2013 Evidence of Coverage

Regence MedAdvantage Basic (PPO)
January 1 – December 31, 2013

Evidence of Coverage:

Your Medicare Health Benefits and Services as a Member of Regence MedAdvantage Basic (PPO)

This booklet gives you the details about your Medicare health care coverage from January 1 – December 31, 2013. It explains how to get coverage for the health care services you need.

This is an important legal document. Please keep it in a safe place.

This plan, Regence MedAdvantage Basic, is offered by Regence BlueCross BlueShield of Utah. (When this Evidence of Coverage says “we,” “us,” or “our,” it means Regence BlueCross BlueShield of Utah. When it says “plan” or “our plan,” it means Regence MedAdvantage Basic.)

Regence BlueCross BlueShield of Utah is a Health plan with a Medicare contract.

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

This information is available electronically and may be available in other formats.

Benefits, premium, deductible, and/or copayments/coinsurance may change on January 1, 2014.
2013 Evidence of Coverage

Table of Contents

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

Chapter 1. Getting started as a member............................................................... 1

Explains 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 membership card, and keeping your membership record up to date.

Chapter 2. Important phone numbers and resources ........................................ 12

Tells you how to get in touch with our plan (Regence MedAdvantage Basic) 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), and the Railroad Retirement Board.

Chapter 3. Using the plan’s coverage for your medical services...................... 23

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) .......... 35

Gives the details about which types of medical care are covered and not covered for you as a member of our plan. Explains how much you will pay as your share of the cost for your covered medical care.

Chapter 5. Asking us to pay our share of a bill you have received for covered medical services.............................................................. 78

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

Chapter 6. Your rights and responsibilities ...................................................... 83
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 7. **What to do if you have a problem or complaint (coverage decisions, appeals, complaints)** ........................................ 97

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

- Explains how to ask for coverage decisions and make appeals if you are having trouble getting the medical care you think is covered by our plan. This includes 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 8. **Ending your membership in the plan** ........................................ 139

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

Chapter 9. **Legal notices** ........................................................................ 147

Includes notices about governing law and about nondiscrimination.

Chapter 10. **Definitions of important words** ............................................. 151

Explains key terms used in this booklet.
Chapter 1. Getting started as a member

SECTION 1 Introduction ............................................................................................................. 3
Section 1.1 You are enrolled in Regence MedAdvantage Basic, which is a Medicare PPO ................................................................. 3
Section 1.2 What is the Evidence of Coverage booklet about? ........................................... 3
Section 1.3 What does this Chapter tell you? ....................................................................... 3
Section 1.4 What if you are new to Regence MedAdvantage Basic? ................................. 3
Section 1.5 Legal information about the Evidence of Coverage ......................................... 4

SECTION 2 What makes you eligible to be a plan member? .............................................. 4
Section 2.1 Your eligibility requirements ............................................................................. 4
Section 2.2 What are Medicare Part A and Medicare Part B? ........................................... 4
Section 2.3 Here is the plan service area for Regence MedAdvantage Basic ............... 5

SECTION 3 What other materials will you get from us? .................................................. 5
Section 3.1 Your plan membership card – Use it to get all covered care ....................... 5
Section 3.2 The Provider Directory: Your guide to all providers in the plan’s network ................................................................. 6

SECTION 4 Your monthly premium for Regence MedAdvantage Basic ......................... 6
Section 4.1 How much is your plan premium? .................................................................. 6
Section 4.2 There are several ways you can pay your plan premium ............................. 7
Section 4.3 Can we change your monthly plan premium during the year? .................... 8

SECTION 5 Please keep your plan membership record up to date .................................. 9
Section 5.1 How to help make sure that we have accurate information about you ......... 9

SECTION 6 We protect the privacy of your personal health information ...................... 10
Section 6.1 We make sure that your health information is protected

SECTION 7 How other insurance works with our plan

Section 7.1 Which plan pays first when you have other insurance?
SECTION 1  Introduction

Section 1.1  You are enrolled in Regence MedAdvantage Basic, which is a Medicare PPO

You are covered by Medicare, and you have chosen to get your Medicare health care coverage through our plan, Regence MedAdvantage Basic.

There are different types of Medicare health plans. Regence MedAdvantage Basic is a Medicare Advantage PPO Plan (PPO stands for Preferred Provider Organization). This plan does not include Part D prescription drug coverage. Like all Medicare health plans, this Medicare PPO 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 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, Regence MedAdvantage Basic, is offered by Regence BlueCross BlueShield of Utah. (When this Evidence of Coverage says “we,” “us,” or “our,” it means Regence BlueCross BlueShield of Utah. When it says “plan” or “our plan,” it means Regence MedAdvantage Basic.)

The word “coverage” and “covered services” refers to the medical care and services available to you as a member of Regence MedAdvantage Basic.

Section 1.3  What does this Chapter tell you?

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

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

Section 1.4  What if you are new to Regence MedAdvantage Basic?

If you are a new member, then it’s important for you to learn what the plan’s rules are and what services are available to you. We encourage you to set aside some time to look through this Evidence of Coverage booklet.
If you are confused or concerned or just have a question, please contact our plan’s Customer Service (phone numbers are printed on the back cover of this booklet).

Section 1.5 Legal information about the Evidence of Coverage

It’s part of our contract with you

This Evidence of Coverage is part of our contract with you about how Regence MedAdvantage Basic covers your care. Other parts of this contract include your enrollment form 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 Regence MedAdvantage Basic between January 1, 2013 and December 31, 2013.

Medicare must approve our plan each year

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

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

Section 2.1 Your eligibility requirements

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

- You live in our geographic service area (section 2.3 below describes our service area)
- -- and -- you have both Medicare Part A and Medicare Part B
- -- and -- you do not have End-Stage Renal Disease (ESRD), with limited exceptions, such as if you develop ESRD when you are already a member of a plan that we offer, or you were a member of a different plan that was terminated.

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

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

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

Section 2.3  Here is the plan service area for Regence MedAdvantage Basic

Although Medicare is a Federal program, Regence MedAdvantage Basic 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 Utah: Box Elder, Cache, Davis, Iron, Morgan, Rich, Salt Lake, Summit, Tooele, Utah, Wasatch, Washington, and Weber counties.

If you plan to move out of the service area, please contact Customer Service (phone numbers are printed on the back cover of this booklet). 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 membership card – Use it to get all covered care

While you are a member of our plan, you must use your membership card for our plan whenever you get any services covered by this plan. Here’s a sample membership card to show you what yours will look like:

As long as you are a member of our plan you must not use your red, white, and blue Medicare card to get covered medical services (with the exception of routine clinical research studies and hospice services). Keep your red, white, and blue Medicare card in a safe place in case you need it later.
Here’s why this is so important: If you get covered services using your red, white, and blue Medicare card instead of using your Regence MedAdvantage Basic membership card while you are a plan member, you may have to pay the full cost yourself.

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

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

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?

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

If you don’t have your copy of the Provider Directory, you can request a copy from Customer Service (phone numbers are printed on the back cover of this booklet). You may ask Customer Service for more information about our network providers, including their qualifications. You can also see the Provider Directory at www.regence.com/medicare, or download it from this website. Both Customer Service and the website can give you the most up-to-date information about changes in our network providers.

SECTION 4 Your monthly premium for Regence MedAdvantage Basic

Section 4.1 How much is your plan premium?

As a member of our plan, you pay a monthly plan premium. For 2013, the monthly premium for Regence MedAdvantage Basic is $32.00. 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).
Many members are required to pay other Medicare premiums

In addition to paying the monthly plan premium, many members are required to pay other Medicare premiums. As explained in Section 2 above, in order to be eligible for our plan, you must be entitled to Medicare Part A and enrolled in Medicare Part B. For that reason, some plan members (those who aren’t eligible for premium-free Part A) pay a premium for Medicare Part A. And most plan members pay a premium for Medicare Part B. **You must continue paying your Medicare premiums to remain a member of the plan.**

Your copy of Medicare & You 2013 gives information about these premiums in the section called “2013 Medicare Costs.” This explains how the Medicare 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 2013 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 There are several ways you can pay your plan premium

There are three ways you can pay your plan premium. Contact Customer Service if you want to change the way you are currently paying your plan premium. Call Customer service at 1 (800) 541-8981 from 8:00 a.m. to 8:00 p.m. Monday through Friday. From October 1 through February 14, our telephone hours are 8:00 a.m. to 8:00 p.m., seven days a week. (TTY/TDD users should call 711.)

If you decide to change the way you pay your premium, it can take up to three months for your new payment method to take effect. While we are processing your request for a new payment method, you are responsible for making sure that your plan premium is paid on time.

**Option 1: You can pay by check**

You may pay your monthly plan premium directly to our plan by check or money order. We will send you a bill on approximately the 15th of the month. Your check or money order must be received by the first of the month. Your check or money order should be made payable to our plan and mailed to our plan at PO Box 3004, Tacoma, WA 98401-3004. **Do not make checks payable to CMS, Medicare or HHS.** You may also drop off your check or money order in person. Please contact Customer Service to find the nearest plan office that can accept your premium payments.

**Option 2: You can have your premium automatically withdrawn from your bank account**

Instead of paying by check, you can have your monthly plan premium automatically withdrawn from your checking or savings account monthly. The funds will be deducted from your account on approximately the third of the month. If you are interested in this
method, please contact Customer Service and they will send you a form to complete. You can also find the form on our website www.regence.com/medicare.

**Option 3: You can have the plan premium taken out of your monthly Social Security check**

You can have the plan premium taken out of your monthly Social Security check. Contact Customer Service for more information on how to pay your plan premium this way. We will be happy to help you set this up. (Phone numbers for Customer Service are printed on the back cover of this booklet.)

**What to do if you are having trouble paying your plan premium**

Your plan premium is due in our office by the 1st of the month. If we have not received your plan premium payment by the 15th of the month we will send you a notice telling you that your plan membership will end if we do not receive your plan premium within two calendar months.

If you are having trouble paying your premium on time, please contact Customer Service to see if we can direct you to programs that will help with your plan premium. (Phone numbers for Customer Service are printed on the back cover of this booklet.)

If we end your membership because you did not pay your premium, you will have health coverage under Original Medicare.

At the time we end your membership, you may still owe us for premiums you have not paid. In the future, if you want to enroll again in our plan (or another plan that we offer), you will need to pay the late premiums before you can enroll.

If you think we have wrongfully ended your membership, you have a right to ask us to reconsider this decision by making a complaint. Chapter 7, Section 7 of this booklet tells how to make a complaint.

If you had an emergency circumstance that was out of your control and it caused you to not be able to pay your premiums within our grace period, you can ask Medicare to reconsider this decision by calling 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

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<th>Section 4.3</th>
<th>Can we change your monthly plan premium during the year?</th>
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**No.** We are not allowed to change the amount we charge for the plan’s monthly plan premium during the year. If the monthly plan premium changes for next year we will tell you in September and the change will take effect on January 1.
Please keep your plan membership record up to date

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

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

The doctors, hospitals, 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 are covered and the cost-sharing amounts for you.** Because of this, it is very important that you help us keep your information up to date.

