

for a drug depends on which of these stages you are in at the time you get a prescription filled or refilled.

Stage 1 <i>Yearly Deductible Stage</i>	Stage 2 <i>Initial Coverage Stage</i>	Stage 3 <i>Coverage Gap Stage</i>	Stage 4 <i>Catastrophic Coverage Stage</i>
Because there is no deductible for the plan, this payment stage does not apply to you.	You begin in this stage when you fill your first prescription of the year. During this stage, the plan pays its share of the cost of your drugs and you pay your share of the cost. You stay in this stage until your year-to-date " total drug costs " (your payments plus any Part D plan's payments) total \$2,930 (Details are in Section 5 of this chapter.)	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. You stay in this stage until your year-to-date " out-of-pocket costs " (your payments) reach a total of \$4,700 This amount and rules for counting costs toward this amount have been set by Medicare. (Details are in Section 6 of this chapter.)	During this stage, the plan will pay most of the cost of your drugs for the rest of the calendar year (through December 31, 2012). (Details are in Section 7 of this chapter.)

Section 3

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

- 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.

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:

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.

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

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

Show your membership card when you get a prescription filled.

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

Make sure we have the information we need.

There are times you may pay for prescription drugs when we will not automatically get the information we need to keep track of your out-of-pocket costs. To help us keep track of your out-of-pocket costs, you may give us copies of receipts for drugs that you have purchased. (If you are billed for a covered drug, you can ask our plan to pay our share of the cost. For instructions on how to do this, go to Chapter 7, Section 2 of this booklet.) Here are some types of situations when you may want to give us copies of your drug receipts to be sure we have a complete record of what you have spent for your drugs:

- When you purchase a covered drug at a network pharmacy at a special price or using a discount card that is not part of 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 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.

Section 4
There is no deductible for your plan.

Section 4.1
You do not pay a deductible for your Part D drugs

There is no deductible for your plan. You begin in the Initial Coverage Stage when you fill your first prescription of the year. See Section 5 for information about your coverage in the Initial Coverage Stage.

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

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

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

The plan has four cost-sharing tiers

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

- **Tier 1** is the lowest cost sharing tier and includes **Generic drugs**.
- **Tier 2** includes **Preferred Brand drugs**.
- **Tier 3** includes **Non-Preferred Brand drugs**.
- **Tier 4** is the highest cost sharing tier, includes **Specialty drugs**.

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

Your pharmacy choices.

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

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

Section 5.2
A table that shows your costs for a one-month supply of a drug.

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

"Copayment" means that you pay a fixed amount each time you fill a prescription.

"Coinsurance" means that you pay a percent of the total cost of the drug each time you fill a prescription.

As shown in the table below, the amount of the copayment or coinsurance depends on which cost-sharing tier your drug is in.

Please note: If your covered drug costs less than the copayment amount listed in the chart, you will pay that lower price for the drug. You pay *either* the full price of the drug *or* the copayment amount, *whichever is lower*.

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.

Your share of the cost when you get a *one-month* supply (or less) of a covered Part D prescription drug from:

	Network pharmacy (up to a 31-day supply)	The plan's mail-order service (up to a 31-day supply)	Network long-term care pharmacy (up to a 31-day supply)	Out-of-network pharmacy (Coverage is limited to certain situations; see Chapter 5 for details.) (up to a 31-day supply)
Cost-Sharing Tier 1 (Generic)	\$5	\$5	\$5	\$5
Cost-Sharing Tier 2 (Preferred Brand)	\$40	\$40	\$40	\$40
Cost-Sharing Tier 3 (Non-Preferred Brand)	\$80	\$80	\$80	\$80
Cost-Sharing Tier 4 (Specialty)	33%	Not available	33%	33%

Section 5.3

A table that shows your costs for a *long-term* (up to a 93-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 93-day supply. (For details on where and how to get a long-term supply of a drug, see Chapter 5.)

The table below shows what you pay when you get a long-term (up to a 93-day) supply of a drug.

Please note: If your covered drug costs less than the copayment amount listed in the chart, you will pay that lower price for the drug. You pay *either* the full price of the drug *or* the copayment amount, *whichever is lower*.

Your share of the cost when you get a *long-term* (93-day) supply of a covered Part D prescription drug from:

	Network pharmacy (up to a 93-day supply)	The plan's mail-order service (up to a 93-day supply)
Cost-Sharing Tier 1 (Generic)	\$10	\$10
Cost-Sharing Tier 2 (Preferred Brand)	\$100	\$100
Cost-Sharing Tier 3 (Non-Preferred Brand)	\$240	\$240
Cost-Sharing Tier 4 (Specialty)	A long-term supply is not available for drugs in Tier 4.	A long-term supply is not available for drugs in Tier 4.

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 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.

Section 6

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

Section 6.1

You stay in the Coverage Gap Stage until your out-of-pocket costs reach \$4,700.

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.

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

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

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

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

- The amount you pay for drugs when you are in any of the following drug payment stages:
 - 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, by AIDS drug assistance programs, 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:

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

Reminder: If any other organization such as the ones listed above pays part or all of your out-of-pocket costs for drugs, you are required to tell 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.

Section 7

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

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

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.

Section 8

What you pay for vaccinations covered by Part

D depends on how and where you get them.

Section 8.1
Our plan has separate coverage for the Part D vaccine medication itself and for the cost of giving you the vaccination shot.

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 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 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 us to pay our 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 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 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.)

To avoid paying the full cost of the vaccine and administration provided by your doctor, as well as ensure there is not a difference between the amount the doctor charges and what we normally pay, your doctor can bill us directly online using TransactRx at www.mytransactrx.com. If you or your doctor have questions, please contact Customer Service (phone numbers are on the back cover of this booklet).

Section 8.2

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

The rules for coverage of vaccinations are complicated. We are here to help. We recommend that you call us first at Customer Service whenever you are planning to get a vaccination (phone numbers are 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 an in-network provider and pharmacy, we can tell you what you need to do to get payment from us for our share of the cost.

Section 9

Do you have to pay the Part D “late enrollment penalty”?

Section 9.1

What is the Part D “late enrollment penalty”?

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

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

When you first enroll in our plan, we let you know the amount of the penalty. Your late enrollment penalty is considered your plan premium. If you do not pay your late enrollment penalty, you could be disenrolled from the plan.

Section 9.2

How much is the Part D late enrollment penalty?

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

First count the number of full months that you delayed enrolling in a Medicare drug plan, after you were eligible to enroll. Or count the number of full months in which you did not have creditable prescription drug coverage, if the break in coverage was 63 days or more. The penalty is 1% for every month that you didn’t have creditable coverage. For example, if you go 14 months without coverage, the penalty will be 14%.

Then Medicare determines the amount of the average monthly premium for Medicare drug plans in the nation from the previous year. For 2012, this average premium amount is \$31.08.

To get your monthly penalty, you multiply the penalty percentage and the average monthly premium and then round it to the nearest 10 cents. In the example here it would be 14% times \$31.08. This equals \$4.3512, which rounds to \$4.35. This amount would be added to the monthly premium for someone with a late enrollment penalty.

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

First, the penalty may change each year, because the average monthly premium can change each year. If the national average premium (as determined by Medicare) increases, your penalty will increase.

Second, you will continue to pay a penalty every month for as long as you are enrolled in a plan that has Medicare Part D drug benefits.

Third, if you are under 65 and currently receiving Medicare benefits, the late enrollment penalty will reset when you turn 65. After age 65, your late enrollment penalty will be based only on the months that you don’t have coverage after your initial enrollment period for aging into Medicare.

Section 9.3

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

Even if you have delayed enrolling in a plan offering Medicare Part D coverage when you

were first eligible, sometimes you do not have to pay the late enrollment penalty.

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

- If you already have prescription drug coverage that is expected to pay, on average, at least as much as Medicare's standard prescription drug coverage. Medicare calls this "creditable drug coverage."

Please note: Creditable coverage could include drug coverage from a former employer or union, TRICARE, or the Department of Veterans Affairs. Your insurer or your human resources department will tell you each year if your drug coverage is creditable coverage. This information may be sent to you in a letter or included in a newsletter from the plan. Keep this information, because you may need it if you join a Medicare drug plan later.

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

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

For additional information about creditable coverage, please look in your *Medicare & You* 2012 Handbook or call Medicare at 1-800-MEDICARE or (800) 633-4227. TTY users call (877) 486-2048. You can call these numbers for free, 24 hours a day, 7 days a week.

- If you were without creditable coverage, but you were without it for less than 63-days in a row.

- If you are receiving "Extra Help" from Medicare.

**Section 9.4
What can you do if you disagree about your late enrollment penalty?**

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

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

**Section 10
Do you have to pay an extra Part D amount because of your income?**

**Section 10.1
Who pays an extra Part D amount because of income?**

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

If you have to pay an extra amount, the Social Security Administration, not your Medicare plan, will send you a letter telling you what that extra amount will be and how to pay it. The extra amount will be withheld from your Social Security, Railroad Retirement Board, or Office of Personnel

Management benefit check, no matter how you usually pay your plan premium, unless your monthly benefit isn't enough to cover the extra amount owed. If your benefit check isn't enough to cover the extra amount, you will get a bill from Medicare. The extra amount must be paid separately and cannot be paid with your monthly plan premium.

Section 10.2
How much is the extra Part D amount?

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

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

If you filed an individual tax return and your income in 2010 was:	If you were married but filed a separate tax return and your income in 2010 was:	If you filed a joint tax return and your income in 2010 was:	This is the monthly cost of your extra Part D amount (to be paid in addition to your plan premium)
Equal to or less than \$85,000	Equal to or less than \$85,000	Equal to or less than \$170,000	\$0
Greater than \$85,000 and less than or equal to \$107,000		Greater than \$170,000 and less than or equal to \$214,000	\$11.60
Greater than \$107,000 and less than or equal to \$160,000		Greater than \$214,000 and less than or equal to \$320,000	\$29.90
Greater than \$160,000 and less than or equal to \$214,000	Greater than \$85,000 and less than or equal to \$129,000	Greater than \$320,000 and less than or equal to \$428,000	\$48.10
Greater than \$214,000	Greater than \$129,000	Greater than \$428,000	\$66.40

Section 10.3
What can you do if you disagree about paying an extra Part D amount?

If you disagree about paying an extra amount because of your income, you can ask the Social Security Administration to review the decision. To find out more about how to do this, contact the Social Security

Administration at (800) 772-1213 or TTY (800) 325-0778.

Chapter 7

Asking us to pay our share of a bill you have received for covered medical services or drugs.

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Section 1

Situations in which you should ask us to pay our share of the cost of your covered services or drugs.

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

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

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

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

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

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 are only responsible for paying your

share of the cost, not for the entire cost. You should ask the provider to bill the plan for our share of the cost.

If you pay the entire amount yourself at the time you receive the care, you need to ask us to pay you back for our share of the cost. Send us the bill, along with documentation of any payments you have made.

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

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

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

Whenever you get a bill from an in-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 an in-network provider, but you feel that you paid too much, send us the bill along with documentation of any payment you have made and ask us to pay you back the difference between the amount you paid and the amount you owed under the plan.

