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#### **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 “Independent Review Organization” is “**Independent Review Entity.**” It is sometimes called “**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 9 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 8 in this chapter tells more about Levels 3, 4, and 5 of the appeals process.

## Section 7 How to ask us to keep covering certain medical services if you think your coverage is ending too soon.

### Section 7.1

***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 10, *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 10, *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 7.2

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

1. **You receive a notice in writing.** At least two days before our plan is going to stop covering your care, the agency or facility that is providing your care will give you a notice. The written notice tells you the date when 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/](http://www.cms.hhs.gov/BNI/)

**3. 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 7.3**

**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 9 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 7.5.

**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 7.4**

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

**Section 7.5**  
**What if you miss the deadline for making your Level 1 Appeal?**

**You can appeal to us instead**  
 As explained above in Section 7.3, 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.*

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 your coverage ends, 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 "Independent Review Organization" is **"Independent Review Entity."** It is sometimes called **"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 9 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 8 in this chapter tells more about Levels 3, 4, and 5 of the appeals process.

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## **Section 8**

### **Taking your appeal to Level 3 and beyond.**

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<b>Section 8.1</b> <b>Levels of Appeal 3, 4, and 5 for Medical Service Appeals.</b>
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This section may be appropriate for you if you have made a Level 1 Appeal and a Level 2 Appeal, and both of your appeals have been turned down.

If the dollar value of the 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 8.2

#### 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 9

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



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

#### Section 9.1

##### What kinds of problems are handled by the complaint process?

This section explains how to use the process for making complaints. The complaint process is used for certain types of problems *only*.

This includes problems related to quality of care, waiting times, and the customer service you receive. Here are examples of the kinds

of problems handled by the complaint process.

## **If you have any of these kinds of problems, you can “make a complaint”**

### **Quality of your medical care**

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

### **Respecting your privacy**

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

### **Disrespect, poor customer service, or other negative behaviors**

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

### **Waiting times**

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

### **Cleanliness**

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

### **Information you get from us**

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

*Below are more examples of possible reasons for making a complaint*

## **Possible complaints (continued)**

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

The process of asking for a coverage decision and making appeals is explained in sections 4-9 of this chapter. If you are asking for a decision or making an appeal, you use that process, not the complaint process.

However, if you have already asked us for a coverage decision or made an appeal, and you think that we are not responding quickly enough, you can also make a complaint about our slowness. Here are examples:

- If you have asked us to give you a “fast response” for a coverage decision or appeal, and we

## Possible complaints (continued)

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 9.2

**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 9.3

**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.

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, 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.

#### **Section 9.4**

**You can also make complaints about quality of care to the Quality Improvement Organization.**

You can make your complaint about the quality of care you received to 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 8

## Ending your membership in the plan

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### Section 1

#### Introduction

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<b>Section 1.1</b> <b>This chapter focuses on ending your membership in our plan.</b>
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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.

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### Section 2

#### When can you end your membership in our plan?

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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. 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.

**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](http://www.medicare.gov)):

- Usually, when you have moved.
- If you have Medicaid.
- 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

**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](http://www.medicare.gov). Or, you can order a printed copy by calling Medicare at the number below.

*You can contact Medicare* at 1-800-MEDICARE or (800) 633-4227, 24 hours a day, 7 days a week. TTY users should call (877) 486-2048.

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## **Section 3**

### **How do you end your membership in our plan?**

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**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.

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

<b>If you would like to switch from our plan to:</b>	<b>This is what you should do:</b>
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. <b>Note:</b> If you disenroll from a Medicare prescription drug plan and go without creditable prescription drug coverage, you may need to pay a late enrollment penalty if you join a Medicare drug plan later. See Chapter 6, Section 10 for more information about the late enrollment penalty.	<b>Send us a written request to disenroll.</b> Contact Customer Service if you need more information on how to do this (phone numbers are on the back cover of this booklet). You can also contact <b>Medicare</b> , 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 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 through our plan.

**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 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.
- If you do not pay the plan premiums for 2 calendar months.
  - We must notify you in writing that you have 2 calendar months to pay the plan premium before we end your membership.

**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 7, Section 9 for information about how to make a complaint.

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# Chapter 9

## Legal notices

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### Section 1

#### Notice about governing law.

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

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### Section 2

#### Notice about nondiscrimination.

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We don't discriminate based on a person's race, disability, religion, sex, health, ethnicity, creed, age, or national origin. All organizations that provide Medicare Advantage Plans, like our plan, must obey Federal laws against discrimination, including Title VI of the Civil Rights Act of 1964, the Rehabilitation Act of 1973, the Age Discrimination Act of 1975, the Americans with Disabilities Act, all other laws that apply to organizations that get Federal funding, and any other laws and rules that apply for any other reason.

## Chapter 10

### 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 7 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 hospital and skilled nursing facility (SNF) services. A benefit period begins the day you go into a hospital or skilled nursing facility. The benefit period ends when you haven't received any inpatient hospital care (or skilled care in a SNF) for 60 days in a row. If you go

into a hospital or a skilled nursing facility after one benefit period has ended, a new benefit period begins. There is no limit to the number of benefit periods.