**Let us know about these changes:**

- Changes to your name, your address, or your phone number
- Changes in any other health insurance coverage you have (such as from 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 you receive care in an out-of-area or out-of-network hospital or emergency room
- If your designated responsible party (such as a caregiver) changes
- If you are participating in a clinical research study

If any of this information changes, please let us know by calling Customer Service (phone numbers are printed on the 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 printed on the back cover of this booklet).
SECTION 6  We protect the privacy of your personal health information

Section 6.1  We make sure that your health information is protected

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

For more information about how we protect your personal health information, please go to Chapter 6, 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 pays first, or you need to update your other insurance information, call Customer Service (phone numbers are printed 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.
Chapter 2. Important phone numbers and resources

SECTION 1  Regence BlueCross BlueShield of Utah contacts  (how to contact us, including how to reach Customer Service at the plan)........ 13

SECTION 2  Medicare  (how to get help and information directly from the Federal Medicare program).......................................................... 16

SECTION 3  State Health Insurance Assistance Program  (free help, information, and answers to your questions about Medicare)................. 18

SECTION 4  Quality Improvement Organization  (paid by Medicare to check on the quality of care for people with Medicare).......................... 19

SECTION 5  Social Security ................................................................. 19

SECTION 6  Medicaid  (a joint Federal and state program that helps with medical costs for some people with limited income and resources)....... 20

SECTION 7  How to contact the Railroad Retirement Board.......................... 21

SECTION 8  Do you have “group insurance” or other health insurance from an employer?........................................................................ 22
How to contact our plan’s Customer Service

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

### Customer Service

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<tr>
<th>CALL</th>
<th>Regence BlueCross BlueShield of Utah Customer Service: 1 (800)-541-8981</th>
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<td></td>
<td>Calls to this number are free. Our telephone hours are 8:00 a.m. to 8:00 p.m., Monday through Friday. From October 1 through February 14, our telephone hours are 8:00 a.m. to 8:00 p.m., seven days a week. Customer Service also has free language interpreter services available for non-English speakers.</td>
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<td>VSP Customer Service: 1 (800) 877-7195</td>
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<td>Calls to this number are free. Live telephone hours are 5:00 a.m. to 8:00 p.m. (PST) Monday through Friday and Saturday from 6:00 a.m. to 5:00 p.m. (PST) The automated system is available 24 hours a day, 7 days a week.</td>
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<tr>
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<th>Regence BlueCross BlueShield of Utah TTY 711</th>
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<td>Calls to this number are free. Our telephone hours are 8:00 a.m. to 8:00 p.m., Monday through Friday. From October 1 through February 14, our telephone hours are 8:00 a.m. to 8:00 p.m., seven days a week. Customer Service also has free language interpreter services available for non-English speakers.</td>
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<td>VSP TTY: 1 (800)428-4833</td>
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<td>Calls to this number are free. Live telephone hours are 5:00 a.m. to 8:00 p.m. Monday through Friday and Saturday from 6:00 a.m. to 5:00 p.m. The automated system is available 24 hours a day, 7 days a week. This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.</td>
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| FAX  | Regence BlueCross BlueShield of Utah: 1(888) 335-2985 |
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 7 (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.

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<th>Coverage Decisions for Medical Care</th>
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<td><strong>WRITE</strong></td>
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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 7 (What to do if you have a problem or complaint (coverage decisions, appeals, complaints)).

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<th>Appeals for Medical Care</th>
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<tr>
<td>CALL</td>
<td>1 (866)749-0355</td>
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<td>Calls to this number are free. Our telephone hours are 8:00 a.m. to 5:00 p.m., Monday through Friday</td>
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<td>TTY</td>
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<td>Calls to this number are free. Our telephone hours are 8:00 a.m. to 5:00 p.m., Monday through Friday</td>
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<td>FAX</td>
<td>1 (888) 309-8784</td>
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<td>PO Box 12625</td>
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<td>Salem, OR 97309-0625</td>
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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 above about making an appeal.) For more information on making a complaint about your medical care, see Chapter 7 (What to do if you have a problem or complaint (coverage decisions, appeals, complaints)).

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<th>Complaints about Medical Care</th>
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<tr>
<td>CALL</td>
<td>1 (866) 749-0355</td>
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<td>Calls to this number are free. Our telephone hours are 8:00 a.m. to 5:00 p.m., Monday through Friday</td>
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Where to send a request asking us to pay for our share of the cost for medical care 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 5 (Asking us to pay our share of a bill you have received for covered medical services).

Please note: If you send us a payment request and we deny any part of your request, you can appeal our decision. See Chapter 7 (What to do if you have a problem or complaint (coverage decisions, appeals, complaints)) for more information.

**Payment Requests For Medical Care**

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<td>Salem, OR 97309-0625</td>
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<tr>
<td>WEBSITE</td>
<td><a href="http://www.myregence.com">www.myregence.com</a></td>
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**SECTION 2 Medicare**

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

Medicare is the Federal health insurance program for people 65 years of age or older, some people under age 65 with disabilities, and people with End-Stage Renal Disease (permanent kidney failure requiring dialysis or a kidney transplant).
The Federal agency in charge of Medicare is the Centers for Medicare & Medicaid Services (sometimes called “CMS”). This agency contracts with Medicare Advantage organizations including us.

### Medicare

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<th>CALL</th>
<th>1-800-MEDICARE, or 1-800-633-4227</th>
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<td>Calls to this number are free.</td>
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<td>24 hours a day, 7 days a week.</td>
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<tr>
<td>TTY</td>
<td>1-877-486-2048</td>
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<tr>
<td></td>
<td>This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.</td>
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<td>Calls to this number are free.</td>
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<tr>
<td>WEBSITE</td>
<td><a href="http://www.medicare.gov">http://www.medicare.gov</a></td>
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<td></td>
<td>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.</td>
</tr>
</tbody>
</table>

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

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

You can also use the website to tell Medicare about any complaints you have about Regence MedAdvantage Basic:

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

If you don’t have a computer, your local library or senior center
may be able to help you visit this website using its computer.
Or, you can call Medicare and tell them what information you
are looking for. They will find the information on the website,
print it out, and send it to you. (You can call Medicare at 1-800-
MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week.
TTY users should call 1-877-486-2048.)

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

The State Health Insurance Assistance Program (SHIP) is a government program
with trained counselors in every state. In Utah, the SHIP is called Health Insurance
Information Program.

Health Insurance Information Program 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.

Health Insurance Information Program 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. Health Insurance Information Program counselors
can also help you understand your Medicare plan choices and answer questions
about switching plans.

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<th>Health Insurance Information Program (Utah’s SHIP)</th>
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<tr>
<td>CALL</td>
</tr>
<tr>
<td>1 (800) 541-7735</td>
</tr>
<tr>
<td>WRITE</td>
</tr>
<tr>
<td>195 North 1950 West</td>
</tr>
<tr>
<td>Salt Lake City, UT 84416</td>
</tr>
<tr>
<td>WEBSITE</td>
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<tr>
<td><a href="http://www.hsdaas.utah.gov/insurance_programs.htm">www.hsdaas.utah.gov/insurance_programs.htm</a></td>
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</table>
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. For Utah, the Quality Improvement Organization is called Health Insight.

Health Insight 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. Health Insight is an independent organization. It is not connected with our plan.

You should contact Health Insight 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.

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<th>Health Insight (Utah’s Quality Improvement Organization)</th>
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<td>WRITE</td>
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SECTION 5 Social Security

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

<table>
<thead>
<tr>
<th>CALL</th>
<th>1-800-772-1213</th>
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<td>Calls to this number are free.</td>
<td></td>
</tr>
<tr>
<td>Available 7:00 am to 7:00 pm, Monday through Friday.</td>
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<tr>
<td>You can use Social Security’s automated telephone services to get recorded information and conduct some business 24 hours a day.</td>
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<tr>
<th>TTY</th>
<th>1-800-325-0778</th>
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<td>This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.</td>
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</tr>
<tr>
<td>Calls to this number are free.</td>
<td></td>
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<tr>
<td>Available 7:00 am to 7:00 pm, Monday through Friday.</td>
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<tr>
<th>WEBSITE</th>
<th><a href="http://www.ssa.gov">http://www.ssa.gov</a></th>
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SECTION 6  Medicaid
(a joint Federal and state program that helps with medical costs for some people with limited income and resources)

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

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

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

To find out more about Medicaid and its programs, contact the Utah Department of Health.

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<th>Utah Department of Health</th>
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<td><strong>WRITE</strong></td>
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<td><strong>WEBSITE</strong></td>
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**SECTION 7  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.

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<th>Railroad Retirement Board</th>
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<td><strong>CALL</strong></td>
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<td>Calls to this number are free.</td>
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<tr>
<td>Available 9:00 am to 3:30 pm, Monday through Friday</td>
</tr>
<tr>
<td>If you have a touch-tone telephone, recorded information and automated services are available 24 hours a day, including weekends and holidays.</td>
</tr>
<tr>
<td><strong>TTY</strong></td>
</tr>
<tr>
<td>This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.</td>
</tr>
<tr>
<td>Calls to this number are not free.</td>
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<tr>
<td><strong>WEBSITE</strong></td>
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SECTION 8  Do you have “group insurance” or other health insurance from an employer?

If you (or your spouse) get benefits from your (or your spouse’s) employer or retiree group, call the employer/union benefits administrator or Customer Service if you have any questions. You can ask about your (or your spouse’s) employer or retiree health benefits, premiums, or the enrollment period. (Phone numbers for Customer Service are printed on the back cover of this booklet.)
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

Section 1.1 What are “network providers” and “covered services”? 

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

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

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

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

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

Section 3.1 Getting care if you have a medical emergency

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

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

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

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

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

Section 5.1 What is a “clinical research study”?

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

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?
Section 6.2  What care from a religious non-medical health care institution is covered by our plan? ................................................................. 33

SECTION 7  Rules for ownership of durable medical equipment ......................... 33

Section 7.1  Will you own the durable medical equipment after making a certain number of payments under our plan? ........................................ 33
SECTION 1 Things to know about getting your medical care covered as a member of our plan

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

For the details on what medical care is covered by our plan and how much you pay 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”?

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, Regence MedAdvantage Basic must cover all services covered by Original Medicare and must follow Original Medicare’s coverage rules.

Regence MedAdvantage Basic 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
You receive your care from a provider who participates in Medicare. As a member of our plan, you can receive your care from either a network provider or an out-of-network provider (for more about this, see Section 2 in this chapter).

- The providers in our network are listed in the Provider Directory.
- If you use an out-of-network provider, your share of the costs for your covered services may be higher.

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

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

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

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

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

To access specialists and other network providers:
- Our plans do not require you to obtain a referral from a primary doctor to see a specialist.
- Some medical services require prior authorization. The plan requires in-network physicians to coordinate prior authorization requests. Please see Chapter 4, Section 2.1 for information about which services require prior authorization.

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. We will send you a letter to let you know if a provider you are seeing is leaving our plan. If you need help finding another network provider, please call Customer Service at the phone number on the back cover of this booklet.
Section 2.2 How to get care from out-of-network providers

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

- You can get your care from an out-of-network provider, however, that provider must be eligible to participate in Medicare. We cannot pay a provider who is not eligible to participate in Medicare. If you receive care from a provider who is not eligible to participate in Medicare, you will be responsible for the full cost of the services you receive. Check with your provider before receiving services to confirm that they are eligible to participate in Medicare.

- You don’t need to get a referral or prior authorization when you get care from out-of-network providers. However, before getting services from out-of-network providers you may want to ask for a pre-visit coverage decision to confirm that the services you are getting are covered and are medically necessary. (See Chapter 7, Section 4 for information about asking for coverage decisions.) This is important because:
  - Without a pre-visit coverage decision, if we later determine that the services are not covered or were not medically necessary, we may deny coverage and you will be responsible for the entire cost. If we say we will not cover your services, you have the right to appeal our decision not to cover your care. See Chapter 7 (What to do if you have a problem or complaint) to learn how to make an appeal.

- It is best to ask an out-of-network provider to bill the plan first. But, if you have already paid for the covered services, we will reimburse you for our share of the cost for covered services. Or if an out-of-network provider sends you a bill that you think we should pay, you can send it to us for payment. See Chapter 5 (Asking us to pay our share of a bill you have received for covered medical services) for information about what to do if you receive a bill or if you need to ask for reimbursement.