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

If you do not have your plan membership card with you, you can ask the pharmacy to call the plan or 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.

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

Section 2

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

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

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

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

You don't have to use the form, but it will help us process the information faster.

Either download a copy of the form from our website www.Medicare.PacificSource.com or call Customer Service and ask for the form. The phone numbers for Customer Service are on the back cover of this booklet.

Mail your request for payment together with any bills or receipts to us at one of these addresses:

Mail your request for medical claim reimbursement, along with any bills or receipts to:

PacificSource Medicare
Attn: Claims Department
2965 NE Connors Avenue
Bend, Oregon, 97701

Mail your request for prescription claim reimbursement, along with any bills or receipts to:

Express Scripts, Inc.
Attn: Med-D Accounts PacificSource Medicare
P.O. Box 66752
St. Louis, MO 63166-6752

You may also call our plan to request payment. For details, go to Chapter 2, Section 1 and look for 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 must submit your claim to us within 1 year 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.

Section 3

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

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

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

If we decide that the medical care or drug is covered and you followed all the rules for getting the care or drug, we will pay for our share of the cost. 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. Instead, we will send you a letter that explains the reasons why we are not sending the payment you have requested and your rights to appeal that decision.

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

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

change the decision we made when we turned down your request for payment.

For the details on how to make this appeal, go to Chapter 9 of this booklet (*What to do if you have a problem or complaint (coverage decisions, appeals, complaints)*). The appeals process is a formal process with detailed procedures and important deadlines. If making an appeal is new to you, you will find it helpful to start by reading Section 4 of Chapter 9. Section 4 is an introductory section that explains the process for coverage decisions and appeals and gives definitions of terms such as "appeal." Then after you have read Section 4, you can go to the section in Chapter 9 that tells what to do for your situation:

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

Section 4

Other situations in which you should save your receipts and send copies to us.

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

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

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

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

Sometimes when you are in the Coverage Gap Stage you can buy your drug at a network pharmacy for a price that is lower than our price.

For example, a pharmacy might offer a special price on the drug. Or you may have a discount card that is outside our benefit that offers a lower price.

Unless special conditions apply, you must use a network pharmacy in these situations and your drug must be on our Drug List.

Save your receipt and send a copy to us so that we can have your out-of-pocket expenses count toward qualifying you for the Catastrophic Coverage Stage.

Please note: If you are in the Coverage Gap Stage, we may not pay for any share of these drug costs. But sending a copy of the receipt allows us to calculate your out-of-pocket costs correctly and may help you qualify for the Catastrophic Coverage Stage more quickly.

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

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

Save your receipt and send a copy to us so that we can have your out-of-pocket expenses count toward qualifying you for the Catastrophic Coverage Stage.

Please note: Because you are getting your drug through the patient assistance program and not through the plan's benefits, we will not pay for any share of these drug costs. But sending a copy of the receipt allows us to

calculate your out-of-pocket costs correctly and may help you qualify for the Catastrophic Coverage Stage more quickly.

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

Chapter 8

Your rights and responsibilities

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Section 1

Our plan must honor your rights as a member of the plan.

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

To get information from us in a way that works for you, please call Customer Service (phone numbers are 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. We can also give you information in Braille, in large print, or other alternate formats if you need it. If you are eligible for Medicare because of a disability, we are required to give you information about the plan's benefits that is accessible and appropriate for you.

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

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

Our plan must obey laws that protect you from discrimination or unfair treatment. *We do not discriminate* based on a person's race, 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* (800) 368-1019 or TTY (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.

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

As a member of our plan, you have the right to choose a Primary Care 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 and still pay the in-network cost-sharing amount.

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

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

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

Federal and state laws protect the privacy of your medical records and personal health

information. We protect your personal health information as required by these laws.

Your "personal health information" includes the personal information you gave us when you enrolled in this plan as well as your medical records and other medical and health information.

The laws that protect your privacy give you rights related to getting information and controlling how your health information is used. We give you a written notice, called a "Notice of Privacy Practice," that tells about these rights and explains how we protect the privacy of your health information.

How do we protect the privacy of your health information?

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

Notice of Privacy Practices.

This notice describes how medical information about you may be used and disclosed, and how you can get access to this information. Please review it carefully.

Protected Health Information (PHI) is any information about your health, your health insurance or health services that you get. PHI also includes information that is created and kept by the Plan. Examples of this type of information are your enrollment in the Plan, your past, present or future physical or mental health condition, health care you have received, or payment for the health care you have received. We are required by law to:

- Keep your PHI private
- Give you this notice as required by the Health Insurance Portability and Accountability Act (HIPAA)
- Follow the policies and procedures in this notice

This notice is given to our members when they enroll with the Plan. We can change this notice at any time. You will be notified of any big changes and may request a copy of this notice at any time. It is also posted on our website: www.Medicare.PacificSource.com.

How We May Use and Share Your PHI.

There are times when we can use and share your PHI without your direct permission. These times are described below.

1. **For Treatment:** We may use and share your PHI with your providers (doctors, pharmacies, hospitals and other

caregivers) who are treating you. For treatment reasons we may also share PHI about claims and services, medical history, eligibility, payment information and other information. For example, we may talk to your doctor about your condition and treatment to improve the care you get.

2. **For Health Care Operations:** We may use or share PHI to do business activities. These activities include things like:
 - Using PHI to find out if the Plan is meeting quality goals and standards
 - For programs that support early detection of diseases, prevention of diseases or case management of diseases
 - Sharing PHI with people and companies that help manage your care
 - Sharing PHI with people and companies that help us perform business. We will only share information if there is a business reason to share it and if there is a signed agreement in place to protect your PHI
 - We may use or share your PHI to give you more information about the Plan or about treatments. For example, we may use your name and address to send a you a newsletter or other information about our activities

Allowed and Required Uses and Sharing of Your PHI.

We may use or share your PHI without your permission if required by state and federal laws. We may share your PHI:

- When required by law or for public health reasons. If we need to give you information about benefits you can get under your plan or in some situations, about health-related products or services that may be of interest to you.
- If law enforcement or specific government agencies ask us through a court order, subpoena, warrant, summons or similar process.
- PHI may be released for law enforcement or specific government functions. These include a request by a law enforcement

official made through a court order, subpoena, warrant, and summons or from a similar process.

We will protect your Personal Health information and make sure that all sharing of this information follows the rules above. If we use or share your information for any other reason, we will get your written permission.

You must sign a special agreement and send it to us so we can share your information. For example, you may agree in writing that the Plan may share information with another person or company such as a caregiver. Remember that once we get permission to share information, we cannot be certain that the person who gets the information from us will not share it with someone else. Again, the only time we would not need your permission is if the use or sharing of this information is allowed or required by law.

Your Rights With PHI.

You have rights about your protected PHI.

1. You have the right to look at and get a copy your PHI. You may look at and get a copy of PHI that is part of a designated record set for as long as we keep this information on file. A designated record set means medical and billing records, and any other records that are used by the Plan. You may have to pay a small fee for the costs of copying, mailing or other materials. You must ask for this in writing. Please send it to the Grievance/Appeals & Privacy Administrator at PacificSource Medicare, PO Box 7469, Bend, Oregon 97708, and we will answer your request within 30 days. If for any reason this information is not in our office, we will answer within 60 days. You may not be able to get some types of PHI like psychotherapy notes or PHI collected by us in preparation for any legal actions.
2. You have the right to ask that the Plan change or modify your PHI. You may ask that the Plan change information that is in a designated record set. We may or may not agree to what you ask. You must ask

us in writing and we will answer whether or not we will make the change. If you do not agree with our answer, you may tell us in writing why you do not agree. We may not agree with what you ask if the information is:

- Not correct or complete
- Was not created by the Plan
- Necessary to meet with state and federal regulations

3. You have the right to a list of those we have shared your PHI with. This listing will not include those that we have shared PHI with for the purposes of treatment, payment, health care operations, or as required by law as listed above. This list will not include any information prior to April 14, 2003. You must ask us in writing and tell us the dates you want us to include.
4. You have the right to restrict or limit us from using your PHI. We may review what you are asking us but we are not required to agree to it. To ask us to limit PHI we may use, you must ask us in writing and tell us what information you want to limit and the dates involved. If we do not agree to what you ask, we will send you a letter. We cannot agree to restrict PHI that we are legally required to share, or that is necessary for treatment, payment, or health care operations.
5. We can communicate with you in different ways. You have the right to ask that we communicate with you in a certain way, such as by telephone or mail. You can also ask that we communicate with you at a certain place, such as sending mail to a specific address. You must ask us in writing. We will review and agree to all reasonable requests
6. You have the right to ask us for a copy of this notice at any time. You may view this notice on line at www.Medicare.PacificSource.com.

Using Your Rights And Complaints.

If you think your privacy has been shared when it should not have been, you may send a written complaint to our Privacy Contact. We will not react against you for your complaint. Please send your complaint to:

PacificSource Medicare
Attn: Grievance/Appeals & Privacy
Administrator
PO Box 7469, Bend, Oregon 97708

You may also send your complaints to the US Department of Health and Human Services:

U.S. Department of Health and Human
Services
200 Independence Ave. SW, Room 509F,
HHH Building, Washington DC 20201
(866) 627-7748 Toll-free
(886) 788-4989 TTY

If you have any questions please call Customer Service (numbers listed on the back of this book). Privacy rules are overseen by the Compliance Officer, who also acts as the Privacy Officer.

This notice is effective April 14, 2003.

Section 1.5

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

As a member of our plan, you have the right to get several kinds of information from us. (As explained 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 in 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 in-network providers including our network pharmacies.

- For example, you have the right to get information from us about the qualifications of the providers and pharmacies in our network and how we pay the providers in our network.
- For a list of the providers in the plan's network, see the *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 at www.Medicare.PacificSource.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

We must support your right to make decisions about your care.

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

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

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

- To know about all of your choices. This means that you have the right to be told about all of the treatment options that are recommended for your condition, no matter what they cost or whether they are covered by 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 this situation. This means that, *if you want to*, you can:

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

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

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

- **Get the form.** If you want to have an advance directive, you can get a form from your lawyer, from a social worker, or from some office supply stores. You can sometimes get advance directive forms from organizations that give people information about Medicare. 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 Oregon Department of

Human Resources, Public Health. See Chapter 2 for contact information.

Section 1.7

You have the right to make complaints and to ask us to reconsider decisions we have made.

If you have any problems or concerns about your covered services or care, Chapter 9 of this booklet tells what you can do. It gives the details about how to deal with all types of problems and complaints.

As explained in Chapter 9, what you need to do to follow up on a problem or concern depends on the situation. You might need to ask 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 (800) 368-1019 or TTY (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 or (800) 633-4227, 24 hours a day, 7 days a week. TTY users should call (877) 486-2048.

Section 1.9
How to get more information about your rights.

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

- You can call Customer Service (phone numbers are 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: www.medicare.gov/Publications/Pubs/pdf/10112.pdf.)
 - Or, you can call 1-800-MEDICARE or (800) 633-4227, 24 hours a day, 7 days a week. TTY users should call (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 to make sure that you are using all of your coverage in combination when you get your covered services from our plan. This is called "coordination of benefits" because it involves coordinating the health and drug benefits you get from our plan with any other health and drug benefits available to you. We'll help you with it. (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 membership card whenever you get your medical care or Part D prescription drugs.