**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. Coinsurance is usually a percentage (for example, 20%).

**Combined Maximum Out-of-Pocket Amount** – This is the most you will pay in a year for all Part A and Part B services from both network (preferred) providers and out-of-network (non-preferred) provider. In addition to the maximum out-of-pocket amount for covered Part A and Part B medical services, we also have a maximum out-of-pocket amount for certain types of services. See Chapter 4, Section 1.2 for information about your combined maximum out-of-pocket amount.

**Comprehensive Outpatient Rehabilitation Facility (CORF)** – A facility that mainly provides rehabilitation services after an illness or injury, and provides a variety of services including physical therapy, social or psychological services, respiratory therapy, occupational therapy 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.

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

**Creditable Prescription Drug Coverage** – 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 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).

**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.

**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.

**Grievance** – A type of complaint you make about us or one of our network providers or pharmacies, including a complaint concerning the quality of your care. This type of complaint does not involve coverage or payment disputes.

**Home Health Aide** – A home health aide provides services that don't need the skills of a licensed nurse or therapist, such as help with personal care (e.g., bathing, using the toilet, dressing, or carrying out the prescribed

exercises). Home health aides do not have a nursing license or provide therapy.

**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.

**In-Network Maximum Out-of-Pocket Amount** – The most you will pay for covered Part A and Part B services received from network (preferred) providers. After you have reached this limit, you will not have to pay anything when you get covered services from network providers for the rest of the contract year. However, until you reach your combined out-of-pocket amount, you must continue to pay your share of the costs when you seek care from an out-of-network (non-preferred) provider. In addition to the maximum out-of-pocket amount for covered 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 in-network maximum out-of-pocket amount.

**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 "**network providers**" when they have an agreement with our plan to accept our payment as payment in full, and in some cases to coordinate as well as provide covered services to members of our plan. Our plan pays network providers based on the agreements it has with the providers or if the providers agree to provide you with plan-covered services. Network providers may also be referred to as "plan providers."

**Low Income Subsidy** – See "Extra Help."  
**Medicaid (or Medical Assistance)** – A joint Federal and state program that helps with

medical costs for some people with low incomes and limited resources. Medicaid programs vary from state to state, but most health care costs are covered if you qualify for both Medicare and Medicaid. See Chapter 2, Section 6 for information about how to contact Medicaid in your state.

**Medically Accepted Indication** – A use of a drug that is either approved by the Food and Drug Administration or supported by certain reference books. See Chapter 5, Section 4 for more information about a medically accepted indication.

**Medically Necessary** – Services, supplies, or drugs that are needed for the prevention, diagnosis, or treatment of your medical condition and meet accepted standards of medical practice.

**Medicare** – The Federal health insurance program for people 65 years of age or older, some people under age 65 with certain disabilities, and people with End-Stage Renal Disease (generally those with permanent kidney failure who need dialysis or a kidney transplant). People with Medicare can get their Medicare health coverage through Original Medicare 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 Health Plan** – A Medicare health plan is offered by a private company that contracts with Medicare to provide Part A and Part B benefits to people with Medicare who enroll in the plan. This term includes all Medicare Advantage Plans, Medicare Cost Plans, Demonstration/Pilot Programs, and Programs of All-inclusive Care for the Elderly (PACE).

**Medicare Prescription Drug Coverage (Medicare Part D)** – Insurance to help pay for outpatient prescription drugs, vaccines, biologicals, and some supplies not covered by Medicare Part A or Part B.

**“Medigap” (Medicare Supplement Insurance) Policy** – Medicare supplement insurance sold by private insurance companies to fill “gaps” in Original Medicare. Medigap policies only work with Original Medicare. (A Medicare Advantage Plan is not a Medigap policy.)

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

**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 7 explains how to ask us for a coverage decision.

**Original Medicare** (“Traditional Medicare” or “Fee-for-service” Medicare) – Original Medicare is offered by the government, and not a private health plan such as Medicare Advantage Plans and prescription drug plans. Under Original Medicare, Medicare services are covered by paying doctors, hospitals, and other health care providers payment amounts established by Congress. You can see any doctor, hospital, or other health care provider that accepts Medicare. You must pay the deductible. Medicare pays its share of the Medicare-approved amount, and you pay your share. Original Medicare has two parts: Part A (Hospital Insurance) and Part B (Medical Insurance) and is available everywhere in the United States.

**Out-of-Network 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 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.)

**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 (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. In the network portion of a PPO, some in-network medical services are covered only if your doctor or other network provider gets “prior authorization” from our plan. In a PPO, you do not need prior authorization to obtain out-of-network services. 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.

**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 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.

**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](mailto:MedicareCS@pacificsource.com)

### WEBSITE

[www.Medicare.PacificSource.com](http://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](http://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](http://www.doi.idaho.gov)