind, or age 65 and older. SSI benefits are not the same as Social Security benefits.

**Urgently Needed Care** – Urgently needed care is care provided to treat a non-emergency, unforeseen medical illness, injury, or condition, that requires immediate medical care, but the plan's network of providers is temporarily unavailable or inaccessible.

## Customer Service

CALL	<b>1-866-550-4736</b> Calls to this number are free 10/15-3/1: 8:00 am to 8:00 pm Local Time Zone, 7 Days a Week; 3/2-10/14: 8:00 am to 8:00 pm Local Time Zone, Monday - Friday Customer Service also has free language interpreter services available for non-English speakers.
TTY/TDD	<b>711</b> This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free. 10/15-3/1: 8:00 am to 8:00 pm Local Time Zone, 7 Days a Week; 3/2-10/14: 8:00 am to 8:00 pm Local Time Zone, Monday - Friday
WRITE	Attn: Customer Service PO Box 690670 San Antonio, TX 78269-0670
WEBSITE	<a href="http://www.PHCcares.com">www.PHCcares.com</a>

## State Health Insurance Assistance Program

Texas Department of Aging and Disability Services is a state program that gets money from the Federal government to give free local health insurance counseling to people with Medicare.

CALL	<b>1-512-438-3011</b>
TTY/TDD	<b>711</b> This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.
WRITE	701 W. 51st St. Austin, TX 78751
WEBSITE	<a href="http://www.dads.state.tx.us">www.dads.state.tx.us</a>

A UnitedHealthcare® Medicare Solution

You are not required to use the plan's Preferred Mail Service Pharmacy to obtain a 90-day supply of your maintenance medications, but you may pay more out-of-pocket compared to using the Preferred Mail Service Pharmacy. Your prescriptions should arrive in about seven days from the date the completed order is received by the Mail Service Pharmacy. You will be contacted by the Preferred Mail Service Pharmacy if there will be an extended delay in the delivery of your medications.

Prescription Solutions® by OptumRx™ is an affiliate of UnitedHealthcare Insurance Company.