Help your doctors and other providers help you by giving them information, asking questions, and following through on your care.

To help your doctors and other health 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 that reason, some plan members must pay a premium for Medicare Part A and most plan members must pay a premium for Medicare Part B to remain a member of the plan.
- For most of your medical services or drugs covered by the plan, you must pay your share of the cost when you get the service or drug. This will be a copayment (a fixed amount) or coinsurance (a percentage of the total cost). 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.

- If you are required to pay a late enrollment penalty, you must pay the penalty to remain a member of the plan.

Tell us if you move.

If you are going to move, it's important to tell us right away. Call Customer Service (phone numbers are 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

Section 1 Introduction.

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

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

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

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

Which one do you use? That depends on the type of problem you are having. The guide in

Section 3 will help you identify the right process to use.

Section 1.2
What about the legal terms?

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

To keep things simple, this chapter explains the legal rules and procedures using simpler words in place of certain legal terms. For example, this chapter generally says “making a complaint” rather than “filing a grievance,” “coverage decision” rather than “organization determination” or “coverage determination,” and “Independent Review Organization”

instead of “Independent Review Entity.” It also uses abbreviations as little as possible. However, it can be helpful – and sometimes quite important – for you to know the correct legal terms for the situation you are in. Knowing which terms to use will help you communicate more clearly and accurately when you are dealing with your problem and get the right help or information for your situation. To help you know which terms to use, we include legal terms when we give the details for handling specific types of situations.

Section 2

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

Section 2.1

Where to get more information and personalized assistance.

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

Get help from an independent government organization.

We are always available to help you. But in some situations you may also want help or guidance from someone who is not connected with us. You can always contact your *State Health Insurance Assistance Program (SHIP)*.

This government program has trained counselors in every state. The program is not connected with us or with any insurance company or health plan. The counselors at this program can help you understand which process you should use to handle a problem you are having. They can also answer your questions, give you more information, and offer guidance on what to do.

The services of SHIP counselors are free. 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 or (800) 633-4227, 24 hours a day, 7 days a week. TTY users should call (877) 486-2048.
- You can visit the Medicare website (www.medicare.gov).

Section 3

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

Section 3.1

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

If you have a problem or concern, you only need to read the parts of this chapter that apply to your situation. The guide that follows will help.

To figure out which part of this chapter will help with your specific problem or concern,
START HERE

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

Yes. My problem is about benefits or coverage. Go on to the next section of this chapter, **Section 4, A guide to the**

No. My problem is not about benefits or coverage. Skip ahead to **Section 10** at the end of this chapter: **How to make a complaint**

To figure out which part of this chapter will help with your specific problem or concern,
START HERE

basics of coverage decisions and making appeals.

about quality of care, waiting times, customer service or other concerns.

Coverage Decisions and Appeals

Section 4

A guide to the basics of coverage decisions and appeals.

Section 4.1

Asking for coverage decisions and making appeals: the big picture.

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

Asking for coverage decisions.

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

and how much we pay. In some cases we might decide a service or drug is not covered or is no longer covered by Medicare for you. If you disagree with this coverage decision, you can make an appeal.

Making an appeal.

If we make a coverage decision and you are not satisfied with this decision, you can “appeal” the decision. An appeal is a formal way of asking us to review and change a coverage decision we have made. When you make an appeal, we review the coverage decision we have made to check to see if we were following all of the rules properly. Your appeal is handled by different reviewers than those who made the original unfavorable decision. When we have completed the review we give you our decision. If we say no to all or part of your Level 1 Appeal, you can go on to a Level 2 Appeal. The Level 2 Appeal is conducted by an independent organization that is not connected to us. (In some situations, your case will be automatically sent to the independent organization for a Level 2 Appeal. If this happens, we will let you know. In other situations, you will need to ask for a Level 2 Appeal.) If you are not satisfied with the decision at the Level 2 Appeal, you may be able to continue through several more levels of appeal.

Section 4.2

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

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

- You can call 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 www.cms.hhs.gov/cmsforms/downloads/cms1696.pdf or on our website at www.Medicare.PacificSource.com.) The form gives that person permission to act on your behalf. It must be signed by you and by the person who you would like to act on your behalf. You must give us a copy of the signed form.

You also have the right to hire a lawyer to act for you.

You may contact your own lawyer, or get the name of a lawyer from your local bar association or other referral service. There are also groups that will give you free legal services if you qualify. However, you are not required to hire a lawyer to ask for any kind of coverage decision or appeal a decision.

Section 4.3

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

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

- **Section 5** of this chapter: “Your medical care: How to ask for a coverage decision or make an appeal”

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

If you’re not sure which section you should be using, please call Customer Service (phone numbers are 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).

Section 5

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



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

Section 5.1

This section tells what to do if you have problems getting coverage for medical care or if you want us to pay you back for our share of the cost of your care.

This section is about your benefits for medical care and services. These 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 7: *How to ask us for a longer hospital stay if you think you are being asked to leave the hospital too soon.*
- Chapter 9, Section 8: *How to ask us to keep covering certain medical services if you think your coverage is ending too soon.* This section is about three services only: home health care, skilled nursing facility care, and Comprehensive Outpatient Rehabilitation Facility (CORF) services.

For *all other* situations that involve being told that medical care you have been getting will

be stopped, use this section (Section 5) as your guide for what to do.

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

Section 5.2
Step-by-step: How to ask for a coverage decision (how to ask our plan to authorize or provide the medical care coverage you want).

Legal Terms
 When a coverage decision involves your medical care, it is called an “**organization determination**.”

Step 1
You ask our plan to make a coverage decision on the medical care you are requesting.

If your health requires a quick response, you should ask us to make a **“fast decision.”**

Legal Terms

A “fast decision” is called an **“expedited 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, 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 10 of this chapter.)

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

A fast decision means we will answer within 72 hours. However, we can take up to 14 more 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 10 of this chapter.) We will call you as soon as we make the decision.

To get a fast decision, you must meet two requirements:

- 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, we will decide whether your health requires that we give you a fast decision.

If we decide that your medical condition does not meet the requirements for a fast decision, we will send you a letter that says so (and we will use the standard deadlines instead).

This letter will tell you that if your doctor asks for the fast decision, we will automatically give a fast decision. The letter will also tell how you can file a “fast complaint” about our decision to give you a standard decision instead of the fast decision you requested. (For more information about the process for making complaints, including fast complaints, see Section 10 of this chapter.)

Step 2

We consider your request for medical care coverage and give you our answer.

Deadlines for a “fast” coverage decision.

Generally, for a fast decision, we will give you our answer *within 72 hours*. As explained 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 10 of this chapter.)

If we do not give you our answer within 72 hours (or if there is an extended time period, by the end of that period), you have the right to appeal. Section 5.3 below tells how to make an appeal.

If our answer is yes to part or all of what you requested, we must authorize or provide the medical care coverage we have agreed to provide within 72 hours after we received your request. If we extended the time needed to make our 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 10 of this chapter.)

If we do not give you our answer within 14 days (or if there is an extended time period, by the end of that period), you have the right to appeal. Section 5.3 below tells how to make an appeal.

If our answer is yes to part or all of what you requested, we must authorize or provide the coverage we have agreed to provide within 14 days after we received your request. If we extended the time needed to make our decision, we will provide the coverage by the end of that extended period.

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

Step 3

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

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

Section 5.3

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

Legal Terms

An appeal to the plan about a medical care coverage decision is called a plan **“reconsideration.”**

Step 1

You contact us and make your appeal.

If your health requires a quick response, you must ask for a **“fast appeal.”**

What to do

*To start an appeal you, your doctor, or your representative, must contact us. 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 about your medical care or about your Part D prescription drugs.**

*If you are asking for a standard appeal, make your standard appeal in writing by submitting a signed request. You may also ask for an appeal by calling us at the phone number shown in Chapter 2, Section 1 (*How to contact us when you are making an appeal about your medical care or about your Part D prescription drugs.*).*

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 www.cms.hhs.gov/cmsforms/downloads/cms1696.pdf or on our website at www.Medicare.PacificSource.com. 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 about your medical care or 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 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. We are allowed to charge a fee for copying and sending this information to you. If you wish, you and your doctor may give us additional information to support your appeal. If your health requires it, ask for a “fast appeal” (you can make a request by calling us)

Legal Terms

A “fast appeal” is also called an **“expedited reconsideration.”**

If you are appealing a decision we made about coverage for care you have not yet received, you and/or your doctor will need to decide if you need a “fast appeal.”

The requirements and procedures for getting a “fast 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

We consider 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 10 of this chapter.)

If we do not give you an answer by the deadline above (or by the end of the extended time period if we took extra days), we are required to send your request on to Level 2 of the appeals process, where it will be reviewed by an independent outside organization. Later in this section, we tell about this review organization and explain what happens at Level 2 of the appeals process.

If our answer is yes to part or all of what you requested, we must authorize or provide the coverage we have agreed to provide within 30 days after we receive your appeal.

If our answer is no to part or all of what you requested, we will send you a written denial notice informing you that we have automatically sent your appeal to the Independent Review Organization for a Level 2 Appeal.

Step 3
If our plan says no to part or all of your appeal, your case will automatically be sent on to the next level of the appeals process.

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

Section 5.4
Step-by-step: How to make a Level 2 Appeal.

If we say 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 we made when we said no to your first appeal. This organization decides whether the decision we made should be changed.

Legal Terms

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

Step 1
The Independent Review Organization reviews your appeal.

The Independent Review Organization is an independent organization that is hired by Medicare.

This organization is not connected with us 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. We are allowed to charge you a fee for copying and sending this information to you.

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.

Step 2
The Independent Review Organization gives you their answer.

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

If the review organization says yes to part or all of what you requested, we must authorize the medical care coverage within 72 hours or

provide the service within 14 calendar days after we receive the decision from the review organization.

If this organization says no to part or all of your appeal, it means they agree with us 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 written 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. For example, to continue and make another appeal at Level 3, the dollar value of the medical care coverage you are requesting must meet a certain minimum. If the dollar value of the coverage you are requesting is too low, you cannot make another appeal, which means that the decision at Level 2 is final.

Step 3

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

There are three additional levels in the appeals process after Level 2 (for a total of five levels of appeal).

If your Level 2 Appeal is turned down and you meet the requirements to continue with the appeals process, you must decide whether you want to go on to Level 3 and make a third appeal. The details on how to do this are in the written notice you got after your Level 2 Appeal.

The Level 3 Appeal is handled by an administrative law judge. Section 9 in this chapter tells more about Levels 3, 4, and 5 of the appeals process.

Section 5.5

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

If you want to ask us for payment for medical care, start by reading Chapter 7 of this booklet: *Asking us to pay our share of a bill you have received for covered medical services or drugs*. Chapter 7 describes the situations in which you may need to ask for reimbursement or to pay a bill you have received from a provider. It also tells how to send us the paperwork that asks us for payment.

Asking for reimbursement is asking for a coverage decision from us.

