

SecureHorizons[®] MedicareComplete[®] Retiree Plan (HMO)

The Evidence of Coverage is an important legal document for you to keep and use as a reference during 2011. It explains:

The details of your Medicare health coverage, including your prescription drugs.
How to get the care you need.

Insured by: UNITEDHEALTHCARE OF CALIFORNIA

Group Name (Plan Sponsor): SO CAL IBEW NECA
Group Number: 004257

California

H0543-806

October 01, 2011 to September 30, 2012

Evidence of Coverage:

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

This booklet gives you the details about your Medicare health care and prescription drug coverage from October 01, 2011 – September 30, 2012. It explains how to get the health care and prescription drugs you need covered. This is an important legal document. Please keep it in a safe place.

This plan, SecureHorizons® MedicareComplete® Retiree Plan (HMO), is offered by UNITEDHEALTHCARE OF CALIFORNIA. (When this **Evidence of Coverage** says “we,” “us,” or “our,” it means UNITEDHEALTHCARE OF CALIFORNIA. When it says “plan” or “our Plan,” it means SecureHorizons® MedicareComplete® Retiree Plan (HMO).)

UnitedHealthcare® Medicare Advantage plans are insured through UnitedHealthcare Insurance Company and its affiliated companies, a Medicare Advantage organization with a Medicare contract.

Customer Service has free language interpreter services available for non-English speakers (phone numbers are on the back cover of this booklet).

Benefits, formulary, pharmacy network, and/or copayments/coinsurance may change on October 1, 2011.

2012 Evidence of Coverage

Table of Contents

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

Chapter 1	Getting started as a member	1-1
	Tells what it means to be in a Medicare health plan and how to use this booklet. Tells about materials we will send you, your Plan premium, your Plan member ID card, and keeping your membership record up to date.	
Chapter 2	Important phone numbers and resources	2-1
	Tells you how to get in touch with our Plan, (SecureHorizons MedicareComplete Retiree Plan (HMO)), and with other organizations including Medicare, the State Health Insurance Assistance Program (SHIP), the Quality Improvement Organization, Social Security, Medicaid (the state health insurance program for people with low incomes), programs that help people pay for their prescription drugs, and the Railroad Retirement Board.	
Chapter 3	Using the plan’s coverage for your medical services	3-1
	Explains important things you need to know about getting your medical care as a member of our Plan. Topics include using the providers in the plan’s network and how to get care when you have an emergency.	
Chapter 4	Medical Benefits Chart (what is covered and what you pay)	4-1
	Gives the details about which types of medical care are covered and not covered for you as a member of our Plan. Tells how much you will pay as your share of the cost for your covered medical care.	
Chapter 5	Using the plan’s coverage for your Part D prescription drugs	5-1
	Explains rules you need to follow when you get your Part D drugs. Tells how to use the plan’s List of Covered Drugs (Formulary) to find out which drugs are covered. Tells which kinds of drugs are not covered. Explains several kinds of restrictions that apply to your coverage for certain drugs. Explains where to get your prescriptions filled. Tells about the plan’s programs for drug safety and managing medications.	

Questions? Call our Customer Service Department listed in Chapter 2.

Chapter 6	What you pay for your Part D prescription drugs	6-1
	Tells about the four stages of drug coverage (Deductible Stage, Initial Coverage Stage, Coverage Gap Stage, Catastrophic Coverage Stage) and how these stages affect what you pay for your drugs. Explains the four cost-sharing tiers for your Part D drugs and tells what you must pay for a drug in each cost-sharing tier. Tells about the late enrollment penalty.	
Chapter 7	Asking us to pay our share of a bill you have received for covered medical services or drugs	7-1
	Tells when and how to send a bill to us when you want to ask us to pay you back for our share of the cost for your covered services or drugs.	
Chapter 8	Your rights and responsibilities	8-1
	Explains the rights and responsibilities you have as a member of our Plan. Tells what you can do if you think your rights are not being respected.	
Chapter 9	What to do if you have a problem or complaint (coverage decisions, appeals, complaints)	9-1
	Tells you step-by-step what to do if you are having problems or concerns as a member of our Plan.	
	<ul style="list-style-type: none">• Explains how to ask for coverage decisions and make appeals if you are having trouble getting the medical care or prescription drugs you think are covered by our Plan. This includes asking us to make exceptions to the rules or extra restrictions on your coverage for prescription drugs, and asking us to keep covering hospital care and certain types of medical services if you think your coverage is ending too soon.• Explains how to make complaints about quality of care, waiting times, customer service, and other concerns.	
Chapter 10	Ending your membership in the plan	10-1
	Tells when and how you can end your membership in the plan. Explains situations in which our Plan is required to end your membership.	
Chapter 11	Legal notices	11-1
	Includes notices about governing law and about nondiscrimination.	
Chapter 12	Definitions of important words	12-1
	Explains key terms used in this booklet.	

Questions? Call our Customer Service Department listed in Chapter 2.

CHAPTER 1: Getting started as a member

SECTION 1 Introduction..... 2

- Section 1.1 You are enrolled in SecureHorizons MedicareComplete Retiree Plan (HMO), which is a Medicare HMO.....2
- Section 1.2 What is the Evidence of Coverage booklet about?..... 2
- Section 1.3 What does this Chapter tell you?..... 2
- Section 1.4 What if you are new to the plan?.....2
- Section 1.5 Legal information about the Evidence of Coverage..... 3

SECTION 2 What makes you eligible to be a plan member?..... 3

- Section 2.1 Your eligibility requirements..... 3
- Section 2.2 What are Medicare Part A and Medicare Part B?.....4
- Section 2.3 Here is the plan service area for SecureHorizons MedicareComplete Retiree Plan (HMO).....4

SECTION 3 What other materials will you get from us?.....6

- Section 3.1 Your Plan member ID card – Use it to get all covered care and prescription drugs. 6
- Section 3.2 The Provider Directory: Your guide to all providers in the plan’s network..... 7
- Section 3.3 The Pharmacy Directory: Your guide to pharmacies in our network..... 8
- Section 3.4 The plan’s List of Covered Drugs (Formulary)..... 8
- Section 3.5 The Explanation of Benefits (the “EOB”): Reports with a summary of payments made for your Part D prescription drugs..... 9

SECTION 4 Your monthly plan premium for the plan..... 9

- Section 4.1 How much is your Plan premium?..... 9
- Section 4.2 Can we change your monthly plan premium during the year?.....10

SECTION 5 Please keep your Plan membership record up to date..... 11

- Section 5.1 How to help make sure that we have accurate information about you.....11

SECTION 6 We protect the privacy of your personal health information..... 12

- Section 6.1 We make sure that your health information is protected.....12

SECTION 7 How other insurance works with our Plan..... 12

- Section 7.1 Which plan pays first when you have other insurance?.....12

Questions? Call our Customer Service Department listed in Chapter 2.

SECTION 1 Introduction

Section 1.1 You are enrolled in SecureHorizons® MedicareComplete® Retiree Plan (HMO), which is a Medicare HMO

You are covered by Medicare, and you have chosen to get your Medicare health care and your prescription drug coverage through our Plan.

There are different types of Medicare health plans. Our Plan is a Medicare Advantage HMO Plan (HMO stands for Health Maintenance Organization). Like all Medicare health plans, this Medicare HMO is approved by Medicare and run by a private company.

Section 1.2 What is the Evidence of Coverage booklet about?

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

This plan, SecureHorizons® MedicareComplete® Retiree Plan (HMO), is offered by UNITEDHEALTHCARE OF CALIFORNIA. (When this **Evidence of Coverage** says “we,” “us,” or “our,” it means UNITEDHEALTHCARE OF CALIFORNIA. When it says “plan” or “our Plan,” it means SecureHorizons® MedicareComplete® Retiree Plan (HMO).)

When the Agreement is purchased by the Group to provide benefits under a welfare plan governed by the Employee Retirement Income Security Act (ERISA), 29 U.S.C. §1001 et seq., we are not the plan administrator or named fiduciary of the welfare plan, as those terms are used in ERISA.

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

Section 1.3 What does this Chapter tell you?

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

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

Section 1.4 What if you are new to the plan?

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

Questions? Call our Customer Service Department listed in Chapter 2.

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

Section 1.5	Legal information about the Evidence of Coverage
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It’s part of our contract with you

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

The contract is in effect for months in which you are enrolled in the plan during your Plan Sponsor’s plan year.

Medicare must approve our Plan each year

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

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

Section 2.1	Your eligibility requirements
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You are eligible for membership in our Plan as long as:

- You meet the eligibility requirements of your former employer, union group or trust administrator (Plan Sponsor)
- You live in our geographic service area (section 2.3 below describes our service area)
- -- **and** -- you are entitled to Medicare Part A
- -- **and** -- you are enrolled in Medicare Part B
- -- **and** -- you do **not** have End-Stage Renal Disease (ESRD), or receive routine kidney dialysis. However, if either of these conditions applies to you, in some instances, you may still be eligible to enroll through a Plan Sponsored Medicare Advantage (MA) health plan or as an individual. You may be newly eligible or able to continue your enrollment under the following circumstances:
 - Individuals with ESRD who age into Medicare can enroll in any Medicare Advantage plan sponsored by their Plan Sponsor regardless of prior commercial coverage affiliation (your health plan coverage prior to you becoming eligible for Medicare).
 - If a Plan Sponsor offers a Medicare Advantage plan as a new option to its employees and retirees, regardless of whether it has been an option in the past, retirees with ESRD may select this new Medicare Advantage plan option as the Plan Sponsor’s open enrollment rules allow. You should contact your Plan Sponsor to determine what their rules allow.

Questions? Call our Customer Service Department listed in Chapter 2.

- If a Plan Sponsor that has been offering a variety of coverage options consolidates its employee/retiree offerings (for example, it drops one or more plans), current members of the dropped plans may be accepted into a Medicare Advantage plan that is offered by the group.
- If a Plan Sponsor has contracted locally with a Medicare Advantage Organization (MAO) in more than one geographic area (for example, in two or more states), a retiree with ESRD who relocates permanently from one geographic location to another may remain with the Medicare Advantage Organization in the Plan Sponsor's local Medicare Advantage plan.
- Individuals with ESRD who are affected by the contract termination, non-renewal or service area reduction of another Medicare Advantage Organization (MAO) may make one election to enroll in a Medicare Advantage plan offered by a different Medicare Advantage Organization during the appropriate election period.
- Once enrolled in a Medicare Advantage plan, an individual with ESRD may elect other Medicare Advantage plans offered by the same Medicare Advantage Organization (within the same CMS contract) during an allowable election period. Standard Medicare Advantage eligibility rules apply.
- **Note:** If you have received a transplant that has restored your kidney function and you no longer require a regular course of dialysis, you **are not** considered to have ESRD and you **are** eligible to enroll in the plan.

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

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

If you are not entitled to Medicare Part A, please refer to your Plan Sponsor's enrollment materials, or contact your Plan Sponsor directly to determine if you are eligible to enroll in our Plan. Some Plan Sponsors have made arrangements with us to purchase Medicare Part A on your behalf.

Section 2.3	Here is the plan service area for SecureHorizons® MedicareComplete® Retiree Plan (HMO)
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Although Medicare is a Federal program, our Plan is available only to individuals who live in our Plan service area. To remain a member of our Plan, you must keep living in this service area. The service area is described below.

Our service area includes these counties in California: Alameda County, Amador County, Contra Costa County, El Dorado County, Fresno County, Imperial County, Kern County, Mendocino County, Merced County, Orange County, Sacramento County, San Francisco County, San Mateo County, Santa Clara County, Santa Cruz County, Shasta County, Sonoma County, Stanislaus County, Tulare County, Yolo County.

Questions? Call our Customer Service Department listed in Chapter 2.

Our service area includes these parts of counties in California: Los Angeles County, Madera County, Nevada County, Placer County, Riverside County, San Bernardino County, San Diego County, San Luis Obispo County, Santa Barbara County, Ventura County, the following zip codes only 90001, 90002, 90003, 90004, 90005, 90006, 90007, 90008, 90009, 90010, 90011, 90012, 90013, 90014, 90015, 90016, 90017, 90018, 90019, 90020, 90021, 90022, 90023, 90024, 90025, 90026, 90027, 90028, 90029, 90030, 90031, 90032, 90033, 90034, 90035, 90036, 90037, 90038, 90039, 90040, 90041, 90042, 90043, 90044, 90045, 90046, 90047, 90048, 90049, 90050, 90051, 90052, 90053, 90054, 90055, 90056, 90057, 90058, 90059, 90060, 90061, 90062, 90063, 90064, 90065, 90066, 90067, 90068, 90069, 90070, 90071, 90072, 90073, 90075, 90076, 90077, 90078, 90079, 90080, 90081, 90082, 90083, 90086, 90087, 90091, 90093, 90094, 90099, 90101, 90201, 90202, 90209, 90210, 90211, 90212, 90213, 90220, 90221, 90222, 90223, 90224, 90230, 90231, 90232, 90233, 90239, 90240, 90241, 90242, 90245, 90247, 90248, 90249, 90250, 90251, 90254, 90255, 90260, 90261, 90262, 90263, 90264, 90265, 90266, 90267, 90270, 90272, 90274, 90275, 90277, 90278, 90280, 90290, 90291, 90292, 90293, 90294, 90295, 90296, 90301, 90302, 90303, 90304, 90305, 90306, 90307, 90308, 90309, 90310, 90311, 90312, 90401, 90402, 90403, 90404, 90405, 90406, 90407, 90408, 90409, 90410, 90411, 90501, 90502, 90503, 90504, 90505, 90506, 90507, 90508, 90509, 90510, 90601, 90602, 90603, 90604, 90605, 90606, 90607, 90608, 90609, 90610, 90637, 90638, 90640, 90650, 90651, 90652, 90660, 90661, 90662, 90670, 90671, 90701, 90702, 90703, 90706, 90707, 90710, 90711, 90712, 90713, 90714, 90715, 90716, 90717, 90723, 90731, 90732, 90733, 90734, 90744, 90745, 90746, 90748, 90749, 90755, 90801, 90802, 90803, 90804, 90805, 90806, 90807, 90808, 90809, 90810, 90813, 90814, 90815, 90822, 90831, 90832, 90833, 90834, 90835, 90853, 91001, 91003, 91006, 91007, 91009, 91010, 91011, 91012, 91016, 91017, 91020, 91021, 91023, 91024, 91025, 91030, 91031, 91040, 91041, 91042, 91043, 91046, 91066, 91077, 91101, 91102, 91103, 91104, 91105, 91106, 91107, 91108, 91109, 91114, 91115, 91116, 91117, 91118, 91201, 91202, 91203, 91204, 91205, 91206, 91207, 91208, 91209, 91210, 91214, 91221, 91222, 91224, 91225, 91226, 91301, 91302, 91303, 91304, 91305, 91306, 91307, 91308, 91309, 91310, 91311, 91313, 91316, 91321, 91322, 91324, 91325, 91326, 91327, 91328, 91331, 91333, 91334, 91335, 91337, 91340, 91341, 91342, 91343, 91344, 91345, 91346, 91350, 91351, 91352, 91353, 91354, 91355, 91356, 91357, 91361, 91364, 91365, 91367, 91372, 91376, 91380, 91381, 91382, 91383, 91384, 91385, 91386, 91387, 91390, 91392, 91393, 91394, 91395, 91396, 91401, 91402, 91403, 91404, 91405, 91406, 91407, 91408, 91409, 91410, 91411, 91412, 91413, 91416, 91423, 91426, 91436, 91501, 91502, 91503, 91504, 91505, 91506, 91507, 91508, 91510, 91601, 91602, 91603, 91604, 91605, 91606, 91607, 91608, 91609, 91610, 91614, 91615, 91616, 91617, 91618, 91702, 91706, 91711, 91714, 91715, 91716, 91722, 91723, 91724, 91731, 91732, 91733, 91734, 91740, 91741, 91744, 91745, 91746, 91747, 91748, 91749, 91750, 91754, 91755, 91765, 91766, 91767, 91768, 91769, 91770, 91773, 91775, 91776, 91778, 91780, 91788, 91789, 91790, 91791, 91792, 91793, 91801, 91802, 91803, 91804, 91896, 91899, 93510, 93532, 93534, 93535, 93536, 93539, 93543, 93544, 93550, 93551, 93552, 93553, 93563, 93584, 93586, 93590, 93591, 93601, 93604, 93614, 93643, 93644, 93645, 93669, 95602, 95712, 95924, 95945, 95946, 95949, 95959, 95960, 95975, 95977, 95602, 95603, 95604, 95631, 95648, 95650, 95658, 95661, 95663, 95677, 95678, 95681, 95703, 95713, 95717, 95722, 95736, 95746, 95747, 95765, 91752, 92201, 92202, 92203, 92210, 92211, 92220, 92223, 92230, 92234, 92235, 92236, 92239, 92240, 92241, 92247, 92248, 92253, 92254, 92255, 92258, 92260, 92261, 92262, 92263, 92264, 92270, 92274, 92276, 92282, 92320, 92501, 92502, 92503, 92504, 92505, 92506, 92507, 92508, 92509, 92513,

Questions? Call our Customer Service Department listed in Chapter 2.

92514, 92515, 92516, 92517, 92518, 92519, 92530, 92531, 92532, 92536, 92539, 92543, 92544, 92545, 92546, 92548, 92549, 92551, 92552, 92553, 92554, 92555, 92556, 92557, 92561, 92562, 92563, 92564, 92567, 92570, 92571, 92572, 92581, 92582, 92583, 92584, 92585, 92586, 92587, 92589, 92590, 92591, 92592, 92593, 92595, 92596, 92860, 92877, 92878, 92879, 92880, 92881, 92882, 92883 91701, 91708, 91709, 91710, 91729, 91730, 91737, 91739, 91743, 91758, 91759, 91761, 91762, 91763, 91764, 91784, 91785, 91786, 92252, 92256, 92284, 92285, 92286, 92301, 92305, 92307, 92308, 92309, 92310, 92311, 92312, 92313, 92316, 92318, 92323, 92324, 92327, 92329, 92334, 92335, 92336, 92337, 92338, 92339, 92340, 92342, 92344, 92345, 92346, 92347, 92354, 92356, 92358, 92359, 92364, 92365, 92366, 92368, 92369, 92371, 92372, 92373, 92374, 92375, 92376, 92377, 92382, 92392, 92393, 92394, 92395, 92397, 92398, 92399, 92401, 92402, 92403, 92404, 92405, 92406, 92407, 92408, 92410, 92411, 92412, 92413, 92423, 92427 91901, 91902, 91903, 91905, 91906, 91908, 91909, 91910, 91911, 91912, 91913, 91914, 91915, 91916, 91917, 91921, 91931, 91932, 91933, 91934, 91935, 91941, 91942, 91943, 91944, 91945, 91946, 91947, 91948, 91950, 91951, 91962, 91963, 91976, 91977, 91978, 91979, 91980, 92003, 92007, 92008, 92009, 92010, 92011, 92013, 92014, 92018, 92019, 92020, 92021, 92022, 92023, 92024, 92025, 92026, 92027, 92028, 92029, 92030, 92033, 92037, 92038, 92039, 92040, 92046, 92049, 92051, 92052, 92054, 92055, 92056, 92057, 92058, 92059, 92060, 92061, 92064, 92065, 92066, 92067, 92068, 92069, 92070, 92071, 92072, 92074, 92075, 92078, 92079, 92081, 92082, 92083, 92084, 92085, 92086, 92088, 92091, 92101, 92102, 92103, 92104, 92105, 92106, 92107, 92108, 92109, 92110, 92111, 92112, 92113, 92114, 92115, 92116, 92117, 92118, 92119, 92120, 92121, 92122, 92123, 92124, 92126, 92127, 92128, 92129, 92130, 92131, 92135, 92137, 92138, 92139, 92142, 92143, 92149, 92150, 92153, 92154, 92159, 92160, 92162, 92163, 92164, 92165, 92166, 92167, 92168, 92169, 92170, 92171, 92172, 92173, 92174, 92175, 92176, 92177, 92178, 92179, 92186, 92190, 92191, 92192, 92193, 92195, 92196, 92197, 92198, 92199 93252, 93401, 93402, 93403, 93405, 93406, 93407, 93410, 93412, 93420, 93421, 93424, 93426, 93428, 93430, 93433, 93435, 93442, 93443, 93444, 93445, 93448, 93449, 93452, 93453, 93454, 93475, 93483 93013, 93014, 93067, 93101, 93102, 93103, 93105, 93107, 93108, 93109, 93110, 93111, 93116, 93117, 93118, 93120, 93121, 93130, 93140, 93150, 93160, 93190, 93254, 93427, 93434, 93440, 93441, 93454, 93455, 93456, 93457, 93458, 93460, 93463, 93464 91361, 93001, 93002, 93003, 93004, 93005, 93006, 93007, 93010, 93011, 93012, 93015, 93016, 93022, 93023, 93024, 93030, 93031, 93032, 93033, 93034, 93035, 93036, 93040, 93041, 93044, 93060, 93061, 93066.

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

SECTION 3 What other materials will you get from us?

Section 3.1 Your Plan member ID card – Use it to get all covered care and prescription drugs
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While you are a member of our Plan, you must use your member ID card for our Plan whenever you get any services covered by this plan and for prescription drugs you get at network pharmacies.

Questions? Call our Customer Service Department listed in Chapter 2.

Here's a sample member ID card to show you what yours will look like:

UnitedHealthcare® UNITEDHEALTHCARE PASSPORT

Health Plan (80840) 911-87726-04

Member ID: 9999999-99 Group Number 060347

Member: JOHN Q PUBLIC PLAN CODE: AAA
GROUP NAME
Payer ID 87726

PCP Name: DOE, M.D., JANE
PCP Phone: (999) 999-9999
MEDICAL GROUP NAME
Copay: Office/ Spec/ ER
\$15/ \$30/ \$50

UnitedHealthcare Group Medicare Advantage (HMO)

H0303 PBP# 804

In an emergency go to the nearest emergency room or call 911. Printed 08/08/11

This card does not guarantee coverage. To verify benefits, view claims, or find a physician, visit www.uhcretiree.com or call member services Monday - Sunday 8:00 am to 8:00 pm local time.

Customer Service: 866-208-3248 TDD 711
myNurseLine: 877-365-7949 TDD 711
Mental Health: 800-579-5222 TDD 711

Providers: www.uhcwest.com 1-888-866-8297
Medical Claim Address: P.O. Box 52078 Phoenix, AZ 85072-2078

Medicare Solutions WEST

Pharmacy Claims: RX Solutions PO Box 6082 Cypress, CA 90630-0082
For Pharmacists: 1-877-889-6510

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

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

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

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

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

What are "network providers"?

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

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

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

If you don't have your copy of the **Provider Directory**, you can request a copy from Customer Service.

Questions? Call our Customer Service Department listed in Chapter 2.

You may ask Customer Service for more information about our network providers, including their qualifications. You can also search for provider information on our website. Both Customer Service and the website can give you the most up-to-date information about changes in our network providers. (You can find our website and phone information in Chapter 2 of this booklet.)

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

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

What are “network pharmacies”?

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

Why do you need to know about network pharmacies?

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

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

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

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

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

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

Questions? Call our Customer Service Department listed in Chapter 2.

Section 3.5	The Explanation of Benefits (the “EOB”): Reports with a summary of payments made for your Part D prescription drugs
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When you use your Part D prescription drug benefits, we will send you a summary report to help you understand and keep track of payments for your Part D prescription drugs. This summary report is called the **Explanation of Benefits** (or the “EOB”).

The **Explanation of Benefits** tells you the total amount you have spent on your Part D prescription drugs and the total amount we have paid for each of your Part D prescription drugs during the month. **Chapter 6 (What you pay for your Part D prescription drugs)** gives more information about the **Explanation of Benefits** and how it can help you keep track of your drug coverage.

An **Explanation of Benefits** summary is also available upon request. To get a copy, please contact Customer Service.

SECTION 4	Your monthly plan premium for the plan
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Section 4.1	How much is your Plan premium?
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Your former employer, union group or trust administrator (Plan Sponsor) is responsible for paying your monthly Plan premium to UnitedHealthcare on your behalf. Your Plan Sponsor determines the amount of any retiree contribution toward the monthly premium for our Plan. Your Plan Sponsor will notify you under separate cover if you must pay any portion of your monthly premium for our Plan. In addition, you must continue to pay your Medicare Part B premium (unless your Part B premium is paid for you by Medicaid or another third party).

In some situations, your Plan premium could be less.

The “Extra Help” program helps people with limited resources pay for their drugs. Chapter 2, Section 7 tells more about this program. If you qualify, enrolling in the program might help to lower the monthly plan premium your Plan Sponsor pays on your behalf.

If you are **already enrolled** and getting help from this program, **the information about premiums in this Evidence of Coverage may not apply to you**. We send you a separate insert, called the “Evidence of Coverage Rider for People Who Get Extra Help Paying for Prescription Drugs” (LIS Rider), which tells you about your drug coverage. If you don’t have this insert, please call Customer Service and ask for the “Evidence of Coverage Rider for People Who Get Extra Help Paying for Prescription Drugs” (LIS Rider). Phone numbers for Customer Service are on the back cover of this booklet.

In some situations, your Plan premium could be more.

In some situations, your Plan premium could be more than the amount listed above in Section 4.1. These situations are described below.

- 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

Questions? Call our Customer Service Department listed in Chapter 2.

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. For more information about Part D premiums based on income, go to Chapter 6, Section 11 of this booklet. You can visit <http://www.medicare.gov> on the web or call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048. You may also call the Social Security Administration at 1-800-772-1213. TTY users should call 1-800-325-0778.

- Some members are required to pay a **late enrollment penalty** because they did not join a Medicare drug plan when they first became eligible or because they had a continuous period of 63 days or more when they didn't have "creditable" prescription drug coverage. ("Creditable" means the drug coverage is at least as good as Medicare's standard drug coverage.) For these members, the late enrollment penalty is added to the plan's monthly premium. Their premium amount will be the monthly plan premium the Plan Sponsor pays each month plus the amount of their late enrollment penalty.
 - If you are required to pay the late enrollment penalty, the amount of your penalty depends on how long you waited before you enrolled in drug coverage or how many months you were without drug coverage after you became eligible. Chapter 6, Section 10 explains the late enrollment penalty.

Many members are required to pay Medicare premiums

As explained in Section 2 above, 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 will be paying a premium for Medicare Part A and most plan members will be paying a premium for Medicare Part B. You must continue paying your Medicare Part B premium to remain a member of the plan.

- Your copy of **Medicare & You 2012** gives information about these premiums in the section called "2012 Medicare Costs." This explains how the Part B premium differs for people with different incomes.
- Everyone with Medicare receives a copy of **Medicare & You** each year in the fall. Those new to Medicare receive it within a month after first signing up. You can also download a copy of **Medicare & You 2012** from the Medicare website (<http://www.medicare.gov>). Or, you can order a printed copy by phone at 1-800-MEDICARE (1-800-633-4227) 24 hours a day, 7 days a week. TTY users call 1-877-486-2048.

Section 4.2	Can we change your monthly plan premium during the year?
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Monthly plan premium changes and employer-sponsored benefit changes are subject to contractual arrangements between your Plan Sponsor and us, and as a result, monthly plan premiums generally do not change during the Plan Sponsor's plan year. Your Plan Sponsor is responsible for notifying you of any monthly plan premium changes or retiree contribution changes (the portion of your monthly plan premium your Plan Sponsor requires you to pay) sixty (60) days prior to the date when the change becomes effective.

However, in some cases, your Plan Sponsor may need to start paying or may be able to stop paying a Late Enrollment Penalty. (The Late Enrollment Penalty may apply if you had a continuous period of

Questions? Call our Customer Service Department listed in Chapter 2.

63 days or more when you didn't have "creditable" prescription drug coverage.) This could happen if you become eligible for the Extra Help program or if you lose your eligibility for the Extra Help program during the year:

- If your Plan Sponsor currently pays the penalty and become eligible for Extra Help during the year, your Plan Sponsor would no longer pay your penalty.
- If the Extra Help program is currently paying your Late Enrollment Penalty and you lose your eligibility during the year, your Plan Sponsor would need to start paying your penalty.

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

SECTION 5 Please keep your Plan membership record up to date

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

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

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

Let us know about these changes:

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

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

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

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

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

Questions? Call our Customer Service Department listed in Chapter 2.

SECTION 6 We protect the privacy of your personal health information

Section 6.1 We make sure that your health information is protected

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

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

SECTION 7 How other insurance works with our Plan

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

When you have other insurance (like employer group health coverage), there are rules set by Medicare that decide whether our Plan or your other insurance pays first. The insurance that pays first is called the “primary payer” and pays up to the limits of its coverage. The one that pays second, called the “secondary payer,” only pays if there are costs left uncovered by the primary coverage. The secondary payer may not pay all of the uncovered costs.

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

- If you have retiree coverage, Medicare pays first.
- If your group health plan coverage is based on your or a family member’s current employment, who pays first depends on your age, the size of the employer, and whether you have Medicare based on age, disability, or End-stage Renal Disease (ESRD):
 - If you’re under 65 and disabled and you or your family member is still working, your Plan pays first if the employer has 100 or more employees or at least one employer in a multiple employer plan has more than 100 employees.
 - If you’re over 65 and you or your spouse is still working, the plan pays first if the employer has 20 or more employees or at least one employer in a multiple employer plan has more than 20 employees.
- If you have Medicare because of ESRD, your group health plan will pay first for the first 30 months after you become eligible for Medicare.

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

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

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

If you have other insurance, tell your doctor, hospital, and pharmacy. If you have questions about who

Questions? Call our Customer Service Department listed in Chapter 2.

pays first, or you need to update your other insurance information, call Customer Service (phone numbers are on the back cover of this booklet.) You may need to give your Plan member ID number to your other insurers (once you have confirmed their identity) so your bills are paid correctly and on time.

Questions? Call our Customer Service Department listed in Chapter 2.

CHAPTER 2: Important phone numbers and resources

SECTION 1 SecureHorizons MedicareComplete Retiree Plan (HMO) Contacts (how to contact us, including how to reach Customer Service at the plan)..... 2

SECTION 2 Medicare (how to get help and information directly from the Federal Medicare program)..... 7

SECTION 3 State Health Insurance Assistance Program (free help, information, and answers to your questions about Medicare)..... 9

SECTION 4 Quality Improvement Organization (paid by Medicare to check on the quality of care for people with Medicare)..... 10

SECTION 5 Social Security..... 10

SECTION 6 Medicaid (a joint Federal and state program that helps with medical costs for some people with limited income and resources)..... 11

SECTION 7 Information about programs to help people pay for their prescription drugs..... 12

SECTION 8 How to contact the Railroad Retirement Board..... 13

SECTION 9 Do you have “group insurance” or other health insurance from an employer?..... 14

Questions? Call our Customer Service Department listed in Chapter 2.

SECTION 1 SecureHorizons® MedicareComplete® Retiree Plan (HMO) Contacts
(how to contact us, including how to reach Customer Service at the plan)

How to contact our Plan's Customer Service

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

Customer Service	
CALL	1-888-867-5548 Calls to this number are free. Hours of Operation: 8 a.m. - 8 p.m. local time, 7 days a week Customer Service also has free language interpreter services available for non-English speakers.
TTY/TDD	711 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free. Hours of Operation: 8 a.m. - 8 p.m. local time, 7 days a week
WRITE	UNITEDHEALTHCARE OF CALIFORNIA UnitedHealthcare Customer Service Department P.O. Box 29675 Hot Springs, AR 71903-9675
WEBSITE	www.UHCRetiree.com

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

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

You may call us if you have questions about our coverage decision process.

Questions? Call our Customer Service Department listed in Chapter 2.

Coverage Decisions for Medical Care	
CALL	1-888-867-5548 Calls to this number are free. Hours of Operation: 8 a.m. - 8 p.m. local time, 7 days a week
TTY/TDD	711 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free. Hours of Operation: 8 a.m. - 8 p.m. local time, 7 days a week
WRITE	UnitedHealthcare P.O. Box 29675 Hot Springs, AR 71903-9675
WEBSITE	www.UHCRetiree.com

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

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

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

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

Appeals and Complaints for Medical Care	
CALL	1-888-867-5548 Calls to this number are free.

Questions? Call our Customer Service Department listed in Chapter 2.

Appeals and Complaints for Medical Care	
	<p>Hours of Operation: 8 a.m. - 8 p.m. local time, 7 days a week</p> <p>For fast/expedited appeals and complaints for medical care: 1-877-262-9203</p> <p>Hours of Operation: 8 a.m. - 8 p.m. local time, 7 days a week</p>
TTY/TDD	<p>711</p> <p>This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.</p> <p>Calls to this number are free.</p> <p>Hours of Operation: 8 a.m. - 8 p.m. local time, 7 days a week</p>
FAX	<p>1-888-517-7113</p> <p>For fast/expedited appeals and complaints for medical care only: 1-866-373-1081</p>
WRITE	<p>Appeals and Grievance Department PO Box 6106, MS CA124-0157 Cypress, CA 90630</p>
WEBSITE	<p>www.UHCRetiree.com</p>

How to contact us when you are asking for a coverage decision about your Part D prescription drugs

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

Questions? Call our Customer Service Department listed in Chapter 2.

Coverage Decisions for Part D Prescription Drugs	
CALL	1-888-867-5548 Calls to this number are free. Hours of Operation: 8 a.m. - 8 p.m. local time, 7 days a week
TTY/TDD	711 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free. Hours of Operation: 8 a.m. - 8 p.m. local time, 7 days a week
WRITE	UnitedHealthcare P.O. Box 29675 Hot Springs, AR 71903-9675
WEBSITE	www.UHCRetiree.com

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

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

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

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

Appeals and Complaints for Part D Prescription Drugs	
CALL	1-888-867-5548 Calls to this number are free.

Questions? Call our Customer Service Department listed in Chapter 2.

Appeals and Complaints for Part D Prescription Drugs	
	<p>Hours of Operation: 8 a.m. - 8 p.m. local time, 7 days a week</p> <p>For fast/expedited appeals and complaints for Part D prescription drugs: 1-800-595-9532</p> <p>Hours of Operation: 8 a.m. - 8 p.m. local time, 7 days a week</p>
TTY/TDD	<p>711</p> <p>This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.</p> <p>Calls to this number are free.</p> <p>Hours of Operation: 8 a.m. - 8 p.m. local time, 7 days a week</p>
FAX	<p>For standard Part D prescription drug appeals and complaints: 1-866-308-6294</p> <p>For fast/expedited Part D prescription drug appeals and complaints: 1-866-308-6296</p>
WRITE	<p>Part D Appeal and Grievance Department PO Box 6106, MS CA124-0197 Cypress, CA 90630-9948</p>
WEBSITE	<p>www.UHCRetiree.com</p>

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

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

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

Questions? Call our Customer Service Department listed in Chapter 2.