- If you are using an out-of-network provider for emergency care, urgently needed care, or out-of-area dialysis, you may not have to pay a higher cost-sharing amount. See Section 3 for more information about these situations.
SECTION 3  How to get covered services when you have an emergency or urgent need for care

Section 3.1  Getting care if you have a medical emergency

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

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

If you have a medical emergency:

- Get help as quickly as possible. Call 911 for help or go to the nearest emergency room or hospital. Call for an ambulance if you need it. You do not need to get approval or a referral first from your PCP.

What is covered if you have a medical emergency?

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

You may also get covered emergency medical care anywhere in the world. For more information, see the Medical Benefits Chart in Chapter 4 of this booklet.

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

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

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, the amount of cost sharing that you pay will depend on whether you get the care from network providers or out-of-network providers. If you get the care from network providers, your share of the costs will usually be lower than if you get the care from out-of-network providers.

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

What is “urgently needed care”? 

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

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

In most situations, if you are in the plan’s service area and you use an out-of-network provider, you will pay a higher share of the costs for your care. However, if the circumstances are unusual or extraordinary, and network providers are temporarily unavailable or inaccessible, we will allow you to get covered services from an out-of-network provider at the lower in-network cost-sharing amount.

Free standing in-network urgent care facilities are available in most areas. If you need assistance locating one contact Customer Service or check our website www.regence.com/medicare for a list of providers. (Customer Service numbers are listed on the back cover of this booklet.)

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 at the lower in-network cost-sharing amount.

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

**Section 4.1 You can ask us to pay our share of the cost of covered services**

If you have paid more than your share for covered services, or if you have received a bill for the full cost of covered medical services, go to Chapter 5 (Asking us to pay our
share of a bill you have received for covered medical services or drugs) for information about what to do.

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

Regence MedAdvantage Basic 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 plan rules were not followed.

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

Chapter 7 (What to do if you have a problem or complaint (coverage decisions, appeals, complaints)) has more information about what to do if you want a coverage decision from us or want to appeal a decision we have already made. You may also call Customer Service to get more information about how to do this (phone numbers are printed on the back cover of this booklet).

For covered services that have a benefit limitation, you pay the full cost of any services you get after you have used up your benefit for that type of covered service. Once a benefit limit has been reached, additional costs will not count toward an out-of-pocket maximum. You can call Customer Service when you want to know how much of your benefit limit you have already used.

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

**Section 5.1**  What is a “clinical research study”?

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

Not all clinical research studies are open to members of our plan. Medicare first needs to approve the research study. If you participate in a study that Medicare has not approved, you will be responsible for paying all costs for your participation in the study.
Once Medicare approves the study, someone who works on the study will contact you to explain more about the study and see if you meet the requirements set by the scientists who are running the study. You can participate in the study as long as you meet the requirements for the study and you have a full understanding and acceptance of what is involved if you participate in the study.

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

If you want to participate in a Medicare-approved clinical research study, you do not need to get approval from us. 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 research study providers instead of from our plan.

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

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

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

Original Medicare pays most of the cost of the covered services you receive as part of the study. After Medicare has paid its share of the cost for these services, our plan will also pay for part of the costs. We will pay the difference between the cost sharing in Original Medicare and your cost sharing as a member of our plan. This means you will pay the same amount for the services you receive as part of the study as you would if you received these services from our plan.
Here’s an example of how the cost sharing works: Let’s say that you have a lab test that costs $100 as part of the research study. Let’s also say that your share of the costs for this test is $20 under Original Medicare, but the test would be $10 under our plan’s benefits. In this case, Original Medicare would pay $80 for the test and we would pay another $10. This means that you would pay $10, which is the same amount you would pay under our plan’s benefits.

In order for us to pay for our share of the costs, you will need to submit a request for payment. With your request, you will need to send us a copy of your Medicare Summary Notices or other documentation that shows what services you received as part of the study and how much you owe. Please see Chapter 5 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 medical condition would normally require only one CT scan.

Do you want to know more?

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

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

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<th>What is a religious non-medical health care institution?</th>
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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?

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

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

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

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

See the benefits chart in Chapter 4 for more information about the inpatient hospital care cost sharing amounts for these services. You are covered for unlimited days each benefit period.

SECTION 7 Rules for ownership of durable medical equipment

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

Durable medical equipment includes items such as oxygen equipment and supplies, wheelchairs, walkers, and hospital beds ordered by a provider for use in the home. Certain items, such as prosthetics, are always owned by the enrollee. In this section, we discuss other types of durable medical equipment that must be rented.
In Original Medicare, people who rent certain types of durable medical equipment own the equipment after paying co-payments for the item for 13 months. As a member of Regence MedAdvantage Basic, 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 printed 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 13 consecutive payments.

If you made payments for the durable medical equipment item under Original Medicare before you joined our plan, these previous Original Medicare payments also do not count toward the 13 consecutive payments. You will have to make 13 consecutive payments for the item under Original Medicare in order to acquire ownership. There are no exceptions to this case when you return to Original Medicare.
Chapter 4. Medical Benefits Chart (what is covered and what you pay)

SECTION 1 Understanding your out-of-pocket costs for covered services ....... 36

Section 1.1 Types of out-of-pocket costs you may pay for your covered services ........................................................................................................................................................................ 36

Section 1.2 What is your yearly plan deductible? ................................................................................................................................. 36

Section 1.3 What is the most you will pay for Medicare Part A and Part B covered medical services? .................................................................................................................................................................................. 37

Section 1.4 Our plan does not allow providers to “balance bill” you .................... 38

SECTION 2 Use the Medical Benefits Chart to find out what is covered for you and how much you will pay ................................................................. 38

Section 2.1 Your medical benefits and costs as a member of the plan ............... 38

Section 2.2 Getting care using our plan’s optional visitor/traveler benefit ........... 74

SECTION 3 What benefits are not covered by the plan? ...................................... 75

Section 3.1 Benefits we do not cover (exclusions) ............................................. 75
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 lists your covered services and shows how much you will pay for each covered service as a member of Regence MedAdvantage Basic. Later in this chapter, you can find information about medical services that are not covered. It also explains limits on certain services.

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

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

- The “deductible” is the amount you must pay for medical services before our plan begins to pay its share. (Section 1.2 tells you more about your yearly plan deductible.)
- A “copayment” is the fixed amount you pay each time you receive certain medical services. You pay a copayment at the time you get the medical service. (The Medical 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 your yearly plan deductible?

Your yearly deductible is $0.00. This is the amount you have to pay out-of-pocket before we will pay our share for your covered medical services.

Until you have paid the deductible amount, you must pay the full cost for most of your covered services. (The deductible does not apply to the services, which are listed below.) Once you have paid your deductible, we will begin to pay our share of the costs for covered medical services and you will pay your share (your copayment or coinsurance amount) for the rest of the calendar year.
The deductible does not apply to some services, including certain in-network preventive services. This means that we will pay our share of the costs for these services even if you haven’t paid your yearly deductible yet. The deductible does not apply to the following services:

- All Medicare covered preventive care and screening tests
- Annual Physical Exam
- Medicare Part B prescription drugs
- Preventive dental services
- Routine vision exam, routine hardware (eyeglass frames and lenses, contact lenses)

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

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

- Your **in-network maximum out-of-pocket amount** is $3,400 for Regence MedAdvantage Basic. This is the most you pay during the calendar year for covered Medicare Part A and Part B services received from in-network providers. The amounts you pay for deductibles, copayments, and coinsurance for covered services from in-network providers count toward this in-network maximum out-of-pocket amount. (The amounts you pay for plan premiums and services from out-of-network providers do not count toward your in-network maximum out-of-pocket amount. In addition, amounts you pay for some services do not count toward your in-network maximum out-of-pocket amount. These services are marked with an asterisk in the Medical Benefits Chart.) If you have paid $3,400 for Regence MedAdvantage Basic for covered Part A and Part B services from in-network providers, you will not have any out-of-pocket costs for the rest of the year when you see our network providers. However, you must continue to pay your plan premium and the Medicare Part B premium (unless your Part B premium is paid for you by Medicaid or another third party).

- Your **combined maximum out-of-pocket amount** is $3,400 for Regence MedAdvantage Basic. This is the most you pay during the calendar year for covered Medicare Part A and Part B services received from both in-network and out-of-network providers. The amounts you pay for deductibles, copayments, and coinsurance for covered services count toward this combined maximum out-of-pocket amount. (The amounts you pay for your plan premiums do not count toward your combined maximum out-of-pocket amount. In addition, amounts you pay for some services do not count toward your combined maximum out-of-pocket amount. These services are marked with an asterisk in the Medical Benefits Chart.) If you have paid $3,400 for Regence MedAdvantage Basic for covered services, you will have 100% coverage and will not have any
out-of-pocket costs for the rest of the year for covered Part A and Part B services. However, you must continue to pay your plan premium and the Medicare Part B premium (unless your Part B premium is paid for you by Medicaid or another third party).

### Section 1.4 Our plan does not allow providers to “balance bill” you

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

Here is how this protection works.

- If your cost sharing is a copayment (a set amount of dollars, for example, $15.00), then you pay only that amount for any covered services from a network provider. You will generally have higher copays when you obtain care from out-of-network providers.

- 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 receive the 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 receive the covered services from an out-of-network provider who participates with Medicare, you pay the coinsurance percentage multiplied by the Medicare payment rate for participating providers.
  - If you receive the covered services from an out-of-network provider who does not participate with Medicare, you pay the coinsurance percentage multiplied by the Medicare payment rate for non-participating providers.

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

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

The Medical Benefits Chart on the following pages lists the services Regence MedAdvantage Basic 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.
- Some of the services listed in the Medical Benefits Chart are covered as in-network services only if your doctor or other network provider gets approval in advance (sometimes called “prior authorization”) from Regence MedAdvantage Basic.
  - Covered services that need approval in advance to be covered as in-network services are marked in bold in the Medical Benefits Chart. In addition, the following services not listed in the Benefits Chart require approval in advance: long term acute care facility, transplants, obesity surgery, orthognathic surgery, sleep apnea surgery, potentially cosmetic procedures, and potentially investigational procedures.
  - You never need approval in advance for out-of-network services from out-of-network providers.
  - While you don’t need approval in advance for out-of-network services, you or your doctor can ask us to make a coverage decision in advance.
- For benefits where your cost-sharing is a coinsurance percentage, the amount you pay depends on what type of provider you receive the services from:
  - If you receive the covered services from 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 receive the covered services from an out-of-network provider who participates with Medicare, you pay the coinsurance percentage multiplied by the Medicare payment rate for participating providers.
  - If you receive the covered services from an out-of-network provider who does not participate with Medicare, you pay the coinsurance percentage multiplied by the Medicare payment rate for non-participating providers.
- For all preventive services that are covered at no cost under Original Medicare, we also cover the service at no cost to you. However, if you also are treated or monitored for an existing medical condition during the visit when you receive the preventive service, a copayment will apply for the care received for the existing medical condition.
- Sometimes, Medicare adds coverage under Original Medicare for new services during the year. If Medicare adds coverage for any services during 2013, either
Medicare or our plan will cover those services.

You will see this apple next to the preventive services in the benefits chart.