If you send us the paperwork that asks for reimbursement, you are asking us to make a coverage decision (for more information about coverage decisions, see Section 4.1 of this chapter). To make this coverage decision, we will check to see if the medical care you paid for is a covered service (see 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 5.3 of this section.

Go to this part for step-by-step instructions. When you are following these instructions, please note:

If you make an appeal for reimbursement, we must give you our answer within 60 calendar days after we receive your appeal. (If you are asking us to pay you back for medical care you have already received and paid for yourself, you are not allowed to ask for a fast appeal.) If the Independent Review Organization reverses our decision to deny payment, we must send the payment you have requested to you or to the provider within 30 calendar days. If the answer to your appeal is yes at any stage of the appeals process after Level 2, we must send the payment you requested to you or to the provider within 60 calendar days.

Section 6

Your Part D prescription drugs: How to ask for a coverage decision or make an appeal.



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

Section 6.1

This section tells you what to do if you have problems getting a Part D drug or

you want us to pay you back for a Part D drug.

Your benefits as a member of 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 our plan's coverage for your Part D prescription drugs*) and Chapter 6 (*What you pay for your Part D prescription drugs*).

Part D coverage decisions and appeals.

As discussed in Section 4 of this chapter, a coverage decision is a decision we make about your benefits and coverage or about the amount we will pay for your drugs.

Legal Terms

An initial coverage decision about your Part D drugs is called a "**coverage determination.**"

Here are examples of coverage decisions you ask us to make about your Part D drugs:

- You ask us to make an exception, including:
 - Asking us to cover a Part D drug that is not on the plan's *List of Covered Drugs (Formulary)*
 - Asking us to waive a restriction on the plan's coverage for a drug (such as

- limits on the amount of the drug you can get)
- o Asking to pay a lower cost-sharing amount for a covered non-preferred drug
- You ask us whether a drug is covered for you and whether you satisfy any applicable coverage rules. (For example, when your drug is on the plan's *List of Covered Drugs (Formulary)* but we require you to get approval from us before we will cover it for you.) **Please note:** If your pharmacy tells you that your prescription cannot be filled

as written, you will get a written notice explaining how to contact us to ask for a coverage decision.

- You ask us to pay for a prescription drug you already bought. This is a request for a coverage decision about payment.

If you disagree with a coverage decision we have made, you can appeal our decision. This section tells you both how to ask for coverage decisions and how to request an appeal. Use the chart below to help you determine which part has information for your situation:

Which of these situations are you in?			
<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? You can ask us to make an exception. (This is a type of coverage decision.) Start with Section 6.2 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? You can ask us for a coverage decision. Skip ahead to Section 6.4 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.) Skip ahead to Section 6.4 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.) Skip ahead to Section 6.5 of this chapter.</p>

Section 6.2
What is an exception?

If a drug is not covered in the way you would like it to be covered, you can ask us to make an "exception." An exception is a type of coverage decision. Similar to other types of coverage decisions, if we turn down your request for an exception, you can appeal our decision. When you ask for an exception, your doctor or other prescriber will need to explain the medical reasons why you need the exception approved. We will then consider your

request. Here are three examples of exceptions that you or your doctor or other prescriber can ask us to make:

- 1. Covering a Part D drug for you that is not on our *List of Covered Drugs (Formulary)*.** (We call it the "Drug List" for short.)

Legal Terms

Asking for coverage of a drug that is not on the Drug List is sometimes called asking for a **"formulary exception."**

If we agree to make an exception and cover a drug that is not on the Drug List, you will need to pay the cost-sharing amount that applies to drugs in the Preferred Brand tier. 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 our coverage for a covered drug. There are extra rules or restrictions that apply to certain drugs on our *List of Covered Drugs (Formulary)* (for more information, go to Chapter 5 and look for Section 5).

Legal Terms

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

The extra rules and restrictions on coverage for certain drugs include:

- *Being required to use the generic version of a drug instead of the brand name drug.*
- *Getting plan approval in advance* before we will agree to cover the drug for you. (This is sometimes called “prior authorization.”)
- *Being required to try a different drug first* before we will agree to cover the drug you are asking for. (This is sometimes called “step therapy.”)
- *Quantity limits.* For some drugs, there are restrictions on the amount of the drug you can have.

If we agree to make an exception and waive a restriction for you, you can ask for an exception to the copayment or coinsurance amount we require you to pay for the drug.

3. Changing coverage of a drug to a lower cost-sharing tier. Every drug on our Drug List is in one of four cost-sharing tiers. In general, the lower the cost-sharing tier number, the less you

will pay as your share of the cost of the drug.

Legal Terms

Asking to pay a lower preferred price for a covered non-preferred drug is sometimes called asking for a **“tiering exception.”**

If your drug is in our Non-Preferred Brand tier you can ask us to cover it at the cost-sharing amount that applies to drugs in our Preferred Brand tier. This would lower your share of the cost for the drug.

You cannot ask us to change the cost-sharing tier for any drug in our Specialty tier.

Section 6.3

Important things to know about asking for exceptions.

Your doctor must tell us the medical reasons.

Your doctor or other prescriber must give us a statement that explains the medical reasons for requesting an exception. For a faster decision, include this medical information from your doctor or other prescriber when you ask for the exception.

Typically, our Drug List includes more than one drug for treating a particular condition. These different possibilities are called “alternative” drugs. If an alternative drug would be just as effective as the drug you are requesting and would not cause more side effects or other health problems, we will generally *not* approve your request for an exception.

We can say yes or no to your request.

If we approve your request for an exception, our approval usually is valid until the end of the plan year. This is true as long as your doctor continues to prescribe the drug for you and that drug continues to be safe and effective for treating your condition.

If we say no to your request for an exception, you can ask for a review of our decision by

making an appeal. Section 6.5 tells how to make an appeal if we say no.

The next section tells you how to ask for a coverage decision, including an exception.

Section 6.4

Step-by-step: How to ask for a coverage decision, including an exception.

Step 1

You ask us to make a coverage decision about the drug(s) or payment you need.

If your health requires a quick response, you must ask us to make a "*fast decision*."

You cannot ask for a fast decision if you are asking us to pay you back for a drug you already bought.

What to do

Request the type of coverage decision you want. Start by calling, writing, or faxing us 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 us to pay you back for a drug, start by reading Chapter 7 of this booklet: *Asking us to pay our share of a bill you have received for covered medical services or drugs*. Chapter 7 describes the situations in which you may need to ask for reimbursement. It also tells how to send us the paperwork that asks us to pay you back for our share of the cost of a drug you have paid for.

If you are requesting an exception, provide the "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 us. Or your doctor or other prescriber can tell us on the phone and follow up by faxing or mailing a written statement if necessary. See Sections 6.2 and 6.3 for more information about exception requests.

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

Legal Terms

A "fast decision" is called an "**expedited coverage determination**."

When we give you our decision, we will use the "standard" deadlines unless we have agreed to use the "fast" deadlines. A standard 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), we 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 10 of this chapter.)

Step 2

We consider 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 hour.

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.

Step 3

If we say no to your coverage request, you decide if you want to make an appeal.

If we say no, you have the right to request an appeal. Requesting an appeal means asking us to reconsider – and possibly change – the decision we made.

Section 6.5

Step-by-step: How to make a Level 1 Appeal (how to ask for a review of a coverage decision made by our plan).

Legal Terms

An appeal to the plan about a Part D drug coverage decision is called a plan “**redetermination.**”

Step 1

You contact us and make your Level 1 Appeal.

If your health requires a quick response, you must ask for a “fast appeal.”

What to do

To start your appeal, you (or your representative or your doctor or other prescriber) must contact us. For details on how to reach us by phone, fax, or mail for any purpose related to your appeal, go to Chapter 2, Section 1, and look for the

section called, *How to contact us when you are making an appeal about your medical care or about your Part D prescription drugs.*

If you are asking for a standard appeal, make your appeal by submitting a written request. You may also ask for an appeal by calling us at the phone number shown in Chapter 2, Section 1 (*How to contact our plan when you are making an appeal about your medical care or about your Part D prescription drugs.*).

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 medical care or 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. We are allowed to charge a fee for copying and sending this information to you.

If you wish, you and your doctor or other prescriber may give us additional information to support your appeal.

If your health requires it, ask for a “fast appeal.”

Legal Terms

A “fast appeal” is also called an **“expedited redetermination.”**

If you are appealing a decision our plan made about a drug you have not yet received, you and your doctor or other prescriber will need to decide if you need a “fast appeal.”

The requirements for getting a “fast appeal” are the same as those for getting a “fast decision” in Section 6.4 of this chapter.

Step 2**Our plan considers your appeal and we give you our answer.**

When our plan is reviewing your appeal, we take another careful look at all of the information about your coverage request. We check to see if we were following all the rules when we said no to your request. We may contact you or your doctor or other prescriber to get more information.

Deadlines for a “fast” appeal.

If we are using the fast deadlines, we must give you our answer within 72 hours after we receive your appeal. We will give you our answer sooner if your health requires it.

If we do not give you an answer within 72 hours, we are required to send your request on to Level 2 of the appeals process, where it will be reviewed by an Independent Review Organization. Later in this section, we tell about this review organization and explain what happens at Level 2 of the appeals process.

If our answer is yes to part or all of what you requested, we must provide the coverage we have agreed to provide within 72 hours after we receive your appeal.

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

Deadlines for a “standard” appeal.

If we are using the standard deadlines, we must give you our answer within 7 calendar days after we receive your appeal. We will give you our decision sooner if you have not received the drug yet and your health condition requires us to do so. If you believe your health requires it, you should ask for “fast” appeal.

If we do not give you a decision within 7 calendar days, we are required to send your request on to Level 2 of the appeals process, where it will be reviewed by an Independent Review Organization. Later in this section, we tell about this review organization and explain what happens at Level 2 of the appeals process.

If our answer is yes to part or all of what you requested – If we approve a request for coverage, we must provide the coverage we have agreed to provide as quickly as your health requires, but no later than 7 calendar days after we receive your appeal.

If we approve a request to pay you back for a drug you already bought, we are required to send payment to you within 30 calendar days after we receive your appeal request.

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

Step 3**If we say no to your appeal, you decide if you want to continue with the appeals process and make another appeal.**

If we say no to your appeal, you then choose whether to accept this decision or continue by making another appeal. If you decide to make another appeal, it means your appeal is going on to Level 2 of the appeals process (see below).

Section 6.6**Step-by-step: How to make a Level 2 Appeal.**

If we say 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 we 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 we say 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. We are allowed to charge you a fee for copying and sending this information to you.

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 us 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 us. Reviewers at the Independent Review Organization will take a careful look at all of the information related to your appeal. The organization will tell you its decision in writing and explain the reasons for it.

Deadlines for "fast" appeal at Level 2.

If your health requires it, ask the Independent Review Organization for a "fast appeal."

If the review organization agrees to give you a "fast appeal," the review organization must give you an answer to your Level 2 Appeal within 72 hours after it receives your appeal request.

If the Independent Review Organization says yes to part or all of what you requested, we must provide the drug coverage that was approved by the review organization within 24 hours after we receive the decision from the review organization.

Deadlines for "standard" appeal at Level 2.

If you have a standard appeal at Level 2, the review organization must give you an answer to your Level 2 Appeal within 7 calendar days after it receives your appeal.