Payment Requests	
CALL	<p>Part D prescription drug payment requests: 1-888-867-5548</p> <p>Calls to this number are free.</p> <p>Hours of Operation: 8 a.m. - 8 p.m. local time, 7 days a week</p> <p>Medical claims requests: 1-888-867-5548</p> <p>Calls to this number are free.</p> <p>Hours of Operation: 8 a.m. - 8 p.m. local time, 7 days a week</p>
TTY/TDD	<p>711</p> <p>This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.</p> <p>Calls to this number are free.</p> <p>Hours of Operation: 8 a.m. - 8 p.m. local time, 7 days a week</p>
WRITE	<p>Part D Prescription drug payment requests: Prescription Solutions by OptumRx PO Box 29045 Hot Springs, AR 71903</p> <p>Medical claims payment requests: Pacificare of California P.O. Box 30968 Salt Lake City, UT 84130-0968</p>
WEBSITE	<p>www.UHCRetiree.com</p>

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

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

Questions? Call our Customer Service Department listed in Chapter 2.

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

Medicare	
CALL	<p>1-800-MEDICARE, or 1-800-633-4227</p> <p>Calls to this number are free.</p> <p>24 hours a day, 7 days a week.</p>
TTY/TDD	<p>1-877-486-2048</p> <p>This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.</p> <p>Calls to this number are free.</p>
WEBSITE	<p>http://www.medicare.gov</p> <p>This is the official government website for Medicare. It gives you up-to-date information about Medicare and current Medicare issues. It also has information about hospitals, nursing homes, physicians, home health agencies, and dialysis facilities. It includes booklets you can print directly from your computer. You can also find Medicare contacts in your state by selecting “Help and Support” and then clicking on “Useful Phone Numbers and Websites.”</p> <p>The Medicare website also has detailed information about your Medicare eligibility and enrollment options with the following tools:</p> <ul style="list-style-type: none">● Medicare Eligibility Tool: Provides Medicare eligibility status information. Select “Find Out if You’re Eligible.”● Medicare Plan Finder: Provides personalized information about available Medicare prescription drug plans, Medicare health plans, and Medigap (Medicare Supplement Insurance) policies in your area. Select “Health & Drug Plans” and then “Compare Drug and Health Plans” or “Compare Medigap Policies.” Because you are covered by an Employer Sponsored plan, you will not find UnitedHealthcare Group Medicare Advantage plans listed on http://www.medicare.gov. These tools provide an estimate of what your out-of-pocket costs might be in different Medicare plans.

Questions? Call our Customer Service Department listed in Chapter 2.

Medicare

If you don't have a computer, your local library or senior center may be able to help you visit this website using its computer. Or, you can call Medicare at the number above and tell them what information you are looking for. They will find the information on the website, print it out, and send it to you.

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

The State Health Insurance Assistance Program (SHIP) is a government program with trained counselors in every state. In your state, the SHIP is called CALIFORNIA HEALTH INSURANCE COUNSELING AND ADVOCACY PROGRAM.

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

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

State Health Insurance Assistance Program (SHIP)

CA

CALIFORNIA HEALTH INSURANCE COUNSELING AND ADVOCACY PROGRAM

CALL 1-916-419-7500

TTY/TDD 1-800-732-2929

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

WRITE 1300 National Drive, Suite 200
Sacramento, CA 95834-1992

Questions? Call our Customer Service Department listed in Chapter 2.

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

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

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

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

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

Quality Improvement Organization (QIO)	
CA California Office (Subsidiary of Health Services Holdings (HSH)):	
CALL	1-818-409-9229
TTY/TDD	1-877-486-2048 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.
WRITE	700 N. Brand Blvd., Suite 370 Glendale, CA 91203
WEBSITE	www.hsag.com

SECTION 5 Social Security

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

Questions? Call our Customer Service Department listed in Chapter 2.

can call Social Security or visit your local Social Security office.

Social Security Administration	
CALL	1-800-772-1213 Calls to this number are free. Available 7:00 am to 7:00 pm, Monday through Friday. You can use Social Security's automated telephone services to get recorded information and conduct some business 24 hours a day.
TTY/TDD	1-800-325-0778 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free. Available 7:00 am to 7:00 pm, Monday through Friday.
WEBSITE	http://www.ssa.gov

SECTION 6

Medicaid

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

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

In addition, there are programs offered through Medicaid that help people with Medicare pay their Medicare costs, such as their Medicare premiums and other costs (for example, your Part A deductible and Part A and Part B coinsurance), if you qualify. These programs help people with limited income and resources save money each year:

- **Qualified Medicare Beneficiary (QMB):** Helps pay Medicare Part A and Part B premiums, and other cost sharing (like deductibles, coinsurance, and copayments).
- **Specified Low-Income Medicare Beneficiary (SLMB) and Qualifying Individual (QI):** Helps pay Part B premiums.
- **Qualified Disabled & Working Individuals (QDWI):** Helps pay Part A premiums.

To find out more about Medicaid and its programs, contact your state Medicaid agency.

Questions? Call our Customer Service Department listed in Chapter 2.

CA Medi-Cal	
CALL	1-916-445-4171
TTY/TDD	711 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.
WRITE	1501 Capitol Avenue Suite 71-4063 MS4607 Sacramento, CA 95899
WEBSITE	www.medi-cal.ca.gov/

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

Medicare’s “Extra Help” Program

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

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

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

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

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

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

Questions? Call our Customer Service Department listed in Chapter 2.

- When we receive the evidence showing your copayment level, we will update our system so that you can pay the correct copayment when you get your next prescription at the pharmacy. If you overpay your copayment, we will reimburse you. Either we will forward a check to you in the amount of your overpayment or we will offset future copayments. If the pharmacy hasn't collected a copayment from you and is carrying your copayment as a debt owed by you, we may make the payment directly to the pharmacy. If a state paid on your behalf, we may make payment directly to the state. Please contact Customer Service if you have questions.

Medicare Coverage Gap Discount Program

The Medicare Coverage Gap Discount Program is available nationwide. Because your Plan does not have a coverage gap, the discounts described here do not apply to you. Instead, the plan continues to cover your drugs at your regular cost-sharing amount until you qualify for the Catastrophic Coverage Stage. Please go to Chapter 6, Section 5 for more information about your coverage during the initial Coverage Stage.

The Medicare Coverage Gap Discount Program provides manufacturer discounts on brand name drugs to Part D enrollees who have reached the coverage gap and are not already receiving "Extra Help." A 50% discount on the negotiated price (excluding the dispensing fee and vaccine administration fee, if any) is available for those brand name drugs from manufacturers that have agreed to pay the discount.

We will automatically apply the discount when your pharmacy bills you for your prescription and your **Explanation of Benefits (EOB)** will show any discount provided. 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. If you reach the coverage gap, the plan pays 7% of the price for generic drugs and you pay the remaining 93% of the price. The coverage for generic drugs works differently than the 50% discount for brand name drugs. For generic drugs, the amount paid by the plan (7%) does not count toward your out-of-pocket costs. Only the amount you pay counts and moves you through the coverage gap. Also, the dispensing fee is included as part of the cost of the drug.

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

SECTION 8 How to contact the Railroad Retirement Board

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

Questions? Call our Customer Service Department listed in Chapter 2.

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

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

If you (or your spouse) have medical or prescription drug coverage through another employer or retiree group, please contact **that group’s benefits administrator**. The benefits administrator can help you determine how your current coverage will work with our Plan. You can also call Customer Service if you have any questions. You can ask about your (or your spouse’s) employer or retiree health benefits, premiums, or the enrollment period.

Questions? Call our Customer Service Department listed in Chapter 2.

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

SECTION 1 Things to know about getting your medical care covered as a member of our Plan.....2
Section 1.1 What are “network providers” and “covered services”?.....2
Section 1.2 Basic rules for getting your medical care covered by the plan.....2

SECTION 2 Use providers in the plan's network to get your medical care..... 3
Section 2.1 You must choose a Primary Care Physician (PCP) to provide and oversee your medical care..... 3
Section 2.2 What kinds of medical care can you get without getting approval in advance from your PCP?..... 4
Section 2.3 How to get care from specialists and other network providers.....4
Section 2.4 How to get care from out-of-network providers..... 6

SECTION 3 How to get covered services when you have an emergency or urgent need for care.... 6
Section 3.1 Getting care if you have a medical emergency.....6
Section 3.2 Getting care when you have an urgent need for care.....7

SECTION 4 What if you are billed directly for the full cost of your covered services?.....7
Section 4.1 You can ask the plan to pay our share of the cost of your covered services.....8
Section 4.2 If services are not covered by our Plan, you must pay the full cost..... 8

SECTION 5 How are your medical services covered when you are in a “clinical research study”?... 8
Section 5.1 What is a “clinical research study”?..... 8
Section 5.2 When you participate in a clinical research study, who pays for what?..... 9

SECTION 6 Rules for getting care covered in a “religious non-medical health care institution”..10
Section 6.1 What is a religious non-medical health care institution?..... 10
Section 6.2 What care from a religious non-medical health care institution is covered by our Plan?.....10

SECTION 7 Rules for ownership of durable medical equipment..... 11
Section 7.1 Will you own your durable medical equipment after making a certain number of payments under our Plan? 11

Questions? Call our Customer Service Department listed in Chapter 2.

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

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

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

Section 1.1 What are “network providers” and “covered services”?
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Here are some definitions that can help you understand how you get the care and services that are covered for you as a member of our Plan:

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

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

As a Medicare health plan, SecureHorizons® MedicareComplete® Retiree Plan (HMO) must cover all services covered by Original Medicare and must follow Original Medicare's coverage rules.

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

- **The care you receive is included in the plan's Medical Benefits Chart** (this chart is in Chapter 4 of this booklet).
- **The care you receive is considered medically necessary.** “Medically necessary” means that the services, supplies, or drugs are needed for the prevention, diagnosis, or treatment of your medical condition and meet accepted standards of medical practice.
- **You have a network primary care physician (a PCP) who is providing and overseeing your care.** As a member of our Plan, you must choose a PCP (for more information about this, see Section 2.1 in this chapter).
 - In most situations, your network PCP must give you approval in advance before you can use

Questions? Call our Customer Service Department listed in Chapter 2.

other providers in the plan's network, such as specialists, hospitals, skilled nursing facilities, or home health care agencies. This is called giving you a "referral." For more information about this, see Section 2.3 of this chapter.

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

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

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

What is a PCP?

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

What types of providers may act as a PCP?

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

What is the role of my PCP?

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

How do you choose your PCP?

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

Because your access to network specialists and hospitals is based upon your PCP selection, if there are

Questions? Call our Customer Service Department listed in Chapter 2.

specific hospitals or physicians or other providers that you want to use, be sure to find out if a PCP refers to those providers, as part of your selection process.

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

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

Changing your PCP

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

If you want to change your PCP within your contracted medical group/IPA, call Customer Service. If the PCP is accepting additional plan members, the change will become effective on the first day of the following month. You will receive a new member ID card that shows this change.

If you want to change to a PCP who is with a different contracted medical group/IPA, call Customer Service. If the new PCP is accepting additional plan members, and your request is received on or before the 15th of the month, the transfer will become effective on the first day of the following month. If your request is received after the 15th of the month, the transfer will become effective the first day of the second month following your request. For example, if we receive your change request on July 15, your change is effective on August 1. If we receive your change request on July 16, your change is effective on September 1. You will receive a new member ID card that shows this change.

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

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

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

Questions? Call our Customer Service Department listed in Chapter 2.

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

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

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

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

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

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

How to access your behavioral health benefit

If you would like to receive a referral for behavioral health services, please contact customer service at the number listed on the back of your member ID card. Depending on your provider, you will be referred back to your PCP or to United Behavioral Health to access these benefits.

If you change your PCP to one who is in a different medical group/IPA, any referrals for behavioral health services you previously received may no longer be valid. In this situation, you will need to ask your new PCP for a new referral, which may require further evaluation. In some cases, the request for a new referral will need to have prior authorization from your medical group/IPA or us.

Since your PCP is responsible for the coordination of all of your health care needs, it is important that you notify him or her if you wish to continue to receive behavioral health services from a provider who was affiliated with your previous PCP or medical group/IPA.

If you continue to receive behavioral health services without a new referral from your new PCP, you may be financially responsible for the cost of those services. In certain circumstances, we may authorize continued care.

Your medical group/IPA may also choose to have you access your behavioral health benefit directly through United Behavioral Health. When you call United Behavioral Health, you will speak with a representative who will check your eligibility and gather basic information about you and your situation. Depending on the help you need, a clinician may then talk with you about the problem you are experiencing and assess which provider and treatment would be appropriate for your situation. If you are referred to a behavioral health provider, you will be authorized for a specific number of visits

Questions? Call our Customer Service Department listed in Chapter 2.

for a specified period of time. You may also call to receive information about **in-network practitioners**, subspecialty care and obtaining care after normal office hours.

Confidentiality is maintained, so please be assured that personal information you discuss with their staff will be kept strictly confidential.

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

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

Section 2.4	How to get care from out-of-network providers
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Care that you receive from out-of-network providers will not be covered unless the care meets one of the three exceptions described in Section 1.2 of this chapter. For information about getting out-of-network care when you have a medical emergency or urgent need for care, please see Section 3 in this chapter.

SECTION 3	How to get covered services when you have an emergency or urgent need for care
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Section 3.1	Getting care if you have a medical emergency
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What is a “medical emergency” and what should you do if you have one?

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

If you have a medical emergency:

- **Get help as quickly as possible.** Call 911 for help or go to the nearest emergency room, hospital, or urgent care center. Call for an ambulance if you need it. You do **not** need to get approval or a referral first from your PCP.
- **As soon as possible, make sure that our Plan has been told about your emergency.** We need to follow up on your emergency care. You or someone else should call to tell us about your emergency care, usually within 48 hours by calling the Customer Service number located in Chapter 2 of this booklet.

What is covered if you have a medical emergency?

You may get covered emergency medical care whenever you need it, anywhere in the world. Our Plan covers ambulance services in situations where getting to the emergency room in any other way could endanger your health. For more information, see the Medical Benefits Chart in Chapter 4 of this

Questions? Call our Customer Service Department listed in Chapter 2.

booklet.

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

After the emergency is over you are entitled to follow-up care to be sure your condition continues to be stable. Your follow-up care will be covered by our Plan. If your emergency care is provided by out-of-network providers, we will try to arrange for network providers to take over your care as soon as your medical condition and the circumstances allow.

What if it wasn't a medical emergency?

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

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

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

Section 3.2	Getting care when you have an urgent need for care
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What is “urgently needed care”?

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

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

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

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

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

SECTION 4	What if you are billed directly for the full cost of your covered services?
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Questions? Call our Customer Service Department listed in Chapter 2.

Section 4.1	You can ask the plan to pay our share of the cost of your covered services
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If you have paid more than your share for covered services, or if you have received a bill for the full cost of covered medical services, go to Chapter 7 (**Asking us to pay our share of a bill you have received for covered medical services or drugs**) for information about what to do.

Section 4.2	If services are not covered by our Plan, you must pay the full cost
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Our Plan covers all medical services that are medically necessary, are listed in the plan's Medical Benefits Chart (this chart is in Chapter 4 of this booklet), and are obtained consistent with plan rules. You are responsible for paying the full cost of services that aren't covered by our Plan, either because they are not plan covered services, or they were obtained out-of-network where not authorized.

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

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

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

SECTION 5	How are your medical services covered when you are in a "clinical research study"?
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Section 5.1	What is a "clinical research study"?
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A clinical research study is a way that doctors and scientists test new types of medical care, like how well a new cancer drug works. They test new medical care procedures or drugs by asking for volunteers to help with the study. This kind of study is one of the final stages of a research process that helps doctors and scientists see if a new approach works and if it is safe.

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

Questions? Call our Customer Service Department listed in Chapter 2.

approve the research study. If you participate in a study that Medicare has **not** approved, **you will be responsible for paying all costs for your participation in the study.**

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

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

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

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

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

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

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

Once you join a Medicare-approved clinical research study, you are covered for routine items and services you receive as part of the study, including:

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

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

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

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

Questions? Call our Customer Service Department listed in Chapter 2.

amount you would pay under our Plan's benefits.

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

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

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

Do you want to know more?

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

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

Section 6.1	What is a religious non-medical health care institution?
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A religious non-medical health care institution is a facility that provides care for a condition that would ordinarily be treated in a hospital or skilled nursing facility care. If getting care in a hospital or a skilled nursing facility is against a member's religious beliefs, we will instead provide coverage for care in a religious non-medical health care institution. You may choose to pursue medical care at any time for any reason. This benefit is provided only for Part A inpatient services (non-medical health care services). Medicare will only pay for non-medical health care services provided by religious non-medical health care institutions.

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

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

Questions? Call our Customer Service Department listed in Chapter 2.

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

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

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

SECTION 7 Rules for ownership of durable medical equipment

Section 7.1	Will you own your durable medical equipment after making a certain number of payments under our Plan?
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Durable medical equipment includes items such as oxygen equipment and supplies, wheelchairs, walkers, and hospital beds ordered by a provider for use in the home. Certain items, such as prosthetics, are always owned by the member. In this section, we discuss other types of durable medical equipment that must be rented.

In Original Medicare, people who rent certain types of durable medical equipment own the equipment after paying copayments for the item for 13 months. As a member of our Plan, however, you usually will not acquire ownership of rented durable medical equipment items no matter how many copayments you make for the item while a member of our Plan. Under certain limited circumstances we will transfer ownership of the durable medical equipment item. Call Customer Service (phone numbers are on the back cover of this booklet) to find out about the requirements you must meet and the documentation you need to provide.

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

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

If you made payments for the durable medical equipment item under Original Medicare **before** you

Questions? Call our Customer Service Department listed in Chapter 2.

joined our Plan, these previous Original Medicare payments also do not count toward the new 13 consecutive payments. You will have to make 13 new consecutive payments for the item under Original Medicare in order to acquire ownership. There are no exceptions to this case when you return to Original Medicare.

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

SECTION 1 Understanding your out-of-pocket costs for covered services..... 2

 Section 1.1 Types of out-of-pocket costs you may pay for your covered services.....2

 Section 1.2 What is the most you will pay for Medicare Part A and Part B covered medical services?.....2

 Section 1.3 Our Plan does not allow providers to “balance bill” you.....3

SECTION 2 Use the Medical Benefits Chart to find out what is covered for you and how much you will pay..... 3

 Section 2.1 Your medical benefits and costs as a member of the plan..... 3

SECTION 3 What Medical benefits are not covered by the plan?..... 34

 Section 3.1 Medical benefits we do not cover (exclusions)..... 34

SECTION 4 Other additional benefits (not covered under Original Medicare)..... 37

 Preventive Dental Services.....38

 Hearing Services..... 55

 Vision Care56

 Routine Chiropractic Services.....58

Questions? Call our Customer Service Department listed in Chapter 2.

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

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

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

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

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

Section 1.2 What is the most you will pay for Medicare Part A and Part B covered medical services?
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Because you are enrolled in a Medicare Advantage Plan, there is a limit to how much you have to pay out-of-pocket each year for in-network medical services that are covered under Part A and Part B (see the Medical Benefits Chart in Section 2, below). This limit is called the maximum out-of-pocket amount for medical services.

As a member of SecureHorizons® MedicareComplete® Retiree Plan (HMO), the most you will have to pay out-of-pocket for in-network covered Part A and Part B services in the 2011 plan year is \$6,700. The amounts you pay for your copayments, and coinsurance for in-network covered services count toward this out-of-pocket amount. In addition, amounts you pay for some services do not count toward your maximum out-of-pocket amount. These services are marked with an asterisk in the Medical Benefits Chart.) If you reach the maximum out-of-pocket amount of \$6,700, you will not have to pay any out-of-pocket costs for the rest of the plan year for in-network covered Part A and Part B services. However, you must continue to pay the Medicare Part B premium (unless your Part B premium is paid for you by Medicaid or another third party.)

Questions? Call our Customer Service Department listed in Chapter 2.

Section 1.3	Our Plan does not allow providers to “balance bill” you
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As a member of SecureHorizons[®] MedicareComplete[®] Retiree Plan (HMO), an important protection for you is that, after you meet any deductibles, you only have to pay the plan’s cost-sharing amount when you get services covered by our plan. We do not allow providers to add additional separate charges such as “balance billing.” This protection (that you never pay more than the plan cost-sharing amount) applies even if we pay the provider less than the provider charges for a service and even if there is a dispute and we don’t pay certain provider charges.

Here is how this protection works.

- If your cost sharing is a copayment (a set amount of dollars, for example, \$15.00), then you pay only that amount for any services from a network provider.
- If your cost sharing is a coinsurance (a percentage of the total charges), then you never pay more than that percentage. However, your cost depends on which type of provider you see:
 - If you obtain covered services from a network provider, you pay the coinsurance percentage multiplied by the plan’s reimbursement rate (as determined in the contract between the provider and the plan).
 - If you obtain covered services from an out-of-network provider who participates with Medicare, you pay the coinsurance percentage multiplied by the Medicare payment rate for participating providers. (Remember, the plan covers services from out-of-network providers only in certain situations, such as when you get a referral.)
 - If you obtain covered services from an out-of-network provider who does not participate with Medicare, then you pay the coinsurance percentage multiplied by the Medicare payment rate for non-participating providers. (Remember, the plan covers services from out-of-network providers only in certain situations, such as when you get a referral.)

SECTION 2	Use the Medical Benefits Chart to find out what is covered for you and how much you will pay
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Section 2.1	Your medical benefits and costs as a member of the plan
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The Medical Benefits Chart on the following pages lists the services SecureHorizons[®] MedicareComplete[®] Retiree Plan (HMO) covers and what you pay out-of-pocket for each service. The services listed in the Medical Benefits Chart are covered only when the following coverage requirements are met:

- Your Medicare covered services must be provided according to the coverage guidelines established by Medicare.
- Your services (including medical care, services, supplies, and equipment) **must** be medically necessary. “Medically necessary” means that the services, supplies, or drugs are needed for the prevention, diagnosis, or treatment of your medical condition and meet accepted standards of medical practice.
- You receive your care from a network provider. In most cases, care you receive from an out-of-

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network provider will not be covered. Chapter 3 provides more information about requirements for using network providers and the situations when we will cover services from an out-of-network provider.

- You have a primary care provider (a PCP) who is providing and overseeing your care. In most situations, your PCP must give you approval in advance before you can see other providers in the plan's network. This is called giving you a "referral." Chapter 3 provides more information about getting a referral and the situations when you do not need a referral.
- For all in-network preventive services that are covered at no cost under Original Medicare, we also cover the service at no cost to you. However, if you also are treated or monitored for an existing medical condition during the visit when you receive the preventive service, a copayment will apply for the care received for the existing medical condition.

Medical Benefits Chart

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

Questions? Call our Customer Service Department listed in Chapter 2.

Services that are covered for you	What you must pay when you get these services
<p>Note: To be an inpatient, your provider must write an order to admit you to the hospital. Even if you stay in the hospital overnight, you might still be considered an “outpatient.” If you are not sure if you are an inpatient, you should ask the hospital staff.</p> <p>You can also find more information in a Medicare fact sheet called “Are You a Hospital Inpatient or Outpatient? If You Have Medicare – Ask!” This fact sheet is available on the Web at http://www.medicare.gov/Publications/Pubs/pdf/11435.pdf or by calling 1-800-MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048. You can call these numbers for free, 24 hours a day, 7 days a week.</p>	
<p>Inpatient Mental Health Care</p> <p>Covered services include:</p> <ul style="list-style-type: none"> ● Mental health care services that require a hospital stay. There is a 190 day lifetime limit for inpatient services in a psychiatric hospital. The 190-day limit does not apply to Mental Health services provided in a psychiatric unit of a general hospital. ● Inpatient substance abuse and detoxification services 	<p>\$0 copayment for each Medicare-covered network hospital stay, up to 190 days.</p> <p>Medicare hospital benefit periods are used to determine the total number of days covered for inpatient mental health care. (See definition of benefit periods in the chapter titled Definitions of important words.) However, the cost sharing described above applies each time you are admitted to the hospital, even if you are admitted multiple times within a benefit period.</p>
<p>Skilled Nursing Facility (SNF) Care</p> <p>(For a definition of “skilled nursing facility care”, see Chapter 12</p>	<p>\$0 copayment each day for Medicare-covered SNF care, up to 100 days.</p>

Questions? Call our Customer Service Department listed in Chapter 2.

<p>Services that are covered for you</p>	<p>What you must pay when you get these services</p>
<p>of this booklet. Skilled nursing facilities are sometimes called “SNFs”.)</p> <p>Covered services include:</p> <ul style="list-style-type: none"> ● Semiprivate room (or a private room if medically necessary) ● Meals, including special diets ● Regular nursing services ● Physical therapy, occupational therapy, and speech therapy ● Drugs administered to you as part of your Plan of care (This includes substances that are naturally present in the body, such as blood clotting factors) ● Blood - including storage and administration. Coverage begins with the first pint of blood that you need. ● Medical and surgical supplies ordinarily provided by SNFs ● Laboratory tests ordinarily provided by SNFs ● X-rays and other radiology services ordinarily provided by SNFs ● Use of appliances such as wheelchairs ordinarily provided by SNFs ● Physician services <p>A 3-day prior hospital stay is not required.</p> <p>Generally, you will get your SNF care from plan facilities. However, under certain conditions listed below, you may be able to pay in-network cost-sharing for a facility that isn’t a plan provider, if the facility accepts our Plan’s amounts for payment.</p> <ul style="list-style-type: none"> ● A nursing home or continuing care retirement community where you were living right before you went to the hospital (as long as it provides skilled nursing facility care). ● A SNF where your spouse is living at the time you leave the hospital. 	<p>You are covered for up to 100 days each benefit period for inpatient services in a SNF, in accordance with Medicare guidelines.</p> <p>A benefit period begins on the first day you go to a Medicare-covered inpatient hospital or a skilled nursing facility. The benefit period ends when you haven’t been an inpatient at any hospital or SNF for 60 days in a row. If you go to the hospital (or SNF) after one benefit period has ended, a new benefit period begins. There is no limit to the number of benefit periods you can have.</p>

Services that are covered for you	What you must pay when you get these services
<p>Inpatient Services Covered During a Non-Covered Inpatient Stay</p> <p>If you have exhausted your inpatient benefits or if the inpatient stay is not reasonable and necessary, we will not cover your inpatient stay. However, in some cases, we will cover certain services you receive while you are in the hospital or the skilled nursing facility (SNF) stay. Covered services include, but are not limited to:</p> <ul style="list-style-type: none"> ● Physician services ● Diagnostic tests (like lab tests) ● X-ray, radium, and isotope therapy including technician materials and services ● Surgical dressings ● Splints, casts and other devices used to reduce fractures and dislocations ● Prosthetics and orthotics devices (other than dental) that replace all or part of an internal body organ (including contiguous tissue), or all or part of the function of a permanently inoperative or malfunctioning internal body organ, including replacement or repairs of such devices 	<p>When your stay is no longer covered, these services will be covered as described in the following sections:</p> <p>Please refer below to Physician services, Including Doctor’s Office Visits.</p> <p>Please refer below to Outpatient Diagnostic Tests and Therapeutic Services and Supplies.</p> <p>Please refer below to Outpatient Diagnostic Tests and Therapeutic Services and Supplies.</p> <p>Please refer below to Outpatient Diagnostic Tests and Therapeutic Services and Supplies.</p> <p>Please refer below to Prosthetic Devices and Related Supplies.</p>

Questions? Call our Customer Service Department listed in Chapter 2.

<p>Services that are covered for you</p>	<p>What you must pay when you get these services</p>
<ul style="list-style-type: none"> ● Leg, arm, back, and neck braces; trusses, and artificial legs, arms, and eyes including adjustments, repairs, and replacements required because of breakage, wear, loss, or a change in the patient’s physical condition ● Physical therapy, speech language therapy, and occupational therapy 	<p>Please refer below to Prosthetic Devices and Related Supplies.</p> <p>Please refer below to Outpatient Rehabilitation Services.</p>
<p>Home Health Agency Care</p> <p>Covered services include:</p> <ul style="list-style-type: none"> ● Part-time or intermittent skilled nursing and home health aide services (To be covered under the home health care benefit, your skilled nursing and home health aide services combined must total fewer than 8 hours per day and 35 hours per week) ● Physical therapy, occupational therapy, and speech therapy ● Medical and social services ● Medical equipment and supplies 	<p>\$0 copayment for all home health visits provided by a network home health agency when Medicare criteria are met.</p> <p>Other copayments or coinsurance may apply (Please see Durable Medical Equipment and Related Supplies for applicable copayments or coinsurance).</p>
<p>Hospice Care</p> <p>You may receive care from any Medicare-certified hospice program. Your hospice doctor can be a network provider or an out-of-network provider.</p> <p>Original Medicare (rather than our Plan) will pay for your hospice services and any Part A and Part B services related to your terminal condition. While you are in the hospice program, your hospice provider will bill Original Medicare for the services that Original Medicare pays for.</p>	<p>When you enroll in a Medicare-certified hospice program, your hospice services and your Part A and Part B services related to your terminal condition are paid for by Original Medicare, not SecureHorizons® MedicareComplete® Retiree Plan (HMO).</p> <p>Note: If you are not entitled to Medicare Part A coverage,</p>

Services that are covered for you	What you must pay when you get these services
<p>Covered services include:</p> <ul style="list-style-type: none"> ● Drugs for symptom control and pain relief ● Short-term respite care ● Home care <p>You are still a member of our Plan. If you need non-hospice care (care that is not related to your terminal condition), you have two options:</p> <ul style="list-style-type: none"> ● You can obtain your non-hospice care from plan providers. In this case, you only pay plan allowed cost sharing ● --or-- You can get your care covered by Original Medicare. In this case, you must pay the cost-sharing amounts under Original Medicare, except for emergency or urgently needed care. However, after payment, you can ask us to pay you back for the difference between the cost sharing in our plan and the cost sharing under Original Medicare. <p>Note: If you need non-hospice care (care that is not related to your terminal condition), you should contact us to arrange the services. Getting your non-hospice care through our network providers will lower your share of the costs for the services.</p> <p>Our Plan covers hospice consultation services (one time only) for a terminally ill person who hasn't elected the hospice benefit.</p>	<p>hospice services are not covered by the plan or by Medicare.</p>
Outpatient Services	
<p>Physician Services, Including Doctor Office Visits</p> <p>Covered services include:</p> <ul style="list-style-type: none"> ● Medically-necessary medical or surgical services furnished in a physician's office 	<p>\$5 copayment for services obtained from a primary care physician or under certain circumstances, treatment by a nurse practitioner or physician's assistant or other non-physician</p>

Services that are covered for you	What you must pay when you get these services
<ul style="list-style-type: none">• Medically-necessary medical or surgical services furnished in a certified ambulatory surgical center or hospital outpatient department • Other health care professionals• Consultation, diagnosis, and treatment by a specialist • Basic hearing and balance exams performed by your specialist, if your doctor orders it to see if you need medical treatment	<p>health care professionals in a primary care physician’s office (as permitted under Medicare rules).</p> <p>You pay these amounts until you reach the out-of-pocket maximum.</p> <p>See “Outpatient surgery” later in this chart for any applicable copayments or coinsurance amounts for ambulatory surgical center visits or in a hospital outpatient setting.</p> <p>\$5 copayment for services obtained from a specialist, or under certain circumstances, treatment by a nurse practitioner or physician’s assistant or other non-physician health care professionals in a specialist’s office (as permitted under Medicare rules).</p> <p>You pay these amounts until you reach the out-of-pocket maximum.</p> <p>\$5 copayment for each Medicare-covered exam.</p> <p>You pay these amounts until you</p>

Questions? Call our Customer Service Department listed in Chapter 2.

Services that are covered for you	What you must pay when you get these services
<ul style="list-style-type: none"> ● Telehealth office visits including consultation, diagnosis and treatment by a specialist ● Second opinion by another provider prior to surgery ● Non-routine dental care (covered services are limited to surgery of the jaw or related structures, setting fractures of the jaw or facial bones, extraction of teeth to prepare the jaw for radiation treatments of neoplastic cancer disease, or services that would be covered when provided by a physician) ● Monitoring services if you are taking anticoagulation medications, such as Coumadin, Heparin or Warfarin (these services may also be referred to as ‘Coumadin Clinic’ services) 	<p>reach the out-of-pocket maximum.</p> <p>\$5 copayment for each visit.</p> <p>You pay these amounts until you reach the out-of-pocket maximum.</p> <p>\$5 copayment for each Medicare-covered visit.</p> <p>You pay these amounts until you reach the out-of-pocket maximum.</p> <p>\$5 copayment for services obtained from a primary care physician.</p> <p>\$5 copayment for services obtained from a specialist.</p> <p>You pay these amounts until you reach the out-of-pocket maximum.</p>
<p>Outpatient Hospital Services</p> <p>We cover medically-necessary services you get in the outpatient department of a hospital for diagnosis or treatment of an illness or injury.</p> <p>Covered services include:</p>	

Questions? Call our Customer Service Department listed in Chapter 2.

Services that are covered for you	What you must pay when you get these services
<ul style="list-style-type: none"> ● Services in an emergency department or outpatient clinic, including same-day surgery ● Laboratory tests billed by the hospital ● Mental health care, including care in a partial-hospitalization program, if a doctor certifies that inpatient treatment would be required without it ● X-rays and other radiology services billed by the hospital ● Medical supplies such as splints and casts ● Certain screenings and preventive services ● Certain drugs and biologicals that you can't give yourself <p>Note: Unless the provider has written an order to admit you as an inpatient to the hospital, you are an outpatient and pay the cost-sharing amounts for outpatient hospital services. Even if</p>	<p>Please refer to Emergency Care or Outpatient Surgery, Including Services Provided at Hospital Outpatient Facilities and Ambulatory Surgical Centers</p> <p>Please refer to Outpatient Diagnostic Tests and Therapeutic Services and Supplies</p> <p>Please refer to Outpatient Mental Health Care</p> <p>Please refer to Outpatient Diagnostic Tests and Therapeutic Services and Supplies</p> <p>Please refer to Outpatient Diagnostic Tests and Therapeutic Services and Supplies</p> <p>Please refer to Preventive Services</p> <p>Please refer to Medicare Part B Prescription Drugs</p>

Questions? Call our Customer Service Department listed in Chapter 2.

Services that are covered for you	What you must pay when you get these services
<p>you stay in the hospital overnight, you might still be considered an “outpatient.” If you are not sure if you are an outpatient, you should ask the hospital staff.</p> <p>You can also find more information in a Medicare fact sheet called “Are You a Hospital Inpatient or Outpatient? If You Have Medicare – Ask!” This fact sheet is available on the Web at http://www.medicare.gov/Publications/Pubs/pdf/11435.pdf or by calling 1-800-MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048. You can call these numbers for free, 24 hours a day, 7 days a week.</p>	
<p>Chiropractic Services</p> <p>Covered services include:</p> <ul style="list-style-type: none"> • We cover only manual manipulation of the spine to correct subluxation 	<p>\$5 copayment for each Medicare-covered visit.</p> <p>You pay these amounts until you reach the out-of-pocket maximum.</p>
<p>Podiatry Services</p> <p>Covered services include:</p> <ul style="list-style-type: none"> • Treatment of injuries and diseases of the feet (such as hammer toe or heel spurs). • Routine foot care for members with certain medical conditions affecting the lower limbs. 	<p>\$5 copayment for each Medicare-covered visit.</p> <p>You pay these amounts until you reach the out-of-pocket maximum.</p>
<p>Outpatient Mental Health Care</p> <p>Covered services include:</p> <p>Mental health services provided by a doctor, clinical psychologist, clinical social worker, clinical nurse specialist, nurse practitioner, physician assistant, or other Medicare-qualified mental health care professional as allowed under</p>	<p>\$5 copayment for each Medicare-covered individual therapy session.</p> <p>\$5 copayment for each Medicare-covered group therapy session.</p>

Questions? Call our Customer Service Department listed in Chapter 2.