Medical Benefits Chart

<table>
<thead>
<tr>
<th>Services that are covered for you</th>
<th>What you must pay when you get these services</th>
<th>What you must pay when you get these services</th>
</tr>
</thead>
<tbody>
<tr>
<td><em>Abdominal aortic aneurysm screening</em></td>
<td>$0 copay</td>
<td>$0 copay</td>
</tr>
<tr>
<td>A one-time screening ultrasound for people at risk. The plan only covers this screening if you get a referral for it as a result of your “Welcome to Medicare” preventive visit.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Ambulance services</th>
<th>$200 copay per one way transport</th>
<th>$200 copay per one way transport</th>
</tr>
</thead>
<tbody>
<tr>
<td>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.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Non-emergency transportation by ambulance is appropriate if it is documented that the member’s condition is such that other means of transportation are</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Services that are covered for you</td>
<td>What you must pay when you get these services</td>
<td>What you must pay when you get these services</td>
</tr>
<tr>
<td>----------------------------------</td>
<td>-----------------------------------------------</td>
<td>-----------------------------------------------</td>
</tr>
<tr>
<td>contraindicated (could endanger the person’s health) and that transportation by ambulance is medically required.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Annual Physical Exam</strong></td>
<td>$0 copay</td>
<td>$0 copay</td>
</tr>
<tr>
<td>In addition to the annual wellness visit you are eligible for an annual physical exam once every calendar year.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Annual wellness visit</strong></td>
<td>There is no coinsurance, copayment, or deductible for the annual wellness visit.</td>
<td>There is no coinsurance, copayment, or deductible for the annual wellness visit.</td>
</tr>
<tr>
<td>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. <strong>Note</strong>: Your first annual wellness visit can’t take place within 12 months of your “Welcome to Medicare” preventive visit. However, you don’t need to have had a “Welcome to Medicare” visit to be covered for annual wellness visits after you've had Part B for 12 months.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Services that are covered for you</td>
<td>What you must pay when you get these services <strong>In-Network</strong></td>
<td>What you must pay when you get these services <strong>Out-of-Network</strong></td>
</tr>
<tr>
<td>----------------------------------</td>
<td>----------------------------------------------------------</td>
<td>----------------------------------------------------------</td>
</tr>
<tr>
<td><strong>Bone mass measurement</strong></td>
<td>$0 copay</td>
<td>$0 copay</td>
</tr>
<tr>
<td>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.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Breast cancer screening</strong></td>
<td>$0 copay</td>
<td>$0 copay</td>
</tr>
<tr>
<td>(mammograms)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Covered services include:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• One screening mammogram every calendar year</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Clinical breast exams once every calendar year</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Cardiac rehabilitation services</strong></td>
<td><strong>Prior authorization is required for in-network, inpatient services.</strong></td>
<td></td>
</tr>
</tbody>
</table>
| Comprehensive programs of cardiac rehabilitation services that include exercise, education, and counseling are covered for members who meet certain conditions with a doctor’s order. The plan also covers intensive cardiac rehabilitation programs that are typically more rigorous or more intense than cardiac rehabilitation programs. | **Inpatient Hospital Stay**
Days 1 to 7 - $200 copay per day. Maximum $1,400 per benefit period. | **Inpatient Hospital Stay**
Days 1 to 7 - $300 copay per day Maximum $2,100 per benefit period. |
|                                | Days 8 and beyond - $0 copay per day                    | Days 8 and beyond - $0 copay per day                     |
|                                | **Outpatient**
$40 copay                                | **Outpatient**
$40 copay                                |
<table>
<thead>
<tr>
<th>Services that are covered for you</th>
<th>What you must pay when you get these services <strong>In-Network</strong></th>
<th>What you must pay when you get these services <strong>Out-of-Network</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Cardiovascular disease risk reduction visit (therapy for cardiovascular disease)</strong></td>
<td>$0 copay</td>
<td>$0 copay</td>
</tr>
<tr>
<td>We cover 1 visit per year with your primary care doctor to help lower your risk for cardiovascular disease. During this visit, your doctor may discuss aspirin use (if appropriate), check your blood pressure, and give you tips to make sure you’re eating well.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Cardiovascular disease testing</strong></td>
<td>$0 copay</td>
<td>$0 copay</td>
</tr>
<tr>
<td>Blood tests for the detection of cardiovascular disease (or abnormalities associated with an elevated risk of cardiovascular disease) once every 5 years (60 months).</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Cervical and vaginal cancer screening</strong></td>
<td>$0 copay</td>
<td>$0 copay</td>
</tr>
</tbody>
</table>
| Covered services include:  
  - For all women: Pap tests and pelvic exams are covered once every calendar year. | | |
| **Chiropractic services** | $20 copay | $40 copay |
| Covered services include:  
  - We cover only manual manipulation of the spine to correct subluxation | | |
<table>
<thead>
<tr>
<th>Services that are covered for you</th>
<th>What you must pay when you get these services</th>
<th>What you must pay when you get these services</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Colorectal cancer screening</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>For people 50 and older, the following are covered:</td>
<td>$0 copay</td>
<td>$0 copay</td>
</tr>
<tr>
<td>• Flexible sigmoidoscopy (or screening barium enema as an alternative) every 48 months</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Fecal occult blood test, every 12 months</td>
<td></td>
<td></td>
</tr>
<tr>
<td>For people at high risk of colorectal cancer, we cover:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Screening colonoscopy (or screening barium enema as an alternative) every 24 months</td>
<td></td>
<td></td>
</tr>
<tr>
<td>For people not at high risk of colorectal cancer, we cover:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Screening colonoscopy every 10 years (120 months), but not within 48 months of a screening sigmoidoscopy</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Dental services</strong> *</td>
<td>20% coinsurance</td>
<td>20% coinsurance</td>
</tr>
<tr>
<td>In general, preventive dental services (such as cleaning, routine dental exams, and dental x-rays) are not covered by Original Medicare.</td>
<td>*You are responsible for amounts above the benefit limit. Coinsurances and amounts beyond benefit limits do not apply to combined out-of-pocket maximum</td>
<td>*You are responsible for amounts above the benefit limit. Coinsurances and amounts beyond benefit limits do not apply to combined out-of-pocket maximum</td>
</tr>
<tr>
<td><strong>We cover:</strong> Preventive Services — You are covered up to $500 every calendar year for:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Preventive Exam – 2 per calendar year</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### Services that are covered for you

<table>
<thead>
<tr>
<th>Services that are covered for you</th>
<th>What you must pay when you get these services</th>
<th>What you must pay when you get these services</th>
</tr>
</thead>
</table>
| • Bitewings – 2 per calendar year (any combination)  
  • Cleanings – 2 per calendar year  
  • Panoramic film – once every 3 years | | |
| See Section 3.1 for exclusions | | |

### Depression screening

- **Description:** We cover 1 screening for depression per year. The screening must be done in a primary care setting that can provide follow-up treatment and referrals.
- **In-Network:** $0 copay
- **Out-of-Network:** $0 copay

### Diabetes screening

- **Description:** We cover this screening (includes fasting glucose tests) if you have any of the following risk factors: high blood pressure (hypertension), history of abnormal cholesterol and triglyceride levels (dyslipidemia), obesity, or a history of high blood sugar (glucose). Tests may also be covered if you meet other requirements, like being overweight and having a family history of diabetes. Based on the results of these tests, you may be eligible for up to two diabetes screenings every 12 months.
- **In-Network:** $0 copay
- **Out-of-Network:** $0 copay
### Diabetes self-management training, diabetic services and supplies

For all people who have diabetes (insulin and non-insulin users).

Covered services include:

- Supplies to monitor your blood glucose: Blood glucose monitor, blood glucose test strips, 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 calendar year of therapeutic custom-molded shoes (including inserts provided with such shoes) and two additional pairs of inserts, or one pair of depth shoes and three pairs of inserts (not including the non-customized removable inserts provided with such shoes). Coverage includes fitting.

- Diabetes self-management training is covered under certain conditions.

<table>
<thead>
<tr>
<th>Services that are covered for you</th>
<th>What you must pay when you get these services <strong>In-Network</strong></th>
<th>What you must pay when you get these services <strong>Out-of-Network</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Diabetes self-management training, diabetic services and supplies</td>
<td>$0 copay</td>
<td>$0 copay</td>
</tr>
<tr>
<td>Durable medical equipment and related supplies</td>
<td>20% coinsurance</td>
<td>30% coinsurance</td>
</tr>
</tbody>
</table>

Prior Authorization is required for certain high dollar in-network services.
Services that are covered for you | What you must pay when you get these services in-Network | What you must pay when you get these services Out-of-Network
--- | --- | ---
(For a definition of “durable medical equipment,” see Chapter 12 of this booklet.)
Covered items include, but are not limited to: wheelchairs, crutches, hospital bed, IV infusion pump, oxygen equipment, nebulizer, and walker.
We cover all medically necessary durable medical equipment covered by Original Medicare. If our supplier in your area does not carry a particular brand or manufacturer, you may ask them if they can special order it for you.

Emergency care
Emergency care refers to services that are:
- Furnished by a provider qualified to furnish emergency services, and
- Needed to evaluate or stabilize an emergency medical condition.
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

$65 copay
Your copay is waived if you are admitted to the hospital within 48 hours for the same condition.

$65 copay
Your copay is waived if you are admitted to the hospital within 48 hours for the same condition.
If you receive emergency care at an out-of-network hospital and need inpatient care after your emergency condition is stabilized, you must move to a network hospital in order to pay the in-network cost-sharing amount for the part of your stay after you are stabilized. If
<table>
<thead>
<tr>
<th>Services that are covered for you</th>
<th>What you must pay when you get these services In-Network</th>
<th>What you must pay when you get these services Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>medical condition that is quickly getting worse.</td>
<td></td>
<td>you stay at the out-of-network hospital, your stay will be covered but you will pay the out-of-network cost-sharing amount for the part of your stay after you are stabilized.</td>
</tr>
<tr>
<td>This benefit is covered world-wide.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Health and wellness education programs</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Care Enhance Nurse Hotline</strong> – available 24 hours a day, seven days a week to answer your health questions. Call 1 (800) 267-6729</td>
<td>There is no coinsurance, copayment, or deductible for the health and wellness education programs</td>
<td></td>
</tr>
<tr>
<td><strong>Healthways SilverSneakers® Fitness Program</strong> – You are eligible to receive a basic fitness membership with access to amenities and fitness classes at participating SilverSneakers locations. If you prefer to exercise at home, SilverSneakers® Home Kits are available. You can choose from the General Exercise Kit, Resistance Kit, Walking Kit, or the Yoga Kit. For more information and to find SilverSneakers participating locations, visit silversneakers.com or call 1-888-423-4632 (TTY: 711), Monday through Friday, 8 a.m. to 8 p.m. EST.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Hearing services</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Diagnostic hearing and balance evaluations performed by your provider to determine if you need</td>
<td>Primary Care $15 copay</td>
<td>Primary Care $40 copay</td>
</tr>
<tr>
<td>Services that are covered for you</td>
<td>What you must pay when you get these services <strong>In-Network</strong></td>
<td>What you must pay when you get these services <strong>Out-of-Network</strong></td>
</tr>
<tr>
<td>----------------------------------</td>
<td>----------------------------------------------------------</td>
<td>----------------------------------------------------------</td>
</tr>
<tr>
<td>medical treatment are covered as outpatient care when furnished by a physician, audiologist, or other qualified provider.</td>
<td>Specialist $40 copay</td>
<td>Specialist $40 copay</td>
</tr>
<tr>
<td><strong>HIV screening</strong>&lt;br&gt;For people who ask for an HIV screening test or who are at increased risk for HIV infection, we cover:</td>
<td>$0 copay</td>
<td>$0 copay</td>
</tr>
<tr>
<td>• One screening exam every 12 months</td>
<td></td>
<td></td>
</tr>
<tr>
<td>For women who are pregnant, we cover:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Up to three screening exams during a pregnancy</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Home health agency care</strong>&lt;br&gt;Prior Authorization may be required for in-network services</td>
<td>10% coinsurance</td>
<td>20% coinsurance</td>
</tr>
<tr>
<td>Prior to receiving home health services, a doctor must certify that you need home health services and will order home health services to be provided by a home health agency. You must be homebound, which means leaving home is a major effort. Covered services include, but are not limited to:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• 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</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### Services that are covered for you

<table>
<thead>
<tr>
<th>In-Network</th>
<th>Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Must total fewer than 8 hours per day and 35 hours per week)</td>
<td></td>
</tr>
<tr>
<td>• Physical therapy, occupational therapy, and speech therapy</td>
<td></td>
</tr>
<tr>
<td>• Medical and social services</td>
<td></td>
</tr>
<tr>
<td>• Medical equipment and supplies</td>
<td></td>
</tr>
</tbody>
</table>

### Hospice care

You may receive care from any Medicare-certified hospice program. Your hospice doctor can be a network provider or an out-of-network provider. Covered services include:

• Drugs for symptom control and pain relief
• Short-term respite care
• Home care

For hospice services and for services that are covered by Medicare Part A or B and are related to your terminal condition:

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.