If the Independent Review Organization says yes to part or all of what you requested – If the Independent Review Organization approves a request for coverage, we must **provide the drug coverage** that was approved by the review organization within 72 hours after we receive the decision from the review organization.

If the Independent Review Organization approves a request to pay you back for a drug you already bought, we are required to send payment to you within 30 calendar days after we receive the decision from the review organization.

What if the review organization says no to your appeal? If this organization says no to your appeal, it means the organization agrees with our decision not to approve your request. (This is called “upholding the decision.” It is also called “turning down your appeal.”)

To continue and make another appeal at Level 3, the dollar value of the drug coverage you are requesting must meet a minimum amount. If the dollar value of the coverage you are requesting is too low, you cannot make another appeal and the decision at Level 2 is final. The notice you get from the Independent Review Organization will tell you the dollar value that must be in dispute to continue with the appeals process.

Step 3

If the dollar value of the coverage you are requesting meets the requirement, you choose whether you want to take your appeal further.

There are three additional levels in the appeals process after Level 2 (for a total of five levels of appeal).

If your Level 2 Appeal is turned down and you meet the requirements to continue with the appeals process, you must decide whether you want to go on to Level 3 and make a third appeal. If you decide to make a third appeal, the details on how to do this are in the written notice you got after your second appeal.

The Level 3 Appeal is handled by an administrative law judge. Section 9 in this chapter tells more about Levels 3, 4, and 5 of the appeals process.

Section 7

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

When you are admitted to a hospital, you have the right to get all of your covered hospital services that are necessary to diagnose and treat your illness or injury. For more information about 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.

Section 7.1

During your inpatient hospital stay, you will get a written notice from Medicare that tells about your rights.

During your hospital stay, you will be given a written notice called *An Important Message from Medicare about Your Rights*. Everyone with Medicare gets a copy of this notice whenever they are admitted to a hospital. Someone at the hospital (for example, a caseworker or nurse) must give it to you within two days after you are admitted. If you do not get the notice, ask any hospital employee for

it. If you need help, please call Customer Service. You can also call 1-800-MEDICARE or (800) 633-4227, 24 hours a day, 7 days a week. TTY users should call (877) 486-2048.

Read this notice carefully and ask questions if you don't understand it.

It tells you about your rights as a hospital patient, including:

- Your right to receive Medicare-covered services during and after your hospital stay, as ordered by your doctor. This includes the right to know what these services are, who will pay for them, and where you can get them.
- Your right to be involved in any decisions about your hospital stay, and know who will pay for it.
- Where to report any concerns you have about quality of your hospital care.
- Your right to appeal your discharge decision if you think you are being discharged from the hospital too soon.

Legal Terms

The written notice from Medicare tells you how you can **"request an immediate review."** Requesting an immediate review is a formal, legal way to ask for a delay in your discharge date so that we will cover your hospital care for a longer time. (Section 7.2 below tells you how you can request an immediate review.)

You must sign the written notice to show that you received it and understand your rights.

- You or someone who is acting on your behalf must sign the notice. (Section 4 of this chapter tells how you can give written permission to someone else to act as your representative.)
- Signing the notice shows *only* that you have received the information about your rights. The notice does not give your discharge date (your doctor or hospital staff will tell you your discharge date). Signing the notice does not mean you are agreeing on a discharge date.

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 or (800) 633-4227, 24 hours a day, 7 days a week. TTY users should call (877) 486-2048. You can also see it online at www.cms.gov/BNI/12_HospitalDischargeAppealNotices.asp.

Section 7.2

Step-by-step: How to make a Level 1 Appeal to change your hospital discharge date.

If you want to ask for your hospital services to be covered by us 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.

Step 1

Contact the Quality Improvement Organization in your state and ask for a "fast review" of your hospital discharge. You must act quickly.

Legal Terms

A "fast review" is also called an "immediate review."

What is the Quality Improvement Organization?

This organization is a group of doctors and other health care professionals who are paid by the Federal government. These experts are not part of 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 7.4.

Ask for a "fast review":

You must ask the Quality Improvement Organization for a "fast review" of your discharge. Asking for a "fast review" means you are asking for the organization to use the "fast" deadlines for an appeal instead of using the standard deadlines.

Legal Terms

A "fast review" is also called an "immediate review" or an "expedited review."

Step 2

The Quality Improvement Organization conducts an independent review of your case.

What happens during this review?

Health professionals at the Quality Improvement Organization (we will call them "the reviewers" 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 we have 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 we think it is right (medically appropriate) for you to be discharged on that date.

Legal Terms

This written explanation is called the "Detailed Notice of Discharge." You can get a sample of this notice by calling

Customer Service or 1-800-MEDICARE or (800) 633-4227), 24 hours a day, 7 days a week. (TTY users should call (877) 486-2048.) Or you can get see a sample notice online at www.cms.hhs.gov/BNI/

Step 3

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

What happens if the answer is yes?

If the review organization says *yes* to your appeal, we must keep providing your covered 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 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 7.3

Step-by-step: How to make a Level 2 Appeal to change your hospital discharge date.

If the Quality Improvement Organization has turned down your appeal, *and* you stay in the hospital after your planned discharge date, then you can make a Level 2 Appeal. During a Level 2 Appeal, you ask the Quality Improvement Organization to take another look at the decision they made on your first appeal. If 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:

We must reimburse you for our share of the costs of hospital care you have received since noon on the day after the date your first appeal was turned down by the Quality Improvement Organization. We must continue providing coverage for your 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. This is called "upholding the decision."

The notice you get will tell you in writing what you can do if you wish to continue with the review process. It will give you the details about how to go on to the next level of appeal, which is handled by a judge.

Step 4**If the answer is no, you will need to decide whether you want to take your appeal further by going on to Level 3.**

There are three additional levels in the appeals process after Level 2 (for a total of five levels of appeal). If the review organization turns down your Level 2 Appeal, you can choose whether to accept that decision or whether to go on to Level 3 and make another appeal. At Level 3, your appeal is reviewed by a judge.

Section 9 in this chapter tells more about Levels 3, 4, and 5 of the appeals process.

Section 7.4**What if you miss the deadline for making your Level 1 Appeal?****You can appeal to us instead.**

As explained above in Section 7.2, you must act quickly to contact the Quality Improvement Organization to start your first appeal of your hospital discharge. ("Quickly" means before

you leave the hospital and no later than your planned discharge date). If you miss the deadline for contacting this organization, there is another way to make your appeal.

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

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

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

Legal Terms

A "fast" review (or "fast appeal") is also called an "**expedited appeal**".

Step 1**Contact us 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 our plan when you are making an appeal about your medical care or about your Part D prescription drugs.*

Be sure to ask for a "fast review." This means you are asking us to give you an answer using the "fast" deadlines rather than the "standard" deadlines.

Step 2**We do a "fast" review of your planned discharge date, checking to see if it was medically appropriate.**

During this review, we take a look at all of the information about your hospital stay. We check to see if your planned discharge date was medically appropriate. We will check to see if the decision about when you should leave the hospital was fair and followed all the rules.

In this situation, we will use the “fast” deadlines rather than the standard deadlines for giving you the answer to this review.

Step 3 **We give you our decision within 72 hours after you ask for a “fast review” (“fast appeal”).**

If we say yes to your fast appeal, it means we have agreed with you that you still need to be in the hospital after the discharge date, and will keep providing your covered services for as long as it is medically necessary. It also means that we have agreed to reimburse you for our share of the costs of care you have received since the date when we said your coverage would end. (You must pay your share of the costs and there may be coverage limitations that apply.)

If we say no to your fast appeal, we are saying that your planned discharge date was medically appropriate. Our coverage for your hospital services ends as of the day we said coverage would end.

If you stayed in the hospital *after* your planned discharge date, then you may have to pay the full cost of hospital care you received after the planned discharge date.

Step 4 **If we say no to your fast appeal, your case will automatically be sent on to the next level of the appeals process.**

To make sure we were following all the rules when we said no to your fast appeal, we are required to send your appeal to the “Independent Review Organization.” When we do this, it means that you are *automatically* going on to Level 2 of the appeals process.

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

If we say 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 we made when we said no to your “fast appeal.” This organization decides whether the decision we made should be changed.

Legal Terms

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

Step 1 **We will automatically forward your case to the Independent Review Organization.**

We are required to send the information for your Level 2 Appeal to the Independent Review Organization within 24 hours of when we tell you that we are saying no to your first appeal. (If you think we are not meeting this deadline or other deadlines, you can make a complaint. The complaint process is different from the appeal process. Section 10 of this chapter tells how to make a complaint.)

Step 2 **The Independent Review Organization does a “fast review” of your appeal. The reviewers give you an answer within 72 hours.**

The Independent Review Organization is an independent organization that is hired by Medicare. This organization is not connected with 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 we 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 us that your planned hospital discharge date was medically appropriate.

The notice you get from the Independent Review Organization will tell you in writing what you can do if you wish to continue with the review process. It will give you the details about how to go on to a Level 3 Appeal, which is handled by a judge.

Step 3

If the Independent Review Organization turns down your appeal, you choose whether you want to take your appeal further.

There are three additional levels in the appeals process after Level 2 (for a total of five levels of appeal). If reviewers say no to your Level 2 Appeal, you decide whether to accept their decision or go on to Level 3 and make a third appeal. Section 9 in this chapter tells more about Levels 3, 4, and 5 of the appeals process.

Section 8

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

Section 8.1

This section is about three services only: Home health care, skilled nursing facility care, and Comprehensive Outpatient Rehabilitation Facility (CORF) services.

This section is about the following types of care *only*:

- **Home health care services** you are getting.
- **Skilled nursing care** you are getting as a patient in a skilled nursing facility. (To learn about requirements for being considered a "skilled nursing facility," see Chapter 12, *Definitions of important words*.)
- **Rehabilitation care** you are getting as an outpatient at a Medicare-approved Comprehensive Outpatient Rehabilitation Facility (CORF). Usually, this means you are getting treatment for an illness or accident, or you are recovering from a major operation. (For more information about this type of facility, see Chapter 12, *Definitions of important words*.)

When you are getting any of these types of care, you have the right to keep getting your covered services for that type of care for as long as the care is needed to diagnose and treat your illness or injury. For more information on your covered services, including your share of the cost and any limitations to coverage that may apply, see Chapter 4 of this booklet: *Medical Benefits Chart (what is covered and what you pay)*.

When we decide 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, *we will stop paying our share of the cost for your care*. If

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

Section 8.2
We will tell you in advance when your coverage will be ending.

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 we 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 you what you can do, the written notice is telling how you can request a **“fast-track appeal.”** Requesting a fast-track appeal is a formal, legal way to request a change to our coverage decision about when to stop your care. (Section 7.3 below tells how you can request a fast-track appeal.)

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

You must sign the written notice to show that you received it.
You or someone who is acting on your behalf must sign the notice. (Section 4 tells how you can give written permission to someone else to act as your representative.)

Signing the notice shows *only* that you have received the information about when your coverage will stop. Signing it does **not** mean you agree with the plan that it’s time to stop getting the care.

Section 8.3
Step-by-step: How to make a Level 1 Appeal to have our plan cover your care for a longer time.