Services that are covered for you	What you must pay when you get these services
applicable state laws.	You pay these amounts until you reach the out-of-pocket maximum.
<p>Partial Hospitalization Services</p> <p>“Partial hospitalization” is a structured program of active psychiatric treatment provided in a hospital outpatient setting or by a community mental health center, that is more intense than the care received in your doctor’s or therapist’s office and is an alternative to inpatient hospitalization.</p>	\$0 copayment each day for Medicare-covered benefits.
<p>Outpatient Substance Abuse Services</p>	<p>\$5 copayment for each Medicare-covered individual therapy session.</p> <p>\$5 copayment for each Medicare-covered group therapy session.</p> <p>You pay these amounts until you reach the out-of-pocket maximum.</p>
<p>Outpatient Surgery, Including Services Provided at Hospital Outpatient Facilities and Ambulatory Surgical Centers</p> <p>Note: If you are having surgery in a hospital, you should check with your provider about whether you will be an inpatient or outpatient. Unless the provider writes an order to admit you as an inpatient to the hospital, you are an outpatient and pay the cost-sharing amounts for outpatient surgery. Even if you stay in the hospital overnight, you might still be considered an “outpatient.”</p>	<p>\$0 copayment for Medicare-covered services provided to you at an outpatient hospital, including but not limited to hospital or other facility charges, physician or surgical charges, and tests.</p> <p>\$0 copayment for Medicare-covered surgical, observation and medical services performed at an</p>

Questions? Call our Customer Service Department listed in Chapter 2.

Services that are covered for you	What you must pay when you get these services
	outpatient hospital based facility. \$0 copayment for Medicare-covered services provided to you at an ambulatory surgical center, including but not limited to hospital or other facility charges, physician or surgical charges, and tests.
<p>Ambulance Services</p> <ul style="list-style-type: none"> • Covered ambulance services include fixed wing, rotary wing, and ground ambulance services, to the nearest appropriate facility that can provide care only if they are furnished to a member whose medical condition is such that other means of transportation are contraindicated (could endanger the person’s health) or if authorized by the plan. The member’s condition must require both the ambulance transportation itself and the level of service provided in order for the billed service to be considered medically necessary. • Non-emergency transportation by ambulance is appropriate if it is documented that the member’s condition is such that other means of transportation are contraindicated (could endanger the person’s health) and that transportation by ambulance is medically required. 	\$0 copayment for each one-way Medicare-covered trip.
<p>Emergency Care</p> <p>Emergency care is care that is needed to evaluate or stabilize an emergency medical condition.</p> <p>A medical emergency is when you, or any other prudent</p>	\$20 copayment for each emergency room visit. You do not pay this amount if you are admitted to the hospital within 24 hours for the same

Questions? Call our Customer Service Department listed in Chapter 2.

Services that are covered for you	What you must pay when you get these services
<p>layperson with an average knowledge of health and medicine, believe that you have medical symptoms that require immediate medical attention to prevent loss of life, loss of a limb, or loss of function of a limb. The medical symptoms may be an illness, injury, severe pain, or a medical condition that is quickly getting worse.</p> <p>Worldwide coverage for emergency department services.</p>	<p>condition.</p> <p>If you receive emergency care at an out-of-network hospital and need inpatient care after your emergency condition is stabilized, you must return to a network hospital in order for your care to continue to be covered or you must have your inpatient care at the out-of-network hospital authorized by the plan and your cost is the cost sharing you would pay at a network hospital.</p> <p>You pay these amounts until you reach the out-of-pocket maximum.</p>
<p>Urgently Needed Care</p> <p>Urgently needed care is care provided to treat a non-emergency, unforeseen medical illness, injury, or condition, that requires immediate medical care, but the plan’s network of providers is temporarily unavailable or inaccessible.</p> <p>Urgently needed care is provided worldwide according to Medicare coverage guidelines.</p>	<p>\$15 copayment for each visit in a network Urgent Care Center.</p> <p>\$25 copayment for each visit in a non-network or an out-of-area facility.</p> <p>You do not pay this amount if you are admitted to the hospital within 24 hours for the same condition.</p> <p>You pay these amounts until you reach the out-of-pocket maximum.</p>

Questions? Call our Customer Service Department listed in Chapter 2.

Services that are covered for you	What you must pay when you get these services
<p>Outpatient Rehabilitation Services</p> <p>Covered services include: physical therapy, occupational therapy, and speech language therapy.</p> <p>Outpatient rehabilitation services are provided in various outpatient settings, such as hospital outpatient departments, independent therapist offices, and Comprehensive Outpatient Rehabilitation Facilities (CORFs).</p>	<p>\$0 copayment for each Medicare-covered physical therapy and speech-language therapy visit.</p> <p>\$0 copayment for each Medicare-covered occupational therapy visit.</p>
<p>Cardiac Rehabilitation Services</p> <p>Comprehensive programs that include exercise, education, and counseling are covered for members who meet certain conditions with a doctor’s referral. The plan also covers intensive cardiac rehabilitation programs that are typically more rigorous or more intense than cardiac rehabilitation programs.</p>	<p>\$0 copayment for each Medicare-covered cardiac rehabilitative visit.</p>
<p>Pulmonary Rehabilitation Services</p> <p>Comprehensive programs of pulmonary rehabilitation are covered for members who have moderate to very severe chronic obstructive pulmonary disease (COPD) and a referral for pulmonary rehabilitation from the doctor treating their chronic respiratory disease.</p>	<p>\$0 copayment for each Medicare-covered pulmonary rehabilitative visit.</p>
<p>Durable Medical Equipment and Related Supplies</p> <p>(For a definition of “durable medical equipment,” see Chapter 12 of this booklet.)</p> <p>Covered items include, but are not limited to: wheelchairs, crutches, hospital bed, IV infusion pump, oxygen equipment, nebulizer, and walker.</p>	<p>\$0 copayment for Medicare-covered benefits.</p>

Questions? Call our Customer Service Department listed in Chapter 2.

Services that are covered for you	What you must pay when you get these services
<p>Prosthetic Devices and Related Supplies</p> <p>Devices (other than dental) that replace a body part or function. These include, but are not limited to: colostomy bags and supplies directly related to colostomy care, pacemakers, braces, prosthetic shoes, artificial limbs, and breast prostheses (including a surgical brassiere after a mastectomy). Includes certain supplies related to prosthetic devices, and repair and/or replacement of prosthetic devices. Also includes some coverage following cataract removal or cataract surgery – see “Vision Care” later in this section for more detail.</p>	<p>\$0 copayment for each Medicare-covered prosthetic or orthotic device, including replacement or repairs of such devices.</p>
<p>Diabetes Self-Management Training, Diabetic Services and Supplies</p> <p>For all people who have diabetes (insulin and non-insulin users). Covered services include:</p> <ul style="list-style-type: none"> ● Blood glucose monitor, blood glucose test strips, lancet devices and lancets, and glucose-control solutions for checking the accuracy of test strips and monitors ● For people with diabetes who have severe diabetic foot disease: One pair per plan year of therapeutic custom-molded shoes (including inserts provided with such shoes) and two additional pairs of inserts, or one pair of depth shoes and three pairs of inserts (not including the non-customized removable inserts provided with such shoes). Coverage includes fitting. ● Diabetes self-management training is covered under 	<p>\$0 copayment for each Medicare-covered diabetes monitoring supply.</p> <p>For cost sharing applicable to insulin and syringes, see Chapter 6 - What you pay for your Part D prescription drugs.</p> <p>\$0 copayment for each pair of Medicare-covered therapeutic shoes.</p> <p>\$0 copayment for Medicare-</p>

Questions? Call our Customer Service Department listed in Chapter 2.

Services that are covered for you	What you must pay when you get these services
certain conditions	covered benefits.
<p>Outpatient Diagnostic Tests and Therapeutic Services and Supplies</p> <p>Covered Services Include:</p> <ul style="list-style-type: none"> ● X-rays ● Radiation (radium and isotope) therapy including technician materials and supplies ● Surgical supplies, such as dressings ● Splints, casts and other devices used to reduce fractures and dislocations ● Laboratory tests ● Blood - including storage and administration. Coverage begins with the first pint of blood that you need. ● Other outpatient diagnostic tests - Non-radiological diagnostic services 	<p>\$0 copayment for each Medicare-covered standard X-ray service.</p> <p>\$0 copayment for each Medicare-covered radiation therapy service.</p> <p>\$0 copayment for each Medicare-covered medical supply.</p> <p>\$0 copayment for Medicare-covered lab services.</p> <p>\$0 copayment for Medicare-covered blood services.</p> <p>\$0 copayment for Medicare-covered non-radiological diagnostic services.</p> <p>Examples include, but are not limited to EKG's, pulmonary function tests, sleep studies and treadmill stress tests.</p>

Questions? Call our Customer Service Department listed in Chapter 2.

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

Questions? Call our Customer Service Department listed in Chapter 2.

Services that are covered for you	What you must pay when you get these services
	facility.
<p>Vision Care</p> <p>Covered services include:</p> <ul style="list-style-type: none"> • Outpatient physician services for the diagnosis and treatment of diseases and conditions of the eye. Original Medicare doesn't cover routine eye exams (eye refractions) for eyeglasses/contacts. • For people who are at high risk of glaucoma, such as people with a family history of glaucoma, people with diabetes, and African-Americans who are age 50 and older: glaucoma screening once per year. • One pair of eyeglasses or contact lenses after each cataract surgery that includes insertion of an intraocular lens. (If you have two separate cataract operations, you cannot reserve the benefit after the first surgery and purchase two eyeglasses after the second surgery.) Corrective lenses/frames (and replacements) needed after a cataract removal without a lens implant. <p>See 'Additional Benefits' section for Non-Medicare Covered Vision Care.</p>	<p>\$5 copayment for each Medicare-covered visit.</p> <p>\$5 copayment for Medicare-covered glaucoma screening.</p> <p>You pay these amounts until you reach the out-of-pocket maximum.</p> <p>\$75 allowance for one pair of Medicare-covered standard glasses or contact lenses after cataract surgery.</p>
<p>Preventive Services</p>	
<p>Note: For all in-network preventive services that are covered at no cost under Original Medicare, we also cover the service at no cost to you. However, if you are treated or monitored for an existing medical condition during the visit when you receive the preventive service, a copayment will apply for the care received for the existing medical condition.</p>	

Services that are covered for you	What you must pay when you get these services
<p>Abdominal Aortic Aneurysm Screening</p> <p>A one-time screening ultrasound for people at risk. The plan only covers this screening if you get a referral for it as a result of your “Welcome to Medicare” physical exam.</p>	<p>\$0 copayment for each Medicare-covered screening.</p>
<p>Bone Mass Measurement</p> <p>For qualified individuals (generally, this means people at risk of losing bone mass or at risk of osteoporosis), the following services are covered every 24 months or more frequently if medically necessary: procedures to identify bone mass, detect bone loss, or determine bone quality, including a physician’s interpretation of the results.</p>	<p>\$0 copayment for each Medicare-covered screening.</p>
<p>Colorectal Cancer Screening</p> <p>For people 50 and older, the following are covered:</p> <ul style="list-style-type: none"> ● Flexible sigmoidoscopy (or screening barium enema as an alternative) every 48 months ● Fecal occult blood test, every 12 months <p>For people at high risk of colorectal cancer, we cover:</p> <ul style="list-style-type: none"> ● Screening colonoscopy (or screening barium enema as an alternative) every 24 months <p>For people not at high risk of colorectal cancer, we cover:</p> <ul style="list-style-type: none"> ● Screening colonoscopy every 10 years (120 months), but not within 48 months of a screening sigmoidoscopy 	<p>\$0 copayment for each Medicare-covered screening</p> <p>A screening colonoscopy or screening sigmoidoscopy does not include polyp removal or biopsy procedures. A colonoscopy or sigmoidoscopy that includes polyp removal or biopsy is a surgical procedure subject to the Outpatient Surgery cost sharing described earlier in this chart.</p>
<p>HIV Screening</p> <p>For people who ask for an HIV screening test or who are at increased risk for HIV infection, we cover:</p> <ul style="list-style-type: none"> ● One screening test every 12 months 	<p>\$0 copayment for each Medicare-covered screening.</p>

Questions? Call our Customer Service Department listed in Chapter 2.

Services that are covered for you	What you must pay when you get these services
For women who are pregnant, we cover: <ul style="list-style-type: none"> ● Up to three screening tests during a pregnancy 	
<p>Immunizations</p> <p>Covered Medicare Part B services include:</p> <ul style="list-style-type: none"> ● Pneumonia vaccine ● Flu shots, once a year in the fall or winter ● Hepatitis B vaccine if you are at high or intermediate risk of getting Hepatitis B ● Other vaccines if you are at risk and they meet Medicare Part B coverage rules <p>We also cover some vaccines under our Part D prescription drug benefit. See Chapter 6 for more information about coverage and applicable cost sharing.</p>	<p>\$0 copayment for each Medicare-covered pneumonia vaccine and flu vaccine.</p> <p>\$0 copayment for Hepatitis B vaccine.</p> <p>\$0 copayment for all other Medicare-covered Immunizations.</p>
<p>Breast Cancer Screening (Mammograms)</p> <p>Covered services include:</p> <ul style="list-style-type: none"> ● One baseline mammogram between the ages of 35 and 39 ● One screening mammogram every 12 months for women age 40 and older ● Clinical breast exam once every 24 months 	<p>\$0 copayment for each Medicare-covered screening.</p>
<p>Cervical and Vaginal Cancer Screening</p> <p>Covered services include:</p> <ul style="list-style-type: none"> ● For all women: Pap tests and pelvic exams are covered once every 24 months ● If you are at high risk of cervical cancer or have had an abnormal Pap test and are of childbearing age: one Pap test every 12 months 	<p>\$0 copayment for each Medicare-covered test or exam.</p>

Questions? Call our Customer Service Department listed in Chapter 2.

Services that are covered for you	What you must pay when you get these services
<p>Prostate Cancer Screening Exams</p> <p>For men age 50 and older, covered services include the following – once every 12 months:</p> <ul style="list-style-type: none"> ● Digital rectal exam ● Prostate Specific Antigen (PSA) test 	<p>\$0 copayment for each Medicare-covered screening exam.</p>
<p>Cardiovascular Disease Testing</p> <p>Blood tests for the detection of cardiovascular disease (or abnormalities associated with an elevated risk of cardiovascular disease) covered once every 5 years (60 months).</p>	<p>\$0 copayment for each Medicare-covered test.</p>
<p>“Welcome to Medicare” Physical Exam</p> <p>The plan covers a one-time “Welcome to Medicare” physical exam, which includes a review of your health, as well as education and counseling about the preventive services you need (including certain screenings and shots), and referrals for other care if needed.</p> <p>Important: You must have the physical exam within the first 12 months you have Medicare Part B. When you make your appointment, let your doctor’s office know you would like to schedule your “Welcome to Medicare” physical exam.</p>	<p>There is no coinsurance, copayment, or deductible for the Welcome to Medicare exam.</p>
<p>Annual Wellness Visit</p> <p>If you’ve had Part B for longer than 12 months, you can get an annual wellness visit to develop or update a personalized prevention plan based on your current health and risk factors. This is covered once every 12 months.</p> <p>Note: Your first annual wellness visit can’t take place within 12</p>	<p>There is no coinsurance, copayment, or deductible for the annual wellness visit.</p>

Services that are covered for you	What you must pay when you get these services
<p>months of your “Welcome to Medicare” exam. However, you don’t need to have had a “Welcome to Medicare” exam to be covered for annual wellness visit after you’ve had Part B for 12 months.</p>	
<p>Diabetes Screening</p> <p>We cover this screening (includes fasting glucose tests) if you have any of the following risk factors: high blood pressure (hypertension), history of abnormal cholesterol and triglyceride levels (dyslipidemia), obesity, or a history of high blood sugar (glucose). Tests may also be covered if you meet other requirements, like being overweight and having a family history of diabetes.</p> <p>Based on the results of these tests, you may be eligible for up to two diabetes screenings every 12 months.</p>	<p>\$0 copayment for each Medicare-covered screening.</p>
<p>Medical Nutrition Therapy</p> <p>This benefit is for people with diabetes, renal (kidney) disease (but not on dialysis), or after a transplant when referred by your doctor.</p> <p>We cover 3 hours of one-on-one counseling services during your first year that you receive medical nutrition therapy services under Medicare (this includes our plan, any other Medicare Advantage plan, or Original Medicare), and 2 hours each year after that. If your condition, treatment, or diagnosis changes, you may be able to receive more hours of treatment with a physician’s referral. A physician must prescribe these services and renew their referral yearly if your treatment is needed into another calendar year.</p>	<p>\$0 copayment for Medicare-covered benefits.</p>
<p>Smoking and Tobacco Use Cessation (Counseling to Stop</p>	<p>\$0 copayment if you haven’t</p>

Questions? Call our Customer Service Department listed in Chapter 2.

Services that are covered for you	What you must pay when you get these services
<p>Smoking)</p> <p>If you use tobacco, but do not have signs or symptoms of tobacco-related disease: we cover two counseling quit attempts within a 12-month period. Each counseling attempt includes up to four face-to-face visits.</p> <p>If you use tobacco and have been diagnosed with a tobacco-related disease or are taking medicine that may be affected by tobacco: we cover cessation counseling services. We cover two counseling quit attempts within a 12-month period. Each counseling attempt includes up to four face-to-face visits, however, you will pay the applicable inpatient or outpatient cost sharing.</p>	<p>been diagnosed with an illness caused or complicated by tobacco use.</p> <p>\$0 copayment if you have been diagnosed with an illness caused or complicated by tobacco use, or you take a medicine that is affected by tobacco use.</p>
Other Services	
<p>Services to Treat Kidney Disease and Conditions</p> <p>Covered services include:</p> <ul style="list-style-type: none"> ● Kidney disease education services to teach kidney care and help members make informed decisions about their care. For members with stage IV chronic kidney disease when referred by their doctor, we cover up to six sessions of kidney disease education services per lifetime. ● Outpatient dialysis treatments (including dialysis treatments when temporarily out of the service area, as explained in Chapter 3) ● Inpatient dialysis treatments (if you are admitted as an inpatient to a hospital for special care) 	<p>\$0 copayment for Medicare-covered benefits.</p> <p>\$0 copayment for Medicare-covered benefits.</p> <p>These services will be covered as described in the following sections: Please refer to Inpatient Hospital Care.</p>

Questions? Call our Customer Service Department listed in Chapter 2.

<p>Services that are covered for you</p>	<p>What you must pay when you get these services</p>
<ul style="list-style-type: none"> ● Self-dialysis training (includes training for you and anyone helping you with your home dialysis treatments) ● Home dialysis equipment and supplies ● Certain home support services (such as, when necessary, visits by trained dialysis workers to check on your home dialysis, to help in emergencies, and check your dialysis equipment and water supply) <p>Certain drugs for dialysis are covered under your Medicare Part B drug benefit. For information about coverage for Part B Drugs, please go to the section below, “Medicare Part B Prescription Drugs.”</p>	<p>Please refer to Home Health Agency Care.</p> <p>Please refer to Durable Medical Equipment and Related Supplies.</p> <p>Please refer to Home Health Agency Care.</p>
<p>Medicare Part B Prescription Drugs</p> <p>These drugs are covered under Part B of Original Medicare. Members of our plan receive coverage for these drugs through our plan. Covered drugs include:</p> <ul style="list-style-type: none"> ● Drugs that usually aren’t self-administered by the patient and are injected or infused while you are getting physician, hospital outpatient, or ambulatory surgical center services ● Drugs you take using durable medical equipment (such as nebulizers) that was authorized by the plan ● Clotting factors you give yourself by injection if you have hemophilia ● Immunosuppressive Drugs, if you were enrolled in Medicare Part A at the time of the organ transplant ● Injectable osteoporosis drugs, if you are homebound, have a bone fracture that a doctor certifies was related to 	<p>\$0 copayment for each Medicare-covered Part B drug.</p> <p>\$0 copayment for each Medicare-covered chemotherapy drugs and the administration of that drug.</p>

Questions? Call our Customer Service Department listed in Chapter 2.

Services that are covered for you	What you must pay when you get these services
<p>post-menopausal osteoporosis, and cannot self-administer the drug</p> <ul style="list-style-type: none"> ● Antigens ● Certain oral anti-cancer drugs and anti-nausea drugs ● Certain drugs for home dialysis, including heparin, the antidote for heparin when medically necessary, topical anesthetics, and erythropoiesis-stimulating agents (such as Epogen®, Procrit®, Epoetin Alfa, Aranesp®, or Darbepoetin Alfa) ● Intravenous Immune Globulin for the home treatment of primary immune deficiency diseases ● Chemotherapy Drugs, and the Administration of chemotherapy drugs <p>Chapter 5 explains the Part D prescription drug benefit, including rules you must follow to have prescriptions covered. What you pay for your Part D prescription drugs through our plan is listed in Chapter 6.</p>	
<p>Outpatient Injectable Medications</p> <p>(Self-administered outpatient injectable medications not covered under Part B of Original Medicare)</p>	<p>\$0 copayment for each self-administered outpatient injectable medication.</p>
Additional Benefits	
<p>Preventive Dental Services</p> <p>In general, preventive dental services (such as cleaning, routine dental exams, and dental x-rays) are not covered by Original Medicare. We cover:</p> <p>Please turn to Section 4 Preventive Dental Services of this chapter for more detailed information about this preventive dental services benefit.</p>	<p>Individual copayments apply and discounts are available for procedures as specified later in this section.</p>

Questions? Call our Customer Service Department listed in Chapter 2.

Services that are covered for you	What you must pay when you get these services
<p>Hearing Services</p> <p>Basic hearing evaluations performed by your provider are covered as outpatient care when furnished by a physician, audiologist, or other qualified provider.</p> <p>Please turn to Section 4 Hearing Services of this chapter for more detailed information about this hearing services benefit.</p>	<p>Routine Hearing Exam</p> <p>\$0 copayment for each routine hearing exam, limited to one exam every 12 months.</p> <p>Hearing Aids (Includes digital hearing aids)</p> <p>Up to \$500 allowance for hearing aids every 3 years.*</p>
<p>Vision Care</p> <p>Please turn to Section 4 Vision Care of this chapter for more detailed information about this vision care benefit.</p>	<p>Routine Eye Exam (refraction)</p> <p>\$15 copayment for a routine eye exam, limited to one exam every 12 months.*</p> <p>Routine Eye Wear</p> <p>Up to \$75 eyeglasses allowance, limited to one pair of standard lenses and standard frames every 2 years.* Contact lenses are not covered.</p>
<p>Health and Wellness Education Program</p> <p>Fitness Program</p>	<p>\$0 membership fee.</p> <p>Monthly basic membership fee for Fitness Program through network fitness centers.</p>
<p>Health and Wellness Education Program</p>	<p>You may call the NurseLine, 24</p>

Questions? Call our Customer Service Department listed in Chapter 2.

Services that are covered for you	What you must pay when you get these services
24-Hour NurseLine/Treatment Decision Support	hours a day, seven days a week and speak to a registered nurse (RN) about your medical concerns and questions.
Health and Wellness Education Program Access Support	You may call the NurseLine, 24 hours a day, seven days a week to help you find a quality doctor and schedule appointments.
Health and Wellness Education Program Group Retiree Case Management	<p>A program that offers guidance and support once you are diagnosed with complex and related co-morbid health conditions and also if you are not engaged in the disease and condition-specific management programs.</p> <p>This program is not required and will not have any effect on your enrollment/membership or benefits. Eligibility requirements must be met in order to qualify and there is no cost to you for the program. To find out if you meet the eligibility requirements, please call Customer Service (phone numbers are on the back cover of this booklet).</p>
Health and Wellness Education Program Advanced Illness Care Management	A multi-dimensional program that utilizes Personal Resource Nurses and an interdisciplinary

Questions? Call our Customer Service Department listed in Chapter 2.

Services that are covered for you	What you must pay when you get these services
	<p>oversight team (including physical, speech, occupational and nutrition therapists, social workers, psychologists, nurses, palliative care physicians, and pharmacists) to identify, engage, assess and monitor members through all stages of disease progression, including death, loss and bereavement.</p>
<p>Health and Wellness Education Program</p> <p>Disease Management</p>	<p>These programs are designed to help you best manage your particular diagnosed condition.</p> <p>The Congestive Heart Failure (CHF) program is designed to help you best manage your condition, educate you on your disease, prevent a reoccurrence of your CHF and recognize changes in symptoms and actively intervene to reduce unnecessary hospitalizations or emergency room visits by monitoring your condition.</p> <p>The Coronary Artery Disease (CAD) and Diabetes program is designed to help you best manage your condition, blood glucose levels and risk factors, reduce unnecessary emergency room visits and hospitalizations, prevent heart attacks and prevent disease progression and</p>

Questions? Call our Customer Service Department listed in Chapter 2.

Services that are covered for you	What you must pay when you get these services
	<p>other illnesses related to coronary artery disease and poorly managed diabetes.</p> <p>The End Stage Renal Disease (ESRD) Services Program provides you with a comprehensive approach for managing your ESRD, both prior to starting dialysis, and during your dialysis treatment, as well as through transplant.</p> <p>These programs are not required and will not have any effect on your enrollment/membership or benefits. Eligibility requirements must be met in order to qualify and there is no cost to you for the programs.</p>
<p>Routine Chiropractic Services</p> <p>Please turn to Section 4 Routine Chiropractic Services of this chapter for more detailed information about this routine chiropractic services benefit.</p>	<p>\$5 copayment per visit for routine chiropractic visits up to 30 visits per plan year.*</p>
<p>* Covered services that do not count toward your maximum out-of-pocket amount.</p>	

Questions? Call our Customer Service Department listed in Chapter 2.

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

Section 3.1 Medical benefits we do not cover (exclusions)

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

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

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

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

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

Questions? Call our Customer Service Department listed in Chapter 2.

- performance), except when medically necessary.
- Cosmetic surgery or procedures, unless because of an accidental injury or to improve a malformed part of the body. However, all stages of reconstruction are covered for a breast after a mastectomy, as well as for the unaffected breast to produce a symmetrical appearance.
 - Routine dental care, such as cleanings, fillings or dentures, except as specifically described in the Medical Benefits Chart in this chapter. However, non-routine dental care required to treat illness or injury may be covered as inpatient or outpatient care.
 - Chiropractic care, other than manual manipulation of the spine consistent with Medicare coverage guidelines, except as specifically described in the Medical Benefits Chart in this chapter.
 - Routine foot care, except for the limited coverage provided according to Medicare guidelines, except as specifically described in the Medical Benefits Chart in this chapter.
 - Orthopedic shoes, unless the shoes are part of a leg brace and are included in the cost of the brace or the shoes are for a person with diabetic foot disease, except as specifically described as a covered service in the Medical Benefits Chart in this chapter.
 - Supportive devices for the feet, except for orthopedic or therapeutic shoes for people with diabetic foot disease.
 - Routine hearing exams, hearing aids, or exams to fit hearing aids, except as specifically described in the Medical Benefits Chart in this chapter.
 - Eyeglasses, routine eye examinations (except as specifically described in the Medical Benefits Chart in this chapter), radial keratotomy, LASIK surgery, vision therapy and other low vision aids. However, eyeglasses are covered for people after cataract surgery.
 - Reversal of sterilization procedures, sex change operations, and non-prescription contraceptive supplies.
 - Acupuncture, except as specifically described in the Medical Benefits Chart in this chapter.
 - Naturopath services (uses natural or alternative treatments), except as specifically described in the Medical Benefits Chart in this chapter.
 - Services provided to veterans in Veterans Affairs (VA) facilities. However, when emergency services are received at VA hospital and the VA cost-sharing is more than the cost-sharing under our Plan, we will reimburse veterans for the difference. Members are still responsible for our cost-sharing amounts.
 - Medical treatment or any services provided in a local, state or federal government facility or agency except when payment under the plan is expressly required by federal or state law.
 - All services, procedures, treatments, medications and supplies related to Workers' Compensation claims.
 - Physical examinations for the purpose of maintaining or obtaining employment, licenses, insurance, court hearings, travel, dietary counseling, weight reduction programs or for premarital and pre-adoption purposes and/or other non-preventive reasons.
 - Abortion, except for cases resulting in pregnancies from rape or incest or that endanger the life of the mother.
 - Smoking cessation products and treatments, except as covered in accordance with Medicare guidelines or as specifically described as a covered service in the Medical Benefits Chart in this chapter.
 - Routine transportation, except as specifically described as a covered service in the Medical

Questions? Call our Customer Service Department listed in Chapter 2.

Benefits Chart in this chapter.

- Health services received as a result of war or any act of war that occurs during the member's term of Coverage under the Evidence of Coverage.
- Health services for treatment of military service related disabilities provided by the Military Health Services System (including CHAMPUS or TRICARE) under which the federal government agrees to pay for the services and supplies.
- Paramedic intercept service (advanced life support provided by an emergency service entity, such as a paramedic services unit, which do not provide ambulance transport), except when Medicare criteria are met.
- Optional, additional, or deluxe features or accessories to durable medical equipment, corrective appliances or prosthetics which are primarily for the comfort or convenience of the Member, or for ambulation primarily in the community, including home and car remodeling or modification.
- Immunizations for foreign travel purposes.
- Substance abuse detoxification and rehabilitation, except as covered in accordance with Medicare guidelines.
- Proton beam therapy for the medically appropriate treatment of prostate cancer is a covered service. Prior authorization must be obtained for all treatment in order for the proton beam therapy to be considered a covered service. Coverage for proton beam therapy for the treatment of prostate cancer is limited to a maximum of the Original Medicare allowable amount for conformal 3D photon beam therapy treatments for prostate cancer. Coverage is subject to coinsurance, including but not limited to, coinsurance for radiation therapy. Members are responsible for any amounts in excess of Original Medicare allowable amounts, and for any travel or other costs associated with obtaining proton beam therapy treatment of prostate cancer.
- The following services and items are excluded from coverage under the UnitedHealthcare United Resource Network transplant program:
 - Unauthorized or not prior authorized organ procurement and transplant related services.
 - Transplants performed in a non-UnitedHealthcare United Resource Network facility, unless specifically authorized by the UnitedHealthcare Medical Director.
 - Non-Medicare-covered organ transplants.
 - Transplant services, including donor costs, when the transplant recipient is not a member.
 - Artificial or non-human organs.
 - Transportation services for any day a member is not receiving medically necessary transplant services, except as covered in accordance with Medicare guidelines.
 - Transportation of any potential donor for typing and matching.
 - Food and housing costs for any day a member is not receiving medically necessary transplant services, except as covered in accordance with Medicare guidelines.
 - Storage costs for any organ or bone marrow, unless authorized by the UnitedHealthcare Transplant Medical Director.
 - Services for which government funding or other insurance coverage is available.
 - Bone marrow transplants or stem cell transplantation, except as a treatment for an appropriate diagnosis as specifically stated in the Medicare coverage guidelines or in the Evidence of Coverage.

Questions? Call our Customer Service Department listed in Chapter 2.

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

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

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

SECTION 4 Other additional benefits (not covered under Original Medicare)

Introduction

Your health and well-being are important to us, which is why we've developed the additional benefit(s) detailed in this section:

- Preventive Dental Services
- Hearing Services
- Vision Care
- Routine Chiropractic Services

The benefit(s) described on the following pages are designed to help you stay healthy and provide well-rounded health coverage. Please read this section carefully, and reference it later if need be, to help you know what services are covered under your Plan. If you ever have questions about what is covered, how to make a claim or about any other issue, please call Customer Service (phone numbers for Customer Service are on the back cover of this booklet). We are always happy to provide answers to any questions you may have. We're here to serve you.

The information in this section describes the following benefits:

- Non-Medicare covered vision exam and eyewear
- Non-Medicare covered hearing exam and hearing aids
- Non-Medicare covered chiropractic care
- Preventive dental benefits

These are covered health services when you follow the coverage rules in the Evidence of Coverage. These services are in addition to Medicare-covered benefits outlined in the Evidence of Coverage. The provisions of this section are incorporated into and made a part of your Evidence of Coverage. The covered health services described in this section are not covered when you are in the service area of an affiliated organization, as defined in the Passport Program Section of your Evidence of Coverage, if

Questions? Call our Customer Service Department listed in Chapter 2.

applicable. Copayments or coinsurance for these covered health services do not apply toward the annual out-of-pocket maximum (if applicable to your Plan) described earlier in this chapter.

Further details on the benefits available as part of your additional benefit(s) (if applicable) are detailed in the section titled: **Covered Services**.

Submit a Claim or Request Reimbursement

When you obtain services, the service provider normally submits a claim on your behalf. If the service provider is unwilling to do so, you can request reimbursement from us. To receive reimbursement, please take the following steps:

- Obtain a copy of your itemized receipt(s) from the provider.
- Make sure the itemized receipt includes the following:
 - The service provider's name, address and phone number
 - Your name
 - The date the service was completed
 - The amount you paid (or "paid in full" if the total amount has been paid)
- Mail the itemized receipt(s) to:
UnitedHealthcare
Claims Department
P.O. Box 489
Cypress, CA 90630

We should receive an itemized receipt from you or the provider within ninety (90) days after the date of service, or as soon thereafter as reasonably possible.

We will process your reimbursement based on your benefits. Upon completion of the reimbursement process, an Explanation of Benefits (EOB) will be sent to your mailing address.

Limitation of Liability

We will not reduce or deny a claim for failure to furnish such proof within the time required, provided a claim is furnished as soon as reasonably possible. Except in the absence of legal capacity, we will not accept a claim more than one (1) year from the date of service.

Access Your Benefits

Each additional benefit detailed here has a directory of network service providers that furnish in-network covered health services. To start using your additional benefit in-network:

Select a network provider* from the **Provider Directory** or **Vision Directory**, or call Customer Service for help in determining a network provider (phone numbers for Customer Service are on the back cover of this booklet).

Preventive Dental Services

Dental Service Providers

Before contacting a provider you will need to determine your network dental office. For more

Questions? Call our Customer Service Department listed in Chapter 2.

information on selecting your assigned network dental office please see the dental benefits section.

- Call your selected provider's office to schedule the services you need.
- Pay the appropriate copayment or coinsurance at the time of your service, if applicable.
- When you go to the provider's office for services, you may be asked to show your member ID card.

*The list of network providers is subject to change. Please confirm, prior to scheduling your appointment, that the provider you selected is still a network provider.

Covered Services

Preventive Dental Services

The following services are covered under your additional dental benefit:

With the dental benefits available through your Plan you will receive savings on more than 100 common dental procedures. You will also save money compared to the costs of out-of-network dental care.

Benefits for covered dental services are payable when diagnosed and performed by your assigned network dental office, but are subject to the limitations and exclusions described later in this section.

Choice of Dental Offices

You must choose an assigned network dental office from the Dental Directory. If the dental office you select is not available, or you fail to select an office, we will assign one to you. If you would like to select another network dental office, you may contact Customer Service (phone numbers for Customer Service are on the back cover of this booklet). If we receive your request to transfer to another network dental provider by the 15th of the month, your transfer will be effective on the 1st day of the following month. For example: If your request to transfer is received by June 15th, your transfer will be effective on July 1st.