For services that are covered by Medicare Part A or B and are not related to your terminal condition: If you need non-emergency, non-urgently needed services that are covered under Medicare Part A or B 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 Regence MedAdvantage Basic. |
<table>
<thead>
<tr>
<th>Services that are covered for you and that are not related to your terminal condition, your cost for these services depends on whether you use a provider in our plan’s network:</th>
</tr>
</thead>
<tbody>
<tr>
<td>- If you obtain the covered services from a network provider, you only pay the plan cost-sharing amount for in-network services.</td>
</tr>
<tr>
<td>- If you obtain the covered services from an out-of-network provider, you pay the plan cost sharing for out-of-network services.</td>
</tr>
</tbody>
</table>

For services that are covered by Regence MedAdvantage Basic but are not covered by Medicare Part A or B: Regence MedAdvantage Basic will continue to cover plan-covered services that are not covered under Part A or B whether or not they are related to your terminal condition. You pay your plan cost sharing amount for these services.

**Note:** If you need non-hospice care (care that is not related to your terminal condition), you should contact us to arrange the services. Getting your non-hospice care through our network providers will lower your share of the costs for the services.

<table>
<thead>
<tr>
<th>What you must pay when you get these services <strong>In-Network</strong></th>
<th>What you must pay when you get these services <strong>Out-of-Network</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Our plans cover hospice consultation services (one time only) for a terminally ill person who hasn’t elected the hospice benefit.</strong></td>
<td>$0 copay</td>
</tr>
<tr>
<td>Services that are covered for you</td>
<td>What you must pay when you get these services <strong>In-Network</strong></td>
</tr>
<tr>
<td>----------------------------------</td>
<td>----------------------------------------------------------</td>
</tr>
<tr>
<td><strong>Immunizations</strong></td>
<td>$0 copay</td>
</tr>
<tr>
<td>Covered Medicare Part B services include:</td>
<td></td>
</tr>
<tr>
<td>• Pneumonia vaccine</td>
<td></td>
</tr>
<tr>
<td>• Flu shots, once a year in the fall or winter</td>
<td></td>
</tr>
<tr>
<td>• Hepatitis B vaccine if you are at high or intermediate risk of getting Hepatitis B</td>
<td></td>
</tr>
<tr>
<td>• Other vaccines if you are at risk and they meet Medicare Part B coverage rules</td>
<td></td>
</tr>
<tr>
<td><strong>Inpatient hospital care</strong></td>
<td>/</td>
</tr>
<tr>
<td><strong>Prior authorization is required for in-network services.</strong></td>
<td>/</td>
</tr>
<tr>
<td><strong>You are covered for unlimited days each benefit period.</strong></td>
<td>/</td>
</tr>
<tr>
<td>Covered services include but are not limited to:</td>
<td>/</td>
</tr>
<tr>
<td>• Semi-private room (or a private room if medically necessary)</td>
<td></td>
</tr>
<tr>
<td>• Meals including special diets</td>
<td></td>
</tr>
<tr>
<td>• Regular nursing services</td>
<td></td>
</tr>
<tr>
<td>• Costs of special care units (such as intensive care or coronary care units)</td>
<td></td>
</tr>
<tr>
<td>• Drugs and medications</td>
<td></td>
</tr>
<tr>
<td>• Lab tests</td>
<td></td>
</tr>
<tr>
<td>• X-rays and other radiology services</td>
<td></td>
</tr>
<tr>
<td>• Necessary surgical and medical supplies</td>
<td></td>
</tr>
<tr>
<td>• Use of appliances, such as</td>
<td></td>
</tr>
<tr>
<td>Days 1 to 7 - $200 copay per day. Maximum $1,400 per benefit period.</td>
<td>Days 1 to 7 - $300 copay per day Maximum $2,100 per benefit period.</td>
</tr>
<tr>
<td>Days 8 and beyond - $0 copay per day</td>
<td>Days 8 and beyond - $0 copay per day</td>
</tr>
<tr>
<td>Benefit Period – The way that both our plan and Original Medicare measures your use of hospital and skilled nursing facility (SNF)</td>
<td>Benefit Period – The way that both our plan and Original Medicare measures your use of hospital and skilled nursing facility (SNF)</td>
</tr>
<tr>
<td>Services that are covered for you</td>
<td>What you must pay when you get these services</td>
</tr>
<tr>
<td>----------------------------------</td>
<td>---------------------------------------------</td>
</tr>
<tr>
<td>wheelchairs</td>
<td>services. A benefit period begins the day you go into a hospital or skilled nursing facility. The benefit period ends when you haven’t received any inpatient hospital care (or skilled care in a SNF) for 60 days in a row. If you go into a hospital or a skilled nursing facility after one benefit period has ended, a new benefit period begins. There is no limit to the number of benefit periods.</td>
</tr>
<tr>
<td>- Operating and recovery room costs</td>
<td></td>
</tr>
<tr>
<td>- Physical, occupational, and speech language therapy</td>
<td></td>
</tr>
<tr>
<td>- Inpatient substance abuse services</td>
<td></td>
</tr>
</tbody>
</table>

Under certain conditions, the following types of transplants are covered: corneal, kidney, kidney-pancreatic, heart, liver, lung, heart/lung, bone marrow, stem cell, and intestinal/multivisceral. If you need a transplant, we will arrange to have your case reviewed by a Medicare-approved transplant center that will decide whether you are a candidate for a transplant. Transplant providers may be local or outside of the service area. If local transplant providers are willing to accept the Original Medicare rate, then you can choose to obtain your transplant services locally or at a distant location offered by the plan. If Regence MedAdvantage Basic provides transplant services at a distant location (outside of the service area) and you chose to obtain transplants at this distant location, we will arrange or pay for appropriate lodging and transportation costs for you and a companion.

Note: Lodging and transportation costs are reimbursable only in the event Regence BlueCross BlueShield of Utah directs you to receive transplant services at a
<table>
<thead>
<tr>
<th>Services that are covered for you</th>
<th>What you must pay when you get these services <strong>In-Network</strong></th>
<th>What you must pay when you get these services <strong>Out-of-Network</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>distant facility or location even though those services are available closer to your home.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Blood - including storage and administration. Coverage of whole blood and packed red cells begins with the first pint of blood that you need.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Physician services</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Note:</strong> To be an inpatient, your provider must write an order to admit you formally as an inpatient of the hospital. Even if you stay in the hospital overnight, you might still be considered an “outpatient.” If you are not sure if you are an inpatient or an outpatient, you should ask the hospital staff. You can also find more information in a Medicare fact sheet called “Are You a Hospital Inpatient or Outpatient? If You Have Medicare – Ask!” This fact sheet is available on the Web at <a href="http://www.medicare.gov/Publications/Pubs/pdf/11435.pdf">http://www.medicare.gov/Publications/Pubs/pdf/11435.pdf</a> or by calling 1-800-MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048. You can call these numbers for free, 24 hours a day, 7 days a week.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Services that are covered for you</td>
<td>What you must pay when you get these services <strong>In-Network</strong></td>
<td>What you must pay when you get these services <strong>Out-of-Network</strong></td>
</tr>
<tr>
<td>---------------------------------</td>
<td>----------------------------------------------------------</td>
<td>----------------------------------------------------------</td>
</tr>
<tr>
<td><strong>Inpatient mental health care</strong></td>
<td>Days 1 to 7 - $200 copay per day. Maximum $1,400 per benefit period. Days 8 and beyond - $0 copay per day</td>
<td>Days 1 to 7 - $300 copay per day Maximum $2,100 per benefit period. Days 8 and beyond - $0 copay per day</td>
</tr>
<tr>
<td><strong>Prior authorization is required for in-network services</strong></td>
<td><strong>Benefit Period</strong> – The way that both our plan and Original Medicare measures your use of hospital and skilled nursing facility (SNF) services. A benefit period begins the day you go into a hospital or skilled nursing facility. The benefit period ends when you haven’t received any inpatient hospital care (or skilled care in a SNF) for 60 days in a row. If you go into a hospital or a skilled nursing facility after one benefit period has ended, a new benefit period begins. There is no limit to the number of benefit periods.</td>
<td><strong>Benefit Period</strong> – The way that both our plan and Original Medicare measures your use of hospital and skilled nursing facility (SNF) services. A benefit period begins the day you go into a hospital or skilled nursing facility. The benefit period ends when you haven’t received any inpatient hospital care (or skilled care in a SNF) for 60 days in a row. If you go into a hospital or a skilled nursing facility after one benefit period has ended, a new benefit period begins. There is no limit to the number of benefit periods</td>
</tr>
<tr>
<td><strong>Inpatient services covered during a non-covered inpatient stay</strong></td>
<td>If you have exhausted your inpatient benefits or if the inpatient stay is not reasonable and necessary, we will not cover your inpatient stay.</td>
<td></td>
</tr>
</tbody>
</table>
### Services that are covered for you

<table>
<thead>
<tr>
<th>Services that are covered for you</th>
<th>What you must pay when you get these services</th>
<th>What you must pay when you get these services</th>
</tr>
</thead>
<tbody>
<tr>
<td>However, in some cases, we will cover certain services you receive while you are in the hospital or the skilled nursing facility (SNF). Covered services include, but are not limited to:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Physician services</td>
<td>Primary Care $15 copay per office service.</td>
<td>Primary Care $40 copay per office service.</td>
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<tr>
<td></td>
<td>Specialist $40 copay per office service</td>
<td>Specialist $40 copay per office service</td>
</tr>
<tr>
<td></td>
<td>Physician/Practitioner Surgical – outpatient, and ambulatory services $0 copay</td>
<td>Physician/Practitioner Surgical – outpatient, and ambulatory services $0 copay</td>
</tr>
<tr>
<td>- Diagnostic tests (like lab tests)</td>
<td>0% Coinsurance</td>
<td>0% Coinsurance</td>
</tr>
<tr>
<td>- X-ray, radium, and isotope therapy including technician materials and services</td>
<td>X-ray 0% Coinsurance</td>
<td>X-ray 20% Coinsurance</td>
</tr>
<tr>
<td></td>
<td>Radiation Therapy 10% Coinsurance</td>
<td>Radiation Therapy 20% Coinsurance</td>
</tr>
<tr>
<td>- Surgical dressings</td>
<td>0% Coinsurance</td>
<td>0% Coinsurance</td>
</tr>
<tr>
<td>- Splints, casts and other devices used to reduce fractures and dislocations</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Prosthetics and orthotics devices (other than dental) that replace all or part of an internal body organ (including</td>
<td>20% Coinsurance</td>
<td>30% Coinsurance</td>
</tr>
<tr>
<td>Services that are covered for you</td>
<td>What you must pay when you get these services <strong>In-Network</strong></td>
<td>What you must pay when you get these services <strong>Out-of-Network</strong></td>
</tr>
<tr>
<td>-------------------------------------------------------------------------------------------------</td>
<td>-------------------------------------------------------------</td>
<td>---------------------------------------------------------------</td>
</tr>
<tr>
<td>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 <strong>Prior authorization is required for certain in-network services over $5,000</strong></td>
<td>20% Coinsurance</td>
<td>30% Coinsurance</td>
</tr>
<tr>
<td>• 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</td>
<td>$40 copay</td>
<td>$40 copay</td>
</tr>
<tr>
<td>• Physical therapy, speech therapy, and occupational therapy</td>
<td></td>
<td></td>
</tr>
<tr>
<td><img src="image" alt="Medical nutrition therapy" /></td>
<td>$0 copay</td>
<td>$0 copay</td>
</tr>
</tbody>
</table>