If you want to ask us to cover your care for a longer period of time, you will need to use the appeals process to make this request. Before you start, understand what you need to do and what the deadlines are.

- **Follow the process.** Each step in the first two levels of the appeals process is explained below.
- **Meet the deadlines.** The deadlines are important. Be sure that you understand and follow the deadlines that apply to things you must do. There are also deadlines our plan must follow. (If you think we are not meeting our deadlines, you can file a complaint. Section 10 of this chapter 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.

Step 1
Make your Level 1 Appeal: contact the Quality Improvement Organization in your state and ask for a review. You must act quickly.

What is the Quality Improvement Organization?

This organization is a group of doctors and other health care experts who are paid by the Federal government. These experts are not part of our plan. They check on the quality of care received by people with Medicare and

review plan decisions about when it's time to stop covering certain kinds of medical care.

How can you contact this organization?

The written notice you received 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 us 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 us instead. For details about this other way to make your appeal, see Section 8.5.

**Step 2
The Quality Improvement Organization conducts an independent review of your case.**

What happens during this review?

Health professionals at the Quality Improvement Organization (we will call them "the reviewers" for short) will ask you (or your representative) why you believe coverage for the services should continue. You don't have to prepare anything in writing, but you may do so if you wish.

The review organization will also look at your medical information, talk with your doctor, and review information that our plan has given to them.

By the end of the day the reviewers informed us of your appeal, and you will also get a written notice from us that gives our reasons for ending our coverage for your services.

Legal Terms

This notice explanation is called the "**Detailed Explanation of Non-Coverage.**"

**Step 3
Within one full day after they have all the information they need, the reviewers will tell you their decision.**

What happens if the reviewers say yes to your appeal?

If the reviewers say *yes* to your appeal, then *we 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.* We will stop paying its share of the costs of this care.

If you decide to keep getting the home health care, or skilled nursing facility care, or Comprehensive Outpatient Rehabilitation Facility (CORF) services *after* this date when your coverage ends, then *you will have to pay the full cost* of this care yourself.

**Step 4
If the answer to your Level 1 Appeal is no, you decide if you want to make another appeal.**

This first appeal you make is "Level 1" of the appeals process. If reviewers say *no* to your

Level 1 Appeal – and you choose to continue getting care after your coverage for the care has ended – then you can make another appeal.

Making another appeal means you are going on to “Level 2” of the appeals process.

Section 8.4

Step-by-step: How to make a Level 2 Appeal to have our plan cover your care for a longer time.

If the Quality Improvement Organization has turned down your appeal and you choose to continue getting care after your coverage for the care has ended, then you can make a Level 2 Appeal. During a Level 2 Appeal, you ask the Quality Improvement Organization to take another look at the decision they made on your first appeal. 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:

Step 1
You contact the Quality Improvement Organization again and ask for another review.

You must ask for this review within 60 days after the day when the Quality Improvement Organization said *no* to your Level 1 Appeal. You can ask for this review only if you continued getting care after the date that your coverage for the care ended.

Step 2
The Quality Improvement Organization does a second review of your situation.

Reviewers at the Quality Improvement Organization will take another careful look at all of the information related to your appeal.

Step 3
Within 14 days, the Quality Improvement Organization reviewers will decide on your appeal and tell you their decision.

What happens if the review organization says yes to your appeal?

We must reimburse you for our share of the costs of care you have received since the date when we said your coverage would end. We 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 we made to your Level 1 Appeal and will not change it.

The notice you get will tell you in writing what you can do if you wish to continue with the review process. It will give you the details about how to go on to the next level of appeal, which is handled by a judge.

Step 4
If the answer is no, you will need to decide whether you want to take your appeal further.

There are three additional levels of appeal after Level 2, for a total of five levels of appeal. If reviewers turn down your Level 2 Appeal, you can choose whether to accept that decision or to go on to Level 3 and make another appeal. At Level 3, your appeal is reviewed by a judge.

Section 9 in this chapter tells more about Levels 3, 4, and 5 of the appeals process.

Section 8.5

What if you miss the deadline for making your Level 1 Appeal?

You can appeal to us instead.

As explained above in Section 8.3, you must act quickly to contact the Quality Improvement Organization to start your first appeal (within a day or two, at the most). If you miss the deadline for contacting this organization, there is another way to make your appeal. If you use this other way of making your appeal, *the first two levels of appeal are different*.

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

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

Here are the steps for a Level 1 Alternate Appeal:

Legal Terms

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

Step 1 Contact us and ask for a “fast review.”

For details on how to contact us, go to Chapter 2, Section 1 and look for the section called, *How to contact our plan when you are making an appeal about your medical care or about your Part D prescription drugs*.

Be sure to ask for a “fast review.” This means you are asking us to give you an answer using the “fast” deadlines rather than the “standard” deadlines.

Step 2 We do a “fast” review of the decision we made about when to end coverage for your services.

During this review, we take another look at all of the information about your case. We check to see if we were following all the rules when we set the date for ending the plan’s coverage for services you were receiving.

We will use the “fast” deadlines rather than the standard deadlines for giving you the answer to this review. (Usually, if you make an appeal to our plan and ask for a “fast review,” we are allowed to decide whether to agree to your request and give you a “fast review.” But in this situation, the rules require us to give you a fast response if you ask for it.)

Step 3 We give you our decision within 72 hours after you ask for a “fast review” (“fast appeal”).

If we say yes to your fast appeal, it means we have agreed with you that you 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 we say no to your fast appeal, then your coverage will end on the date we have told you and we will not pay after this date. We will stop paying its share of the costs of this care.

If you continued to get home health care, or skilled nursing facility care, or Comprehensive Outpatient Rehabilitation Facility (CORF) services *after* the date when we said your coverage would end, then you will have to pay the full cost of this care yourself.

Step 4 If we say no to your fast appeal, your case will automatically go on to the next level of the appeals process.

To make sure we were following all the rules when we said no to your fast appeal, we are required to send your appeal to the “Independent Review Organization.” When we do this, it means that you are *automatically* going on to Level 2 of the appeals process.

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

If we say 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 we made when we said no to your “fast appeal.” This organization decides whether the decision we made should be changed.

Legal Terms

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

Step 1 We will automatically forward your case to the Independent Review Organization.

We are required to send the information for your Level 2 Appeal to the Independent Review Organization within 24 hours of when we tell you that we are saying no to your first appeal. (If you think we are not meeting this deadline or other deadlines, you can make a complaint. The complaint process is different from the appeal process. Section 10 of this chapter tells how to make a complaint.)

Step 2 The Independent Review Organization does a “fast review” of your appeal. The reviewers give you an answer within 72 hours.

The Independent Review Organization is an independent organization that is hired by Medicare. This organization is not connected with 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 we 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.

Step 3 If the Independent Review Organization turns down your appeal, you choose whether you want to take your appeal further.

There are three additional levels of appeal after Level 2, for a total of five levels of appeal. If reviewers say no to your Level 2 Appeal, you can choose whether to accept that decision or whether to go on to Level 3 and make another appeal. At Level 3, your appeal is reviewed by a judge.

Section 9 in this chapter tells more about Levels 3, 4, and 5 of the appeals process.

Section 9

Taking your appeal to Level 3 and beyond.

Section 9.1 Levels of Appeal 3, 4, and 5 for Medical Service Appeals

This section may be appropriate for you if you have made a Level 1 Appeal and a Level 2 Appeal, and both of your appeals have been turned down.

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

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

Level 3 Appeal
A judge who works for the Federal government will review your appeal and give you an answer. This judge is called an "Administrative Law Judge."

If the Administrative Law Judge says yes to your appeal, the appeals process may or may not be over.

We will decide whether to appeal this decision to Level 4. Unlike a decision at Level 2 (Independent Review Organization), we have the right to appeal a Level 3 decision that is favorable to you.

- If we decide *not* to appeal the decision, we must authorize or provide you with the service within 60 days after receiving the judge's decision.
- If we decide to appeal the decision, we will send you a copy of the Level 4 Appeal request with any accompanying

documents. We may wait for the Level 4 Appeal decision before authorizing or providing the service in dispute.

If the Administrative Law Judge says no to your appeal, the appeals process may or may not be over.

- If you decide to accept this decision that turns down your appeal, the appeals process is over.
- If you do not want to accept the decision, you can continue to the next level of the review process. If the administrative law judge says no to your appeal, the notice you get will tell you what to do next if you choose to continue with your appeal.

Level 4 Appeal

The **Medicare Appeals Council** will review your appeal and give you an answer. The Medicare Appeals Council works for the Federal government.

If the answer is yes, or if the Medicare Appeals Council denies our request to review a favorable Level 3 Appeal decision, the appeals process may or may not be over.

We will decide whether to appeal this decision to Level 5. Unlike a decision at Level 2 (Independent Review Organization), we have the right to appeal a Level 4 decision that is favorable to you.

- If we decide *not* to appeal the decision, we must authorize or provide you with the service within 60 days after receiving the Medicare Appeals Council's decision.
- If we decide to appeal the decision, we will let you know in writing.

If the answer is no or if the Medicare Appeals Council denies the review request, the appeals process may or may not be over.

- If you decide to accept this decision that turns down your appeal, the appeals process is over.
- If you do not want to accept the decision, you might be able to continue to the next level of the review process. If the Medicare Appeals Council says no to your appeal, the

notice you get will tell you whether the rules allow you to go on to a Level 5 Appeal. If the rules allow you to go on, the written notice will also tell you who to contact and what to do next if you choose to continue with your appeal.

Level 5 Appeal

A judge at the **Federal District Court** will review your appeal.

This is the last step of the administrative appeals process.

Section 9.2

Levels of Appeal 3, 4, and 5 for Part D Drug Appeals.

This section may be appropriate for you if you have made a Level 1 Appeal and a Level 2 Appeal, and both of your appeals have been turned down.

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

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

Level 3 Appeal

A judge who works for the Federal government will review your appeal and give you an answer. This judge is called an "Administrative Law Judge."

If the answer is yes, the appeals process is over.

What you asked for in the appeal has been approved. We must *authorize or provide the drug coverage* that was approved by the Administrative Law Judge *within 72 hours (24 hours for expedited appeals) or make payment*

no later than 30 calendar days after we receive the decision.

If the answer is no, the appeals process may or may not be over.

- If you decide to accept this decision that turns down your appeal, the appeals process is over.
- If you do not want to accept the decision, you can continue to the next level of the review process. If the administrative law judge says no to your appeal, the notice you get will tell you what to do next if you choose to continue with your appeal.

Level 4 Appeal

The **Medicare Appeals Council** will review your appeal and give you an answer. The Medicare Appeals Council works for the Federal government.

If the answer is yes, the appeals process is over.

What you asked for in the appeal has been approved. 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 calendar days* after we receive the decision.

If the answer is no, the appeals process may or may not be over.

- If you decide to accept this decision that turns down your appeal, the appeals process is over.
- If you do not want to accept the decision, you might be able to continue to the next level of the review process. If the Medicare Appeals Council says no to your appeal, the notice you get will tell you whether the rules allow you to go on to Level 5 Appeal. If the rules allow you to go on, the written notice will also tell you who to contact and what to do next if you choose to continue with your appeal.