To ensure continuity of care, all treatments started at your assigned network dental office should be completed before you request a change to another network dental office unless a quality-of-care issue is identified. If you elect to change network dental offices without completing treatment, you may be responsible for the UCR fees at your new assigned network dental office. We are **not** responsible for the continued participation of any dental provider in the contracting network.

If you decide to transfer your records to a different assigned network dental office, you will be subject to a duplication fee of \$.25 per page or \$.50 per page for records that are copied from microfilm and any additional reasonable clerical costs incurred in making the records available. Duplication of X-rays will be subject to a fee of \$10.

Making an Appointment

Once you have an assigned network dental office, you can make an appointment by directly calling that dental office. If you have any questions regarding office location, office hours, emergency hours or other network dental providers in your area, please call your assigned network dental office or call Customer Service (phone numbers for Customer Service are on the back cover of this booklet).

Dental Benefits

Questions? Call our Customer Service Department listed in Chapter 2.

- You are required to pay the \$5 office visit fee for up to four (4) office visits per year. You pay \$0 for additional office visits per year. This fee is due in addition to any other discount fees specified for procedures or services rendered.
- You pay \$8 for each oral examination up to four (4) oral examinations per year. You pay \$0 for additional examinations per year.
- You pay \$15 for each routine cleaning once every six (6) months.
- You pay \$22 for a complete X-ray series prescribed by your assigned network dentist. Reduced rates are available for individual procedures.
- The services of a specialist are not a covered dental service.

Please note that when you make an appointment with your assigned network dentist, you will be responsible for a \$5 office visit copayment in addition to the discounted fee for the procedures performed. Unlimited general dentistry for covered procedures at assigned network dentists.

2012 Schedule of Dental Plan Discount Fees

(These discounts apply only with your assigned network dentist.)

ADA CODE	American Dental Association Description	Dental Plan 2012
OFFICE VISIT		\$5
DIAGNOSTIC		
D0120	Periodic oral examination	\$8
D0140	Initial oral examination - problem focused	\$11
D0150	Comprehensive oral examination	\$10
D0160	Detailed and extensive oral evaluation-problem focused, by report	\$12
D0170	Re-evaluation- limited, problem focused	\$11
D0180	Comprehensive periodontal evaluation	\$10
D0210	Intraoral-complete series (including bitewings; every two years ¹)	\$22
D0220	Intraoral-periapical-first film	\$5
D0230	Intraoral-periapical-each additional film	\$3
D0240	Intraoral-occlusal film	\$6
D0270	Bitewings-single film	\$5
D0272	Bitewings-two films	\$9
D0274	Bitewings-four films	\$11
D0330	Panoramic film (non - orthodontic)	\$18
	Initial charting with pocket depth summary	\$10
D0460	Pulp vitality tests	\$8

Questions? Call our Customer Service Department listed in Chapter 2.

PREVENTIVE		
D1110	Prophylaxis-adult (once every six months)	\$15
	Prophylaxis-adult (second cleaning)	\$15
D1330	Oral hygiene instruction	NC
RESTORATIVE		
D2140	Amalgam-one surface, primary or permanent	\$50
D2150	Amalgam-two surfaces, primary or permanent	\$59
D2160	Amalgam-three surfaces, primary or permanent	\$70
D2161	Amalgam-four or more surfaces, primary or permanent	\$82
D2330	Resin-one surface, anterior	\$64
D2331	Resin-two surfaces, anterior	\$75
D2332	Resin-three surfaces, anterior	\$84
D2335	Resin-four or more surfaces or involving incisal angle (anterior)	\$94
D2391	Resin-based composite crown - one surface, posterior	\$66
D2392	Resin-based composite crown - two surfaces, posterior	\$85
D2393	Resin-based composite crown - three surfaces, posterior	\$102
D2394	Resin-based composite crown - four or more surfaces, posterior	\$117
D2710	Crown-resin (laboratory)	\$172
D2712	Crown- 3/4 resin-based composite (indirect)	\$172
D2720	Crown-resin with high noble metal ²	\$438
D2721	Crown-resin with predominantly base metal	\$385
D2722	Crown-resin with noble metal ²	\$438
D2740	Crown-porcelain/ceramic substrate (not for molars)	\$487
D2750	Crown-porcelain fused to high noble metal ²	\$469
D2751	Crown-porcelain fused to predominantly base metal	\$447
D2752	Crown-porcelain fused to noble metal ²	\$455
D2780	Crown - 3/4 cast high noble metal	\$459
D2781	Crown - 3/4 cast predominantly base metal	\$459
D2782	Crown - 3/4 cast noble metal ²	\$459
D2783	Crown- 3/4 porcelain/ceramic ²	\$366
D2790	Crown-full cast high noble metal ²	\$461
D2791	Crown-full cast predominantly base metal	\$428
D2792	Crown-full cast noble metal ²	\$455

Questions? Call our Customer Service Department listed in Chapter 2.

RESTORATIVE		
D2794	Crown-titanium ²	\$428
D2915	Recement cast or prefabricated post and core	\$33
D2920	Recement crown	\$33
D2931	Prefabricated stainless steel crown - permanent tooth (when suggested by DDS)	\$105
D2932	Prefabricated resin crown	\$105
D2940	Sedative filling	\$30
D2951	Pin retention - per tooth, in addition to restoration	\$23
D2952	Cast post and core in addition to crown ²	\$135
D2953	Each additional cast post - same tooth	\$108
D2954	Prefabricated post and core in addition to crown	\$108
D2957	Each additional prefabricated post - same tooth	\$87
D2970	Temporary crown (fractured tooth)	\$50
D2971	Additional procedures to construct new crown under existing partial denture framework	\$100
D2975	Coping	\$50
ENDODONTICS		
INCLUDES ALL INTRAOPERATIVE X-RAYS		
D3110	Pulp cap-direct (excluding final restoration)	\$27
D3120	Pulp cap-indirect (excluding final restoration)	\$45
D3220	Therapeutic pulpotomy (excluding final restoration)	\$46
D3310	Anterior (excluding final restoration)	\$308
D3320	Bicuspid (excluding final restoration)	\$364
D3330	Molar (excluding final restoration)	\$490
D3332	Incomplete endodontic therapy; inoperable, unrestorable or fractured tooth	\$245
D3950	Canal preparation and fitting of performed dowel or post, should not be reported in conjunction with 02952 or 02954 by the same practitioner	\$60
PERIODONTICS		
INCLUDES USUAL POSTOPERATIVE SERVICES		
D4341	Periodontal scaling and root planning - four or more teeth per quadrant	\$90

Questions? Call our Customer Service Department listed in Chapter 2.

PERIODONTICS		
INCLUDES USUAL POSTOPERATIVE SERVICES		
D4342	Periodontal scaling and root planning - one to three teeth per quadrant	\$45
D4355	Full mouth debridement to enable comprehensive periodontal evaluation and diagnosis	\$50
D4910	Periodontal maintenance procedures (following active therapy; once every six months)	\$54
PROSTHODONTICS (REMOVEABLE)		
INCLUDES ROUTINE POST DELIVERY CARE		
Adjustments for new dentures are included in the discount fee for six months following delivery, if the adjustments are made by the same network dentist who originally made the denture. For existing dentures or new dentures after the initial six months, you are responsible for the listed discount fee for a denture adjustment.		
D5110	Complete upper	\$528
D5120	Complete lower	\$536
D5130	Immediate upper	\$540
D5140	Immediate lower	\$534
D5211	Upper partial-resin base (including any conventional clasps, rests and teeth)	\$480
D5212	Lower partial-resin base (including any conventional clasps, rests and teeth)	\$477
D5213	Upper partial-cast metal base with resin saddles (including any conventional clasps, rests and teeth)	\$681
D5214	Lower partial-cast metal base with resin saddles (including any conventional clasps, rests and teeth)	\$690
D5225	Maxillary partial denture - flexible base (including any clasps, rests and teeth)	\$480
D5226	Mandibular partial denture - flexible base (including any clasps, rests and teeth)	\$477
D5281	Removable unilateral partial denture-one piece cast metal, (including clasps and pontics)	\$496
D5410	Adjust complete denture-upper	\$30
D5411	Adjust complete denture-lower	\$30
D5421	Adjust partial denture-upper	\$30
D5422	Adjust partial denture-lower	\$30

Questions? Call our Customer Service Department listed in Chapter 2.

PROSTHODONTICS (REMOVEABLE)		
INCLUDES ROUTINE POST DELIVERY CARE		
D5510	Repair broken complete denture base	\$64
D5520	Replace missing or broken teeth-complete denture (each tooth)	\$54
D5610	Repair resin denture or base	\$69
D5620	Repair cast framework	\$63
D5630	Repair or replace broken clasp	\$77
D5640	Replace broken teeth-per tooth	\$60
D5650	Add tooth to existing partial denture	\$78
D5660	Add clasp to existing partial denture	\$90
D5670	Replace all teeth and acrylic on cast metal framework (maxillary)	\$341
D5671	Replace all teeth and acrylic on cast metal framework (mandibular)	\$345
D5730	Reline complete upper denture (chairside)	\$111
D5731	Reline complete lower denture (chairside)	\$108
D5740	Reline upper partial denture (chairside)	\$89
D5741	Reline lower partial denture (chairside)	\$105
D5750	Reline complete upper denture (laboratory)	\$165
D5751	Reline complete lower denture (laboratory)	\$158
D5760	Reline upper partial denture (laboratory)	\$159
D5761	Reline mandibular partial denture (laboratory)	\$162
PROSTHODONTICS, FIXED		
EACH ABUTMENT AND EACH PONTIC CONSTITUTE A UNIT IN A FIXED PARTIAL		
D6210	Pontic-cast high noble metal ²	\$438
D6211	Pontic-cast predominantly base metal	\$405
D6212	Pontic-cast noble metal ²	\$435
D6214	Pontic-titanium ²	\$405
D6240	Pontic-porcelain fused to high noble metal ²	\$455
D6241	Pontic-porcelain fused to predominantly base metal	\$420
D6242	Pontic-porcelain fused to noble metal ²	\$441
D6245	Pontic-porcelain/ceramic	\$455
D6250	Pontic-resin with high noble metal ²	\$487

Questions? Call our Customer Service Department listed in Chapter 2.

PROSTHODONTICS, FIXED		
EACH ABUTMENT AND EACH PONTIC CONSTITUTE A UNIT IN A FIXED PARTIAL		
D6251	Pontic-resin with predominantly base metal	\$430
D6252	Pontic-resin with noble metal ²	\$430
D6720	Crown-resin with high noble metal ²	\$434
D6721	Crown-resin with predominantly base metal	\$434
D6722	Crown-resin with noble metal ²	\$434
D6740	Crown-porcelain/ceramic	\$487
D6750	Crown-porcelain fused to high noble metal ²	\$456
D6751	Crown-porcelain fused to predominantly base metal	\$438
D6752	Crown-porcelain fused to noble metal ²	\$455
D6780	Crown-3/4 cast high noble metal ²	\$438
D6781	Crown-3/4 cast predominantly base metal	\$459
D6782	Crown-3/4 cast noble metal ²	\$459
D6783	Crown-3/4 cast porcelain/ceramic	\$459
D6790	Crown-full cast high noble metal ²	\$455
D6791	Crown-full cast predominantly base metal	\$428
D6792	Crown-full cast noble metal ²	\$438
D6794	Crown-titanium ²	\$428
D6930	Recement bridge	\$43
D6970	Cast post and core in addition to bridge retainer ²	\$131
D6971	Cast post as part of bridge retainer	\$131
D6972	Prefabricated post and core in addition to bridge retainer	\$105
D6973	Core build up for retainer, including any pins	\$105
D6976	Each additional cast post - same tooth	\$105
D6977	Each additional prefabricated post - same tooth	\$84
ORAL SURGERY		
INCLUDES LOCAL ANESTHESIA, SUTURING AND ROUTINE POSTOPERATIVE CARE		
D7111	Extraction, coronal remnants - deciduous tooth	\$51
D7140	Extraction, erupted tooth or exposed root (elevation and/or forceps removal)	\$54

Questions? Call our Customer Service Department listed in Chapter 2.

ORAL SURGERY		
INCLUDES LOCAL ANESTHESIA, SUTURING AND ROUTINE POSTOPERATIVE CARE		
D7510	Incision and drainage of abscess - intraoral soft tissue	\$65
D7511	Incision and drainage of abscess - intraoral soft tissue - complicated (includes drainage of multiple fascial spaces)	\$98
ADJUNCTIVE GENERAL SERVICES		
D9110	Palliative (emergency) treatment of dental pain-minor procedures	\$38
D9215	Local anesthesia	NC
D9248	Non-intravenous conscious sedation	NTCV
D9430	Office visit for observation (during regularly scheduled hours)	\$5
D9440	Office visit - after regularly scheduled hours	\$50
D9450	Case presentation, detailed and extensive treatment planning	NTCV
D9951	Occlusal adjustment-limited	\$35
	Broken Appointment Fee	NC
	Annual maximum on Specialty Referral	NTCV

¹This benefit covers more than one year, and may be changed or terminated at the end of the calendar year. You will be notified in advance of any changes.

²If precious metal is used, an additional fee may be charged. The charge may not exceed actual lab cost of metal.

NC= No Charge

NTCV= Not Covered

American Dental Associates (ADA) codes not listed in this booklet are not covered benefits.

Making the Most of Your Covered Services

Receiving Services

You must obtain covered dental services through your assigned network dental office, except for those dental services defined as emergency care in this booklet. The fees for any dental procedures not provided by your assigned network dental office, or not provided as an emergency care or an out-of-area service, may be your responsibility at the dental provider's Usual, Customary and Reasonable (UCR) charges.

If your assigned network dental office is unable to perform under the terms of its contract, has breached the contract or has been canceled by us, we will notify you 30 days in advance of termination, so that you may choose another assigned network dental office. If another assigned network dental office is not available within a reasonable distance from your primary residence or work place, we will

Questions? Call our Customer Service Department listed in Chapter 2.

refer you to an out-of-network provider, and you will be instructed on reimbursement procedures for service costs in excess of the dental plan benefit discount fees.

Continuity of Care

If, upon your effective date, you are under treatment for an acute condition through an out-of-network dental provider, we will honor your claims. If you are a member who is undergoing treatment for either an acute condition or a serious chronic condition, you may call Customer Service for directions on continuing your care.

Emergency Care

Your assigned network dental office will be available for emergency care 24 hours a day, seven days a week. If you need emergency care, you must contact your assigned network dental office. If your acute emergent condition prevents you from contacting your assigned network dental office or you are out of area, you may receive care by any licensed dentist. We will reimburse you for the covered emergency care only, up to \$50 per occurrence. Send us the itemized bill, marked paid, along with a brief explanation of why emergency care was necessary, within 60 days to the address listed under **How to Submit a Claim or Request Reimbursement** earlier in this section. We will provide reimbursement within 30 days of receipt. You do **not** have to submit a claim form. You must use the emergency dentist **only** for relief of pain or to immediately diagnose and treat a condition that a reasonable person under the circumstance believes that if not given immediate attention may lead to disability, dysfunction or death. We will cover out-of-area follow-up care by an out-of-network dental provider as long as the care continues to meet the definition of emergency care.

Please see **How to Submit a Claim or Request Reimbursement** earlier in this section for more information on how to submit the costs for emergency services for reimbursement.

Termination of your Dental Benefits

If you cease to be a member of the Plan, your dental benefits will terminate on the same effective date as your disenrollment from the Plan. If you are undergoing treatment for an acute condition at the time of your termination, your assigned network dental office will complete treatment for this condition. If we cancel your assigned network dental office's contract or if your assigned network dental office cancels its contract with us, it will be our responsibility to see that you receive your dental benefits at another network dental office. We may terminate your membership for additional reasons. Please see the chapter of the Evidence of Coverage titled: **Ending your membership in the Plan.**

Organization Determination, Appeal and Grievance Procedures

The appeals and grievance provisions described below are in addition to the Organization Determination, Appeal and Grievance Procedures of your Evidence of Coverage.

General Information on the Medicare Appeal Process

You have the right to appeal any organization determination about our payment for, or failure to arrange or continue to arrange for, what you believe are covered services under your Medicare Advantage Plan.

Use the appeal procedure when you want us to reconsider a decision (organization determination) that was made regarding a service or the amount we paid for a service.

Questions? Call our Customer Service Department listed in Chapter 2.

Use the grievance procedure for any complaints or other disputes that are not denied claims or denied services subject to organization determination as explained above. If you have a question about which complaint process to use, please call Customer Service.

1. You may notify us of your concern or submit a complaint either by telephone or in writing. Please call UnitedHealthcare Customer Service (phone numbers for Customer Service are on the back cover of this booklet). You may also write a letter to the Appeals Department at:

Appeals and Grievance Department

P.O. Box 6106

Mail Stop CY124-0157

Cypress, CA 90630

You will be sent an acknowledgement of receipt of your complaint within five (5) working days. If you have any questions about the status of your complaint, you may contact Customer Service at any time.

2. An appeals coordinator will conduct an investigation of your complaint. The appeals coordinator may request and review any relevant dental records from your assigned network dental office or other provider, as appropriate. If a quality-of-care issue is identified, the appeals coordinator and the Quality Improvement Department will take appropriate action or recommend a review by the Peer Review Committee. A written response will be sent to you within thirty (30) days.

3. If you are dissatisfied with the written response following the investigation, you may request an additional review. You must request the review within thirty (30) days of receiving the written response from us. Your complaint will be reviewed and you will be notified of the completion of the review within thirty (30) days. Please refer to the chapter of the Evidence of Coverage titled: **What to do if you have a problem or complaint** for the process to follow.

Dental Benefits, Procedures and Discount Fees

We will provide you with dental benefits only for the covered dental services listed in the Schedule of Dental Discount Fees. **It is your responsibility to understand your dental coverage and use your dental benefits appropriately.** Covered dental services are a dental benefit only when diagnosed as needed by your assigned network dental office.

Many services require a payment. This additional payment is called a discount fee. This amount is listed next to each procedure on the Schedule of Discount Fees. Other procedures do not require a discount fee. These are listed as “NC,” No Charge. Some procedures are not dental benefits of this dental plan; those are listed as “NTCV,” Not Covered, or “UCR,” Usual, Customary and Reasonable.

Network dentists will ask all members to sign an informed consent document detailing the risks, dental benefits and alternatives to all recommended treatments. You may choose the least expensive clinically acceptable procedure (such as an extraction instead of a crown and root canal therapy). In the performance of recommended dental treatments, outcomes cannot always be accurately predicted. Sometimes, during a specific procedure, an immediate change in treatment may be required. In these instances, the dental professional must stop the procedure and fully inform you of the change in treatment, risks and financial impact.

Glossary of Dental Terms

Questions? Call our Customer Service Department listed in Chapter 2.

1. **Assigned Network Dentist or Dental Office** – The dentist or dental office, contracting with us, where you are assigned to receive dental benefits.
2. **Covered Dental Service(s)** – Those dental benefits, treatments and services listed below, diagnosed and provided by your assigned network dental office.
3. **Dental Benefits** – The dental benefits available to members under the Plan.
4. **Dental Plan** – A plan-sponsored dental benefit with applicable discount fees, Limitations and Exclusions offered to plan members.
5. **Discount Fee** – The fee charged by your assigned network dental office at the time covered dental services are performed in accordance with your dental benefit.
6. **Exclusion** – Any services or items not included under the dental benefit.
7. **Health Plan** – The plan under which a member receives covered medical services. For members of the dental plan, the health plan is SecureHorizons[®] MedicareComplete[®] Retiree Plan (HMO).
8. **Limitation** – Any restriction on dental plan benefits (other than exclusion) under the dental plan.
9. **Not Covered Benefit** – A non-covered dental service, for which there is no covered service that may serve as an acceptable clinical alternative. Because there is no covered allowance, when this type of treatment is done, members can be charged the dentists' full UCR.
10. **Palliative Care** – Action that relieves pain but does not cure a problem.
11. **Prophylaxis (Teeth Cleaning)** – The routine cleaning of the teeth, including polishing and required supragingival (above the gum) and coronal scaling.
12. **Specialty or Specialist** – Services of a dentist who has been certified as a dental practice specialist by the appropriate board or authority.
13. **Usual, Customary and Reasonable (UCR)** – The fee a dental provider most frequently charges for services rendered.

Limitations and Exclusions

Please note the following limitations and exclusions apply to all additional benefits. Certain services and items are not covered by your additional benefit(s), including these general ones:

- Government treatment for any services provided in a local, state or federal government facility or agency except when payment under the plan is expressly required by federal or state law.
- Any treatment or services caused by or arising out of the course of employment or covered under any public liability insurance, including, but not limited to, Worker's Compensation programs.

The following items and services are limited and excluded from your additional dental benefit as indicated:

Limitations of Benefits

All dental procedures and services are limited as specifically described below

1. Non-Covered Benefits

Assigned network dentists and network dental Specialists may offer members Dental Services that are not included on the list of dental benefits, and for which there is no alternative listed covered dental services. In such cases, the assigned network dentist may offer the service for the dentist's UCR. For example, if an assigned network dentist offers and the member consents to cosmetic tooth bleaching, there is no alternative Covered Dental Service and the dentist may charge UCR.

Questions? Call our Customer Service Department listed in Chapter 2.

2. Laboratory Upgrades

A. Upgrades to a Covered Procedure:

Fees for upgrades such as precious or semiprecious metal alloys, upgraded denture teeth, permanent denture soft acrylic bases, and denture characterization or “personalization” will be limited to the additional laboratory fee charged to the network dentist by the dental laboratory for the upgrade. For example, the assigned network dentist diagnoses, and the member accepts, the alternative of a precious metal (gold) crown instead of a base metal crown. The network dentist may charge no more than the listed Discount Fee for the base metal crown, plus the actual fee charged by the dental laboratory for the use of the precious metal.

B. Treatment Plan decision making when two or more treatment alternatives are Covered

When several covered dental services are treatment alternatives for needed care, all treatment alternatives are considered covered dental services. The determination of which Covered Dental Service best meets the member’s needs is the decision or judgment of the treating network dentist in concert with the member. In this instance, either chosen Covered Dental Service would be available to the member at the listed Discount Fee for the chosen covered dental services. An example is the decision with regard to the replacement of bilateral missing teeth. In this scenario, either the removable partial denture or the fixed bridges would be considered a Covered Dental Service. The choice would be made by the assigned network dentist and the member considering professionally recognized standards of care, clinical condition of each restoration, technical difficulty of both restorative alternatives and any other factors that may be present with regard to the member’s specific dental condition.

3. Restorations, “Fillings” and Crowns

- A. Amalgam, resin-based composite, and/or tooth-colored filling material restorations for treatment of decay or broken teeth are covered under your dental benefits. If a tooth can be restored with such materials, any cast restoration (crown) is considered not a Covered Benefit. If such a procedure is performed, the member must pay the network dentist’s UCR fee.
- B. Restorations using resin-based composite or tooth-colored filling material are covered on all teeth with the exception of the primary posterior (molar and bicuspid) teeth.
- C. Porcelain, porcelain fused to metal (PFM), and cast metal crowns are not a Covered Dental Service for children under 16 years of age. The Covered Dental Service in such cases is a prefabricated stainless steel or resin crown. If a porcelain, PFM or cast metal crown is performed, the parent or guardian must pay the network dentist’s UCR fee.
- D. If a porcelain, PFM or cast metal crown is less than five years old, even if unserviceable, its replacement is not a Covered Dental Service.

4. Fixed Bridges

- A. Both a new bridge and a new partial denture are not covered benefits in the same arch. In such cases the Covered Dental Service is for a partial denture that would replace all missing teeth in the arch or multiple bridges.
- B. Fixed bridges are not a dental benefit for members under 16 years of age. In such a case, the dental benefit is for a removable denture, or space maintainer. If the bridge is performed, the member or guardian must pay the network dentist’s UCR fee.

Questions? Call our Customer Service Department listed in Chapter 2.

- C. If an unserviceable existing bridge is less than five years old; its replacement is not a Covered Benefit.

5. Office Visit Benefit

- A. The Discount Fee specified in this schedule for office visits is limited to four per year. This fee(s) is due in addition to any other Discount Fee(s) specified for procedures or services rendered. Office visits beyond four per year are provided at no charge.
- B. The Discount Fee specified in this schedule for oral examinations is limited to four per year, per member. Oral examinations beyond four per year are provided at no charge. This fee(s) is due in addition to any other Discount Fee(s) specified for procedures or services rendered.
- C. The office visit fee for fillings is due only once per quadrant, even if fillings are done on separate visits.
- D. The office visit fee for root canals and crowns is due only once per procedure, regardless of the number of visits necessary to complete that procedure. For multiple procedures, the office visit fee is due once for each procedure.
- E. Covered general dental services are unlimited when prescribed and performed by the assigned network dental office, subject to the Limitations and Exclusions of your dental plan. The services of a Specialist are not a covered dental benefit.

6. Workers' Compensation

Should any benefit or service be rendered as a result of a Workers' Compensation Injury Claim, the member shall assign his/her right to reimbursement from other sources to us or the network dental provider who rendered the services. Any reimbursement in excess of the reasonable value of the services performed shall be refunded by us or the network dental provider who rendered the service(s).

7. Prophylaxis (Cleaning)

Routine cleaning of teeth, including polishing and required supragingival (above the gum) and coronal scaling, is an allowable preventive Covered Dental Service once every six months when diagnosed as needed by the assigned network dental office.

8. Full Mouth Radiographs (X-rays)

X-rays are limited to once in a two-year period. Bitewing X-rays are limited to no more than one series of four in any six-month period.

9. Periodontal Scaling and Root Planing

Both procedures are covered dental services only when the need can be demonstrated radio graphically and/or by pocket charting. Only two quadrants are allowable at an appointment with a maximum of four quadrants per Calendar Year.

10. Periodontal Maintenance Procedures

(ADA procedure #4910) are dental benefits following active therapy once every six months at the assigned network dental office.

11. Prosthetics

- A. Removable Prosthetics

Questions? Call our Customer Service Department listed in Chapter 2.

1. Temporary or Transitional Dentures are not a Covered Benefit.
2. Partial and Full Dentures
 - a. When permanent teeth are missing, a fixed bridge and/or a tooth supported partial denture is a dental benefit. The dental benefit is dependent upon:
 - The Exclusions and Limitations, and
 - The specific treatment recommendations of your assigned network dental office in concert with the member, subject to clinical appropriateness, and the best alternatives available to meet the member's dental needs and to restore function.
 - b. Laboratory Upgrades include, but are not limited to:
 - Precious metal for removable appliance framework or a metal base for a full denture
 - "Personalization" and characterization
 - Special denture teeth
3. Specialized services and laboratory upgrades for dentures, or charges for specialized techniques involving precision attachments or stressbreakers are not covered benefits. Denture(s) "personalization," characterization or special teeth are laboratory upgrades, which are limited to the amount actually charged by the dental laboratory for the upgrade.
4. Denture Repairs and Relines
 - a. The addition of new denture teeth for existing full or partial dentures is covered if a natural tooth or a denture tooth is lost.
 - b. Replacement of an existing full or partial denture is a dental benefit only if the existing denture is at least 5 years old, has been determined unserviceable and cannot be made serviceable by the network dentist:
 - c. If an existing permanent denture needs to be repaired and/or relined to be made serviceable, then repairs and/or relines are also a dental benefit. Denture relines are limited to twice per year from the date of delivery. The addition of denture teeth, repairs and relines of secondary ("back-up," "spare" or "temporary") dentures are not covered benefits.
 - d. Adjustments for new dentures are included in the Discount Fee for the denture for six months following delivery, if the adjustments are made by the same network dentist who originally made the denture. For existing dentures or new dentures after the initial six months, the member is responsible for the listed Discount Fee for a denture adjustment. Adjustments of secondary ("back-up" or "spare") dentures are not a Covered Benefit.

B. Fixed Prosthetics:

To replace missing natural teeth, a fixed bridge is covered unless:

1. The clinical condition of the teeth that would support the bridge is unfavorable.
2. There are inadequate teeth available to support the bridge.
3. The same dental arch has a serviceable existing partial denture to which additional denture teeth may be added to replace the missing natural teeth.
4. A member under 16 years of age loses a permanent tooth, in which case, an interim anterior

Questions? Call our Customer Service Department listed in Chapter 2.

stayplate would be the Covered Dental Service to replace the missing tooth.

5. The new bridge would replace an existing bridge that is either less than five years old or still serviceable.
6. The bridge would be supported in whole or in part by dental implants or acid-etched resin bridge retainers (a “Maryland” bridge).
7. A bridge would be used only to realign malaligned teeth.
8. It is a long spanning bridge (anything beyond four abutments and/or pontics).
9. The bridge would have an abutment (support) only on one side.

C. Single Crowns:

Single crowns are a Covered Dental Service when there is not enough retentive quality left in a tooth to hold a filling or if the tooth requires cuspal protection to avoid an unacceptable risk of tooth fracture. The use of precious or semi-precious metals in crowns is considered a laboratory upgrade, which the assigned network dentist may offer the member for a fee not to exceed the amount charged to the dentist by the dental laboratory for the use of these upgraded metal alloys. The assigned network dentist may not, however, charge any additional laboratory fee in excess of the listed Discount Fee if a base metal alloy is used in a crown.

1. Replacement of a crown is a Covered Dental Service as long as the existing restoration is at least five years old, unserviceable and cannot be made serviceable, as determined by the assigned network dentist.
2. For crowns and fixed bridges, the maximum dental benefit within a 12-month period is any combination of seven crowns or pontics (artificial teeth that are part of a fixed bridge). If more than seven crowns and/or pontics are done for a member within a twelve-month period, the assigned network dentist’s fee for any additional crowns within that period would not be limited to the listed Discount Fee, but instead can reflect the network dentist’s UCR.

12. Occlusal Adjustment – Complete (D9952)

Reshaping of the biting surfaces of the teeth to create harmonious contact and relationships between teeth in the upper and lower jaw. The correction of occlusion on natural teeth or existing restorations is not a Covered Benefit. However, adjustment of the bite on a new restoration, crown, bridge and denture will be provided at no additional charge, if performed by the assigned network dentist who provided the service.

13. Dowel Posts and Pins

Dowel posts are a dental benefit for teeth that have had root canal therapy and lack sufficient structure to otherwise support and retain a crown. Pins are a separate dental benefit if deemed by the assigned network dentist necessary to provide adequate retention of a restoration.

14. Restorations and Dental Prosthetics

Restorations and/or fixed or removable prosthetics needed solely to increase vertical dimension or restore the occlusal plane are not covered benefits.

Exclusion of Benefits

The following dental procedures and services are excluded dental benefits and not covered benefits as specifically described below:

Questions? Call our Customer Service Department listed in Chapter 2.

1. Referral to a Specialist.
2. Dental services provided by a Specialist.
3. Cosmetic dental care.
4. General anesthesia (intravenous sedation), relative analgesia (N2O2) and the services of an anesthesiologist or nurse anesthesiologist.
5. The provision of dental services in hospitals, extended care facilities or members' homes.
6. Treatment of fractured bones and dislocated joints.
7. Replacement of lost or stolen dentures is not covered. Crowns or bridgework lost due to negligence are not covered, unless the crown or bridge became dislodged because of recurrent dental caries, tooth fracture, substandard tooth preparation or poor margins (as previously determined in an examination by the assigned network dentist or based upon a review of a pre-existing radiograph).
8. Replacement of lost, stolen or broken orthodontic appliances.
9. Services which are provided to the member by a state government or agency or are provided without cost to the member by a municipality, county or other subdivision.
10. Dental expense incurred in connection with any dental procedure started after termination of eligibility for benefits.
11. Work-in-progress such as the completion of dental services started before the member's effective date with the Plan, or started by an out-of-network dentist without our prior approval. **Note:** This Exclusion does not apply to a current member who has a temporary placed, a tooth opened and medicated as a palliative service while Out-of-Area or when the assigned network dentist is unavailable to render Palliative Care.
12. The treatment of congenital and/or developmental malformations, which includes the treatment of congenitally missing and extra, supernumerary teeth and related pathology.
13. The treatment of non-dentigerous cysts, benign and malignant tumors, neoplasms and dysplasias.
14. Dental ridge augmentation, vestibuloplasties and the excision of benign hyperplastic tissue.
15. Drugs prescribed by a dentist or drugs used for dental treatment, except in accordance with Medicare guidelines.
16. Any dental procedure unable to be performed in the assigned network dental office because of the member's general health and physical limitations.
17. Oral surgery and procedures performed to facilitate or allow orthodontic treatment, which include, but are not limited to: orthodontic extraction, serial extraction, orthognathic surgery, transeptal fiberotomy, gingivectomy and surgery to uncover impacted teeth.
18. Services rendered by a dental office other than member's assigned network dental office, unless previously authorized by us in writing. An exception is made for emergency care.
19. The placement, maintenance and removal of implants. Crowns and fixed prosthesis supported by implants.
20. Restorations of natural teeth other than those needed for replacement of unserviceable existing restorations or to replace tooth structure lost due to fracture, endodontic access preparations or dental caries. Treatment includes, but is not limited to:
 - Replacing or stabilizing tooth structure loss by attrition, abrasion or erosion.
 - Periodontal splinting/grafting.
 - The replacement of otherwise serviceable amalgam restorations, with new reiterations of a different material solely to eliminate the presence of amalgam.
21. Restorations and dental prosthetics that are done solely to alter the vertical dimension of occlusion,

Questions? Call our Customer Service Department listed in Chapter 2.

alter the plane of occlusion, modify a parafunctional habit, and/or treat temporomandibular joint dysfunction and/or myofascial pain syndrome. If performed, the member must pay UCR. These services include, but are not limited to:

- Realignment of teeth.
- Gnathologic recording.
- Occlusal Adjustment – Complete (D9952).
- Occlusal splints and night guards.
- Overlays, implant supported partial dentures and overdentures.
- The replacement of otherwise serviceable existing restorations and dental prosthetics.
- Precision attachments and stressbreakers.

22. Dental services which we determine not to be medically necessary or consistent with good professional practice.
23. The provision of dental services which would not be consistent with the member's dental needs and/or generally accepted professional standards of dental therapeutics for that member.
24. The premature extraction of asymptomatic or non-pathologic impacted teeth at an early stage of tooth development, which, if allowed to further develop and erupt, would reduce the likelihood of needing a more invasive surgery and/or experiencing postoperative complications.
25. Adjunctive dental services that are performed only to allow or facilitate the performance of another non-covered dental service.
26. Medical services for treatment of fractures, dislocations, tumors, non-dentigerous cysts, and neoplasms, and other medically necessary surgeries of the jaws or related joints. Requests for such services should be submitted to the member's full service medical health plan.
27. Liability insurance cases: Dental care which is covered under automobile, medical, no-fault or similar type insurance.

Hearing Services

Hearing Service Providers

Your health plan network hearing service provider, EPIC Hearing Healthcare, can help get you started. You can contact EPIC Hearing Healthcare at **1-866-956-5400**, (TTY: **711**), 6 a.m. to 6 p.m. PST, Monday through Friday so they can help to locate a provider in your area. Or, you can visit www.epichearing.com. Please call Customer Service if you have any questions about your hearing services. The phone numbers and hours of operation for Customer Service are located on the back cover of this booklet.