This benefit is for people with diabetes, renal (kidney) disease (but not on dialysis), or after a kidney transplant when ordered by your doctor.
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
### Services that are covered for you

**What you must pay when you get these services In-Network**

**What you must pay when you get these services Out-of-Network**

| Changes, you may be able to receive more hours of treatment with a physician’s order. A physician must prescribe these services and renew their order yearly if your treatment is needed into the next calendar year. |

| Medicare Part B prescription drugs |

These drugs are covered under Part B of Original Medicare. Members of our plan receive coverage for these drugs through our plan. Covered drugs include:

- Drugs 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 were authorized by the plan
- Clotting factors you give yourself by injection if you have hemophilia
- Immunosuppressive Drugs, if you were enrolled in Medicare Part A at the time of the organ transplant
- Injectable osteoporosis drugs, if you are homebound, have a bone fracture that a doctor certifies was related to post-menopausal osteoporosis, and cannot self-administer the

| Immunosuppressive Drugs |

10% Coinsurance (Deductible Waived)

| All other Part B Drugs |

20% Coinsurance

| Home Infusion Drugs, Supplies and Services |

$0 copay for home infusion drugs that would normally be covered under Part D. This cost-sharing amount will also cover the supplies and services associated with home infusion of these drugs

| Immunosuppressive Drugs |

10% Coinsurance (Deductible Waived)

| All other Part B Drugs |

20% Coinsurance

| Home Infusion Drugs, Supplies and Services |

$0 copay for home infusion drugs that would normally be covered under Part D. This cost-sharing amount will also cover the supplies and services associated with home infusion of these drugs
<table>
<thead>
<tr>
<th>Services that are covered for you</th>
<th>What you must pay when you get these services</th>
<th>What you must pay when you get these services</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td><strong>In-Network</strong></td>
<td><strong>Out-of-Network</strong></td>
</tr>
<tr>
<td><strong>drug</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Antigens</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Certain oral anti-cancer drugs and anti-nausea drugs</td>
<td>$0 copay for obesity screening</td>
<td>$0 copay for obesity screening</td>
</tr>
<tr>
<td>• Certain drugs for home dialysis, including heparin, the antidote for heparin when medically necessary, topical anesthetics, and erythropoisis-stimulating agents (such as Epogen®, Procrit®, Epoetin Alfa, Aranesp®, or Darbepoetin Alfa)</td>
<td>Primary Care $0 copay per obesity therapy visit</td>
<td>Primary Care $0 copay per obesity therapy visit</td>
</tr>
<tr>
<td>• Intravenous Immune Globulin for the home treatment of primary immune deficiency diseases</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Obesity screening and therapy to promote sustained weight loss</strong></td>
<td>$0 copay for obesity screening</td>
<td>$0 copay for obesity screening</td>
</tr>
<tr>
<td>If you have a body mass index of 30 or more, we cover intensive counseling to help you lose weight. This counseling is covered if you get it in a primary care setting, where it can be coordinated with your comprehensive prevention plan. Talk to your primary care doctor or practitioner to find out more.</td>
<td>Primary Care $0 copay per obesity therapy visit</td>
<td>Primary Care $0 copay per obesity therapy visit</td>
</tr>
<tr>
<td><strong>Outpatient diagnostic tests and therapeutic services and supplies</strong></td>
<td>0% Coinsurance</td>
<td>20% Coinsurance</td>
</tr>
<tr>
<td>Covered services include, but are not limited to:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• X-rays</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### 2013 Evidence of Coverage for Regence MedAdvantage Basic
Chapter 4: Medical Benefits Chart (what is covered and what you pay)

<table>
<thead>
<tr>
<th>Services that are covered for you</th>
<th>What you must pay when you get these services <strong>In-Network</strong></th>
<th>What you must pay when you get these services <strong>Out-of-Network</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>• Radiation (radium and isotope) therapy including technician materials and supplies</td>
<td>10% Coinsurance</td>
<td>20% Coinsurance</td>
</tr>
<tr>
<td>• Surgical supplies, such as dressings</td>
<td>0% Coinsurance</td>
<td>0% Coinsurance</td>
</tr>
<tr>
<td>• Splints, casts and other devices used to reduce fractures and dislocations</td>
<td>0% Coinsurance</td>
<td>0% Coinsurance</td>
</tr>
<tr>
<td>• Laboratory tests</td>
<td>0% Coinsurance</td>
<td>0% Coinsurance</td>
</tr>
<tr>
<td>• Blood. Coverage begins with the first pint of blood that you need — Coverage of storage and administration begins with the first pint of blood that you need.</td>
<td>0% Coinsurance</td>
<td>0% Coinsurance</td>
</tr>
<tr>
<td>• Other outpatient diagnostic tests <strong>Prior authorization is required for in-network imaging benefits such as:</strong></td>
<td>20% Coinsurance</td>
<td>30% Coinsurance</td>
</tr>
<tr>
<td>o Magnetic Resonance Imaging (MRI)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>o Computer Tomography (CT/CAT) scans</td>
<td></td>
<td></td>
</tr>
<tr>
<td>o Positron Emission Tomography (PET) scans</td>
<td></td>
<td></td>
</tr>
<tr>
<td>o Nuclear Medicine Cardiology Testing</td>
<td></td>
<td></td>
</tr>
<tr>
<td>o Other complex imaging.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### Services that are covered for you

<table>
<thead>
<tr>
<th>Services that are covered for you</th>
<th>What you must pay when you get these services <strong>In-Network</strong></th>
<th>What you must pay when you get these services <strong>Out-of-Network</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Outpatient hospital services</strong></td>
<td>Emergency Visit $65 copay</td>
<td>Emergency Visit $65 copay</td>
</tr>
<tr>
<td></td>
<td>Outpatient Surgery $175 copay</td>
<td>Outpatient Surgery $225 copay</td>
</tr>
<tr>
<td></td>
<td>0% Coinsurance</td>
<td>0% Coinsurance</td>
</tr>
<tr>
<td></td>
<td>Outpatient Mental Health $40 copay</td>
<td>Outpatient Mental Health $40 copay</td>
</tr>
<tr>
<td></td>
<td>Partial Hospitalization 0% Coinsurance</td>
<td>Partial Hospitalization 0% Coinsurance</td>
</tr>
<tr>
<td></td>
<td>X-Rays 0% Coinsurance</td>
<td>X-Rays 20% Coinsurance</td>
</tr>
<tr>
<td></td>
<td>Radiation Therapy 10% Coinsurance</td>
<td>Radiation Therapy 20% Coinsurance</td>
</tr>
<tr>
<td></td>
<td>Complex Imaging (MRI, PET scans, CT scans, Nuclear</td>
<td>Complex Imaging (MRI, PET scans, CT scans, Nuclear</td>
</tr>
<tr>
<td></td>
<td>Medicine Cardiology Testing and any other complex</td>
<td>Medicine Cardiology Testing and any other complex</td>
</tr>
<tr>
<td></td>
<td>imaging) 20% Coinsurance</td>
<td>imaging) 30% Coinsurance</td>
</tr>
</tbody>
</table>

We cover medically-necessary services you get in the outpatient department of a hospital for diagnosis or treatment of an illness or injury. Covered services include, but are not limited to:

- Services in an emergency department or outpatient clinic, such as observation services or outpatient surgery
- Laboratory and diagnostic 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

**Prior authorization is required for in-network imaging benefits such as:**
- Magnetic Resonance Imaging (MRI)
- Computer Tomography (CT/CAT) scans
- Positron Emission Tomography (PET) scans
- Nuclear Medicine Cardiology Testing
- Other complex imaging.
<table>
<thead>
<tr>
<th>Services that are covered for you</th>
<th>What you must pay when you get these services <strong>In-Network</strong></th>
<th>What you must pay when you get these services <strong>Out-of-Network</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>• Medical supplies such as splints and casts</td>
<td>0% Coinsurance</td>
<td>0% Coinsurance</td>
</tr>
<tr>
<td>• Certain screenings and preventive services</td>
<td>0% Coinsurance</td>
<td>0% Coinsurance</td>
</tr>
<tr>
<td>• Certain drugs and biologicals that you can't give yourself</td>
<td>Imunosuppressive Drugs</td>
<td>Imunosuppressive Drugs</td>
</tr>
<tr>
<td></td>
<td>10% Coinsurance (Deductible Waived)</td>
<td>10% Coinsurance (Deductible Waived)</td>
</tr>
<tr>
<td></td>
<td>All other Part B Drugs</td>
<td>All other Part B Drugs</td>
</tr>
<tr>
<td></td>
<td>20% Coinsurance</td>
<td>20% Coinsurance</td>
</tr>
</tbody>
</table>

**Note:** Unless the provider has written an order to admit you as an inpatient to the hospital, you are an outpatient and pay the cost-sharing amounts for outpatient hospital services. Even if you stay in the hospital overnight, you might still be considered an “outpatient.” If you are not sure if you are an outpatient, you should ask the hospital staff. You can also find more information in a Medicare fact sheet called “Are You a Hospital Inpatient or Outpatient? If You Have Medicare – Ask!” This fact sheet is available on the Web at [http://www.medicare.gov/Publications/Pubs/pdf/11435.pdf](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.
<table>
<thead>
<tr>
<th>Services that are covered for you</th>
<th>What you must pay when you get these services In-Network</th>
<th>What you must pay when you get these services Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Outpatient mental health care</td>
<td>$40 copay</td>
<td>$40 copay</td>
</tr>
<tr>
<td>Prior authorization may be required for in-network services.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>A treatment plan is required after 20 visits (all services combined:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>chemical dependency, psychological testing, electro convulsive, office</td>
<td></td>
<td></td>
</tr>
<tr>
<td>visits.)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Covered services include:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mental health services provided by a state-licensed psychiatrist or</td>
<td></td>
<td></td>
</tr>
<tr>
<td>doctor, clinical psychologist, clinical social worker, clinical</td>
<td></td>
<td></td>
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<tr>
<td>nurse specialist, nurse practitioner, physician assistant, or other</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medicare-qualified mental health care professional as allowed under</td>
<td></td>
<td></td>
</tr>
<tr>
<td>applicable state laws.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Outpatient rehabilitation services</td>
<td>$40 copay</td>
<td>$40 copay</td>
</tr>
<tr>
<td>Prior authorization may be required for in-network services</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Covered services include:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>physical therapy, occupational therapy, and speech language therapy.</td>
<td></td>
<td></td>
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<tr>
<td>Outpatient rehabilitation services are provided in various outpatient</td>
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<td></td>
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<tr>
<td>settings, such as hospital outpatient departments, independent</td>
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<td></td>
</tr>
<tr>
<td>therapist offices, and Comprehensive Outpatient Rehabilitation Facilities (CORFs).</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Services that are covered for you</td>
<td>What you must pay when you get these services <strong>In-Network</strong></td>
<td>What you must pay when you get these services <strong>Out-of-Network</strong></td>
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<tr>
<td><strong>Outpatient substance abuse services</strong>&lt;br&gt;A treatment plan is required after 20 visits (all services combined: chemical dependency, psych testing, electro convulsive, office visits.)</td>
<td>$40 copay</td>
<td>$40 copay</td>
</tr>
<tr>
<td><strong>Outpatient surgery, including services provided at hospital outpatient facilities and ambulatory surgical centers</strong>&lt;br&gt;Prior authorization is required for certain in-network services.&lt;br&gt;Note: If you are having surgery in a hospital facility, 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.”</td>
<td>$175 copay</td>
<td>$225 copay</td>
</tr>
<tr>
<td><strong>Partial hospitalization services</strong>&lt;br&gt;“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.</td>
<td>$0 copay</td>
<td>$0 copay</td>
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## Services that are covered for you