Level 5 Appeal

A judge at the **Federal District Court** will review your appeal.

This is the last step of the appeals process.

Making Complaints

Section 10

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



If your problem is about decisions related to benefits, coverage, or payment, then this section is *not for you*. Instead, you need to use the process for coverage decisions and appeals. Go to Section 4 of this chapter.

<p>Section 10.1 What kinds of problems are handled by the complaint process?</p>
--

This section explains how to use the process for making complaints. The complaint process is used for certain types of problems *only*. This includes problems related to quality of care, waiting times, and the customer service you receive. Here are examples of the kinds of problems handled by the complaint process.

If you have any of these kinds of problems, you can “make a complaint”**Quality of your medical care**

- Are you unhappy with the quality of the care you have received (including care in the hospital)?

Respecting your privacy

- Do you believe that someone did not respect your right to privacy or shared information about you that you feel should be confidential?

Disrespect, poor customer service, or other negative behaviors

- Has someone been rude or disrespectful to you?
- Are you unhappy with how our Customer Service has treated you?
- Do you feel you are being encouraged to leave the plan?

Waiting times

- Are you having trouble getting an appointment, or waiting too long to get it?
- Have you been kept waiting too long by doctors, pharmacists, or other health professionals? Or by our Customer Service or other staff at the plan?
 - Examples include waiting too long on the phone, in the waiting room, when getting a prescription, or in the exam room.

Cleanliness

- Are you unhappy with the cleanliness or condition of a clinic, hospital, or doctor’s office?

Information you get from us

- Do you believe we have not given you a notice that we are required to give?
- Do you think written information we have given you is hard to understand?

Below are more examples of possible reasons for making a complaint

These types of complaints are all related to the *timeliness* of our actions related to coverage decisions and appeals

The process of asking for a coverage decision and making appeals is explained in sections 4-9 of this chapter. If you are asking for a decision or making an appeal, you use that process, not the complaint process. However, if you have already asked us for a coverage decision or made an appeal, and you think that we are not responding quickly enough, you can also make a complaint about our slowness. Here are examples:

- If you have asked us to give you a “fast 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 10.2

The formal name for “making a complaint” is “filing a grievance.”

Legal Terms

- What this section calls a “**complaint**” is also called a “**grievance.**”
- Another term for “**making a complaint**” is “**filing a grievance.**”
- Another way to say “**using the process for complaints**” is “**using the process for filing a grievance.**”

Section 10.3

Step-by-step: Making a complaint.

Step 1

Contact us promptly – either by phone or in writing.

Usually, calling Customer Service is the first step. If there is anything else you need to do, Customer Service will let you know. Call (541) 385-5315 or toll-free (888) 863-3637 or TTY (800) 735-2900. Our hours are:

- **From October 15 to February 14:** 8:00 a.m. to 8:00 p.m. local time zone, seven days a week.
- **From February 15 to October 14:** 8:00 a.m. to 8:00 p.m. local time zone, Monday through Friday. During this time of the year, please leave a message on weekends, holidays, and after hours. We will return your call the next business day.

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, put your complaint in writing, we will respond to your complaint in writing. If you do this, it means that we will use our formal procedure for answering Grievances. Here’s how it works:

- You or your legal representative may file the Grievance. Your representative may be a friend, lawyer, advocate, doctor, or anyone else you formally name as your representative. If your representative is not

someone who is already authorized by a Court or under State law to act for you, then you and that person must sign and date a statement that gives the person legal permission to be your representative. To learn how to name your representative, you may contact Customer Service at the numbers listed above.

- If you file your Grievance in writing, please send it to the address listed on the cover of this handbook. We will write you or your representative and let you know how we have addressed your concerns within 30 calendar days of receiving your Grievance. In some instances we may need additional time to research and address your concern. If this is the case, we may extend the 30 day timeframe by up to 14 calendar days, and keep you informed of how your Grievance is being handled. The 14 day extension may also be applied upon your request.
- If your Grievance is related to the denial of an expedited (fast) Organizational Determination or reconsideration, then you will be entitled to an expedited (fast) Grievance. We will also expedite your Grievance if it relates to a Plan decision to extend the 14 day timeframe for an Organizational Determination or the 30 day timeframe for a reconsideration request. We will respond to expedited reasons for this answer. We must respond whether we agree with the complaint or not.

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 Terms

What this section calls a “**fast complaint**” is also called an “**expedited grievance.**”

Step 2

We look into your complaint and give you our answer.

If possible, we will answer you right away. If you call us with a complaint, we may be able to give you an answer on the same phone call. If your health condition requires us to answer quickly, we will do that.

Most complaints are answered in 30 calendar days. If we need more information and the delay is in your best interest or if you ask for more time, we can take up to 14 more calendar days (44 calendar days total) to answer your complaint.

If we do not agree with some or all of your complaint or don't take responsibility for the problem you are complaining about, we will let you know. Our response will include our reasons for this answer. We must respond whether we agree with the complaint or not.

<p>Section 10.4 You can also make complaints about quality of care to the Quality Improvement Organization.</p>

You can make your complaint about the quality of care you received to us by using the step-by-step process outlined above.

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

You can make your complaint to the Quality Improvement Organization.

If you prefer, you can make your complaint about the quality of care you received directly to this organization (*without* making the complaint to us).

The Quality Improvement Organization is a group of practicing doctors and other health care experts paid by the Federal government to check and improve the care given to Medicare patients.

To find the name, address, and phone number of the Quality Improvement Organization for your state, 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 us and also to the Quality Improvement Organization.

Chapter 10

Ending your membership in the plan

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Section 1

Introduction

Section 1.1 This chapter focuses on ending your membership in our plan

Ending your membership in our plan may be **voluntary** (your own choice) or **involuntary** (not your own choice): You might leave our plan because you have decided that you *want* to leave. There are only certain times during the year, or certain situations, when you may voluntarily end your membership in the plan. Section 2 tells you *when* you can end your membership in the plan. The process for voluntarily ending your membership varies depending on what type of new coverage you are choosing. Section 3 tells you *how* to end your membership in each situation. There are

also limited situations where you do not choose to leave, but we are required to end your membership. Section 5 tells you about situations when we must end your membership. If you are leaving 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?

You may end your membership in our plan only during certain times of the year, known as enrollment periods. All members have the opportunity to leave the plan during the Annual Enrollment Period and during the annual Medicare Advantage Disenrollment Period. In certain situations, you may also be

eligible to leave the plan at other times of the year.

Section 2.1
You can end your membership during the Annual Enrollment Period.

You can end your membership during the *Annual Enrollment Period* (also known as the "Annual Coordinated Election Period"). This is the time when you should review your health and drug coverage and make a decision about your coverage for the upcoming year.

When is the Annual Enrollment Period?

This happens from October 15 to December 7 in 2011.

What type of plan can you switch to during the Annual Enrollment Period?

During this time, you can review your health coverage and your prescription drug coverage. You can choose to keep your current coverage or make changes to your coverage for the upcoming year. If you decide to change to a new plan, you can choose any of the following types of plans:

- Another Medicare 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.
- – *or* – Original Medicare *without* a separate Medicare prescription drug plan.

If you receive Extra Help from Medicare to pay for your prescription drugs: If you switch to Original Medicare and do not enroll in a separate Medicare prescription drug plan, Medicare may enroll you in a drug plan, unless you have opted out of automatic enrollment. **Note:** If you disenroll from Medicare prescription drug coverage and go without creditable prescription drug coverage, you may need to pay a late enrollment penalty if you join a Medicare drug plan later. ("Creditable" coverage means the coverage is expected to pay, on average, at least as much as Medicare's standard prescription drug coverage.) See Chapter 6, Section 9 for

more information about the late enrollment penalty.

When will your membership end? Your membership will end when your new plan's coverage begins on January 1.

Section 2.2
You can end your membership during the annual Medicare Advantage Disenrollment Period, but your choices are more limited.

You have the opportunity to make *one* change to your health coverage during the annual *Medicare Advantage Disenrollment Period*.

When is the annual Medicare Advantage Disenrollment Period?

This happens every year from January 1 to February 14.

What type of plan can you switch to during the annual Medicare Advantage Disenrollment Period?

During this time, you can cancel your Medicare Advantage Plan enrollment and switch to Original Medicare. If you choose to switch to Original Medicare during this period, you have until February 14 to join a separate Medicare prescription drug plan to add drug coverage.

When will your membership end?

Your membership will end on the first day of the month after we get your request to switch to Original Medicare. If you also choose to enroll in a Medicare prescription drug plan, your membership in the drug plan will begin the first day of the month after the drug plan gets your enrollment request.

Section 2.3
In certain situations, you can end your membership during a Special Enrollment Period.

In certain situations, members of our plan may be eligible to end their membership at other times of the year. This is known as a *Special Enrollment Period*.

Who is eligible for a Special Enrollment Period?

If any of the following situations apply to you, you are eligible to end your membership during a Special Enrollment Period. These are just examples, for the full list you can contact the plan, call Medicare, or visit the Medicare website (www.medicare.gov):

- Usually, when you have moved.
- If you have Medicaid.
- If you are eligible for Extra Help with paying for your Medicare prescriptions.
- If we violate our contract with you.
- If you are getting care in an institution, such as a nursing home or long-term care hospital.

When are Special Enrollment Periods?

The enrollment periods vary depending on your situation.

What can you do?

To find out if you are eligible for a Special Enrollment Period, please call Medicare at 1-800-MEDICARE or (800) 633-4227, 24 hours a day, 7 days a week. TTY users call (877) 486-2048. If you are eligible to end your membership because of a special situation, you can choose to change both your Medicare health coverage and prescription drug coverage. This means you can choose any of the following types of plans:

- 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.
- – *or* – Original Medicare *without* a separate Medicare prescription drug plan.

If you receive Extra Help from Medicare to pay for your prescription drugs:

If you switch to Original Medicare and do not enroll in a separate Medicare prescription drug plan, Medicare may enroll you in a drug plan, unless you have opted out of automatic enrollment. **Note:** If you disenroll from Medicare prescription drug coverage and go without creditable prescription drug coverage,

you may need to pay a late enrollment penalty if you join a Medicare drug plan later. (“Creditable” coverage means the coverage is expected to pay, on average, at least as much as Medicare’s standard prescription drug coverage.) See Chapter 6, Section 9 for more information about the late enrollment penalty.

When will your membership end?

Your membership will usually end on the first day of the month after we receive your request to change your plan.

Section 2.4

Where can you get more information about when you can end your membership?

If you have any questions or would like more information on when you can end your membership:

- *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 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 or (800) 633-4227, 24 hours a day, 7 days a week. TTY users should call (877) 486-2048.

Section 3

How do you end your membership in our plan?

Section 3.1

Usually, you end your membership by enrolling in another plan

Usually, to end your membership in our plan, you simply enroll in another Medicare plan during one of the enrollment periods (see Section 2 for information about the

enrollment periods). However, if you want to switch from our plan to Original Medicare *without* a 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 or (800) 633-4227, 24 hours a day, 7 days a week. TTY users should call (877) 486-2048.