Covered Services

Hearing Services

The following services are covered under your additional hearing benefit:

Routine Hearing Exam

- You can receive a complete hearing exam, every 12 months, through a network hearing service provider

Questions? Call our Customer Service Department listed in Chapter 2.

- No authorization needed

Please see the chart above for any copayment or coinsurance that may be due at the time of your exam.

Limitations and Exclusions

Please note the following limitations and exclusions apply to all additional benefits. Certain services and items are not covered by your additional benefit(s), including these general ones:

- Government treatment for any services provided in a local, state or federal government facility or agency except when payment under the plan is expressly required by federal or state law.
- Any treatment or services caused by or arising out of the course of employment or covered under any public liability insurance, including, but not limited to, Worker's Compensation programs.

The limitations and exclusions below apply to your additional hearing aid benefit:

Covered expenses related to hearing aids are limited to plan Usual and Customary (U&C) charge of a basic hearing aid to provide functional improvement. Certain hearing aid items and services are not covered. Items and services that are not covered include, but are not limited to, the following:

- Replacement of a hearing aid that is lost, broken or stolen if occurrence exceeds covered rate of occurrence
- Repair of the hearing aid and related services
- Surgically implanted hearing devices
- An eyeglass-type hearing aid or additional charges for a hearing aid designed specifically for cosmetic purposes
- Services or supplies rendered to a member after cessation of coverage, except, if a hearing aid is ordered while coverage is in force and such hearing aid is delivered within 60 days after the date of cessation, the hearing aid will be considered a covered hearing aid expense
- Services or supplies that are not necessary according to professionally accepted standards of practice

This list is subject to change. Please call our Customer Service Department at the phone number listed in Chapter 2 of the Evidence of Coverage if you are not certain which medical group/IPA you currently belong to, or need an updated list of providers.

Vision Care

Vision Service Providers

If you belong to one of the network medical groups/IPAs listed below, you will receive your routine vision care through your medical group/IPA. Contact your medical group/IPA office to arrange an appointment. If you do not belong to any of these medical groups, you will receive your routine vision care through a network vision provider. Please reference your vision directory for a list of network vision providers.

California

Questions? Call our Customer Service Department listed in Chapter 2.

Alamitos IPA
Beaver Medical Group
Centre for Health Care
Encompass Medical Group
HealthCare Partners Medical Group/East LA
HealthCare Partners Medical Group/El Monte
HealthCare Partners Medical Group/Glendale
HealthCare Partners Medical Group/LA
HealthCare Partners Medical Group/Montebello
HealthCare Partners Medical Group – South Bay
Lakewood Health Plan
Sharp Community Medical Group
Sharp Community Medical Group/Chula Vista
Sharp Community Medical Group/Coronado
Sharp Community Medical Group/Graybill
Sharp Community Medical Group/Grossmont
Sharp Community/Inland North
Sharp Rees-Stealy Medical Group Inc.
Texas
Health TX
WellMed

*This list is subject to change. Please call our Customer Service Department at the phone number listed in Chapter 2 of the Evidence of Coverage if you are not certain which medical group/IPA you currently belong to, or need an updated list of providers.

Covered Services

Vision Care

The following services are covered under your vision benefit:

Routine Eye Exam (refraction)

- A complete vision exam every 12 months, through a network vision service provider
- No authorization needed

Routine Eye Wear

The plan provides an eyewear benefit for vision correction not related to cataract surgery. Eyewear

Questions? Call our Customer Service Department listed in Chapter 2.

consists of frames and lenses (eyeglasses).

You are covered for frames and lenses (one pair of eyeglasses) through a network vision service provider. The following information is listed in the chart above:

- The copayment or coinsurance for the standard or retail eyewear (i.e., \$20 or 20%), if applicable.
- The copayment or coinsurance for standard or retail lenses (i.e., \$20 or 20%), if applicable.
- The copayment or coinsurance for standard or retail frames (i.e., \$20 or 20%), if applicable.
- The specific limit for the standard or retail eyewear (i.e., up to \$70), if applicable.
- The specific limit for standard or retail eyeglasses (i.e., up to \$70), if applicable.
- The specific limit for the non-standard eyewear (i.e., up to \$70), if applicable.
- The specific limit for non-standard eyeglasses (i.e., up to \$70), if applicable.
- How often you can receive the eyewear (i.e. every 24 months), if applicable.

Limitations and Exclusions

Please note the following limitations and exclusions apply to all additional benefits. Certain services and items are not covered by your additional benefit(s), including these general ones:

- Government treatment for any services provided in a local, state or federal government facility or agency except when payment under the plan is expressly required by federal or state law.
- Any treatment or services caused by or arising out of the course of employment or covered under any public liability insurance, including, but not limited to, Worker's Compensation programs.

The limitations and exclusions below apply to your additional vision benefit:

- Orthoptics or vision training and any associated supplemental testing.
- Plano lenses (non-prescription).
- Two pair of glasses instead of bifocals.
- Contact lenses.
- Subnormal (low) vision aids.
- Replacement of lenses and frames which are lost or broken, except at the normal intervals when services are otherwise available.
- LASIK, surgeries or other laser procedures for refractive error.
- Any eye examination or corrective eyewear required by an employer as a condition of employment.

Cosmetic services and/or materials including, but not limited to: blended (no-line) bifocal or trifocal lenses, oversize lenses (62 mm or greater), photochromic lenses, tinted lenses (except Pink or Rose #1 or #2), progressive, polycarbonate or multifocal lenses, the coating or laminating of the lens or lenses, UV (ultraviolet) lenses, polycarbonate/high index lenses, anti-reflective coating, scratch resistant coating, edge polish, cosmetic lenses and other cosmetic processes.

Routine Chiropractic Services

Chiropractic Service Providers

Questions? Call our Customer Service Department listed in Chapter 2.

Your health plan network chiropractic service provider, OptumHealth Physical Health of California may be reached at **1-800-428-6337** (TTY **1-888-877-5378**) 8 a.m. to 5 p.m. PST, Monday through Friday.

Covered Services

Routine Chiropractic Services

The following services are covered under your additional chiropractic benefit:

- You are covered up to a maximum number of visits per year, including evaluation of X-rays.
- You are covered for an initial examination with a network chiropractor to determine the nature of your problem and, if necessary, to prepare a treatment plan.
- Subsequent office visits to network chiropractors, as indicated by a treatment plan, may involve manipulations, adjustments, therapy, X-ray procedures and laboratory tests in various combinations.
- You are covered for conjunctive therapy, as set forth in the treatment plan, involving therapies such as ultrasound and electrical muscle stimulation.
- If a separate appointment is made to re-evaluate your treatment plan, a copayment or coinsurance will be required, and the visit will count against your annual maximum.
- X-rays and laboratory tests are covered in full when prescribed by a network chiropractor. X-ray interpretations or consultations are covered only when performed by a network chiropractor or an American Radiology Association (ARA) radiologist when determined to be medically necessary.

Please refer to the chart above for your copayment or coinsurance and the number of visits allowed under this plan.

Limitations and Exclusions

Please note the following limitations and exclusions apply to all additional benefits. Certain services and items are not covered by your additional benefit(s), including these general ones:

- Government treatment for any services provided in a local, state or federal government facility or agency except when payment under the plan is expressly required by federal or state law.
- Any treatment or services caused by or arising out of the course of employment or covered under any public liability insurance, including, but not limited to, Worker's Compensation programs.

The following items and services are limited and excluded from your additional chiropractic benefit as indicated:

- Terms and conditions of coverage not outlined in the Evidence of Coverage.
- Any accommodation, service, supply or other item determined not to be medically necessary, except for routine covered chiropractic services.
- Any service or treatment delivered by an out-of-network chiropractor, except for emergency chiropractic services.
- Services for examination and/or treatment of strictly non-neuromuscular-skeletal disorders.
- Services not documented as necessary and appropriate or classified as experimental or investigational chiropractic care.

Questions? Call our Customer Service Department listed in Chapter 2.

- Diagnostic scanning, including Magnetic Resonance Imaging (MRI), CAT scans and/or other types of diagnostic scanning.
- Any services or treatment for Temporomandibular Joint Disease (TMJ). TMJ is a condition of the jaw joint that commonly causes headaches, tenderness of the jaw muscles or dull aching facial pain.
- Treatment or service for pre-employment physicals or vocational rehabilitation.
- Thermography.
- Hypnotherapy, behavior training, sleep therapy, weight programs, educational programs, non-medical self-care or self-help, or any self-help physical exercise training, or any related diagnostic testing.
- Air conditioners, air purifiers, therapeutic mattress supplies or any other similar devices or appliances.
- Vitamins, minerals, nutritional supplements or other similar-type products.
- Manipulation under anesthesia, hospitalization or any related services.

Prescription drugs or medicines, including a non-legend or proprietary medicine or medication not requiring a prescription order.

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

SECTION 1 Introduction.....	3
Section 1.1 This chapter describes your coverage for Part D drugs.....	3
Section 1.2 Basic rules for the plan's Part D drug coverage.....	4
SECTION 2 Fill your prescription at a network pharmacy or through the plan's preferred mail-order service.....	4
Section 2.1 To have your prescription covered, use a network pharmacy.....	4
Section 2.2 Finding network pharmacies.....	4
Section 2.3 Using the plan's preferred mail-order services.....	5
Section 2.4 How can you get a long-term supply of drugs?.....	5
Section 2.5 When can you use a pharmacy that is not in the plan's network?.....	6
SECTION 3 Your drugs need to be on the plan's "Drug List".....	7
Section 3.1 The "Drug List" tells which Part D drugs are covered.....	7
Section 3.2 There are 4 "cost sharing tiers" for drugs on the Drug List.....	7
Section 3.3 How can you find out if a specific drug is on the Drug List?.....	8
SECTION 4 There are restrictions on coverage for some drugs.....	8
Section 4.1 Why do some drugs have restrictions?.....	8
Section 4.2 What kinds of restrictions?.....	8
Section 4.3 Do any of these restrictions apply to your drugs?.....	9
SECTION 5 What if one of your drugs is not covered in the way you'd like it to be covered?.....	10
Section 5.1 There are things you can do if your drug is not covered in the way you'd like it to be covered.....	10
Section 5.2 What can you do if your drug is not on the Drug List or if the drug is restricted in some way?.....	10
Section 5.3 What can you do if your drug is in a cost-sharing tier you think is too high?.....	12
SECTION 6 What if your coverage changes for one of your drugs?.....	13
Section 6.1 The Drug List can change during the year.....	13
Section 6.2 What happens if coverage changes for a drug you are taking?.....	13
SECTION 7 What types of drugs are not covered by the plan?.....	14
Section 7.1 Types of drugs we do not cover.....	14
SECTION 8 Show your Plan member ID card when you fill a prescription.....	15
Section 8.1 Show your member ID card.....	15
Section 8.2 What if you don't have your member ID card with you?.....	15
SECTION 9 Part D drug coverage in special situations.....	15
Section 9.1 What if you're in a hospital or a skilled nursing facility for a stay that is covered by the plan?.....	15
Section 9.2 What if you're a resident in a long-term care facility?.....	16
Section 9.3 What if you're also getting drug coverage from an employer or another retiree group	

Questions? Call our Customer Service Department listed in Chapter 2.

plan?..... 16

SECTION 10 Programs on drug safety and managing medications.....17

Section 10.1 Programs to help members use drugs safely..... 17

Section 10.2 Programs to help members manage their medications..... 17



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

There are programs to help people with limited resources pay for their drugs. The “Extra Help” program helps people with limited resources pay for their drugs. For more information, see Chapter 2, Section 7.

Are you currently getting help to pay for your drugs?

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

SECTION 1 Introduction

Section 1.1 This chapter describes your coverage for Part D drugs
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This chapter explains rules for using your coverage for Part D drugs. The next chapter tells what you pay for Part D drugs (Chapter 6, **What you pay for your Part D prescription drugs**).

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

- The plan covers drugs you are given during covered stays in the hospital or in a skilled nursing facility. Chapter 4 (**Medical Benefits Chart, what is covered and what you pay**) tells about the benefits and costs for drugs during a covered hospital or skilled nursing facility stay.
- Medicare Part B also provides benefits for some drugs. Part B drugs include certain chemotherapy drugs, certain drug injections you are given during an office visit, and drugs you are given at a dialysis facility. Chapter 4 (**Medical Benefits Chart, what is covered and what you pay**) tells about your benefits and costs for Part B drugs.

The two examples of drugs described above are covered by the plan's medical benefits. The rest of your prescription drugs are covered under the plan's Part D benefits. **This chapter explains rules for using your coverage for Part D drugs.** The next chapter tells what you pay for Part D drugs (Chapter 6, **What you pay for your Part D prescription drugs**).

Questions? Call our Customer Service Department listed in Chapter 2.

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

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

SECTION 2	Fill your prescription at a network pharmacy or through the plan's preferred mail-order service
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Section 2.1	To have your prescription covered, use a network pharmacy
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In most cases, your prescriptions are covered **only** if they are filled at the plan's network pharmacies. (See Section 2.5 for information about when we would cover prescriptions filled at out-of-network pharmacies.)

A network pharmacy is a pharmacy that has a contract with the plan to provide your covered prescription drugs. The term "covered drugs" means all of the Part D prescription drugs that are covered on the plan's Drug List.

Section 2.2	Finding network pharmacies
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How do you find a network pharmacy in your area?

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

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

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

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

Questions? Call our Customer Service Department listed in Chapter 2.

What if you need a specialized pharmacy?

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

- Pharmacies that supply drugs for home infusion therapy.
- Pharmacies that supply drugs for residents of a long-term care facility. Usually, a long-term care facility (such as a nursing home) has its own pharmacy. Residents may get prescription drugs through the facility's pharmacy as long as it is part of our network. If your long-term care pharmacy is not in our network, please contact Customer Service.
- Pharmacies that serve the Indian Health Service / Tribal / Urban Indian Health Program (not available in Puerto Rico). Except in emergencies, only Native Americans or Alaska Natives have access to these pharmacies in our network.
- Pharmacies that dispense drugs that are restricted by the FDA to certain locations or that require special handling, provider coordination, or education on their use. (Note: This scenario should happen rarely.)

To locate a specialized pharmacy, look in your **Pharmacy Directory** or call Customer Service.

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

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

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

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

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

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

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

1. **Some retail pharmacies** in our network allow you to get a long-term supply of mail-order drugs. Some of these retail pharmacies may agree to accept the mail-order cost-sharing amount

Questions? Call our Customer Service Department listed in Chapter 2.

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

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

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

Your prescription may be covered in certain situations

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

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

- **Prescriptions for a Medical Emergency**

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

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

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

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

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

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

How do you ask for reimbursement from the plan?

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

Questions? Call our Customer Service Department listed in Chapter 2.

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

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

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

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

The drugs on the Drug List are only those covered under Medicare Part D (earlier in this chapter, Section 1.1 explains about Part D drugs).

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

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

The Drug List includes both brand name and generic drugs

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

What is not on the Drug List?

The plan does not cover all prescription drugs.

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

Section 3.2 There are 4 "cost sharing tiers" for drugs on the Drug List
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Every drug on the plan's Drug List is in one of 4 cost-sharing tiers. In general, the higher the cost-sharing tier, the higher your cost for the drug:

Tier 1 – Preferred Generic Drugs (includes most generic and some lower-cost brand name prescription drugs)

Tier 2 – Preferred Brand Drugs (includes many common brand name and some higher-cost generic drugs)

Questions? Call our Customer Service Department listed in Chapter 2.

Tier 3 – Non-Preferred Brand Drugs (includes non-preferred brand name drugs and non-preferred generic drugs)

Tier 4 – Specialty Tier Drugs (includes unique or very high-cost drugs)

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

The amount you pay for drugs in each cost-sharing tier is shown in Chapter 6 (**What you pay for your Part D prescription drugs**).

Section 3.3	How can you find out if a specific drug is on the Drug List?
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You have three ways to find out:

1. Check the most recent Drug List we sent you in the mail. (Please note: The Drug List we send includes information for the covered drugs that are most commonly used by our members. However, we cover additional drugs that are not included in the printed Drug List. If one of your drugs is not listed in the Drug List, you should visit our website or contact Customer Service to find out if we cover it.)
2. Visit the plan's website (www.UHCRetiree.com). The Drug List on the website is always the most current.
3. Call Customer Service to find out if a particular drug is on the plan's Drug List or to ask for a copy of the list. Phone numbers for Customer Service are on the back cover of this booklet.

SECTION 4	There are restrictions on coverage for some drugs
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Section 4.1	Why do some drugs have restrictions?
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For certain prescription drugs, special rules restrict how and when the plan covers them. A team of doctors and pharmacists developed these rules to help our members use drugs in the most effective ways. These special rules also help control overall drug costs, which keeps your drug coverage more affordable.

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

If there is a restriction for your drug, it usually means that you or your provider will have to take extra steps in order for us to cover the drug. If you want us to waive the restriction for you, you will need to use the formal appeals process and ask us to make an exception. We may or may not agree to waive the restriction for you. (See Chapter 9, Section 6.4 for information about asking for exceptions.)

Section 4.2	What kinds of restrictions?
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Our Plan uses different types of restrictions to help our members use drugs in the most effective ways. The sections below tell you more about the types of restrictions we use for certain drugs.

Questions? Call our Customer Service Department listed in Chapter 2.

Restricting brand name drugs when a generic version is available

Generally, a “generic” drug works the same as a brand name drug, and usually costs less. **When a generic version of a brand name drug is available, our network pharmacies will provide you the generic version.** We usually will not cover the brand name drug when a generic version is available. However, if your provider has told us the medical reason that the generic drug will not work for you OR has written “No substitutions” on your prescription for a brand name drug OR has told us the medical reason that neither the generic drug nor other covered drugs that treat the same condition will work for you, then we will cover the brand name drug. (Your share of the cost may be greater for the brand name drug than for the generic drug.)

Getting plan approval in advance

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

Trying a different drug first

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

Quantity limits

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

Section 4.3	Do any of these restrictions apply to your drugs?
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The plan's Drug List includes information about the restrictions described above. To find out if any of these restrictions apply to a drug you take or want to take, check the Drug List. For the most up-to-date information, call Customer Service (phone numbers are on the back cover of this booklet) or check our website (www.UHCRetiree.com).

If there is a restriction for your drug, it usually means that you or your provider will have to take extra steps in order for us to cover the drug. If there is a restriction on the drug you want to take, you should contact Customer Service to learn what you or your provider would need to do to get coverage for the drug. If you want us to waive the restriction for you, you will need to use the formal appeals process and ask us to make an exception. We may or may not agree to waive the restriction for you. (See Chapter 9, Section 6.4 for information about asking for exceptions.)

Questions? Call our Customer Service Department listed in Chapter 2.

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

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

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

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

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

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

Section 5.2 What can you do if your drug is not on the Drug List or if the drug is restricted in some way?

If your drug is not on the Drug List or is restricted, here are things you can do:

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

You may be able to get a temporary supply

Questions? Call our Customer Service Department listed in Chapter 2.

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

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

1. **The change to your drug coverage must be one of the following types of changes:**
 - The drug you have been taking is **no longer on the plan's Drug List**.
 - -- or -- the drug you have been taking is **now restricted in some way** (Section 4 in this chapter tells about restrictions).
2. **You must be in one of the situations described below:**
 - **For those members who were in the plan last year and aren't in a long-term care facility:**
We will cover a temporary supply of your drug **one time only during the first 90 days of the plan year**. This temporary supply will be for a maximum of a 31-day supply, or less if your prescription is written for fewer days. The prescription must be filled at a network pharmacy.
 - **For those members who are new to the plan and aren't in a long-term care facility:**
We will cover a temporary supply of your drug **one time only during the first 90 days of your membership** in the plan. This temporary supply will be for a maximum of a 31-day supply, or less if your prescription is written for fewer days. The prescription must be filled at a network pharmacy.
 - **For those members who are new to the plan and reside in a long-term care facility:**
We will cover a temporary supply of your drug **during the first 90 days of your membership** in the plan. The first supply will be for a maximum of a 31-day supply, or less if your prescription is written for fewer days. If needed, we will cover additional refills during your first 90 days in the plan.
 - **For those members who have been in the plan for more than 90 days and reside in a long-term care facility and need a supply right away:**
We will cover one 31-day supply, or less if your prescription is written for fewer days. This is in addition to the above long-term care transition supply.
 - **For those current members with level of care changes:**
There may be unplanned transitions such as hospital discharges or level of care changes that occur after the first 90 days that you are enrolled as a member in our Plan. If you are prescribed a drug that is not on our formulary or your ability to get your drugs is limited, you are required to use the plan's exception process. You may request a one-time emergency supply of up to 31 days to allow you time to discuss alternative treatment with your doctor or to pursue a formulary exception.

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

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

You can change to another drug

Questions? Call our Customer Service Department listed in Chapter 2.

Start by talking with your provider. Perhaps there is a different drug covered by the plan that might work just as well for you. You can call Customer Service to ask for a list of covered drugs that treat the same medical condition. This list can help your provider to find a covered drug that might work for you.

You can ask for an exception

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

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

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

Section 5.3	What can you do if your drug is in a cost-sharing tier you think is too high?
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If your drug is in a cost-sharing tier you think is too high, here are things you can do:

You can change to another drug

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

You can ask for an exception

For drugs in Tiers 1, 2 and 3, you and your provider can ask the plan to make an exception in the cost-sharing tier for the drug so that you pay less for it. If your provider says that you have medical reasons that justify asking us for an exception, your provider can help you request an exception to the rule.

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

Drugs in some of our cost-sharing tiers are not eligible for this type of exception. We do not lower the cost-sharing amount for drugs in Tier 4.

Questions? Call our Customer Service Department listed in Chapter 2.

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

Section 6.1	The Drug List can change during the year
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Most of the changes in drug coverage happen at the beginning of each plan year. However, during the year, the plan might make many kinds of changes to the Drug List. For example, the plan might:

- **Add or remove drugs from the Drug List.** New drugs become available, including new generic drugs. Perhaps the government has given approval to a new use for an existing drug. Sometimes, a drug gets recalled and we decide not to cover it. Or we might remove a drug from the list because it has been found to be ineffective.
- **Move a drug to a higher or lower cost-sharing tier.**
- **Add or remove a restriction on coverage for a drug** (for more information about restrictions to coverage, see Section 4 in this chapter).
- **Replace a brand-name drug with a generic drug.**

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

Section 6.2	What happens if coverage changes for a drug you are taking?
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How will you find out if your drug's coverage has been changed?

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

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

Do changes to your drug coverage affect you right away?

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

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

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

In some cases, you will be affected by the coverage change before the next plan year:

Questions? Call our Customer Service Department listed in Chapter 2.

- If a **brand name drug you are taking is replaced by a new generic drug**, the plan must give you at least 60 days' notice or give you a 60-day refill of your brand name drug at a network pharmacy.
 - During this 60-day period, you should be working with your provider to switch to the generic or to a different drug that we cover.
 - Or you and your provider can ask the plan to make an exception and continue to cover the brand-name drug for you. For information on how to ask for an exception, see Chapter 9 (**What to do if you have a problem or complaint (coverage decisions, appeals, complaints)**).
- Again, if a drug is **suddenly recalled** because it's been found to be unsafe or for other reasons, the plan will immediately remove the drug from the Drug List. We will let you know of this change right away.
 - Your provider will also know about this change, and can work with you to find another drug for your condition.

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

Section 7.1	Types of drugs we do not cover
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This section tells you what kinds of prescription drugs are “excluded.” This means Medicare does not pay for these drugs.

If you get drugs that are excluded, you must pay for them yourself. We won't pay for the drugs that are listed in this section. The only exception: If the requested drug is found upon appeal to be a drug that is not excluded under Part D and we should have paid for or covered it because of your specific situation. (For information about appealing a decision we have made to not cover a drug, go to Chapter 9, Section 6.5 in this booklet.)

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

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

Also, by law, these categories of drugs are not covered by Medicare drug plans:

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

Questions? Call our Customer Service Department listed in Chapter 2.

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

Please note: Your Plan Sponsor **may** have elected to offer some of the drugs listed above to you as an additional benefit. If so, you will receive additional information about the drugs they have chosen to offer to you separately, in your Plan materials.

If you receive Extra Help paying for your drugs, your state Medicaid program may cover some prescription drugs not normally covered in a Medicare drug plan. Please contact your state Medicaid program to determine what drug coverage may be available to you. (You can find phone numbers and contact information for Medicaid in Chapter 2, Section 6.)

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

Section 8.1 Show your member ID card

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

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

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

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

SECTION 9 Part D drug coverage in special situations

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

If you are admitted to a hospital or to a skilled nursing facility for a stay covered by the plan, we will generally cover the cost of your prescription drugs during your stay. Once you leave the hospital or

Questions? Call our Customer Service Department listed in Chapter 2.

skilled nursing facility, the plan will cover your drugs as long as the drugs meet all of our rules for coverage. See the previous parts of this section that tell about the rules for getting drug coverage. Chapter 6 (**What you pay for your Part D prescription drugs**) gives more information about drug coverage and what you pay.

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

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

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

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

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

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

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

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

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

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

In general, if you are currently employed, the retiree group prescription drug coverage you get from us through your Plan Sponsor will be **secondary** to coverage through your current employer.

Special note about 'creditable coverage':

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

Questions? Call our Customer Service Department listed in Chapter 2.

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

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

SECTION 10 Programs on drug safety and managing medications

Section 10.1 Programs to help members use drugs safely
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We conduct drug use reviews for our members to help make sure that they are getting safe and appropriate care. These reviews are especially important for members who have more than one provider who prescribes their drugs.

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

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

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

Section 10.2 Programs to help members manage their medications
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We have programs that can help our members with special situations. For example, some members have several complex medical conditions or they may need to take many drugs at the same time, or they could have very high drug costs.

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

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

Questions? Call our Customer Service Department listed in Chapter 2.

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

SECTION 1 Introduction	3
Section 1.1 Use this chapter together with other materials that explain your drug coverage	3
SECTION 2 What you pay for a drug depends on which “drug payment stage” you are in when you get the drug	4
Section 2.1 What are the drug payment stages for our Plan members?	4
SECTION 3 We send you reports that explain payments for your drugs and which payment stage you are in	5
Section 3.1 We send you a monthly report called the “Explanation of Benefits” (the “EOB”).....	5
Section 3.2 Help us keep our information about your drug payments up to date	6
SECTION 4 There is no deductible for the plan.....	7
Section 4.1 You do not pay a deductible for your Part D drugs.....	7
SECTION 5 During the Initial Coverage Stage, the plan pays its share of your drug costs and you pay your share	7
Section 5.1 What you pay for a drug depends on the drug and where you fill your prescription.....	7
Section 5.2 A table that shows your costs for a covered drug.....	8
Section 5.3 You stay in the Initial Coverage Stage until your total drug costs for the year reach \$2,840.....	9
SECTION 6 During the Coverage Gap Stage, the plan continues to pay its share of the cost of your drugs and you pay your share of the cost.....	10
Section 6.1 You stay in the Coverage Gap Stage until your out-of-pocket costs reach \$4,550.....	10
Section 6.2 How Medicare calculates your out-of-pocket costs for prescription drugs.....	11
SECTION 7 During the Catastrophic Coverage Stage, the plan pays most of the cost for your drugs.....	12
Section 7.1 Once you are in the Catastrophic Coverage Stage, you will stay in this stage for the rest of the year.....	13
SECTION 8 Additional benefits information.....	13
Section 8.1 Our Plan has benefit limitations.....	13
SECTION 9 What you pay for vaccinations covered by Part D depends on how and where you get them.....	13
Section 9.1 Our Plan has separate coverage for the Part D vaccine medication itself and for the cost of giving you the vaccination shot.....	13
Section 9.2 You may want to call us at Customer Service before you get a vaccination.....	15
SECTION 10 Do you have to pay the Part D “late enrollment penalty”?.....	15
Section 10.1 What is the Part D “late enrollment penalty”?.....	15
Section 10.2 How much is the Part D late enrollment penalty?.....	16
Section 10.3 In some situations, you can enroll late and not have to pay the penalty.....	16

Questions? Call our Customer Service Department listed in Chapter 2.

Section 10.4 What can you do if you disagree about your late enrollment penalty?	17
SECTION 11 Do you have to pay an extra Part D amount because of your income?.....	17
Section 11.1 Who pays an extra Part D amount because of income?	17
Section 11.2 How much is the extra Part D amount?	18
Section 11.3 What can you do if you disagree about paying an extra Part D amount?	18



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

There are programs to help people with limited resources pay for their drugs. The “Extra Help” program helps people with limited resources pay for their drugs. For more information, see Chapter 2, Section 7.

Are you currently getting help to pay for your drugs?

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

SECTION 1 Introduction

Section 1.1	Use this chapter together with other materials that explain your drug coverage
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This chapter focuses on what you pay for your Part D prescription drugs. To keep things simple, we use “drug” in this chapter to mean a Part D prescription drug. As explained in Chapter 5, not all drugs are Part D drugs – some drugs are covered under Medicare Part A or Part B and other drugs are excluded from Medicare coverage by law.

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

- **The plan’s List of Covered Drugs (Formulary).** To keep things simple, we call this the “Drug List”.
 - This Drug List tells which drugs are covered for you.
 - It also tells which of the 4 “cost-sharing tiers” the drug is in and whether there are any restrictions on your coverage for the drug.
 - If you need a copy of the Drug List, call Customer Service (phone numbers are on the back cover of this booklet). You can also find the Drug List on our website at www.UHCRetiree.com. The Drug List on the website is always the most current.
- **Chapter 5 of this booklet.** Chapter 5 gives the details about your prescription drug coverage, including rules you need to follow when you get your covered drugs. Chapter 5 also tells which types of prescription drugs are not covered by our Plan.

Questions? Call our Customer Service Department listed in Chapter 2.

- **The plan's Pharmacy Directory.** In most situations you must use a network pharmacy to get your covered drugs (see Chapter 5 for the details). The **Pharmacy Directory** has a list of pharmacies in the plan's network. It also explains how you can get a long-term supply of a drug (such as filling a prescription for a three-month's supply).

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

Section 2.1 What are the drug payment stages for our Plan members?
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As shown in the table below, there are "drug payment stages" for your prescription drug coverage under our Plan. How much you pay for a drug depends on which of these stages you are in at the time you get a prescription filled or refilled.

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

STAGE 1	STAGE 2	STAGE 3	STAGE 4
Yearly Deductible Stage	Initial Coverage Stage	Coverage Gap Stage	Catastrophic Coverage Stage
<p>Because there is no deductible for the plan, this payment stage does not apply to you.</p>	<p>You begin in this stage when you fill your first prescription of the year.</p> <p>During this stage, the plan pays its share of the cost of your drugs and you pay your share of the cost.</p> <p>You stay in this stage until your year-to-date “total drug costs” (your payments plus any Part D plan’s payments) total \$2,840.</p> <p>(Details are in Section 5 of this chapter.)</p>	<p>The plan continues to pay its share of the cost of your drugs and you pay your share of the cost.</p> <p>You stay in this stage until your year-to-date “out-of-pocket costs” (your payments) reach a total of \$4,550. This amount and rules for counting costs toward this amount have been set by Medicare.</p> <p>(Details are in Section 6 of this chapter.)</p>	<p>During this stage, the plan will pay most of the cost of your drugs for the rest of the plan year.</p> <p>(Details are in Section 7 of this chapter.)</p>

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

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

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

Questions? Call our Customer Service Department listed in Chapter 2.

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

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

- **Information for that month.** This report gives the payment details about the prescriptions you have filled during the previous month. It shows the total drug costs, what the plan paid, and what you and others on your behalf paid.
- **Totals for the year since January 1.** This is called “year-to-date” information. It shows you the total drug costs and total payments for your drugs since the year began.

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 member ID card when you get a prescription filled.** To make sure we know about the prescriptions you are filling and what you are paying, show your Plan member ID card every time you get a prescription filled.
- **Make sure we have the information we need.** There are times you may pay for prescription drugs when we will not automatically get the information we need to keep track of your out-of-pocket costs. To help us keep track of your out-of-pocket costs, you may give us copies of receipts for drugs that you have purchased. (If you are billed for a covered drug, you can ask our Plan to pay our share of the cost of the drug. For instructions on how to do this, go to Chapter 7, Section 2 of this booklet.) Here are some types of situations when you may want to give us copies of your drug receipts to be sure we have a complete record of what you have spent for your drugs:
 - When you purchase a covered drug at a network pharmacy at a special price or using a discount card that is not part of our Plan’s benefit.
 - When you made a copayment for drugs that are provided under a drug manufacturer patient assistance program.
 - Any time you have purchased covered drugs at out-of-network pharmacies or other times you have paid the full price for a covered drug under special circumstances.
- **Send us information about the payments others have made for you.** Payments made by certain other individuals and organizations also count toward your out of pocket costs and help qualify you for catastrophic coverage. For example, payments made by 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.

Questions? Call our Customer Service Department listed in Chapter 2.

SECTION 4 There is no deductible for the 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 amount). Your share of the cost will vary depending on the drug and where you fill your prescription.

The plan has 4 cost-sharing tiers

Every drug on the plan's Drug List is in one of 4 cost-sharing tiers. In general, the higher the cost-sharing tier number, the higher your cost for the drug:

Tier 1 – Preferred Generic Drugs (includes most generic and some lower-cost brand name prescription drugs)

Tier 2 – Preferred Brand Drugs (includes many common brand name and some higher-cost generic drugs)

Tier 3 – Non-Preferred Brand Drugs (includes non-preferred brand name drugs and non-preferred generic drugs)

Tier 4 – Specialty Tier Drugs (includes unique or very high-cost 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 preferred or non-preferred 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**.

Questions? Call our Customer Service Department listed in Chapter 2.

Section 5.2 A table that shows your costs for a covered 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.

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

The table below shows what you pay when you get a 31-day supply and a long-term up to a 90-day supply of a drug.

Your share of the cost when you get a covered Part D prescription drug from:			
	Network Pharmacy (up to a 31-day supply)	The Plan’s Mail-Order Service (up to a 90-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 Preferred Generic Drugs	\$5 copayment	Preferred mail service pharmacy - \$10 copayment Non-preferred mail service pharmacy - \$15 copayment	\$5 copayment*

Questions? Call our Customer Service Department listed in Chapter 2.

Your share of the cost when you get a covered Part D prescription drug from:			
	Network Pharmacy (up to a 31-day supply)	The Plan's Mail-Order Service (up to a 90-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 2 Preferred Brand Drugs	\$15 copayment	Preferred mail service pharmacy - \$30 copayment Non-preferred mail service pharmacy - \$45 copayment	\$15 copayment*
Cost-Sharing Tier 3 Non-Preferred Brand Drugs	\$15 copayment	Preferred mail service pharmacy - \$30 copayment Non-preferred mail service pharmacy - \$45 copayment	\$15 copayment*
Cost-Sharing Tier 4 Specialty Tier Drugs	\$15 copayment	Preferred mail service pharmacy - \$30 copayment Non-preferred mail service pharmacy - \$45 copayment	\$15 copayment*

*You will not be reimbursed for the difference between the Out-of-Network Pharmacy charge and the plan's In-Network allowable amount.

Section 5.3	You stay in the Initial Coverage Stage until your total drug costs for the year reach \$2,840
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You stay in the Initial Coverage Stage until the total amount for the prescription drugs you have filled and refilled reaches the \$2,840 **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

Questions? Call our Customer Service Department listed in Chapter 2.