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<thead>
<tr>
<th>Services that are covered for you</th>
<th>What you must pay when you get these services In-Network</th>
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<tbody>
<tr>
<td><strong>Physician/Practitioner services, including doctor’s office visits</strong></td>
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<tr>
<td>Covered services include:</td>
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<tr>
<td>• Medically-necessary medical care or surgery services furnished in a physician’s office, certified ambulatory surgical center, hospital outpatient department, or any other location</td>
<td>Primary Care $15 copay per office service.</td>
<td>Primary Care $40 copay per office service.</td>
</tr>
<tr>
<td>• Consultation, diagnosis, and treatment by a specialist</td>
<td>Specialist $40 copay per office service</td>
<td>Specialist $40 copay per office service</td>
</tr>
<tr>
<td>• Basic hearing and balance exams performed by your specialist, if your doctor orders it to see if you need medical treatment.</td>
<td>Physician/Practitioner Surgical – outpatient, and ambulatory services $0 copay</td>
<td>Physician/Practitioner Surgical – outpatient, and ambulatory services $0 copay</td>
</tr>
<tr>
<td>• Second opinion prior to surgery</td>
<td></td>
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<tr>
<td>• 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)</td>
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<tr>
<td><strong>Podiatry services</strong></td>
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<tr>
<td>Covered services include:</td>
<td>$15 copay</td>
<td>$40 copay</td>
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<tr>
<td>• Diagnosis and the medical or surgical treatment of injuries and diseases of the feet (such as hammer toe or heel spurs).</td>
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<tr>
<td>Services that are covered for you</td>
<td>What you must pay when you get these services</td>
<td>What you must pay when you get these services</td>
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<tr>
<td>• Routine foot care for members with certain medical conditions affecting the lower limbs</td>
<td>In-Network</td>
<td>Out-of-Network</td>
</tr>
<tr>
<td>• Prostate cancer screening exams</td>
<td>$0 copay</td>
<td>$0 copay</td>
</tr>
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</table>
| For men age 50 and older, covered services include the following - once every calendar year:  
  • Digital rectal exam  
  • Prostate Specific Antigen (PSA) test |                                                |                                            |
| Prosthetic devices and related supplies | 20% coinsurance                             | 30% coinsurance                              |
| Prior authorization is required for certain in-network services over $5,000  
Devices (other than dental) that replace all or part of 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. | $0 copay | $0 copay |
<table>
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<tr>
<th>Services that are covered for you</th>
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<tr>
<td><strong>Pulmonary rehabilitation services</strong>&lt;br&gt; Comprehensive programs of pulmonary rehabilitation are covered for members who have moderate to very severe chronic obstructive pulmonary disease (COPD) and an order for pulmonary rehabilitation from the doctor treating the chronic respiratory disease.</td>
<td><strong>Inpatient Hospital Stay</strong>&lt;br&gt; Days 1 to 7 - $200 copay per day.&lt;br&gt; Maximum $1,400 per benefit period.&lt;br&gt; Days 8 and beyond - $0 copay per day&lt;br&gt; <strong>Outpatient</strong>&lt;br&gt; $40 copay</td>
<td><strong>Inpatient Hospital Stay</strong>&lt;br&gt; Days 1 to 7 - $300 copay per day.&lt;br&gt; Maximum $2,100 per benefit period.&lt;br&gt; Days 8 and beyond - $0 copay per day&lt;br&gt; <strong>Outpatient</strong>&lt;br&gt; $40 copay</td>
</tr>
<tr>
<td><strong>Screening and counseling to reduce alcohol misuse</strong>&lt;br&gt; We cover one alcohol misuse screening for adults with Medicare (including pregnant women) who misuse alcohol, but aren’t alcohol dependent.&lt;br&gt; If you screen positive for alcohol misuse, you can get up to 4 brief face-to-face counseling sessions per year (if you’re competent and alert during counseling) provided by a qualified primary care doctor or practitioner in a primary care setting.</td>
<td>$0 copay for alcohol misuse screening&lt;br&gt; <strong>Primary Care</strong>&lt;br&gt; $0 copay per visit</td>
<td>$0 copay for alcohol misuse screening&lt;br&gt; <strong>Primary Care</strong>&lt;br&gt; $0 copay per visit</td>
</tr>
<tr>
<td><strong>Screening for sexually transmitted infections (STIs) and counseling to prevent STIs</strong>&lt;br&gt; We cover sexually transmitted infection (STI) screenings for chlamydia, gonorrhea, syphilis, and Hepatitis B. These screenings are</td>
<td>$0 copay for screening&lt;br&gt; <strong>Primary Care</strong>&lt;br&gt; $0 copay per visit</td>
<td>$0 copay for screening&lt;br&gt; <strong>Primary Care</strong>&lt;br&gt; $0 copay per visit</td>
</tr>
<tr>
<td>Services that are covered for you</td>
<td>What you must pay when you get these services In-Network</td>
<td>What you must pay when you get these services Out-of-Network</td>
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<td>covered for pregnant women and for certain people who are at increased risk for an STI when the tests are ordered by a primary care provider. We cover these tests once every 12 months or at certain times during pregnancy. We also cover up to 2 individual 20 to 30 minute, face-to-face high-intensity behavioral counseling sessions each year for sexually active adults at increased risk for STIs. We will only cover these counseling sessions as a preventive service if they are provided by a primary care provider and take place in a primary care setting, such as a doctor’s office.</td>
<td></td>
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</tr>
<tr>
<td><strong>Services to treat kidney disease and conditions</strong></td>
<td>$0 copay</td>
<td>$0 copay</td>
</tr>
<tr>
<td>Covered services include:</td>
<td>10% coinsurance</td>
<td>10% coinsurance</td>
</tr>
<tr>
<td>• 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.</td>
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<tr>
<td>• Outpatient dialysis treatments (including dialysis treatments when temporarily out of the service area, as explained in Chapter 3)</td>
<td></td>
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<tr>
<td>Services that are covered for you</td>
<td>What you must pay when you get these services <strong>In-Network</strong></td>
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<tr>
<td>• Inpatient dialysis treatments (if you are admitted as an inpatient to a hospital for special care)</td>
<td>Days 1 to 7 - $200 copay per day. Maximum $1,400 per benefit period. Days 8 and beyond - $0 copay per day 10% coinsurance</td>
<td>Days 1 to 7 - $300 copay per day Maximum $2,100 per benefit period. Days 8 and beyond - $0 copay per day 10% coinsurance</td>
</tr>
<tr>
<td>• Self-dialysis training (includes training for you and anyone helping you with your home dialysis treatments)</td>
<td>10% coinsurance</td>
<td>10% coinsurance</td>
</tr>
<tr>
<td>• Home dialysis equipment and supplies</td>
<td>10% coinsurance</td>
<td>10% coinsurance</td>
</tr>
<tr>
<td>• 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)</td>
<td>10% coinsurance</td>
<td>10% coinsurance</td>
</tr>
<tr>
<td></td>
<td>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.”</td>
<td></td>
</tr>
<tr>
<td><strong>Skilled nursing facility (SNF) care</strong> (For a definition of “skilled nursing facility care,” see Chapter 12 of this booklet. Skilled nursing facilities are sometimes called “SNFs.”)</td>
<td>Days 1 to 20 $40 copay per day Days 21 to 100 $80 copay per day You are covered up to 100 days each benefit period.</td>
<td>Days 1 to 20 $60 copay per day Days 21 to 100 $100 copay per day You are covered up to 100 days each benefit period.</td>
</tr>
<tr>
<td><strong>No prior hospital stay is required.</strong></td>
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</table>
## Services that are covered for you

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<tr>
<td>In-Network</td>
<td>Out-of-Network</td>
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</table>

Prior authorization is required for in-network services.

Covered services include but are not limited to:
- Semiprivate room (or a private room if medically necessary)
- Meals, including special diets
- Skilled 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 of whole blood and packed red cells begins only with the first pint of blood that you need. All other components of blood are covered beginning with the first pint used.
- Medical and surgical supplies ordinarily provided by SNFs
- Laboratory tests ordinarily provided by SNFs
- X-rays and other radiology services ordinarily provided by SNFs
- Use of appliances such as wheelchairs ordinarily provided by SNFs
- Physician/Practitioner services

Generally, you will get your SNF care from network facilities. However, under certain conditions listed below, you may be able to pay

### Benefit Period

- The way that both our plan and Original Medicare measures your use of hospital and skilled nursing facility (SNF) services. A benefit period begins the day you go into a hospital or skilled nursing facility. The benefit period ends when you haven’t received any inpatient hospital care (or skilled care in a SNF) for 60 days in a row. If you go into a hospital or a skilled nursing facility after one benefit period has ended, a new benefit period begins. There is no limit to the number of benefit periods.

### Benefit Period

- The way that both our plan and Original Medicare measures your use of hospital and skilled nursing facility (SNF) services. A benefit period begins the day you go into a hospital or skilled nursing facility. The benefit period ends when you haven’t received any inpatient hospital care (or skilled care in a SNF) for 60 days in a row. If you go into a hospital or a skilled nursing facility after one benefit period has ended, a new benefit period begins. There is no limit to the number of benefit periods.
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</table>
| in-network cost sharing for a facility that isn't a network provider, if the facility accepts our plan's amounts for payment.  
  - A nursing home or continuing care retirement community where you were living right before you went to the hospital (as long as it provides skilled nursing facility care).  
  - A SNF where your spouse is living at the time you leave the hospital. |                                               |                                               |
| Smoking and tobacco use cessation (counseling to stop smoking or tobacco use)                   |                                               |                                               |
| 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 as a preventive service with no cost to you. Each counseling attempt includes up to four face-to-face visits.  
If you use tobacco and have been diagnosed with a tobacco-related disease or are taking medicine that may be affected by tobacco: We cover cessation counseling services. We cover two counseling quit attempts within a 12-month period, however, you will pay the applicable inpatient or outpatient cost sharing. Each counseling attempt includes up to four face-to-face visits. | $0 copay                                      | $0 copay                                      |
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<tr>
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<tr>
<td><strong>Urgently needed care</strong></td>
<td>Urgent Care Center $15 copay</td>
<td>Urgent Care Center $40 copay</td>
</tr>
<tr>
<td>Urgently needed care is care provided to treat a non-emergency, unforeseen medical illness, injury, or condition that requires immediate medical care. Urgently needed care may be furnished by in-network providers or by out-of-network providers when network providers are temporarily unavailable or inaccessible. This benefit is covered world-wide.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Vision care</strong></td>
<td>$40 copay</td>
<td>$40 copay</td>
</tr>
<tr>
<td>Covered services include:</td>
<td>$0 copay</td>
<td>$0 copay</td>
</tr>
<tr>
<td>• Outpatient physician services for the diagnosis and treatment of diseases and injuries of the eye, including treatment for age-related macular degeneration. Original Medicare doesn’t cover routine eye exams (eye refractions) for eyeglasses/contacts.</td>
<td></td>
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</tr>
<tr>
<td>• 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.</td>
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<tr>
<td>Services that are covered for you</td>
<td>What you must pay when you get these services <strong>In-Network</strong></td>
<td>What you must pay when you get these services <strong>Out-of-Network</strong></td>
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| • 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. | $0 copay for standard hardware and lenses | $0 copay for standard hardware and lenses  
Cost sharing may apply if provider does not accept Medicare assignment. |

**Vision Care - Routine**  
*Routine vision care must be received from Vision Service Plan (VSP) providers to have in-network cost sharing.*

- Routine vision exams – one exam once every calendar year
- Eyeglasses and contact lenses – Up to $100 every calendar year on Regence MedAdvantage Basic. You are responsible for any remaining amounts.