Note: If you disenroll from Medicare prescription drug coverage and go without creditable prescription drug coverage, you may need to pay a late enrollment penalty if you join a Medicare drug plan later. (“Creditable” coverage means the coverage is expected to pay, on average, at least as much as Medicare’s standard prescription drug coverage.) See Chapter 6, Section 9 for more information about the late enrollment penalty.

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

If you would like to switch from our plan to:	This is what you should do:
Another Medicare health plan.	Enroll in the new Medicare health plan. You will automatically be disenrolled from our plan when your new plan’s coverage begins.
Original Medicare <i>with</i> a separate Medicare prescription drug plan.	Enroll in the new Medicare prescription drug plan. You will automatically be disenrolled from our plan when your new plan’s coverage begins.
Original Medicare <i>without</i> a separate Medicare prescription drug plan. Note: If you disenroll from a Medicare prescription drug plan and go without creditable prescription drug coverage, you may need to pay a late enrollment penalty if you join a Medicare drug plan later. See Chapter 6, Section 9 for more information about the late enrollment penalty.	Send us a written request to disenroll. Contact Customer Service if you need more information on how to do this (phone numbers are on the back cover of this booklet). You can also contact Medicare , at 1-800-MEDICARE or (800) 633-4227, 24 hours a day, 7 days a week, and ask to be disenrolled. TTY users should call (877) 486-2048. You will be disenrolled from our plan when your coverage in Original Medicare begins.

Section 4

Until your membership ends, you must keep getting your medical services and drugs through our plan.

Section 4.1
Until your membership ends, you are still a member of our plan.

If you leave our plan, it may take time before your membership ends and your new Medicare coverage goes into effect. (See Section 2 for information on when your new coverage begins.) During this time, you must continue to get your medical care and prescription drugs through our plan. You should continue to use our network pharmacies to get your prescriptions filled until your membership in our plan ends. Usually, your prescription drugs are only covered if they are filled at a network pharmacy including through our mail-order pharmacy services. If you are hospitalized on the day that your membership ends, your hospital stay will usually be covered by our plan until you are discharged (even if you are discharged after your new health coverage begins).

Section 5

We must end your membership in the plan in certain situations.

Section 5.1
When must we end your membership in the plan?

We must end your membership in the plan if any of the following happen:

- If you do not stay continuously enrolled in Medicare Part A and Part B.
 - If you move out of our service area for more than six months.
 - If you move or take a long trip, you need to call Customer Service to find out if the place you are moving or traveling to is in our plan's area.

- If you become incarcerated (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 membership 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).

Section 5.2
We cannot ask you to leave our plan for any reason related to your health.

What should you do if this happens?

If you feel that you are being asked to leave our plan because of a health-related reason, you should call Medicare at 1-800-MEDICARE or (800) 633-4227. TTY users should call (877) 486-2048. You may call 24 hours a day, 7 days a week.

Section 5.3
You have the right to make a complaint if we end your membership in our plan.

If we end your membership in our plan, we must tell you our reasons in writing for ending your membership. We must also explain how you can make a complaint about our decision to end your membership. You can also look in Chapter 9, Section 10 for information about how to make a complaint.

Chapter 11

Legal Notices

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Section 1

Notice about governing law.

Many laws apply to this *Evidence of Coverage* and some additional provisions may apply because they are required by law. This may affect your rights and responsibilities even if the laws are not included or explained in this document. The principal law that applies to this document is Title XVIII of the Social Security Act and the regulations created under the Social Security Act by the Centers for Medicare & Medicaid Services, or CMS. In addition, other Federal laws may apply and, under certain circumstances, the laws of the state you live in.

Section 2

Notice about nondiscrimination.

We don't discriminate based on a person's race, disability, religion, sex, health, ethnicity, creed, age, or national origin. All organizations that provide Medicare Advantage Plans, like 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.

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.

Annual Enrollment Period – A set time each fall when members can change their health or drugs plans or switch to Original Medicare. The Annual Enrollment Period is from October 15 until December 7, 2011.

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.

Balance Billing – A situation in which a provider (such as a doctor or hospital) bills a patient more than the plan's cost-sharing amount for services. As a member of our plan, you only have to pay the plan's cost-sharing amounts when you get services covered by our plan. We do not allow providers to "balance bill" you. See Chapter 4, Section 1.4 for more information about balance billing.

Benefit Period – The way that both our plan and Original Medicare measures your use of skilled nursing facility (SNF) services. A benefit period begins the day you go into a skilled nursing facility. The benefit period ends when you haven't received any skilled care in a SNF for 60 days in a row. If you go into a skilled nursing facility after one benefit period has ended, a new benefit period

begins. There is no limit to the number of benefit periods.

Brand Name Drug – A prescription drug that is manufactured and sold by the pharmaceutical company that originally researched and developed the drug. Brand name drugs have the same active-ingredient formula as the generic version of the drug. However, generic drugs are manufactured and sold by other drug manufacturers and are generally not available until after the patent on the brand name drug has expired.

Catastrophic Coverage Stage – The stage in the Part D Drug Benefit where you pay a low copayment or coinsurance for your drugs after you or other qualified parties on your behalf have spent \$4,700 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.

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%).

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.

Copayment – An amount you may be required to pay as your share of the cost for a medical service or supply, like a doctor's visit, hospital 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. (This is in addition to the plan's monthly premium.) 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.

Cost-Sharing Tier – Every drug on the list of covered drugs is in one of *four* cost-sharing tiers. In general, the higher the cost-sharing tier, the higher your cost for the drug.

Coverage Determination – A decision about whether a drug prescribed for you is covered by the plan and the amount, if any, you are required to pay for the prescription. In general, if you bring your prescription to a pharmacy and the pharmacy tells you the prescription isn't covered under your plan, that isn't a coverage determination. You need to call or write to 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.

Deductible – The amount you must pay for health care or prescriptions before our plan begins to pay.

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.

Durable Medical Equipment – Certain medical equipment that is ordered by your doctor for use at home. Examples are walkers, wheelchairs, or hospital beds.

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

Emergency Care – Covered services that are: 1) rendered by a provider qualified to furnish emergency services; and 2) needed to 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 in-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.

In-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.

In-Network Provider – “Provider” is the general term we use for doctors, other health care professionals, hospitals, and other health care facilities that are licensed or certified by Medicare and by the State to provide health care services. We call them “**in-network providers**” when they have an agreement with 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 in-network providers based on the agreements it has with the providers or if the providers agree to provide you with plan-covered services. In-network providers may also be referred to as “plan providers.”

Initial Coverage Limit – The maximum limit of coverage under the Initial Coverage Stage.

Initial Coverage Stage – This is the stage before your total drug expenses have reached \$2,930, 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.

Late Enrollment Penalty – An amount added to your monthly premium for Medicare drug coverage if you go without creditable coverage (coverage that is expected to pay,

on average, at least as much as standard Medicare prescription drug coverage) for a continuous period of 63 days or more. You pay this higher amount as long as you have a Medicare drug plan. There are some exceptions. For example, if you receive Extra Help from Medicare to pay your prescription drug plan costs, the late enrollment penalty rules do not apply to you. If you receive Extra Help, you do not pay a penalty, even if you go without “creditable” prescription drug coverage.

List of Covered Drugs (Formulary or “Drug List”) – A list of prescription drugs covered by 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. In addition to the maximum out-of-pocket amount for in-network covered *Part A* and Part B medical services, we also have a maximum out-of-pocket amount for certain types of services. See Chapter 4, Section 1.2 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.

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 or a Medicare Advantage Plan.

Medicare Advantage Disenrollment Period – A set time each year when members in a Medicare Advantage plan can cancel their plan enrollment and switch to Original Medicare. The Medicare Advantage Disenrollment Period is from January 1 until February 14, 2011.

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, 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 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, and 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).

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.

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.

Preferred Provider Organization (PPO) Plan – A Preferred Provider Organization plan is a Medicare Advantage Plan that has a network of contracted providers that have agreed to treat plan members for a specified payment amount. A PPO plan must cover all plan benefits whether they are received from network or out-of-network providers. Member cost sharing will generally be higher when plan benefits are received from out-of-network providers. PPO plans have an annual limit on your out-of-pocket costs for services received from network (preferred) providers and a higher limit on your total combined out-of-pocket costs for services from both in-network (preferred) and out-of-network (non-preferred) providers.

Premium – The periodic payment to Medicare, an insurance company, or a health care plan for health or prescription drug coverage.

Primary Care Provider (PCP) – Your primary care provider 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 provider before you see any other health care provider. See Chapter 3, Section 2.1 for information about Primary Care Provider.

Prior Authorization – Approval in advance to get services or certain drugs that may or may not be on our formulary. Some in-network medical services are covered only if your doctor or other in-network provider gets “prior authorization” from our plan. Covered services that need prior authorization are

marked in the Benefits Chart in Chapter 4. Some drugs are covered only if your doctor or other network provider gets “prior authorization” from us. Covered drugs that need prior authorization are marked in the formulary.

Quality Improvement Organization (QIO) – A group of practicing doctors and other health care experts paid by the Federal government to check and improve the care given to Medicare patients. 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.

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 Enrollment Period – A set time when members can change their health or drugs plans or return to Original Medicare. Situations in which you may be eligible for a Special Enrollment Period include: if you move outside the service area, if you are getting “Extra Help” with your prescription drug costs, if you move into a nursing home, or if we violate our contract with you.

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.

PacificSource Medicare Customer Service

CALL

(541) 385-5315 or (888) 863-3637 (calls to this number are free). Hours are:

- **From October 15 to February 14:** 8:00 a.m. to 8:00 p.m. local time zone, seven days a week.
- **From February 15 to October 14:** 8:00 a.m. to 8:00 p.m. local time zone, Monday through Friday. During this time of the year, please leave a message on weekends, holidays, and after hours. We will return your call the next business day.

Customer Service also has free language interpreter services available for non-English speakers.

TTY

(800) 735-2900. 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 are:

- **From October 15 to February 14:** 8:00 a.m. to 8:00 p.m. local time zone, seven days a week.
- **From February 15 to October 14:** 8:00 a.m. to 8:00 p.m. local time zone, Monday through Friday. During this time of the year, please leave a message on weekends, holidays, and after hours. We will return your call the next business day.

FAX

(541) 322-6423

WRITE

PacificSource Medicare
PO Box 7469, Bend, Oregon 97708
MedicareCS@pacificsource.com

WEBSITE

www.Medicare.PacificSource.com

State Health Insurance Assistance Program (SHIP)

SHIBA is a state program that gets money from the Federal government to give free local health insurance counseling to people with Medicare.

Senior Health Insurance Benefits Assistance (SHIBA) (Oregon's SHIP)

CALL

(800) 722-4134 Calls to this number are free. (503) 378-2014

WRITE

Senior Health Insurance Benefits Assistance
350 Winter Street NE, Suite 330, Salem, Oregon, 97301

WEBSITE

oregonshiba.org

Senior Health Insurance Benefits Advisors (SHIBA) (Idaho's SHIP)

CALL

(800) 247-4422 Calls to this number are free. (208) 334-4352.

WRITE

Senior Health Insurance Benefits Advisors
700 West State Street, Boise, ID 83720-0043

WEBSITE

www.doi.idaho.gov