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 \$2,840 limit in a year.

We will let you know if you reach this \$2,840 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, the plan continues to pay its share of the cost of your drugs and you pay your share of the cost**

Section 6.1	You stay in the Coverage Gap Stage until your out-of-pocket costs reach \$4,550
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After you leave the Initial Coverage Stage, we will continue to pay our share of the cost of your drugs and you pay your share until your yearly out-of-pocket costs reach a maximum amount that Medicare has set. In 2011, that amount is \$4,550.

Medicare Coverage Gap Discount Program

The Medicare Coverage Gap Discount Program provides manufacturer discounts on brand name drugs to Part D enrollees who have reached the coverage gap and are not already receiving “Extra Help.” A 50% discount on the negotiated price (excluding the dispensing fee) is available for those brand name drugs from manufacturers that have agreed to pay the discount.

We will automatically apply the discount when your pharmacy bills you for your prescription and your Explanation of Benefits will show any discount provided. The amount discounted by the manufacturer counts toward your out-of-pocket costs as if you had paid this amount and moves you through the coverage gap.

We will continue to pay our share of the cost of your drugs during the coverage gap stage. If you fill a prescription for a brand name drug then the discount applies to your share of cost. You will pay your share of your copayment or coinsurance and the remainder will be from manufacturers that have agreed to pay the discount. You will still pay your entire share of cost for any generic drugs you need.

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

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 \$4,550, you leave the Coverage Gap Stage and move on to the Catastrophic Coverage Stage.

Questions? Call our Customer Service Department listed in Chapter 2.

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, or 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 \$4,550 in out-of-pocket costs within the plan 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.
- Prescription drugs covered by Part A or Part B
- Payments you make toward drugs covered under our additional coverage but not normally covered in a Medicare Prescription Drug Plan.
- Payments you make toward prescription drugs not normally covered in a Medicare Prescription Drug Plan
- Payments made by the plan for your generic drugs while in the Coverage Gap
- Payments for your drugs that are made by group health plans including employer health plans.
- Payments for your drugs that are made by insurance plans and government-funded health programs such as TRICARE and the Veteran's Administration.
- Payments for your drugs made by a third-party with a legal obligation to pay for prescription costs (for example, Worker's Compensation).

Reminder: If any other organization such as the ones listed above pays part or all of your out-of-pocket costs for drugs, you are required to tell our Plan. Call Customer Service to let us know (phone numbers are on the back cover of this booklet).

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

- **We will help you.** The **Explanation of Benefits (EOB)** report we send to you includes the current amount of your out-of-pocket costs (Section 3 in this chapter tells about this report). When you reach a total of \$4,550 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**

Questions? Call our Customer Service Department listed in Chapter 2.

Section 7.1	Once you are in the Catastrophic Coverage Stage, you will stay in this stage for the rest of the year
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You qualify for the Catastrophic Coverage Stage when your out-of-pocket costs have reached the \$4,550 limit for the plan year. Once you are in the Catastrophic Coverage Stage, you will stay in this payment stage until the end of the plan 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** – \$2.50 copayment for a generic drug or a drug that is treated like a generic. Or a \$6.30 copayment for all other drugs.
- **Our Plan pays the rest** of the cost.

SECTION 8 **Additional benefits information**

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

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

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

Section 9.1	Our Plan has separate coverage for the Part D vaccine medication itself and for the cost of giving you the vaccination shot
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Our Plan provides coverage of a number of Part D vaccines. We also cover vaccines that are considered medical benefits. You can find out about coverage of these vaccines by going to the Medical Benefits Chart in Chapter 4, Section 2.1.

Questions? Call our Customer Service Department listed in Chapter 2.

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 and/or coinsurance for the vaccine itself.
- Our Plan will pay for the cost of giving you the vaccination shot.

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

- When you get the vaccination, you will pay for the entire cost of the vaccine and its administration.
- You can then ask our Plan to pay our share of the cost by using the procedures that are described in Chapter 7 of this booklet (**Asking the plan to pay its share of a bill you have received for covered medical services or drugs**).
- You will be reimbursed the amount you paid less your normal copayment and/or coinsurance for the vaccine (including administration) less any difference between the amount the doctor charges and what we normally pay. (If you get

Questions? Call our Customer Service Department listed in Chapter 2.

Extra Help, we will reimburse you for this difference.)

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

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

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

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

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

SECTION 10	Do you have to pay the Part D "late enrollment penalty"?
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Section 10.1	What is the Part D "late enrollment penalty"?
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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

Questions? Call our Customer Service Department listed in Chapter 2.

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 prescriptions drug coverage.) The amount of the penalty depends on how long you waited to enroll in a creditable prescription drug coverage plan anytime after the end of your initial enrollment period or how many full calendar months you went without creditable prescription drug coverage.

The penalty is added to your monthly premium. (For members who must pay a late enrollment penalty, the amount of the penalty will be added to the bill we send to your Plan Sponsor.) When you first enroll in our Plan we let you know the amount of the penalty.

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

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

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

- First count the number of full months that you delayed enrolling in a Medicare drug plan, after you were eligible to enroll. Or count the number of full months in which you did not have creditable prescription drug coverage, if the break in coverage was 63 days or more. The penalty is 1% for every month that you didn't have creditable coverage. For example, if you go 14 months without coverage, the penalty will be 14%.
- Then Medicare determines the amount of the average monthly premium for Medicare drug plans in the nation from the previous year. For 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, which equals \$4.35. This rounds to \$4.40. This amount would be added **to the Plan Sponsor's 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 10.3 In some situations, you can enroll late and not have to pay the penalty

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

Questions? Call our Customer Service Department listed in Chapter 2.

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 (1-800-633-4227). TTY users call 1-877-486-2048. You can call these numbers for free, 24 hours a day, 7 days a week.
- If you were without creditable coverage, but you were without it for less than 63 days in a row.
- If you are receiving “Extra Help” from Medicare.

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

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

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

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

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

Questions? Call our Customer Service Department listed in Chapter 2.

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 11.2 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 11.3 What can you do if you disagree about paying an extra Part D amount?

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

Questions? Call our Customer Service Department listed in Chapter 2.

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

SECTION 1 Situations in which you should ask us to pay our share of the cost of your covered services or drugs.....2

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 2

SECTION 2 How to ask us to pay you back or to pay a bill you have received.....4

Section 2.1 How and where to send us your request for payment..... 4

SECTION 3 We will consider your request for payment and say yes or no 4

Section 3.1 We check to see whether we should cover the service or drug and how much we owe.....4

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 5

SECTION 4 Other situations in which you should save your receipts and send copies to us..... 5

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..... 5

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 a network provider sends you a bill you think you should not pay

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

Questions? Call our Customer Service Department listed in Chapter 2.

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

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

5. When you pay the full cost for a prescription because you don't have your Plan member ID card with you

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

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

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

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

For example, the drug may not be on the plan's **List of Covered Drugs (Formulary)**; or it could have a requirement or restriction that you didn't know about or don't think should apply to you. If you decide to get the drug immediately, you may need to pay the full cost for it.

- Save your receipt and send a copy to us when you ask us to pay you back. In some situations, we may need to get more information from your doctor in order to pay you back for our share of the cost.

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.

Questions? Call our Customer Service Department listed in Chapter 2.

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.

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

Part D Prescription drug payment requests
UnitedHealthcare
P.O. Box 29675
Hot Springs, AR 71903-9675

Medical Claims payment requests
UnitedHealthcare
P.O. Box 29675
Hot Springs, AR 71903-9675

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

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

Please be sure to contact Customer Service if you have any questions. If you don't know what you should have paid, or you receive bills and you don't know what to do about those bills, we can help. You can also call if you want to give us more information about a request for payment you have already sent to us.

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

Questions? Call our Customer Service Department listed in Chapter 2.

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

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

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

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

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

Questions? Call our Customer Service Department listed in Chapter 2.

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

CHAPTER 8: Your rights and responsibilities

SECTION 1 Our Plan must honor your rights as a member of the plan..... 2

Section 1.1 You have a right to receive information about the organization, its services, its practitioners and providers and member rights and responsibilities. We must provide information in a way that works for you (in languages other than English, in large print or other alternate formats, etc.).....2

Section 1.2 You have a right to be treated with respect and recognition of your dignity and right to privacy. We must treat you with fairness and respect at all times.....2

Section 1.3 We must ensure that you get timely access to your covered services and drugs.....2

Section 1.4 We must protect the privacy of your personal health information..... 3

Section 1.5 We must give you information about the plan, its network of providers, and your covered services.....13

Section 1.6 You have a right to participate with practitioners in making decisions about your health care. We must support your right to make decisions about your care and a candid discussion of appropriate or medically necessary treatment options for your conditions, regardless of cost or benefit coverage..... 14

Section 1.7 You have a right to voice complaints or appeals about the organization or the care it provides. You have the right to make complaints and to ask us to reconsider decisions we have made.....15

Section 1.8 What can you do if you think you are being treated unfairly or your rights are not being respected?.....16

Section 1.9 You have a right to make recommendations regarding the organization’s member rights and responsibilities policy. How to get more information about your rights...16

SECTION 2 You have some responsibilities as a member of the plan.....17

Section 2.1 What are your responsibilities?.....17

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

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

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

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

Section 1.2	You have a right to be treated with respect and recognition of your dignity and right to privacy. We must treat you with fairness and respect at all times
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Our Plan must obey laws that protect you from discrimination or unfair treatment. **We do not discriminate** based on a person's race, ethnicity, national origin, religion, gender, age, mental or physical disability, health status, claims experience, medical history, genetic information, evidence of insurability, or geographic location within the service area.

If you want more information or have concerns about discrimination or unfair treatment, please call the Department of Health and Human Services' **Office for Civil Rights** 1-800-368-1019 (TTY/TDD 1-800-537-7697) or your local Office for Civil Rights.

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

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

As a plan member, you have the right to get appointments and covered services from the plan's

Questions? Call our Customer Service Department listed in Chapter 2.

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

How to Receive Care After Hours

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

If you think that you are not getting your medical care or Part D drugs within a reasonable amount of time, Chapter 9, Section 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
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Federal and state laws protect the privacy of your medical records and personal health information. We protect your personal health information as required by these laws.

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

How do we protect the privacy of your health information?

- We make sure that unauthorized people don't see or change your records.
- In most situations, if we give your health information to anyone who isn't providing your care or paying for your care, **we are required to get written permission from you first**. Written permission can be given by you or by someone you have given legal power to make decisions for you.
- There are certain exceptions that do not require us to get your written permission first. These exceptions are allowed or required by law.
 - For example, we are required to release health information to government agencies that are checking on quality of care.
 - Because you are a member of our Plan through Medicare, we are required to give Medicare your health information including information about your Part D prescription drugs. If Medicare releases your information for research or other uses, this will be done according to Federal statutes and regulations.

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

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

Questions? Call our Customer Service Department listed in Chapter 2.

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

If you have questions or concerns about the privacy of your personal health information, please call Customer Service (phone numbers are on the back cover of this booklet).

MEDICAL INFORMATION PRIVACY NOTICE

THIS 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.

Effective January 1, 2011

We¹ are required by law to protect the privacy of your health information. We are also required to send you this notice, which explains how we may use information about you and when we can give out or “disclose” that information to others. You also have rights regarding your health information that are described in this notice. We are required by law to abide by the terms of this notice.

¹ This Medical Information Notice of Privacy Practices applies to the following health plans that are affiliated with UnitedHealth Group: All Savers Insurance Company; All Savers Life Insurance Company of California; American Medical Security Life Insurance Company; AmeriChoice of Connecticut, Inc.; AmeriChoice of Georgia, Inc.; AmeriChoice of New Jersey, Inc.; AmeriChoice of Pennsylvania, Inc.; Arizona Physicians IPA, Inc.; Citrus Health Care, Inc.; Dental Benefit Providers of California, Inc.; Dental Benefit Providers of Illinois, Inc.; Evercare of Arizona, Inc.; Evercare of New Mexico, Inc.; Evercare of Texas, LLC; Golden Rule Insurance Company; Health Plan of Nevada, Inc.; MAMSI Life and Health Insurance Company; MD - Individual Practice Association, Inc.; Midwest Security Life Insurance Company; National Pacific Dental, Inc.; Neighborhood Health Partnership, Inc.; Nevada Pacific Dental; Optimum Choice, Inc.; Oxford Health Insurance, Inc.; Oxford Health Plans (CT), Inc.; Oxford Health Plans (NJ), Inc.; Oxford Health Plans (NY), Inc.; PacifiCare Dental; PacifiCare Dental of Colorado, Inc.; PacifiCare Life and Health Insurance Company; PacifiCare Life Assurance Company; PacifiCare of Arizona, Inc.; PacifiCare of Colorado, Inc.; PacifiCare of Nevada, Inc.; Physicians Health Choice of Texas, LLC.; Sierra Health & Life Insurance Co., Inc.; UHC of California; U.S. Behavioral Health Plan, California; Unimerica Insurance Company; Unimerica Life Insurance Company of New York; Unison Family Health Plan of Pennsylvania, Inc.; Unison Health Plan of Delaware, Inc.; Unison Health Plan of Tennessee, Inc.; Unison Health Plan of the Capital Area, Inc.; United Behavioral Health; UnitedHealthcare Community Plan of OH, Inc.; UnitedHealthcare Insurance Company; UnitedHealthcare Insurance Company of Illinois; UnitedHealthcare Insurance Company of New York; UnitedHealthcare Insurance Company of the River Valley; UnitedHealthcare Insurance Company of Ohio; UnitedHealthcare of Alabama, Inc.; UnitedHealthcare of Arizona, Inc.; UnitedHealthcare of Arkansas, Inc.; UnitedHealthcare Benefits of Texas, Inc.; UnitedHealthcare of Colorado, Inc.; UnitedHealthcare of Florida, Inc.; UnitedHealthcare of Georgia, Inc.; UnitedHealthcare of the Great Lakes Health Plan, Inc.; UnitedHealthcare of Illinois, Inc.; UnitedHealthcare of Kentucky, Ltd.; UnitedHealthcare of Louisiana, Inc.; UnitedHealthcare of Mid-Atlantic, Inc.; UnitedHealthcare of the Midlands, Inc.; UnitedHealthcare of the Midwest, Inc.; United HealthCare of Mississippi, Inc.; UnitedHealthcare of New England, Inc.; UnitedHealthcare of New York, Inc.; UnitedHealthcare of North Carolina, Inc.; UnitedHealthcare of Ohio, Inc.;

Questions? Call our Customer Service Department listed in Chapter 2.

The terms “information” or “health information” in this notice include any information we maintain that reasonably can be used to identify you and that relates to your physical or mental health condition, the provision of health care to you, or the payment for such health care.

We have the right to change our privacy practices and the terms of this notice. If we make a material change to our privacy practices, we will provide to you a revised notice by direct mail or electronically as permitted by applicable law. In all cases, we will post the revised notice on your health plan website (You can find our website and contact information in Chapter 2 of this booklet). We reserve the right to make any revised or changed notice effective for information we already have and for information that we receive in the future.

How We Use or Disclose Information

We must use and disclose your health information to provide that information:

- To you or someone who has the legal right to act for you (your personal representative) in order to administer your rights as described in this notice; and
- To the Secretary of the Department of Health and Human Services, if necessary, to make sure your privacy is protected.

We have the right to use and disclose health information for your treatment, to pay for your health care and to operate our business. For example, we may use or disclose your health information:

- **For Payment** of premiums due us, to determine your coverage, and to process claims for health care services you receive, including for subrogation or coordination of other benefits you may have. For example, we may tell a doctor whether you are eligible for coverage and what percentage of the bill may be covered.
- **For Treatment.** We may use or disclose health information to aid in your treatment or the coordination of your care. For example, we may disclose information to your physicians or hospitals to help them provide medical care to you.
- **For Health Care Operations.** We may use or disclose health information as necessary to operate and manage our business activities related to providing and managing your health care coverage. For example, we might talk to your physician to suggest a disease management or wellness program that could help improve your health or we may analyze data to determine how we can improve our services.
- **To Provide You Information on Health Related Programs or Products** such as alternative medical treatments and programs or about health-related products and services, subject to limits imposed by law.
- **For Plan Sponsors.** If your coverage is through an employer sponsored group health plan, we may share summary health information and enrollment and disenrollment information with the plan sponsor. In addition, we may share other health information with the plan sponsor for plan administration if the plan sponsor agrees to special restrictions on its use and disclosure of the information in accordance with federal law.

UnitedHealthcare of Oklahoma, Inc.; UnitedHealthcare of Oregon, Inc.; UnitedHealthcare of Pennsylvania, Inc.; UnitedHealthcare of South Carolina, Inc.; UnitedHealthcare of Tennessee, Inc.; UnitedHealthcare of Texas, Inc.; UnitedHealthcare of Utah, Inc.; UnitedHealthcare of Washington, Inc.; UnitedHealthcare of Wisconsin, Inc.; UnitedHealthcare Plan of the River Valley, Inc.

Questions? Call our Customer Service Department listed in Chapter 2.

- **For Reminders.** We may use or disclose health information to send you reminders about your benefits or care, such as appointment reminders with providers who provide medical care to you.

We may use or disclose your health information for the following purposes under limited circumstances:

- **As Required by Law.** We may disclose information when required to do so by law.
- **To Persons Involved With Your Care.** We may use or disclose your health information to a person involved in your care or who helps pay for your care, such as a family member, when you are incapacitated or in an emergency, or when you agree or fail to object when given the opportunity. If you are unavailable or unable to object, we will use our best judgment to decide if the disclosure is in your best interests.
- **For Public Health Activities** such as reporting or preventing disease outbreaks.
- **For Reporting Victims of Abuse, Neglect or Domestic Violence** to government authorities that are authorized by law to receive such information, including a social service or protective service agency.
- **For Health Oversight Activities** to a health oversight agency for activities authorized by law, such as licensure, governmental audits and fraud and abuse investigations.
- **For Judicial or Administrative Proceedings** such as in response to a court order, search warrant or subpoena.
- **For Law Enforcement Purposes.** We may disclose your health information to a law enforcement official for purposes such as providing limited information to locate a missing person or report a crime.
- **To Avoid a Serious Threat to Health or Safety** to you, another person, or the public, by, for example, disclosing information to public health agencies or law enforcement authorities, or in the event of an emergency or natural disaster.
- **For Specialized Government Functions** such as military and veteran activities, national security and intelligence activities, and the protective services for the President and others.
- **For Workers' Compensation** as authorized by, or to the extent necessary to comply with, state workers compensation laws that govern job-related injuries or illness.
- **For Research Purposes** such as research related to the evaluation of certain treatments or the prevention of disease or disability, if the research study meets privacy law requirements.
- **To Provide Information Regarding Decedents.** We may disclose information to a coroner or medical examiner to identify a deceased person, determine a cause of death, or as authorized by law. We may also disclose information to funeral directors as necessary to carry out their duties.
- **For Organ Procurement Purposes.** We may use or disclose information to entities that handle procurement, banking or transplantation of organs, eyes or tissue to facilitate donation and transplantation.
- **To Correctional Institutions or Law Enforcement Officials** if you are an inmate of a correctional institution or under the custody of a law enforcement official, but only if necessary (1) for the institution to provide you with health care; (2) to protect your health and safety or the health and safety of others; or (3) for the safety and security of the correctional institution.
- **To Business Associates** that perform functions on our behalf or provide us with services if the information is necessary for such functions or services. Our business associates are required, under contract with us, to protect the privacy of your information and are not allowed to use or

Questions? Call our Customer Service Department listed in Chapter 2.

disclose any information other than as specified in our contract.

- **For Data Breach Notification Purposes.** We may use your contact information to provide legally-required notices of unauthorized acquisition, access, or disclosure of your health information. We may send notice directly to you or provide notice to the sponsor of your Plan through which you receive coverage.
- **Additional Restrictions on Use and Disclosure.** Certain federal and state laws may require special privacy protections that restrict the use and disclosure of certain health information, including highly confidential information about you. “Highly confidential information” may include confidential information under Federal laws governing alcohol and drug abuse information and genetic information as well as state laws that often protect the following types of information:
 1. HIV/AIDS;
 2. Mental health;
 3. Genetic tests;
 4. Alcohol and drug abuse;
 5. Sexually transmitted diseases and reproductive health information; and
 6. Child or adult abuse or neglect, including sexual assault.

If a use or disclosure of health information described above in this notice is prohibited or materially limited by other laws that apply to us, it is our intent to meet the requirements of the more stringent law. Attached to this notice is a Summary of Federal and State Laws on Use and Disclosure of Certain Types of Medical Information.

Except for uses and disclosures described and limited as set forth in this notice, we will use and disclose your health information only with a written authorization from you. Once you give us authorization to release your health information, we cannot guarantee that the person to whom the information is provided will not disclose the information. You may take back or “revoke” your written authorization at anytime in writing, except if we have already acted based on your authorization. To find out where to mail your written authorization and how to revoke an authorization, contact the phone number listed on the back of your ID card.

What Are Your Rights

The following are your rights with respect to your health information:

- **You have the right to ask to restrict** uses or disclosures of your information for treatment, payment, or health care operations. You also have the right to ask to restrict disclosures to family members or to others who are involved in your health care or payment for your health care. We may also have policies on dependent access that authorize your dependents to request certain restrictions. **Please note that while we will try to honor your request and will permit requests consistent with our policies, we are not required to agree to any restriction.**
- **You have the right to ask to receive confidential communications** of information in a different manner or at a different place (for example, by sending information to a P.O. Box instead of your home address). We will accommodate reasonable requests where a disclosure of all or part of your health information otherwise could endanger you. We will accept verbal requests to receive confidential communications, but requests to modify or cancel a previous confidential communication request must be made in writing. Mail your request to the address

Questions? Call our Customer Service Department listed in Chapter 2.

listed below.

- **You have the right to see and obtain a copy** of health information that may be used to make decisions about you such as claims and case or medical management records. You also may in some cases receive a summary of this health information. You must make a written request to inspect and copy your health information. Mail your request to the address listed below. In certain limited circumstances, we may deny your request to inspect and copy your health information. We may charge a reasonable fee for any copies. If we deny your request, you have the right to have the denial reviewed. If we maintain an electronic health record containing your health information, when and if we are required by law, you will have the right to request that we send a copy of your health information in an electronic format to you or to a third party that you identify. We may charge a reasonable fee for sending the electronic copy of your health information.
- **You have the right to ask to amend** information we maintain about you if you believe the health information about you is wrong or incomplete. Your request must be in writing and provide the reasons for the requested amendment. Mail your request to the address listed below. If we deny your request, you may have a statement of your disagreement added to your health information.
- **You have the right to receive an accounting** of certain disclosures of your information made by us during the six years prior to your request. This accounting will not include disclosures of information made: (i) prior to April 14, 2003; (ii) for treatment, payment, and health care operations purposes; (iii) to you or pursuant to your authorization; and (iv) to correctional institutions or law enforcement officials; and (v) other disclosures for which federal law does not require us to provide an accounting.
- **You have the right to a paper copy of this notice.** You may ask for a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice. You also may also obtain a copy of this notice on your health plan website (You can find our website and contact information in Chapter 2 of this booklet).

Exercising Your Rights

- **Contacting your Health Plan.** If you have any questions about this notice or want to exercise any of your rights, please **call the phone number on the back of your ID card** or you may contact the UnitedHealth Group Customer Call Center at 1-866-633-2446.
- **Submitting a Written Request.** Mail to us your written requests for modifying or cancelling a confidential communication, for copies of your records, or for amendments to your record, at the following address:

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

- **Filing a Complaint.** If you believe your privacy rights have been violated, you may file a complaint with us at the address listed above.

You may also notify the Secretary of the U.S. Department of Health and Human Services of your

Questions? Call our Customer Service Department listed in Chapter 2.

complaint. We will not take any action against you for filing a complaint.

FINANCIAL INFORMATION PRIVACY NOTICE

THIS NOTICE DESCRIBES HOW FINANCIAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Effective January 1, 2011

We² are committed to maintaining the confidentiality of your personal financial information. For the purposes of this notice, “personal financial information” means information, other than health information, about an enrollee or an applicant for health care coverage that identifies the individual, is not generally publicly available and is collected from the individual or is obtained in connection with providing health care coverage to the individual.

Information We Collect

We collect personal financial information about you from the following sources:

- Information we receive from you on applications or other forms, such as name, address, age and social security number; and
- Information about your transactions with us, our affiliates or others, such as premium payment history.

Disclosure of Information

We do not disclose personal financial information about our enrollees or former enrollees to any third party, except as required or permitted by law.

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

In the course of our general business practices, we may disclose personal financial information about you or others without your permission to our corporate affiliates to provide them with information about your transactions, such as your premium payment history.

Confidentiality and Security

We restrict access to personal financial information about you to our employees and service providers who are involved in administering your health care coverage and providing services to you. We maintain physical, electronic and procedural safeguards in compliance with federal standards to guard your personal financial information. We conduct regular audits to guarantee appropriate and secure handling and processing of our enrollees' information.

Your Right to Access and Correct Personal Information

If you reside in certain States³, you may have a right to request access to the personal financial information that we record about you. Your right includes the right to know the source of the information and the identity of the persons, institutions, or types of institutions to whom we have disclosed such information within 2 years prior to your request. Your right includes the right to view such information and copy it in person, or request that a copy of it be sent to you by mail (for which we may charge you a reasonable fee to cover our costs). Your right also includes the right to request corrections, amendments or deletions of any information in our possession. The procedures that you must follow to request access to or an amendment of your information are as follows:

To obtain access to your information: Submit a request in writing that includes your name, address, social security number, telephone number, and the recorded information to which you would like access. State in the request whether you would like access in person or a copy of the information sent to you by mail. Upon receipt of your request, we will contact you within 30 business days to arrange providing you with access in person or the copies that you have requested.

To correct, amend, or delete any of your information: Submit a request in writing that includes your name, address, social security number, telephone number, the specific information in dispute, and the identity of the document or record that contains the disputed information. Upon receipt of your request, we will contact you within 30 business days to notify you either that we have made the correction, amendment or deletion, or that we refuse to do so and the reasons for the refusal, which you will have an opportunity to challenge.

Send written requests to access, correct, amend or delete information to:

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

³ California and Massachusetts.

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

Revised: January 1, 2011

The first part of this Notice, which provides our privacy practices for Medical Information describes how we may use and disclose your health information under federal privacy rules. There are other laws that may limit our rights to use and disclose your health information beyond what we are allowed to do under the federal privacy rules. The purpose of the charts below is to:

1. show the categories of health information that are subject to these more restrictive laws; and
2. give you a general summary of when we can use and disclose your health information without your consent.

If your written consent is required under the more restrictive laws, the consent must meet the particular rules of the applicable federal or state law.

Summary of Federal Laws

Alcohol & Drug Abuse Information	
We are allowed to use and disclose alcohol and drug abuse information that is protected by federal law only (1) in certain limited circumstances, and/or disclose only (2) to specific recipients.	
Genetic Information	
We are not allowed to use genetic information for underwriting purposes.	

Summary of State Laws

General Health Information	
We are allowed to disclose general health information only (1) under certain limited circumstances, and /or (2) to specific recipients.	CA, NE, RI, VT, WA, WI
HMOs must give enrollees an opportunity to approve or refuse disclosures, subject to certain exceptions.	KY
You may be able to restrict certain electronic disclosures of such health information.	NV
We are not allowed to use health information for certain purposes.	CA, NH
Prescriptions	
We are allowed to disclose prescription-related information only (1) under certain limited circumstances, and /or (2) to specific recipients.	ID, NV
Communicable Diseases	
We are allowed to disclose communicable disease information only (1) under certain limited circumstances, and /or (2) to specific recipients.	AZ, IN, MI, OK

Questions? Call our Customer Service Department listed in Chapter 2.

Summary of State Laws

You may be able to restrict certain electronic disclosures of such health information.	NV
Sexually Transmitted Diseases and Reproductive Health	
We are allowed to disclose sexually transmitted disease and/or reproductive health information only (1) under certain limited circumstances and/or (2) to specific recipients.	MT, NJ, WA
You may be able to restrict certain electronic disclosures of such health information.	NV
Alcohol and Drug Abuse	
We are allowed to use and disclose alcohol and drug abuse information (1) under certain limited circumstances, and/or disclose only (2) to specific recipients.	CT, HI, KY, IL, IN, IA, LA, MD, MA, NH, NV, WA, WI
Disclosures of alcohol and drug abuse information may be restricted by the individual who is the subject of the information.	WA
Genetic Information	
We are not allowed to disclose genetic information without your written consent.	CA, CO, HI, IL, KY, NY, TN
We are allowed to disclose genetic information only (1) under certain limited circumstances and/or (2) to specific recipients.	GA, IA, MD, MA, MO, NV, NH, NM, RI, SC, TX, UT, VT
Restrictions apply to (1) the use, and/or (2) the retention of genetic information.	FL, GA, IA, LA, MD, OH, SC, SD, UT, VT
HIV / AIDS	
We are allowed to disclose HIV/AIDS-related information only (1) under certain limited circumstances and/or (2) to specific recipients.	AZ, AR, CA, CT, DE, FL, HI, IL, IN, MI, MT, NY, NC, PA, PR, RI, TX, VT, WV
Certain restrictions apply to oral disclosures of HIV/AIDS-related information.	CT
You may be able to restrict certain electronic disclosures of such health information.	NV
Mental Health	
We are allowed to disclose mental health information only (1) under certain limited circumstances and/or (2) to specific recipients.	CA, CT, DC, HI, IL, IN, KY, MA, MI, PR, WA, WI
Disclosures may be restricted by the individual who is the subject of the information.	WA
Certain restrictions apply to oral disclosures of mental health information.	CT
Certain restrictions apply to the use of mental health information.	ME

Questions? Call our Customer Service Department listed in Chapter 2.

Summary of State Laws

Child or Adult Abuse	
We are allowed to use and disclose child and/or adult abuse information only (1) under certain limited circumstances, and/or disclose only (2) to specific recipients.	AL, CO, IL, LA, NE, NJ, NM, RI, TN, TX, UT, WI
You may be able to limit or restrict certain electronic disclosures of such health information.	NV

Section 1.5	We must give you information about the plan, its network of providers, and your covered services
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As a member of our Plan, you have the right to get several kinds of information from us. (As explained above in Section 1.1, you have the right to get information from us in a way that works for you. This includes getting the information in languages other than English and large print or other alternate formats.)

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

- **Information about our Plan.** This includes, for example, information about the plan’s financial condition. It also includes information about the number of appeals made by members and the plan’s performance ratings, including how it has been rated by plan members and how it compares to other Medicare health plans.
- **Information about our network providers including our network pharmacies.**
 - For example, you have the right to get information from us about the qualifications of the providers and pharmacies in our network and how we pay the providers in our network.
 - For a list of the providers in the plan’s network, see the **Provider Directory**.
 - For a list of the pharmacies in the plan’s network, see the **Pharmacy Directory**.
 - For more detailed information about our providers or pharmacies, you can call Customer Service (phone numbers are on the back cover of this booklet) or visit our website www.UHCRetiree.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

Questions? Call our Customer Service Department listed in Chapter 2.

even if you received the medical service or drug from an out-of-network provider or pharmacy.

- If you are not happy or if you disagree with a decision we make about what medical care or Part D drug is covered for you, you have the right to ask us to change the decision. You can ask us to change the decision by making an appeal. For details on what to do if something is not covered for you in the way you think it should be covered, see Chapter 9 of this booklet. It gives you the details about how to make an appeal if you want us to change our decision. (Chapter 9 also tells about how to make a complaint about quality of care, waiting times, and other concerns.)
- If you want to ask our Plan to pay our share of a bill you have received for medical care or a Part D prescription drug, see Chapter 7 of this booklet.

Section 1.6	You have a right to participate with practitioners in making decisions about your health care. We must support your right to make decisions about your care and a candid discussion of appropriate or medically necessary treatment options for your conditions, regardless of cost or benefit coverage.
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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

Questions? Call our Customer Service Department listed in Chapter 2.

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 appropriate state-specific agency, for example, your State Department of Health. See Chapter 2, Section 3 for contact information regarding your state-specific agency.

Section 1.7

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

Questions? Call our Customer Service Department listed in Chapter 2.

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

If you think you have been treated unfairly or your rights have not been respected due to your race, disability, religion, sex, health, ethnicity, creed (beliefs), age, or national origin, you should call the Department of Health and Human Services' **Office for Civil Rights** at 1-800-368-1019 or TTY 1-800-537-7697, or call your local Office for Civil Rights.

Is it about something else?

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

- You can **call Customer Service** (phone numbers are on the back cover of this booklet).
- You can **call the State Health Insurance Assistance Program**. For details about this organization and how to contact it, go to Chapter 2, Section 3.
- Or, **you can call Medicare** at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

Section 1.9	You have a right to make recommendations regarding the organization's member rights and responsibilities policy. How to get more information about your rights
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There are several places where you can get more information about your rights:

- You can **call Customer Service** (phone numbers are on the back cover of this booklet).
- You can **call the State Health Insurance Assistance Program**. For details about this organization and how to contact it, go to Chapter 2, Section 3.
- You can contact **Medicare**.
 - You can visit the Medicare website to read or download the publication "Your Medicare Rights & Protections." (The publication is available at: <http://www.medicare.gov/Publications/Pubs/pdf/10112.pdf>.)
 - Or, you can call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

Questions? Call our Customer Service Department listed in Chapter 2.

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 member ID 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 (or their plan sponsor) 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

Questions? Call our Customer Service Department listed in Chapter 2.

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)

BACKGROUND

SECTION 1 Introduction 3
 Section 1.1 What to do if you have a problem or concern.....3
 Section 1.2 What about the legal terms?..... 3

SECTION 2 You can get help from government organizations that are not connected with us..... 3
 Section 2.1 Where to get more information and personalized assistance.....3

SECTION 3 To deal with your problem, which process should you use?..... 4
 Section 3.1 Should you use the process for coverage decisions and appeals? Or should you use the process for making complaints?..... 4

COVERAGE DECISIONS AND APPEALS

SECTION 4 A guide to the basics of coverage decisions and appeals..... 5
 Section 4.1 Asking for coverage decisions and making appeals: the big picture.....5
 Section 4.2 How to get help when you are asking for a coverage decision or making an appeal....6
 Section 4.3 Which section of this chapter gives the details of your situation?..... 7

SECTION 5 Your medical care: How to ask for a coverage decision or make an appeal..... 7
 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.....7
 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).....9
 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)..... 11
 Section 5.4 Step-by-step: How to make a Level 2 Appeal..... 13
 Section 5.5 What if you are asking our Plan to pay you for our share of a bill you have received for medical care?..... 15

SECTION 6 Your Part D prescription drugs: How to ask for a coverage decision or make an appeal..... 16
 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.....16
 Section 6.2 What is an exception?.....18
 Section 6.3 Important things to know about asking for exceptions.....19
 Section 6.4 Step-by-step: How to ask for a coverage decision, including an exception.....20
 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).....22
 Section 6.6 Step-by-step: How to make a Level 2 Appeal..... 24

Questions? Call our Customer Service Department listed in Chapter 2.

SECTION 7	How to ask us to cover a longer inpatient hospital stay if you think the doctor is discharging you too soon.....	26
Section 7.1	During your inpatient hospital stay, you will get a written notice from Medicare that tells about your rights.....	26
Section 7.2	Step-by-step: How to make a Level 1 Appeal to change your hospital discharge date.....	27
Section 7.3	Step-by-step: How to make a Level 2 Appeal to change your hospital discharge date.....	30
Section 7.4	What if you miss the deadline for making your Level 1 Appeal?.....	31
SECTION 8	How to ask us to keep covering certain medical services if you think your coverage is ending too soon.....	33
Section 8.1	This section is about three services only: Home health care, skilled nursing facility care, and Comprehensive Outpatient Rehabilitation Facility (CORF) services.....	33
Section 8.2	We will tell you in advance when your coverage will be ending.....	34
Section 8.3	Step-by-step: How to make a Level 1 Appeal to have our Plan cover your care for a longer time.....	34
Section 8.4	Step-by-step: How to make a Level 2 Appeal to have our Plan cover your care for a longer time.....	36
Section 8.5	What if you miss the deadline for making your Level 1 Appeal?.....	37
SECTION 9	Taking your appeal to Level 3 and beyond.....	40
Section 9.1	Levels of Appeal 3, 4, and 5 for Medical Service Appeals.....	40
Section 9.2	Levels of Appeal 3, 4, and 5 for Part D Drug Appeals.....	41
MAKING COMPLAINTS		
SECTION 10	How to make a complaint about quality of care, waiting times, customer service, or other concerns.....	42
Section 10.1	What kinds of problems are handled by the complaint process?.....	43
Section 10.2	The formal name for “making a complaint” is “filing a grievance”.....	45
Section 10.3	Step-by-step: Making a complaint.....	45
Section 10.4	You can also make complaints about quality of care to the Quality Improvement Organization.....	46

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

Questions? Call our Customer Service Department listed in Chapter 2.

knowledge you need to take the next step.

Get help from an independent government organization

We are always available to help you. But in some situations you may also want help or guidance from someone who is not connected with us. You can always contact your **State Health Insurance Assistance Program (SHIP)**. This government program has trained counselors in every state. The program is not connected with our Plan or with any insurance company or health plan. The counselors at this program can help you understand which process you should use to handle a problem you are having. They can also answer your questions, give you more information, and offer guidance on what to do.

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

You can also get help and information from Medicare

For more information and help in handling a problem, you can also contact Medicare. Here are two ways to get information directly from Medicare:

- You can call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.
- You can visit the Medicare website (<http://www.medicare.gov>).

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?
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If you have a problem or concern, you only need to read the parts of this chapter that apply to your situation. The 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 prescriptions drugs.)

Yes.

My problem is about benefits or coverage.

Go on to the next section of this chapter, **Section 4, “A guide to the basics of coverage decisions and making appeals.”**

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 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

Questions? Call our Customer Service Department listed in Chapter 2.

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 our Plan. (In some situations, your case will be automatically sent to the independent organization for a Level 2 Appeal. If this happens, we will let you know. In other situations, you will need to ask for a Level 2 Appeal.) If you are not satisfied with the decision at the Level 2 Appeal, you may be able to continue through several more levels of appeal.

Section 4.2	How to get help when you are asking for a coverage decision or making an appeal
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Would you like some help? Here are resources you may wish to use if you decide to ask for any kind of coverage decision or appeal a decision:

- **You can call us at Customer Service** (phone numbers are on the back cover of this booklet).
- **To get free help from an independent organization** that is not connected with our Plan, contact your State Health Insurance Assistance Program (see Section 2 of this chapter).
- **Your doctor or other provider can make a request for you.** Your doctor or other provider can request a coverage decision or a Level 1 Appeal on your behalf. To request any appeal after Level 1, your doctor or other provider must be appointed as your representative.
- **You can ask someone to act on your behalf.** If you want to, you can name another person to act for you as your “representative” to ask for a coverage decision or make an appeal.
 - There may be someone who is already legally authorized to act as your representative under State law.
 - If you want a friend, relative, your doctor or other provider, or other person to be your representative, call Customer Service and ask for the “Appointment of Representative” form. (The form is also available on Medicare’s website at <http://www.cms.hhs.gov/cmsforms/downloads/cms1696.pdf>.) The form gives that person permission to act on your behalf. It must be signed by you and by the person who you would like to act on your behalf. You must give our Plan a copy of the signed form.
- **You also have the right to hire a lawyer to act for you.** You may contact your own lawyer, or get the name of a lawyer from your local bar association or other referral service. There are also groups that will give you free legal services if you qualify. However, **you are not required to hire a lawyer** to ask for any kind of coverage decision or appeal a decision.

Questions? Call our Customer Service Department listed in Chapter 2.

Section 4.3	Which section of this chapter gives the details of <u>your</u> situation?
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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
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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
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This section is about your benefits for medical care and services. These benefits are described in Chapter 4 of this booklet: **Medical Benefits Chart (what is covered and what you pay)**. To keep things simple, we generally refer to “medical care coverage” or “medical care” in the rest of this section, instead of repeating “medical care or treatment or services” every time.

This section tells what you can do if you are in any of the five following situations:

1. You are not getting certain medical care you want, and you believe that this care is covered by our Plan.
2. Our Plan will not approve the medical care your doctor or other medical provider wants to give you, and you believe that this care is covered by the plan.

Questions? Call our Customer Service Department listed in Chapter 2.

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 to cover a longer inpatient hospital stay if you think the doctor is discharging you too soon.**
 - Chapter 9, Section 8: **How to ask us to keep covering certain medical services if you think your coverage is ending too soon.** This section is about three services only: home health care, skilled nursing facility care, and Comprehensive Outpatient Rehabilitation Facility (CORF) services.
 - For **all other** situations that involve being told that medical care you have been getting will be stopped, use this section (Section 5) as your guide for what to do.

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

Questions? Call our Customer Service Department listed in Chapter 2.

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)
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Legal Terms	When a coverage decision involves your medical care, it is called an “organization determination.”
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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.”
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Legal Terms	A “fast decision” is called an “expedited determination.”
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How to request coverage for the medical care you want

- Start by calling or writing our Plan to make your request for us to provide coverage for the medical care you want. You, or your doctor, or your representative can do this.
- For the details on how to contact us, go to Chapter 2, Section 1 and look for the section called, **How to contact us when you are asking for a coverage decision about your medical care.**

Generally we use the standard deadlines for giving you our decision

When we give you our decision, we will use the “standard” deadlines unless we have agreed to use the “fast” deadlines. **A standard decision means we will give you an answer within 14 days** after we receive your request.

- **However, we can take up to 14 more calendar days** if you ask for more time, or if we need information (such as medical records) that may benefit you. If we decide to take extra days to make the decision, we will tell you in writing.
- If you believe we should **not** take extra days, you can file a “fast complaint” about our decision to take extra days. When you file a fast complaint, we will give you an answer to your complaint within 24 hours. (The process for making a complaint is different from the process for coverage decisions and appeals. For more information about the process for making complaints, including fast complaints, see Section 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**

Questions? Call our Customer Service Department listed in Chapter 2.

yet received. (You cannot get a fast decision if your request is about payment for medical care you have already received.)

- You can get a fast decision **only** if using the standard deadlines **could cause serious harm to your health or hurt your ability to function.**
- **If your doctor tells us that your health requires a “fast decision,” we will automatically agree to give you a fast decision.**
- If you ask for a fast decision on your own, without your doctor’s support, our Plan will decide whether your health requires that we give you a fast decision.
 - If we decide that your medical condition does not meet the requirements for a fast decision, we will send you a letter that says so (and we will use the standard deadlines instead).
 - This letter will tell you that if your doctor asks for the fast decision, we will automatically give a fast decision.
 - The letter will also tell how you can file a “fast complaint” about our decision to give you a standard decision instead of the fast decision you requested. (For more information about the process for making complaints, including fast complaints, see Section 10 of this chapter.)

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

- Generally, for a fast decision, we will give you our answer **within 72 hours.**
 - As explained above, we can take up to 14 more calendar days under certain circumstances. If we decide to take extra days to make the decision, we will tell you in writing.
 - If you believe we should **not** take extra days, you can file a “fast complaint” about our decision to take extra days. When you file a fast complaint, we will give you an answer to your complaint within 24 hours. (For more information about the process for making complaints, including fast complaints, see Section 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.

Questions? Call our Customer Service Department listed in Chapter 2.

- 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.
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- If our Plan says no, you have the right to ask us to reconsider – and perhaps change – this decision by making an appeal. Making an appeal means making another try to get the medical care coverage you want.
- If you decide to make an appeal, it means you are going on to Level 1 of the appeals process (see Section 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)
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Legal Terms	An appeal to the plan about a medical care coverage decision is called a plan “ reconsideration. ”
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Step 1:	You contact our Plan and make your appeal. If your health requires a quick response, you must ask for a “ fast appeal. ”
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What to do

- **To start your appeal, you, your doctor, or your representative, must contact our Plan.** For details on how to reach us for any purpose related to your appeal, go to Chapter 2, Section 1 look for section called, **How to contact us when you are making an appeal or complaint about your medical care.**
- **If you are asking for a standard appeal, make your standard appeal in writing by submitting a signed request.**
 - If you have someone appealing our decision for you other than your doctor, your appeal must include an Appointment of Representative form authorizing this person to represent you. (To get the form, call Customer Service and ask for the “Appointment of Representative” form. It is also available on Medicare’s website at <http://www.cms.hhs.gov/>)

Questions? Call our Customer Service Department listed in Chapter 2.

cmsforms/downloads/cms1696.pdf.) While we can accept an appeal request without the form, we cannot complete our review until we receive it. If we do not receive the form within 44 days after receiving your appeal request (our deadline for making a decision on your appeal), your appeal request will be sent to the Independent Review Organization for dismissal.

- **If you are asking for a fast appeal, make your appeal in writing or call us** at the phone number shown in Chapter 2, Section 1 (**How to contact us when you are making an appeal or complaint about your medical care**).
- **You must make your appeal request within 60 calendar days** from the date on the written notice we sent to tell you our answer to your request for a coverage decision. If you miss this deadline and have a good reason for missing it, we may give you more time to make your appeal. Examples of good cause for missing the deadline may include if you had a serious illness that prevented you from contacting us or if we provided you with incorrect or incomplete information about the deadline for requesting an appeal.
- **You can ask for a copy of the information regarding your medical decision and add more information to support your appeal.**
 - You have the right to ask us for a copy of the information regarding your appeal.
 - If you wish, you and your doctor may give us additional information to support your appeal.

If your health requires it, ask for a “fast appeal” (you can make a request by calling us)

Legal Terms A “fast appeal” is also called an “ expedited reconsideration. ”
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- If you are appealing a decision our Plan made about coverage for care you have not yet received, you and/or your doctor will need to decide if you need a “fast appeal.”
- The requirements and procedures for getting a “fast appeal” are the same as those for getting a “fast decision.” To ask for a fast appeal, follow the instructions for asking for a fast decision. (These instructions are given earlier in this section.)
- If your doctor tells us that your health requires a “fast appeal,” we will give you a fast appeal.

Step 2:

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

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

Deadlines for a “fast” appeal

- When we are using the fast deadlines, we must give you our answer **within 72 hours after we receive your appeal**. We will give you our answer sooner if your health requires us to do so.
 - However, if you ask for more time, or if we need to gather more information that may benefit you, we **can take up to 14 more calendar days**. If we decide to take extra days to make the decision, we will tell you in writing.
 - If we do not give you an answer within 72 hours (or by the end of the extended time period

Questions? Call our Customer Service Department listed in Chapter 2.

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

Section 5.4	Step-by-step: How to make a Level 2 Appeal
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If our Plan says no to your Level 1 Appeal, your case will **automatically** be sent on to the next level of the appeals process. During the Level 2 Appeal, the **Independent Review Organization** reviews the decision our Plan made when we said no to your first appeal. This organization decides whether the decision we made should be changed.

<p>Legal Terms The formal name for the “Independent Review Organization” is the “Independent Review Entity.” It is sometimes called the “IRE.”</p>

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

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

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

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

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

<p>Step 2:</p>	<p>The Independent Review Organization gives you their answer.</p>
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The Independent Review Organization will tell you its decision in writing and explain the reasons for it.

- **If the review organization says yes to part or all of what you requested,** we must authorize the medical care coverage within 72 hours or provide the service within 14 calendar days after we receive the decision from the review organization.
- **If this organization says no to part or all of your appeal,** it means they agree with our Plan that your request (or part of your request) for coverage for medical care should not be approved.

Questions? Call our Customer Service Department listed in Chapter 2.

(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 amount that must be in dispute to continue with the appeals process. For example, to continue and make another appeal at Level 3, the dollar value of the medical care coverage you are requesting must meet a certain minimum. If the dollar value of the coverage you are requesting is too low, you cannot make another appeal, which means that the decision at Level 2 is final.

Step 3:	If your case meets the requirements, you choose whether you want to take your appeal further.
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- There are three additional levels in the appeals process after Level 2 (for a total of five levels of appeal).
- If your Level 2 Appeal is turned down and you meet the requirements to continue with the appeals process, you must decide whether you want to go on to Level 3 and make a third appeal. The details on how to do this are in the written notice you got after your Level 2 Appeal.
- The Level 3 Appeal is handled by an administrative law judge. Section 9 in this chapter tells more about Levels 3, 4, and 5 of the appeals process.

Section 5.5	What if you are asking our Plan to pay you for our share of a bill you have received for medical care?
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If you want to ask our Plan for payment for medical care, start by reading Chapter 7 of this booklet: **Asking us to pay our share of a bill you have received for covered medical services or drugs**. Chapter 7 describes the situations in which you may need to ask for reimbursement or to pay a bill you have received from a provider. It also tells how to send us the paperwork that asks us for payment.

Asking for reimbursement is asking for a coverage decision from our Plan

If you send us the paperwork that asks for reimbursement, you are asking us to make a coverage decision (for more information about coverage decisions, see Section 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.

Questions? Call our Customer Service Department listed in Chapter 2.

(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
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Your benefits as a member of our Plan include coverage for many outpatient prescription drugs. Medicare calls these outpatient prescription drugs “Part D drugs.” You can get these drugs as long as they are included in our Plan’s **List of Covered Drugs (Formulary)** and the use of the drug is a medically accepted indication. (A “medically accepted indication” is a use of the drug that is either approved by the Food and Drug Administration or supported by certain reference books. See Chapter 5, Section 4 for more information about a medically accepted indication.)

- **This section is about your Part D drugs only.** To keep things simple, we generally say “drug” in the rest of this section, instead of repeating “covered outpatient prescription drug” or “Part D drug” every time.
- For details about what we mean by Part D drugs, the **List of Covered Drugs (Formulary)**, rules and restrictions on coverage, and cost information, see Chapter 5 (**Using the plan’s**

Questions? Call our Customer Service Department listed in Chapter 2.

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 An initial coverage decision about your Part D drugs is called **Terms** a “**coverage determination.**”

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

- You ask us to make an exception, including:
 - Asking us to cover a Part D drug that is not on the plan’s **List of Covered Drugs (Formulary)**
 - Asking us to waive a restriction on the plan’s coverage for a drug (such as limits on the amount of the drug you can get)
 - Asking to pay a lower cost-sharing amount for a covered non-preferred drug
- You ask us whether a drug is covered for you and whether you satisfy any applicable coverage rules. (For example, when your drug is on the plan’s **List of Covered Drugs (Formulary)** but we require you to get approval from us before we will cover it for you.)
 - Please note: If your pharmacy tells you that your prescription cannot be filled as written, you will get a written notice explaining how to contact us to ask for a coverage decision.
- You ask us to pay for a prescription drug you already bought. This is a request for a coverage decision about payment.

If you disagree with a coverage decision we have made, you can appeal our decision.

This section tells you both how to ask for coverage decisions and how to request an appeal. Use the chart below to help you determine which part has information for your situation:

Which of these situations are you in?			
<p>Do you need a drug that isn't on our Drug List or need us to waive a rule or restriction on a drug we cover?</p> <p>You can ask us to make an exception. (This is a type of coverage decision.)</p> <p>Start with 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?</p> <p>You can ask us for a coverage decision.</p> <p>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.)</p> <p>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.)</p> <p>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 the plan to make an “exception.” An exception is a type of coverage decision. Similar to other types of coverage decisions, if we turn down your request for an exception, you can appeal our decision.

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

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

Legal 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 Tier Three. 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.)

Questions? Call our Customer Service Department listed in Chapter 2.

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

Legal 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 our Plan agrees to make an exception and waive a restriction for you, you can ask for an exception to the copayment or coinsurance amount we require you to pay for the drug.
3. **Changing coverage of a drug to a lower cost-sharing tier.** Every drug on the plan’s 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 Tier Three you can ask us to cover it at the cost-sharing amount that applies to drugs in Tier Two. 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 Tier Four (Specialty Drugs).

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.

Our Plan can say yes or no to your request

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

Questions? Call our Customer Service Department listed in Chapter 2.

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
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Step 1:	You ask our Plan to make a coverage decision about the drug(s) or payment you need. If your health requires a quick response, you must ask us to make a “fast decision.” You cannot ask for a fast decision if you are asking us to pay you back for a drug you already bought.
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What to do

- **Request the type of coverage decision you want.** Start by calling or writing our Plan to make your request. You, your representative, or your doctor (or other prescriber) can do this. For the details, go to Chapter 2, Section 1 and look for the section called, **How to contact us when you are asking for a coverage decision about your Part D prescription drugs.** Or if you are asking us to pay you back for a drug, go to the section called, **Where to send a request that asks us to pay for our share of the cost for medical care or a drug you have received.**
- **You or your doctor or someone else who is acting on your behalf** can ask for a coverage decision. Section 5 of this chapter tells how you can give written permission to someone else to act as your representative. You can also have a lawyer act on your behalf.
- **If you want to ask our Plan to pay you back for a drug,** start by reading Chapter 7 of this booklet: **Asking us to pay our share of a bill you have received for covered medical services or drugs.** Chapter 7 describes the situations in which you may need to ask for reimbursement. It also tells how to send us the paperwork that asks us to pay you back for our share of the cost of a drug you have paid for.
- **If you are requesting an exception, provide the “doctor’s statement.”** Your doctor or other prescriber must give us the medical reasons for the drug exception you are requesting. (We call this the “doctor’s statement.”) Your doctor or other prescriber can mail the statement to our Plan. Or your doctor or other prescriber can tell us on the phone and follow up by mailing the signed statement. 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 A “fast decision” is called an “expedited coverage Terms determination.”
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- 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

Questions? Call our Customer Service Department listed in Chapter 2.

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

- You can get a fast decision **only** if using the standard deadlines could **cause serious harm to your health or hurt your ability to function.**
- **If your doctor or other prescriber tells us that your health requires a “fast decision,” we will automatically agree to give you a fast decision.**
- If you ask for a fast decision on your own (without your doctor’s or other prescriber’s support), our Plan will decide whether your health requires that we give you a fast decision.
 - If we decide that your medical condition does not meet the requirements for a fast decision, we will send you a letter that says so (and we will use the standard deadlines instead).
 - This letter will tell you that if your doctor or other prescriber asks for the fast decision, we will automatically give a fast decision.
 - The letter will also tell how you can file a complaint about our decision to give you a standard decision instead of the fast decision you requested. It tells how to file a “fast” complaint, which means you would get our answer to your complaint within 24 hours. (The process for making a complaint is different from the process for coverage decisions and appeals. For more information about the process for making complaints, see Section 10 of this chapter.)

Step 2:	Our Plan considers your request and we give you our answer.
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Deadlines for a “fast” coverage decision

- If we are using the fast deadlines, we must give you our answer **within 24 hours.**
 - Generally, this means within 24 hours after we receive your request. If you are requesting an exception, we will give you our answer within 24 hours after we receive your doctor’s statement supporting your request. We will give you our answer sooner if your health requires us to.
 - If we do not meet this deadline, we are required to send your request on to Level 2 of the appeals process, where it will be reviewed by an independent outside organization. Later in this section, we tell about this review organization and explain what happens at Appeal Level 2.
- **If our answer is yes to part or all of what you requested,** we must provide the coverage we have agreed to provide within 24 hours after we receive your request or doctor’s statement supporting your request.
- **If our answer is no to part or all of what you requested,** we will send you a written statement that explains why we said no.

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

- If we are using the standard deadlines, we must give you our answer **within 72 hours.**
 - Generally, this means within 72 hours after we receive your request. If you are requesting an exception, we will give you our answer within 72 hours after we receive your doctor’s statement supporting your request. We will give you our answer sooner if your health requires us to.
 - If we do not meet this deadline, we are required to send your request on to Level 2 of the

Questions? Call our Customer Service Department listed in Chapter 2.

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

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)
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Legal Terms	An appeal to the plan about a Part D drug coverage decision is called a plan “redetermination.”
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Step 1:	You contact our Plan and make your Level 1 Appeal. If your health requires a quick response, you must ask for a “fast appeal.”
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What to do

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

Questions? Call our Customer Service Department listed in Chapter 2.

appeal about your Part D prescription drugs).

- **You must make your appeal request within 60 calendar days** from the date on the written notice we sent to tell you our answer to your request for a coverage decision. If you miss this deadline and have a good reason for missing it, we may give you more time to make your appeal. Examples of good cause for missing the deadline may include if you had a serious illness that prevented you from contacting us or if we provided you with incorrect or incomplete information about the deadline for requesting an appeal.
- **You can ask for a copy of the information in your appeal and add more information.**
 - You have the right to ask us for a copy of the information regarding your appeal.
 - If you wish, you and your doctor or other prescriber may give us additional information to support your appeal.

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

Legal Terms A “fast appeal” is also called an “ expedited redetermination. ”
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- If you are appealing a decision our Plan made about a drug you have not yet received, you and your doctor or other prescriber will need to decide if you need a “fast appeal.”
- The requirements for getting a “fast appeal” are the same as those for getting a “fast decision” in Section 6.4 of this chapter.

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

Deadlines for a “fast” appeal

- If we are using the fast deadlines, we must give you our answer **within 72 hours after we receive your appeal.** We will give you our answer sooner if your health requires it.
 - If we do not give you an answer within 72 hours, we are required to send your request on to Level 2 of the appeals process, where it will be reviewed by an Independent Review Organization. Later in this section, we tell about this review organization and explain what happens at Level 2 of the appeals process.
- **If our answer is yes to part or all of what you requested,** we must provide the coverage we have agreed to provide within 72 hours after we receive your appeal.
- **If our answer is no to part or all of what you requested,** we will send you a written statement that explains why we said no and how to appeal our decision.

Deadlines for a “standard” appeal

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

Questions? Call our Customer Service Department listed in Chapter 2.

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

Section 6.6	Step-by-step: How to make a Level 2 Appeal
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If our Plan says no to your appeal, you then choose whether to accept this decision or continue by making another appeal. If you decide to go on to a Level 2 Appeal, the **Independent Review Organization** reviews the decision our Plan made when we said no to your first appeal. This organization decides whether the decision we made should be changed.

Legal Terms The formal name for the “Independent Review Organization” is the “ Independent Review Entity. ” It is sometimes called the “ IRE. ”
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Step 1:	To make a Level 2 Appeal, you must contact the Independent Review Organization and ask for a review of your case.
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- If our Plan says no to your Level 1 Appeal, the written notice we send you will include **instructions on how to make a Level 2 Appeal** with the Independent Review Organization. These instructions will tell who can make this Level 2 Appeal, what deadlines you must follow, and how to reach the review organization.
 - When you make an appeal to the Independent Review Organization, we will send the information we have about your appeal to this organization. This information is called your “case file.” **You have the right to ask us for a copy of your case file.**
 - You have a right to give the Independent Review Organization additional information to
- Questions? Call our Customer Service Department listed in Chapter 2.**

support your appeal.

Step 2:	The Independent Review Organization does a review of your appeal and gives you an answer.
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- **The Independent Review Organization is an independent organization that is hired by Medicare.** This organization is not connected with our Plan and it is not a government agency. This organization is a company chosen by Medicare to review our decisions about your Part D benefits with our Plan.
- Reviewers at the Independent Review Organization will take a careful look at all of the information related to your appeal. The organization will tell you its decision in writing and explain the reasons for it.

Deadlines for a “fast” appeal at Level 2

- If your health requires it, ask the Independent Review Organization for a “fast appeal.”
- If the review organization agrees to give you a “fast appeal,” the review organization must give you an answer to your Level 2 Appeal **within 72 hours** after it receives your appeal request.
- **If the Independent Review Organization says yes to part or all of what you requested,** we must provide the drug coverage that was approved by the review organization **within 24 hours** after we receive the decision from the review organization.

Deadlines for a “standard” appeal at Level 2

- If you have a standard appeal at Level 2, the review organization must give you an answer to your Level 2 Appeal **within 7 calendar days** after it receives your appeal.
- **If the Independent Review Organization says yes to part or all of what you requested –**
 - If the Independent Review Organization approves a request for coverage, we must **provide the drug coverage** that was approved by the review organization **within 72 hours** after we receive the decision from the review organization.
 - If the Independent Review Organization approves a request to pay you back for a drug you already bought, we are required to **send payment to you within 30 calendar days** after we receive the decision from the review organization.

What if the review organization says no to your appeal?

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

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

Questions? Call our Customer Service Department listed in Chapter 2.

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.
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- There are three additional levels in the appeals process after Level 2 (for a total of five levels of appeal).
- If your Level 2 Appeal is turned down and you meet the requirements to continue with the appeals process, you must decide whether you want to go on to Level 3 and make a third appeal. If you decide to make a third appeal, the details on how to do this are in the written notice you got after your second appeal.
- The Level 3 Appeal is handled by an administrative law judge. Section 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
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During your hospital stay, you will be given a written notice called **An Important Message from Medicare about Your Rights**. Everyone with Medicare gets a copy of this notice whenever they are admitted to a hospital. Someone at the hospital (for example, a caseworker or nurse) must give it to you within two days after you are admitted. If you do not get the notice, ask any hospital employee for it. If you need help, please call Customer Service. You can also call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

- 1. Read this notice carefully and ask questions if you don’t understand it.** It tells you about your rights as a hospital patient, including:

Questions? Call our Customer Service Department listed in Chapter 2.

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

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

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

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

3. Keep your copy of the signed notice so you will have the information about making an appeal (or reporting a concern about quality of care) handy if you need it.

- If you sign the notice more than 2 days before the day you leave the hospital, you will get another copy before you are scheduled to be discharged.
- To look at a copy of this notice in advance, you can call Customer Service or 1-800 MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048. You can also see it online at http://www.cms.gov/BNI/12_HospitalDischargeAppealNotices.asp.

Section 7.2 Step-by-step: How to make a Level 1 Appeal to change your hospital discharge date

If you want to ask for your hospital services to be covered by our Plan for a longer time, you will need to use the appeals process to make this request. Before you start, understand what you need to do and what the deadlines are.

- **Follow the process.** Each step in the first two levels of the appeals process is explained below.
- **Meet the deadlines.** The deadlines are important. Be sure that you understand and follow the deadlines that apply to things you must do.
- **Ask for help if you need it.** If you have questions or need help at any time, please call Customer Service (phone numbers are on the back cover of this booklet). Or call your State Health Insurance Assistance Program, a government organization that provides personalized assistance

Questions? Call our Customer Service Department listed in Chapter 2.

(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.
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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.”

Questions? Call our Customer Service Department listed in Chapter 2.

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

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

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

Step 3:	Within one full day after it has all the needed information, the Quality Improvement Organization will give you its answer to your appeal.
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What happens if the answer is yes?

- If the review organization says **yes** to your appeal, **our Plan must keep providing your covered hospital services for as long as these services are medically necessary.**
- You will have to keep paying your share of the costs (such as deductibles or copayments, if these apply). In addition, there may be limitations on your covered hospital services. (See Chapter 4 of this booklet).

What happens if the answer is no?

- If the review organization says **no** to your appeal, they are saying that your planned discharge date is medically appropriate. If this happens, **our Plan’s coverage for your hospital services will end** at noon on the day **after** the Quality Improvement Organization gives you its answer to your appeal.
- If the review organization says **no** to your appeal and you decide to stay in the hospital, then **you may have to pay the full** cost of hospital care you receive after noon on the day after the Quality Improvement Organization gives you its answer to your appeal.

Step 4:	If the answer to your Level 1 Appeal is no, you decide if you want to make another appeal.
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Questions? Call our Customer Service Department listed in Chapter 2.

- 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
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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:

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

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

<u>Step 3:</u>	Within 14 calendar days, the Quality Improvement Organization reviewers will decide on your appeal and tell you their decision.
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If the review organization says yes:

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

If the review organization says no:

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

Questions? Call our Customer Service Department listed in Chapter 2.

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.
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- There are three additional levels in the appeals process after Level 2 (for a total of five levels of appeal). If 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?
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You can appeal to our Plan 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 our Plan, asking for a “fast review.” A fast review is an appeal that uses the fast deadlines instead of the standard deadlines.

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

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

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

Questions? Call our Customer Service Department listed in Chapter 2.

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

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

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

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

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

Step 1:	We will automatically forward your case to the Independent Review Organization.
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- We are required to send the information for your Level 2 Appeal to the Independent Review Organization within 24 hours of when we tell you that we are saying no to your first appeal. (If you think we are not meeting this deadline or other deadlines, you can make a complaint. The complaint process is different from the appeal process. Section 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.
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- **The Independent Review Organization is an independent organization that is hired by Medicare.** This organization is not connected with our Plan and it is not a government agency.

Questions? Call our Customer Service Department listed in Chapter 2.

This organization is a company chosen by Medicare to handle the job of being the Independent Review Organization. Medicare oversees its work.

- Reviewers at the Independent Review Organization will take a careful look at all of the information related to your appeal of your hospital discharge.
- **If this organization says yes to your appeal**, then our Plan must reimburse you (pay you back) for our share of the costs of hospital care you have received since the date of your planned discharge. We must also continue the plan's coverage of your hospital services for as long as it is medically necessary. You must continue to pay your share of the costs. If there are coverage limitations, these could limit how much we would reimburse or how long we would continue to cover your services.
- **If this organization says no to your appeal**, it means they agree with our Plan that your planned hospital discharge date was medically appropriate.
 - The notice you get from the Independent Review Organization will tell you in writing what you can do if you wish to continue with the review process. It will give you the details about how to go on to a Level 3 Appeal, which is handled by a judge.

Step 3:	If the Independent Review Organization turns down your appeal, you choose whether you want to take your appeal further.
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- There are three additional levels in the appeals process after Level 2 (for a total of five levels of appeal). If reviewers say no to your Level 2 Appeal, you decide whether to accept their decision or go on to Level 3 and make a third appeal.
- Section 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 <u>only</u>: Home health care, skilled nursing facility care, and Comprehensive Outpatient Rehabilitation Facility (CORF) services
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This section is about the following types of care **only**:

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

When you are getting any of these types of care, you have the right to keep getting your covered services for that type of care for as long as the care is needed to diagnose and treat your illness or injury.

Questions? Call our Customer Service Department listed in Chapter 2.

For more information on your covered services, including your share of the cost and any limitations to coverage that may apply, see Chapter 4 of this booklet: **Medical Benefits Chart (what is covered and what you pay)**.

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

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

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

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

Legal Terms In telling what you can do, the written notice is telling how you can request a **“fast-track appeal.”** Requesting a fast-track appeal is a formal, legal way to request a change to our coverage decision about when to stop your care. (Section 8.3 below tells how you can request a fast-track appeal.)

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

2. **You must sign the written notice to show that you received it.**
 - You or someone who is acting on your behalf must sign the notice. (Section 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.

Questions? Call our Customer Service Department listed in Chapter 2.

- **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.
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What is the Quality Improvement Organization?

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

How can you contact this organization?

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

What should you ask for?

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

Your deadline for contacting this organization.

- You must contact the Quality Improvement Organization to start your appeal **no later than noon of the day after you receive the written notice telling you when we will stop covering your care.**
- If you miss the deadline for contacting the Quality Improvement Organization about your appeal, you can make your appeal directly to our Plan instead. For details about this other way to make your appeal, see Section 8.5.

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

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

Questions? Call our Customer Service Department listed in Chapter 2.

you wish.

- The review organization will also look at your medical information, talk with your doctor, and review information that our Plan has given to them.
- By the end of the day the reviewers informed our Plan of your appeal, and you will also get a written notice from the plan that gives our reasons for ending the plan's coverage for your services.

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

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 **our Plan must keep providing your covered services for as long as it is medically necessary.**
- You will have to keep paying your share of the costs (such as deductibles or copayments, if these apply). In addition, there may be limitations on your covered services (see Chapter 4 of this booklet).

What happens if the reviewers say no to your appeal?

- If the reviewers say **no** to your appeal, then **your coverage will end on the date we have told you.** Our Plan will stop paying its share of the costs of this care.
- If you decide to keep getting the home health care, or skilled nursing facility care, or Comprehensive Outpatient Rehabilitation Facility (CORF) services **after** this date when your coverage ends, then **you will have to pay the full cost** of this care yourself.

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:

Questions? Call our Customer Service Department listed in Chapter 2.

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

Step 2:	The Quality Improvement Organization does a second review of your situation.
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- 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.
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What happens if the review organization says yes to your appeal?

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

What happens if the review organization says no?

- It means they agree with the decision they made to your Level 1 Appeal and will not change it.
- The notice you get will tell you in writing what you can do if you wish to continue with the review process. It will give you the details about how to go on to the next level of appeal, which is handled by a judge.

Step 4:	If the answer is no, you will need to decide whether you want to take your appeal further.
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- There are three additional levels of appeal after Level 2, for a total of five levels of appeal. If reviewers turn down your Level 2 Appeal, you can choose whether to accept that decision or to go on to Level 3 and make another appeal. At Level 3, your appeal is reviewed by a judge.
- Section 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?
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You can appeal to our Plan instead

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

Questions? Call our Customer Service Department listed in Chapter 2.

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

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

Here are the steps for a Level 1 Alternate Appeal:

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

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

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

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

Step 4:	If our Plan says no to your fast appeal, your case will automatically go on to the next level of the appeals process.
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Questions? Call our Customer Service Department listed in Chapter 2.

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

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

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

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

Step 1:	We will automatically forward your case to the Independent Review Organization.
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- We are required to send the information for your Level 2 Appeal to the Independent Review Organization within 24 hours of when we tell you that we are saying no to your first appeal. (If you think we are not meeting this deadline or other deadlines, you can make a complaint. The complaint process is different from the appeal process. Section 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.
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- **The Independent Review Organization is an independent organization that is hired by Medicare.** This organization is not connected with our Plan and it is not a government agency. This organization is a company chosen by Medicare to handle the job of being the Independent Review Organization. Medicare oversees its work.
- Reviewers at the Independent Review Organization will take a careful look at all of the information related to your appeal.
- **If this organization says yes to your appeal,** then our Plan must reimburse you (pay you back) for our share of the costs of care you have received since the date when we said your coverage would end. We must also continue to cover the care for as long as it is medically necessary. You must continue to pay your share of the costs. If there are coverage limitations, these could limit how much we would reimburse or how long we would continue to cover your services.
- **If this organization says no to your appeal,** it means they agree with the decision our Plan made to your first appeal and will not change it.
 - The notice you get from the Independent Review Organization will tell you in writing what you can do if you wish to continue with the review process. It will give you the details about how to go on to a Level 3 Appeal.

Questions? Call our Customer Service Department listed in Chapter 2.

Step 3:	If the Independent Review Organization turns down your appeal, you choose whether you want to take your appeal further.
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- There are three additional levels of appeal after Level 2, for a total of five levels of appeal. If reviewers say no to your Level 2 Appeal, you can choose whether to accept that decision or whether to go on to Level 3 and make another appeal. At Level 3, your appeal is reviewed by a judge.
- Section 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
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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.”
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- **If the Administrative Law Judge says yes to your appeal, the appeals process may or may not be over** - We will decide whether to appeal this decision to Level 4. Unlike a decision at Level 2 (Independent Review Organization), we have the right to appeal a Level 3 decision that is favorable to you.
 - If we decide **not** to appeal the decision, we must authorize or provide you with the service within 60 days after receiving the judge’s decision.
 - If we decide to appeal the decision, we will send you a copy of the Level 4 Appeal request with any accompanying documents. We may wait for the Level 4 Appeal decision before authorizing or providing the service in dispute.
- **If the Administrative Law Judge says no to your appeal, the appeals process may or may not be over.**
 - If you decide to accept this decision that turns down your appeal, the appeals process is over.
 - If you do not want to accept the decision, you can continue to the next level of the review process. If the administrative law judge says no to your appeal, the notice you get will tell

Questions? Call our Customer Service Department listed in Chapter 2.

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

Level 5 Appeal	A judge at the Federal District Court will review your appeal.
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- 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."
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Questions? Call our Customer Service Department listed in Chapter 2.

- **If the answer is yes, the appeals process is over.** What you asked for in the appeal has been approved. We must **authorize or provide the drug coverage** that was approved by the Administrative Law Judge **within 72 hours (24 hours for expedited appeals) or make payment no later than 30 days** after we receive the decision.
- **If the answer is no, the appeals process may or may not be over.**
 - If you decide to accept this decision that turns down your appeal, the appeals process is over.
 - If you do not want to accept the decision, you can continue to the next level of the review process. If the administrative law judge says no to your appeal, the notice you get will tell you what to do next if you choose to continue with your appeal.

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.
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- **If the answer is yes, the appeals process is over.** What you asked for in the appeal has been approved. We must **authorize or provide the drug coverage** that was approved by the Medicare Appeals Council **within 72 hours (24 hours for expedited appeals) or make payment no later than 30 days** after we receive the decision.
- **If the answer is no, the appeals process may or may not be over.**
 - If you decide to accept this decision that turns down your appeal, the appeals process is over.
 - If you do not want to accept the decision, you might be able to continue to the next level of the review process. If the Medicare Appeals Council says no to your appeal, the notice you get will tell you whether the rules allow you to go on to a Level 5 Appeal. If the rules allow you to go on, the written notice will also tell you who to contact and what to do next if you choose to continue with your appeal.

Level 5 Appeal	A judge at the Federal District Court will review your appeal.
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- 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

Questions? Call our Customer Service Department listed in Chapter 2.



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

Section 10.1 What kinds of problems are handled by the complaint process?

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

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

Quality of your medical care

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

Respecting your privacy

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

Disrespect, poor customer service, or other negative behaviors

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

Waiting times

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

Cleanliness

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

Information you get from us

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

**The next page has more examples of
possible reasons for making a complaint**

Possible complaints

(continued)

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

The process of asking for a coverage decision and making appeals is explained in sections 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. 1-888-867-5548, 711, 8 a.m. - 8 p.m. local time, 7 days a week.
- **If you do not wish to call (or you called and were not satisfied), you can put your complaint in**

Questions? Call our Customer Service Department listed in Chapter 2.

writing and send it to us. If you put your complaint in writing, we will respond to your complaint in writing.

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

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

Step 2:

We look into your complaint and give you our answer.

- **If possible, we will answer you right away.** If you call us with a complaint, we may be able to give you an answer on the same phone call. If your health condition requires us to answer quickly, we will do that.
- **Most complaints are answered in 30 calendar days.** If we need more information and the delay is in your best interest or if you ask for more time, we can take up to 14 more calendar days (44 calendar days total) to answer your complaint.
- **If we do not agree** with some or all of your complaint or don’t take responsibility for the problem you are complaining about, we will let you know. Our response will include our reasons for this answer. We must respond whether we agree with the complaint or not.

Section 10.4

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

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

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

- **You can make your complaint to the Quality Improvement Organization.** If you prefer, you can make your complaint about the quality of care you received directly to this organization (**without** making the complaint to our Plan).
 - The Quality Improvement Organization is a group of practicing doctors and other health care experts paid by the Federal government to check and improve the care given to

Questions? Call our Customer Service Department listed in Chapter 2.

Medicare patients.

- To find the name, address, and phone number of the Quality Improvement Organization for your state, look in Chapter 2, Section 4, of this booklet. If you make a complaint to this organization, we will work with them to resolve your complaint.
- **Or you can make your complaint to both at the same time.** If you wish, you can make your complaint about quality of care to our Plan and also to the Quality Improvement Organization.

CHAPTER 10: Ending your membership in the plan

SECTION 1 Introduction.....2
 Section 1.1 This chapter focuses on ending your membership in our Plan.....2

SECTION 2 When can you end your membership in our Plan?..... 2
 Section 2.1 You can end your membership during the Annual Enrollment Period.....2
 Section 2.2 You can end your membership during the annual Medicare Advantage Disenrollment Period, but your choices are more limited..... 3
 Section 2.3 In certain situations, you can end your membership during a Special Enrollment Period.....4
 Section 2.4 Where can you get more information about when you can end your membership?..... 4

SECTION 3 How do you end your membership in our Plan?.....5
 Section 3.1 Usually, you end your membership by enrolling in another plan..... 5

SECTION 4 Until your membership ends, you must keep getting your medical services and drugs through our Plan..... 6
 Section 4.1 Until your membership ends, you are still a member of our Plan.....6

SECTION 5 We must end your membership in the plan in certain situations.....6
 Section 5.1 When must we end your membership in the plan?..... 6
 Section 5.2 We cannot ask you to leave our Plan for any reason related to your health.....7
 Section 5.3 You have the right to make a complaint if we end your membership in our Plan.....7

Questions? Call our Customer Service Department listed in Chapter 2.

SECTION 1 Introduction

Section 1.1	This chapter focuses on ending your membership in our Plan
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Ending your membership in the plan may be **voluntary** (your own choice) or **involuntary** (not your own choice):

- You might leave our Plan because you have decided that you **want** to leave.
 - 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 and prescription drugs through our Plan until your membership ends.

In the event you choose to end your membership in our Plan, re-enrollment may not be permitted, or you may have to wait until your Plan Sponsor's next Open Enrollment Period. You should consult with your Plan Sponsor regarding the availability of other employer-sponsored coverage prior to ending your Plan membership outside of your Plan Sponsor's Open Enrollment Period. It is important to understand your Plan Sponsor's eligibility policies, and the possible impact to your retiree health care coverage options and other retirement benefits before submitting your request to end your membership in our Plan.

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

Because you are enrolled in our Plan through your Plan Sponsor, you are only allowed to make plan changes at times designated by your Plan Sponsor. If you choose to disenroll from your employer-sponsored health care coverage, the following will apply.

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
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Questions? Call our Customer Service Department listed in Chapter 2.

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 a Medicare prescription drug coverage and go without creditable prescription drug coverage, you may need to pay a late enrollment penalty if you join a Medicare drug plan later. (“Creditable” coverage means the coverage is expected to pay, on average, at least as much as Medicare’s standard prescription drug coverage.) See Chapter 6, Section 10 for more information about the late enrollment penalty.

- **When will your 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
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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 14th 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.

Questions? Call our Customer Service Department listed in Chapter 2.

Section 2.3	In certain situations, you can end your membership during a Special Enrollment Period
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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 at (<http://www.medicare.gov>):
 - Usually, when you have moved.
 - If you have Medicaid through Medi-Cal.
 - If we violate our contract with you.
 - If you are eligible for Extra Help with paying for your Medicare prescriptions.
 - If you are getting care in an institution, such as a nursing home or long-term care hospital.
 - You lose eligibility for employer sponsored benefits.
 - **When are Special Enrollment Periods?** The enrollment periods vary depending on your situation.
 - **What can you do?** To find out if you are eligible for a Special Enrollment Period, please call Medicare at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users call 1-877-486-2048. If you are eligible to end your membership because of a special situation, you can choose to change both your Medicare health coverage and prescription drug coverage. This means you can choose any of the following types of plans:
 - 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 10 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?
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If you have any questions or would like more information on when you can end your membership:

- Call your Plan Sponsor

Questions? Call our Customer Service Department listed in Chapter 2.

- You can **call Customer Service** (phone numbers are on the back cover of this booklet)
- You can find the information in the **Medicare & You 2012** handbook.
 - Everyone with Medicare receives a copy of **Medicare & You** each fall. Those new to Medicare receive it within a month after first signing up.
 - You can also download a copy from the Medicare website (<http://www.medicare.gov>). Or, you can order a printed copy by calling Medicare at the number below.
- You can contact **Medicare** at 1-800-MEDICARE (1-800-633-4227) 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

SECTION 3 How do you end your membership in our Plan?

Section 3.1	Usually, you end your membership by enrolling in another plan
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Usually, to end your membership in our Plan, you simply enroll in another Medicare plan during your Plan Sponsor’s Open Enrollment Period, or 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 (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

Note: If you disenroll from Medicare prescription drug coverage and go without creditable prescription drug coverage, you may need to pay a late enrollment penalty if you join a Medicare drug plan later. (“Creditable” coverage means the coverage is expected to pay, on average, at least as much as Medicare’s standard prescription drug coverage.) See Chapter 6, Section 10 for more information about the late enrollment penalty.

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

If you would like to switch from our Plan to:	This is what you should do:
<ul style="list-style-type: none"> ● Another Medicare health plan. 	<ul style="list-style-type: none"> ● Enroll in the new Medicare health plan. You will automatically be disenrolled from our Plan when your new plan’s coverage begins.
<ul style="list-style-type: none"> ● Original Medicare with a separate Medicare prescription drug plan. 	<ul style="list-style-type: none"> ● Enroll in the new Medicare prescription drug plan. You will automatically be disenrolled from

Questions? Call our Customer Service Department listed in Chapter 2.

If you would like to switch from our Plan to:	This is what you should do:
	our Plan when your new plan's coverage begins.
<ul style="list-style-type: none"> ● Original Medicare without a separate Medicare prescription drug plan. <ul style="list-style-type: none"> ○ Note: If you disenroll from a Medicare prescription drug plan and go without creditable prescription drug coverage, you may need to pay a late enrollment penalty if you join a Medicare drug plan later. See Chapter 6, Section 10 for more information about the late enrollment penalty. 	<ul style="list-style-type: none"> ● 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 (1-800-633-4227) 24 hours a day, 7 days a week and ask to be disenrolled. TTY users should call 1-877-486-2048. ● You will be disenrolled from 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:

Questions? Call our Customer Service Department listed in Chapter 2.

- We are notified that you no longer meet the eligibility requirements of your former employer, union group or trust administrator (Plan Sponsor).
- Your former employer, union group or trust administrator's (Plan Sponsor's) contract with us is terminated.
- If you do not stay continuously enrolled in Medicare Part A and Part B.
- If you become incarcerated (go to prison).
- If you lie about or withhold information about other insurance you have that provides prescription drug coverage.
- If you intentionally give us incorrect information when you are enrolling in our Plan and that information affects your eligibility for our Plan.
- If you continuously behave in a way that is disruptive and makes it difficult for us to provide medical care for you and other members of our Plan.
 - We cannot make you leave our Plan for this reason unless we get permission from Medicare first.
- If you let someone else use your member ID card to get medical care.
 - If we end your membership because of this reason, Medicare may have your case investigated by the Inspector General.

Where can you get more information?

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

- You can call **Customer Service** for more information (phone numbers are on the back cover of this booklet).

Section 5.2 We <u>cannot</u> 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 (1-800-633-4227). TTY users should call 1-877-486-2048. You may call 24 hours a day, 7 days a week.

Section 5.3 You have the right to make a complaint if we end your membership in our Plan
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If we end your membership in our Plan, we must tell you our reasons in writing for ending your membership. We must also explain how you can make a complaint about our decision to end your membership. You can also look in Chapter 9, Section 10 for information about how to make a complaint.

Questions? Call our Customer Service Department listed in Chapter 2.

CHAPTER 11: Legal notices

SECTION 1 Notice about governing law.....	2
SECTION 2 Notice about nondiscrimination.....	2
SECTION 3 Member liability.....	2
SECTION 4 Medicare-covered services must meet requirement of reasonable and necessary.....	3
SECTION 5 Third party liability and subrogation.....	3
SECTION 6 Non duplication of benefits with automobile, accident or liability coverage.....	4
SECTION 7 Acts beyond our control.....	4
SECTION 8 Contracting medical providers and network hospitals are independent contractors.....	4
SECTION 9 Our contracting arrangements.....	5
SECTION 10 How our network providers are compensated.....	5
SECTION 11 Technology assessment.....	6
SECTION 12 Member statements.....	6
SECTION 13 Information upon request.....	6
SECTION 14 Internal protection of information within UnitedHealth Group.....	7
SECTION 15 2011 Enrollee Fraud & Abuse Communication	7

Questions? Call our Customer Service Department listed in Chapter 2.

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.

SECTION 3 Member liability

Note: This section only applies to you if you are required by your Plan rules to obtain a referral before seeing non-network providers. Please see the chapter entitled **Using the plan's coverage for your medical services** to see if your Plan requires referrals to non-network providers.

You will be liable if you receive services from non-network providers without authorization or a referral.

In the event we fail to reimburse network provider's charges for covered services, you will not be liable for any sums owed by us. Neither the plan nor Medicare will pay for those services except for the following eligible expenses:

- Emergency services
- Urgently needed services Out-of-area and routine travel dialysis (must be received in a Medicare Certified Dialysis Facility within the United States)
- Post-stabilization services

If you enter into a private contract with a non-network provider, neither the plan nor Medicare will pay for those services.

Questions? Call our Customer Service Department listed in Chapter 2.

SECTION 4 Medicare-covered services must meet requirement of reasonable and necessary

In determining coverage, services must meet the reasonable and necessary requirements under Medicare in order to be covered under your Plan, unless otherwise listed as a covered service. A service is “reasonable and necessary” if the service is:

- Safe and effective;
- Not experimental or investigational; and
- Appropriate, including the duration and frequency that is considered appropriate for the service, in terms of whether it is:
 1. Furnished in accordance with accepted standards of medical practice for the diagnosis or treatment of the patient’s condition or to improve the function of a malformed body member;
 2. Furnished in a setting appropriate to the patient’s medical needs and condition;
 3. Ordered and furnished by qualified personnel;
 4. One that meets, but does not exceed, the patient’s medical need; and
 5. At least as beneficial as an existing and available medically appropriate alternative.

SECTION 5 Third party liability and subrogation

If you suffer an injury or illness for which any third party is liable or responsible due to any negligent or intentional act or omission causing illness or injury to you, you must promptly notify us of the injury or illness. We will send you a statement of the amounts we paid for services provided in connection with the injury or illness. If you recover any sums from any third party, we shall be reimbursed out of any such recovery from any third party for the payments we made on your behalf, subject to the limitations in the following paragraphs.

- 1) **Our payments are less than the recovery amount.** If our payments are less than the total recovery amount from any third party (the “recovery amount”), then our reimbursement is computed as follows:
 - a) **First:** Determine the ratio of the procurement costs to the recovery amount (the term “procurement costs” means the attorney fees and expenses incurred in obtaining a settlement or judgment).
 - b) **Second:** Apply the ratio calculated above to our payment. The result is our share of procurement costs.
 - c) **Third:** Subtract our share of procurement costs from our payments. The remainder is our reimbursement amount.
- 2) **Our payments equal or exceed the recovery amount.** If our payments equal or exceed the recovery amount, our reimbursement amount is the total recovery amount minus the total procurement costs.

Questions? Call our Customer Service Department listed in Chapter 2.

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- 3) **We incur procurement costs because of opposition to our reimbursement.** If we must bring suit against the party that received the recovery amount because that party opposes our reimbursement, our reimbursement amount is the lower of the following:
- a) our payments made on your behalf for services; or
 - b) the recovery amount, minus the party's total procurement cost.

Subject to the limitations stated above, you agree to grant us an assignment of, and a claim and a lien against, any amounts recovered through settlement, judgment or verdict. You may be required by us and you agree to execute documents and to provide information necessary to establish the assignment, claim, or lien to ascertain our right to reimbursement.

SECTION 6 Non duplication of benefits with automobile, accident or liability coverage

If you are receiving benefits as a result of other automobile, accident or liability coverage, we will not duplicate those benefits. It is your responsibility to take whatever action is necessary to receive payment under automobile, accident, or liability coverage when such payments may reasonably be expected, and to notify us of such coverage when available. If we happen to duplicate benefits to which you are entitled under other automobile, accident or liability coverage, we may seek reimbursement of the reasonable value of those benefits from you, your insurance carrier, or your health care provider to the extent permitted under State and/or federal law. We will provide benefits over and above your other automobile, accident or liability coverage, if the cost of your health care services exceeds such coverage. **You are required to cooperate with us in obtaining payment from your automobile, accident or liability coverage carrier. Your failure to do so may result in termination of your Plan membership.**

SECTION 7 Acts beyond our control

If, due to a natural disaster, war, riot, civil insurrection, complete or partial destruction of a facility, ordinance, law or decree of any government or quasi-governmental agency, labor dispute (when said dispute is not within our control), or any other emergency or similar event not within the control of us, network providers may become unavailable to arrange or provide health services pursuant to this Evidence of Coverage and Disclosure Information, then we shall attempt to arrange for covered services insofar as practical and according to our best judgment. Neither we nor any network provider shall have any liability or obligation for delay or failure to provide or arrange for covered services if such delay is the result of any of the circumstances described above.

SECTION 8 Contracting medical providers and network hospitals are independent contractors

Questions? Call our Customer Service Department listed in Chapter 2.

The relationships between us and our network providers and network hospitals are independent contractor relationships. None of the network providers or network hospitals or their physicians or employees are employees or agents of UnitedHealthcare. An agent would be anyone authorized to act on our behalf. Neither we nor any employee of UnitedHealthcare is an employee or agent of the network providers or network hospitals.

SECTION 9 Our contracting arrangements

In order to obtain quality service in an efficient manner, we pay providers using various payment methods, including capitation, per diem, incentive and discounted Fee-for-Service arrangements. Capitation means paying an agreed upon dollar amount per month for each member assigned to the provider. Per diem means paying a fixed dollar amount per day for all services rendered, such as inpatient hospital and skilled nursing facility stays. Incentive means a payment that is based on appropriate medical management by the provider. Discounted Fee-for-Service means paying an agreed upon fee schedule which is a reduction from their usual and customary charges.

You are entitled to ask if we have special financial arrangements with the network providers that may affect the use of referrals and other services that you might need. To obtain this information, call Customer Service and request information about the network provider's payment arrangements.

SECTION 10 How our network providers are compensated

The following is a brief description of how we pay our network providers:

We typically contract with individual physicians and medical groups, often referred to as Independent Practitioner Associations ("IPAs"), to provide medical services and with hospitals to provide services to members. The contracting medical groups/IPAs in turn, employ or contract with individual physicians.

Most of the individual physicians are paid on a Fee-for-Service arrangement. In addition, some physicians receive an agreed-upon monthly payment from us to provide services to members. The monthly payment may be either a fixed dollar amount for each member, or a percentage of the monthly plan premium received by us. The monthly payment typically covers professional services directly provided by individual physicians and may also cover certain referral services.

Most of the contracted medical groups/IPAs receive an agreed upon monthly payment from us to provide services to members. The monthly payment may be either a fixed dollar amount for each member or a percentage of the monthly plan premium received by us. The monthly payment typically covers professional services directly provided by the contracted medical group/IPA, and may also cover certain referral services. Some of our network hospitals receive similar monthly payments in return for arranging hospital services for members. Other hospitals are paid on a discounted Fee-for-Service or fixed charge per day of hospitalization.

Each year, we and the contracted medical group/IPA agree on a budget for the cost of services covered

Questions? Call our Customer Service Department listed in Chapter 2.

under the program for all plan members treated by the contracted medical group/IPA. At the end of the year, the actual cost of services for the year is compared to the agreed-upon budget. If the actual cost of services is less than the agreed-upon budget, the contracted medical group/IPA shares in the savings. The network hospital and the contracted medical group/IPA typically participate in programs for hospital services similar to that described above.

Stop-loss insurance protects the contracted medical groups/IPAs and network hospitals from large financial losses and helps the providers with resources to cover necessary treatment. We provide stop-loss protection to the contracted medical groups/IPAs and network hospitals that receive capitation payments. If any capitated providers do not obtain stop-loss protection from us, they must obtain stop-loss insurance from an insurance carrier acceptable to us. You may obtain additional information on compensation arrangements by contacting Customer Service or your contracted medical group/IPA, however, specific compensation terms and rates are confidential and will not be disclosed.

SECTION 11 Technology assessment

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

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

SECTION 12 Member statements

In the absence of fraud, all statements made by you will be deemed representations and not warranties. No such representation will void coverage or reduce covered services under this Evidence of Coverage or be used in defense of a legal action unless it is contained in a written application.

SECTION 13 Information upon request

As a plan member, you have the right to request information on the following:

Questions? Call our Customer Service Department listed in Chapter 2.

-
- General coverage and comparative plan information
 - Utilization control procedures
 - Quality improvement programs
 - Statistical data on grievances and appeals
 - The financial condition of UnitedHealthcare

SECTION 14 Internal protection of information within UnitedHealth Group

UnitedHealth Group collects and maintains oral, written and electronic information to administer our business and to provide products, services and information of importance to our enrollees. We provide physical, electronic and procedural security safeguards in the handling and maintenance of our enrollees' information to protect against risks such as loss, destruction or misuse. We conduct regular audits to guarantee appropriate and secure handling and processing of our enrollees' information.

SECTION 15 2011 Enrollee Fraud & Abuse Communication

2011 Enrollee Fraud & Abuse Communication

How you can fight healthcare fraud

Our company is committed to preventing fraud, waste, and abuse in Medicare benefit programs and we're asking for your help. If you identify a potential case of fraud, please report it to us immediately. Here are some examples of potential Medicare fraud cases:

- A health care provider – such as a physician, pharmacy, or medical device company – bills for services you never got,
- A supplier bills for equipment different from what you got
- Someone uses another person's Medicare card to get medical care, prescriptions, supplies or equipment
- Someone bills for home medical equipment after it has been returned.
- A company offers a Medicare drug or health plan that hasn't been approved by Medicare.
- A company uses false information to mislead you into joining a Medicare drug or health plan.

To report a potential case of fraud in a Medicare benefit program, call United HealthCare Insurance Company's dedicated fraud hotline at 1-877-637-5595, 24 hours a day, 7 days a week. TTY/TDD users may call 1-877-730-4203.

This hotline allows you to report cases anonymously and confidentially. We will make every effort to maintain your confidentiality. However, if law enforcement needs to get involved, we may not be able to guarantee your confidentiality. Please know that our organization will not take any action against you for reporting a potential fraud case in good faith.

You may also report potential prescription drug program fraud cases to the Medicare program directly at 1-877-7SafeRx (1-877-772-3379). For potential medical or non-prescription fraud cases, you may

Questions? Call our Customer Service Department listed in Chapter 2.

report to the Medicare program directly at 1-800-Medicare (1-800-633-4227). The Medicare fax number is 1-717-975-4442 and the Web site is www.medicare.gov.

For more information, request the guide titled “Protecting Medicare and You from Fraud” by calling 1-800-Medicare (1-800-633-4227). TTY/TDD users should call 1-877-486-2048. A customer service representative can answer your questions 24 hours a day, 7 days a week.

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 SecureHorizons® MedicareComplete® Retiree Plan (HMO), 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 1.3 for more information about balance billing.

Benefit period – The way that Original Medicare measures your use of hospital and skilled nursing facility (SNF) services. A benefit period begins the day you go into a hospital or skilled nursing facility. The benefit period ends when you haven't received any inpatient hospital care (or skilled care in a SNF) for 60 days in a row. If you go into a hospital or a skilled nursing facility after one benefit period has ended, a new benefit period begins. You must pay the inpatient hospital deductible for each benefit period. There is no limit to the number of benefit periods. For Inpatient Hospital Care, Medicare-defined hospital benefit periods do not apply. For inpatient hospital care, the cost sharing described in the Medical Benefits Chart in Chapter 4 applies each time you are admitted to the hospital. For each inpatient hospital stay, you are covered for unlimited days as long as the hospital stay is covered in accordance with plan rules.

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

Catastrophic Coverage Stage – The stage in the Part D Drug Benefit where you pay a low copayment or coinsurance for your drugs after you or other qualified parties on your behalf have spent \$4,550 in covered drugs during the covered year.

Centers for Medicare & Medicaid Services (CMS) – The Federal agency that administers Medicare. Chapter 2 explains how to contact CMS.

Clinical Research Study – A clinical research study is a way that doctors and scientists test new types

Questions? Call our Customer Service Department listed in Chapter 2.

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

Coinsurance – An amount you may be required to pay as your share of the cost for services or prescription drugs. Coinsurance is usually a percentage (for example, 20%).

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

Co-Payment, Copayment, Copay – An amount you may be required to pay as your share of the cost for a medical service or supply, like a doctor’s visit, hospital outpatient visit, or a prescription drug. A copayment is usually a set amount, rather than a percentage. For example, you might pay \$10 or \$20 for a doctor’s visit or prescription drug.

Cost Sharing – Cost sharing refers to amounts that a member has to pay when services or drugs are received. Cost sharing includes any combination of the following three types of payments: (1) any deductible amount a plan may impose before services or drugs are covered; (2) any fixed “copayment” amount that a plan requires when a specific service or drug is received; or (3) any “coinsurance” amount, a percentage of the total amount paid for a service or drug that a plan requires when a specific service or drug is received.

Cost-Sharing Tier – Every drug on the list of covered drugs is in one of 4 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.

Questions? Call our Customer Service Department listed in Chapter 2.

Customer Service – A department within our Plan responsible for answering your questions about your membership, benefits, grievances, and appeals. See Chapter 2 for information about how to contact Customer Service.

Disenroll or Disenrollment – The process of ending your membership in our Plan. Disenrollment may be voluntary (your own choice) or involuntary (not your own choice).

Dispensing Fee – A fee charged each time a covered drug is dispensed to pay for the cost of filling a prescription. The dispensing fee covers costs such as the pharmacist’s time to prepare and package the prescription.

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 network providers or pharmacies, including a complaint concerning the quality of your care. This type of complaint does not involve coverage or payment disputes.

Home Health Aide – A home health aide provides services that don’t need the skills of a licensed nurse or therapist, such as help with personal care (e.g., bathing, using the toilet, dressing, or carrying out the prescribed exercises). Home health aides do not have a nursing license or provide therapy.

Home Health Care – Skilled nursing care and certain other health care services that you get in your home for the treatment of an illness or injury. Covered services are listed in the Benefits Chart in Chapter 4, Section 2.1 under the heading “Home health care.” If you need home health care services, our Plan will cover these services for you provided the Medicare coverage requirements are met. Home

Questions? Call our Customer Service Department listed in Chapter 2.

health care can include services from a **home health aide** if the services are part of the home health plan of care for your illness or injury. They aren't covered unless you are also getting a covered skilled service. Home health services don't include the services of housekeepers, food service arrangements, or full time nursing care at home.

Hospice Care – A special way of caring for people who are terminally ill and providing counseling for their families. Hospice care is physical care and counseling that is given by a team of people who are part of a Medicare-certified public agency or private company. Depending on the situation, this care may be given in the home, a hospice facility, a hospital, or a nursing home. Care from a hospice is meant to help patients in the last months of life by giving comfort and relief from pain. The focus is on care, not cure. For more information on hospice care visit www.medicare.gov and under “Search Tools” choose “Find a Medicare Publication” to view or download the publication “Medicare Hospice Benefits.” Or, call **1-800-MEDICARE (1-800-633-4227)**. **TTY/TDD** users should call **1-877-486-2048**. You may call 24 hours a day/7 days a week. Note: If you are not entitled to Medicare Part A coverage, hospice services are not covered by Medicare or the plan.

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 \$2,840 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 plan year for in-network covered Part A and Part B services. Amounts you or your Plan Sponsor 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. 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,

Questions? Call our Customer Service Department listed in 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, 2012.

Medicare Advantage (MA) Plan – Sometimes called Medicare Part C. A plan offered by a private company that contracts with Medicare to provide you with all your Medicare Part A and Part B benefits. A Medicare Advantage Plan can be an HMO, PPO, POS, a Private Fee-for-Service (PFFS) plan, or a Medicare Medical Savings Account (MSA) plan. When you are enrolled in a Medicare Advantage Plan, Medicare services are covered through the plan, and are not paid for under Original Medicare. In most cases, Medicare Advantage Plans also offer Medicare Part D (prescription drug coverage). These plans are called **Medicare Advantage Plans with Prescription Drug Coverage**. Everyone who has Medicare Part A and Part B is eligible to join any Medicare health plan that is offered in their area, except people with End-Stage Renal Disease (unless certain exceptions apply).

Medicare Allowable Cost – The maximum price of a service for reimbursement purposes under Original Medicare.

Medicare Coverage Gap Discount Program – A program that provides discounts on most covered Part D brand name drugs to Part D enrollees who have reached the Coverage Gap Stage and who are not already receiving “Extra Help.” Discounts are based on agreements between the Federal government and certain drug manufacturers. For this reason, most, but not all, brand name drugs are discounted.

Medicare Health Plan – A Medicare health plan is offered by a private company that contracts with Medicare to provide Part A and Part B benefits to people with Medicare who enroll in the plan. This term includes all Medicare Advantage Plans, Medicare Cost Plans, Demonstration/Pilot Programs, and Programs of All-inclusive Care for the Elderly (PACE).

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

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

Member (Member of our Plan, or “Plan Member”) – A person with Medicare who is eligible to get covered services, who has enrolled in our Plan and whose enrollment has been confirmed by the

Questions? Call our Customer Service Department listed in Chapter 2.

Centers for Medicare & Medicaid Services (CMS).

Network Mail-Service Pharmacy – A network mail-service pharmacy that generally offers a longer-term supply of Medicare Part D covered drugs to members of our Plan.

Network Pharmacy – A network pharmacy is a pharmacy where members of our Plan can get their prescription drug benefits. We call them “network pharmacies” because they contract with our Plan. In most cases, your prescriptions are covered only if they are filled at one of our network pharmacies.

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

Organization Determination – The Medicare Advantage organization has made an organization determination when it, or one of its providers, makes a decision about whether services are covered or how much you have to pay for covered services. Organization determinations are called “coverage decisions” in this booklet. Chapter 9 explains how to ask us for a coverage decision.

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

Out-of-Network Pharmacy – A pharmacy that doesn’t have a contract with our Plan to coordinate or provide covered drugs to members of our Plan. As explained in this Evidence of Coverage, most drugs you get from out-of-network pharmacies are not covered by our Plan unless certain conditions apply.

Out-of-Network Provider or Out-of-Network Facility – A provider or facility with which we have not arranged to coordinate or provide covered services to members of our Plan. Out-of-network providers are providers that are not employed, owned, or operated by our Plan or are not under contract to deliver covered services to you.

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

Questions? Call our Customer Service Department listed in Chapter 2.

excluded by Congress from being covered as Part D drugs.

Plan Sponsor – Your former employer, union group or trust administrator.

Plan Year – The period of time your Plan Sponsor has contracted with us to provide covered services and covered drugs to you through the plan. Your Plan Sponsor’s plan year is listed inside the front cover of the Evidence of Coverage.

Preferred Mail-Service Network Pharmacy – Our preferred network mail-service pharmacy, Prescription Solutions by OptumRx, offers covered drugs to members of our Plan at lower cost-sharing levels than apply at our other network mail-service pharmacy.

Primary Care Physician (PCP) – Your primary care physician is the doctor or other provider you see first for most health problems. He or she makes sure you get the care you need to keep you healthy. He or she also may talk with other doctors and health care providers about your care and refer you to them. In many Medicare health plans, you must see your primary care physician before you see any other health care provider. See Chapter 3, Section 2.1 for information about Primary Care Physicians.

Prior Authorization – Approval in advance to get certain drugs that may or may not be on our formulary. 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.

Providers – Doctors and other health care professionals that the state licenses to provide medical services and care. The term “providers” also includes hospitals and other health care facilities.

Quality Improvement Organization (QIO) – A group of practicing doctors and other health care experts paid by the Federal government to check and improve the care given to Medicare patients. See Chapter 2, Section 4 for information about how to contact the QIO for your state.

Quantity Limits – A management tool that is designed to limit the use of selected drugs for quality, safety, or utilization reasons. Limits may be on the amount of the drug that we cover per prescription or for a defined period of time.

Referral – A formal recommendation by your PCP for you to receive care from a specialist or network provider.

Rehabilitation Services – These services include physical therapy, speech and language therapy, and occupational therapy.

Service Area – A geographic area where a health plan accepts members if it limits membership based on where people live. For plans that limit which doctors and hospitals you may use, it’s also generally the area where you can get routine (non-emergency) services. The plan may disenroll you if you move out of the plan’s service area.

Skilled Nursing Facility (SNF) Care – Skilled nursing care and rehabilitation services provided on a continuous, daily basis, in a skilled nursing facility. Examples of skilled nursing facility care include physical therapy or intravenous injections that can only be given by a registered nurse or doctor.

Special 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.

Questions? Call our Customer Service Department listed in Chapter 2.

Step Therapy – A utilization tool that requires you to first try another drug to treat your medical condition before we will cover the drug your physician may have initially prescribed.

Supplemental Security Income (SSI) – A monthly benefit paid by the Social Security Administration to people with limited income and resources who are disabled, blind, or age 65 and older. SSI benefits are not the same as Social Security benefits.

Urgently Needed Care – Urgently needed care is care provided to treat a non-emergency, unforeseen medical illness, injury, or condition, that requires immediate medical care, but the plan's network of providers is temporarily unavailable or inaccessible.

Customer Service

CALL	1-888-867-5548 Calls to this number are free 8 a.m. - 8 p.m. local time, 7 days a week Customer Service also has free language interpreter services available for non-English speakers.
TTY/TDD	711 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free. 8 a.m. - 8 p.m. local time, 7 days a week
WRITE	UnitedHealthcare P.O. Box 29675 Hot Springs, AR 71903-9675
WEBSITE	www.UHCRetiree.com

State Health Insurance Assistance Program

CALIFORNIA HEALTH INSURANCE COUNSELING AND ADVOCACY PROGRAM is a state program that gets money from the Federal government to give free local health insurance counseling to people with Medicare.

CALL	1-916-419-7500
TTY/TDD	1-800-732-2929 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.
WRITE	1300 National Drive, Suite 200 Sacramento, CA 95834-1992

A UnitedHealthcare® Medicare Solution

You are not required to use the plan's Preferred Mail Service Pharmacy to obtain a 90-day supply of your maintenance medications, but you may pay more out-of-pocket compared to using the Preferred Mail Service Pharmacy. Your prescriptions should arrive in about seven days from the date the completed order is received by the Mail Service Pharmacy. You will be contacted by the Preferred Mail Service Pharmacy if there will be an extended delay in the delivery of your medications.

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