<table>
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<th>$35 copay</th>
<th>$35 copay</th>
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</table>
| | *Copayments and payments beyond benefit limits do not apply to combined out-of-pocket maximum.* | VSP will reimburse up to $45 for a routine vision exam from an out-of-network provider. You are responsible for any remaining amounts.  
*Copayments and payments beyond benefit limits do not apply to combined out-of-pocket maximum.* |
### Services that are covered for you

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<tr>
<th>Services that are covered for you</th>
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<th>What you must pay when you get these services \textbf{Out-of-Network}</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>“Welcome to Medicare” Preventive Visit</strong></td>
<td>There is no coinsurance, copayment, or deductible for the “Welcome to Medicare” preventive visit.</td>
<td>There is no coinsurance, copayment, or deductible for the “Welcome to Medicare” preventive visit.</td>
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</table>

The plan covers the one-time “Welcome to Medicare” preventive visit. The visit 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. **Important:** We cover the “Welcome to Medicare” preventive visit only within the first 12 months you have Medicare Part B. When you make your appointment, let your doctor’s office know you would like to schedule your “Welcome to Medicare” preventive visit.

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**Section 2.2 Getting care using our plan’s optional visitor/traveler benefit**

When you are continuously absent from our plan’s service area for more than six months, we usually must disenroll you from our plan. However, we offer as a supplemental benefit a visitor/traveler program, which will allow you to remain enrolled in our plan when you are outside of our service area for up to 12 months. This program is available to all Regence BlueCross BlueShield of Utah members who are temporarily out of the plan’s service area.


When traveling outside the plan service area, Members can see any participating \textit{Blue Medicare Advantage PPO Network} doctor or hospital and receive the highest level of benefits (in-network) through our visitor/traveler program. However, be aware that in some of the states listed, there is no state-wide PPO network. Members can also see
non-contracted Providers outside of *Blue Medicare Advantage PPO Network* service area, but will have higher out-of-pocket costs.

To find a *Blue Medicare Advantage PPO Network* participating provider, you can:
- Call 1-800-810-BLUE (2583)
- Visit [www.bcbs.com/mobile](http://www.bcbs.com/mobile) to search online for participating providers or to download the Blue National Doctor & Hospital Finder application for your mobile device.
- Call Customer Service (phone numbers are on the cover of this booklet)

Members with the visitor/traveler benefit can stay enrolled in our plan for up to 12 months out of area. If you have not returned to the plan’s service area within 12 months, you will be disenrolled from the plan.

**Your Liability Calculation**

The cost of the service, on which your liability (coinsurance) is based, will be either:
- The Medicare allowable amount for covered services, or
- The amount either we negotiate with the provider or the local Blue Medicare Advantage PPO plan negotiates with its provider on behalf of our members, if applicable. The amount negotiated may be either higher than, lower than or equal to the Medicare allowable amount.

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

#### Section 3.1 Benefits we do *not* cover (exclusions)

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

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

If you get benefits that are excluded, you must pay for them yourself. We won’t pay for the excluded medical benefits listed in this section (or elsewhere in this booklet), and neither will Original Medicare. The only exception: If a benefit on the exclusion list is found upon appeal to be a medical benefit that we should have paid for or covered because of your specific situation. (For information about appealing a decision we have made to not cover a medical service, go to Chapter 7, Section 5.3 in this booklet.)

In addition to any exclusions or limitations described in the Benefits Chart, or anywhere else in this *Evidence of Coverage*, 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 or by our plan. (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 is care provided in a nursing home, hospice, or other facility setting when you do not require skilled medical care or skilled nursing care. Custodial care is personal care that does not require the continuing attention of trained medical or paramedical personnel, such as care that helps you with activities of daily living, such as bathing or dressing.
• Homemaker services include basic household assistance, including light housekeeping or light meal preparation.
• Fees charged by your immediate relatives or members of your household.
• Meals delivered to your home.
• Elective or voluntary enhancement procedures or services (including weight loss, hair growth, sexual performance, athletic performance, cosmetic purposes, anti-aging and mental performance), except when medically necessary.
• Cosmetic surgery or procedures, unless because of an accidental injury or to improve a malformed part of the body. However, all stages of reconstruction are covered for a breast after a mastectomy, as well as for the unaffected breast to produce a symmetrical appearance.
• Routine dental care, such as cleanings, fillings or dentures. However, non-routine dental care required to treat illness or injury may be covered as inpatient or outpatient care.
• Preventive dental limitations, such as restorative and major dental care (such as filings or dentures), intraoral complete series X-rays, or other dental services are not covered. Periodontal scaling, root planning and debridement is therapeutic (not preventive) and is not covered.
• Chiropractic care, other than manual manipulation of the spine consistent with Medicare coverage guidelines.
• Routine foot care, except for the limited coverage provided according to Medicare guidelines.
• 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.
• 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.
• Radial keratotomy, LASIK surgery, vision therapy and other low vision aids.
• Reversal of sterilization procedures, sex change operations, and non-prescription contraceptive supplies.
• Acupuncture.
• Naturopath services (uses natural or alternative treatments).
• 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.

The plan will not cover the excluded services listed above. Even if you receive the services at an emergency facility, the excluded services are still not covered.
Chapter 5. Asking us to pay our share of a bill you have received for covered medical services

SECTION 1  Situations in which you should ask us to pay our share of the cost of your covered services ............................................................. 79

Section 1.1 If you pay our plan’s share of the cost of your covered services, or if you receive a bill, you can ask us for payment ........................................ 79

SECTION 2  How to ask us to pay you back or to pay a bill you have received ........................................................................................................ 81

Section 2.1 How and where to send us your request for payment .................. 81

SECTION 3  We will consider your request for payment and say yes or no........ 81

Section 3.1 We check to see whether we should cover the service and how much we owe ................................................................................. 81

Section 3.2 If we tell you that we will not pay for all or part of the medical care, you can make an appeal ..................................................................... 82
SECTION 1  Situations in which you should ask us to pay our share of the cost of your covered services

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

Sometimes when you get medical care, 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 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 medical care from a provider who is not in our plan’s network

   When you received 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. (Your share of the cost may be higher for an out-of-network provider than for a network provider.)
   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.
     o If the provider is owed anything, we will pay the provider directly.
     o If you have already paid more than your share of the cost of the service, we will determine how much you owed and pay you back for our share of the cost.
   
   • **Please note:** While you can get your care from an out-of-network provider, the provider must be eligible to participate in Medicare. We cannot pay a provider who is not eligible to participate in Medicare. If the provider is not eligible to participate in Medicare, you will be responsible for the full cost of the services you receive.
2. **When a network provider sends you a bill you think you should not pay**

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

- You only have to pay your cost-sharing amount when you get services covered by our plan. We do not allow providers to add additional separate charges, called “balance billing.” This protection (that you never pay more than your cost-sharing amount) applies even if we pay the provider less than the provider charges for a service and even if there is a dispute and we don’t pay certain provider charges. For more information about “balance billing,” go to Chapter 4, Section 1.4.

- Whenever you get a bill from a network provider that you think is more than you should pay, send us the bill. We will contact the provider directly and resolve the billing problem.

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

3. **If you are retroactively enrolled in our plan.**

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

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

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

We will accept paper claims as long as we receive your request for reimbursement less than 90 days from the day the prescription was filled.

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 7 of this booklet (*What to do if you have a problem or complaint (coverage decisions, appeals, complaints)*) has information about how to make an appeal.
SECTION 2  How to ask us to pay you back or to pay a bill you have received

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

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

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

- **For medical claims:**
  Regence MedAdvantage Basic
  PO Box 12625
  Salem, OR 97309-0625
  **You must submit your claim to us within 12 months** of the date you received the service or item.

- **Send out-of-network routine vision claims only** to this address:
  VSP
  PO Box 997105
  Sacramento, CA 95899-7105
  **You must submit your claim to VSP within 12 months** of the date you received the service or item.

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 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 is covered and you followed all the rules for getting the care, we will pay for our share of the cost. If you have already paid for the service, we will mail your reimbursement of our share of the cost to you. If you have not paid for the service 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.)

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

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

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

For the details on how to make this appeal, go to Chapter 7 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 7. 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 5.3 in Chapter 7 that tells what to do if you want to make an appeal about getting paid back for a medical service.
Chapter 6. Your rights and responsibilities

SECTION 1  Our plan must honor your rights as a member of the plan .......... 84

Section 1.1 We must provide information in a way that works for you; documents are available in electronic format and may be available in other formats ................................................................. 84

Section 1.2 We must treat you with fairness and respect at all times .............. 84

Section 1.3 We must ensure that you get timely access to your covered services ................................................................................................................................. 84

Section 1.4 We must protect the privacy of your personal health information ...... 85

Section 1.5 We must give you information about the plan, its network of providers, and your covered services ......................................................................................... 90

Section 1.6 We must support your right to make decisions about your care ........ 91

Section 1.7 You have the right to make complaints and to ask us to reconsider decisions we have made ............................................................ 93

Section 1.8 What can you do if you believe you are being treated unfairly or your rights are not being respected? ......................................................... 93

Section 1.9 How to get more information about your rights ............................. 94

SECTION 2  You have some responsibilities as a member of the plan ............. 94

Section 2.1 What are your responsibilities? ..................................................... 94
SECTION 1  Our plan must honor your rights as a member of the plan

Section 1.1  We must provide information in a way that works for you; documents are available in electronic format and may be available in other formats

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

Our plan has people and free language interpreter services available to answer questions from non-English speaking members. We can also give you information in electronic 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  We must treat you with fairness and respect at all times

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

If you want more information or have concerns about discrimination or unfair treatment, please call the Department of Health and Human Services’ Office for Civil Rights 1-800-368-1019 (TTY 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 printed 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

You have the right to choose a provider for your care.
As a plan member, you have the right to get appointments and covered services from your providers *within a reasonable amount of time*. This includes the right to get timely services from specialists when you need that care.

If you think that you are not getting your medical care within a reasonable amount of time, Chapter 7, Section 9 of this booklet tells what you can do. (If we have denied coverage for your medical care and you don’t agree with our decision, Chapter 7, Section 4 tells what you can do.)

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

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

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

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

### How do we protect the privacy of your health information?

- We make sure that unauthorized people don’t see or change your records.

- In most situations, if we give your health information to anyone who isn’t providing your care or paying for your care, *we are required to get written permission from you first*. Written permission can be given by you or by someone you have given legal power to make decisions for you.

- There are certain exceptions that do not require us to get your written permission first. These exceptions are allowed or required by law.
  - For example, we are required to release health information to government agencies that are checking on quality of care.
  - Because you are a member of our plan through Medicare, we are required to give Medicare your health information. If Medicare releases your information for research or other uses, this will be done according to Federal statutes and regulations.

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

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

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

If you have questions or concerns about the privacy of your personal health information,
please call Customer Service (phone numbers are printed on the back cover of this
booklet).

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE
USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS
INFORMATION.

PLEASE REVIEW IT CAREFULLY.

We, at Regence BlueCross BlueShield of Utah, know you value your privacy. That is
why we are committed to the confidentiality and security of your personal information.
We maintain physical, administrative and technical safeguards to protect against
unauthorized access, use, or disclosure of your personal information.

We collect personal information, such as your name, contact information, and health
information, from you, your health care providers, and other insurers that provide you
coverage. We are required by law to maintain the privacy of this protected health
information and to explain our legal duties and privacy practices. We provide the
protections and apply the practices described in this notice to all personal information
that we maintain, including to personal information of former members who are no
longer covered by us. We hope this notice will clarify our responsibilities to you and
give you an understanding of your rights. We abide by the notice that is currently in
effect. This notice is in effect as of April 1, 2006.

Your Rights

Inspection and Copies. You have the right to request an inspection or copies of
protected health information that we maintain about you in a “designated record set”
except psychotherapy notes and information that we compiled in anticipation of, or for
use in, a civil, criminal, or administrative proceeding. A “designated record set” is a
group of records that is used to administer your health benefits, including enrollment
information and claims. We may limit the information that you can inspect or copy if we
have reason to believe that is necessary to protect you or another person from harm. If
we limit your right to inspect or copy, you can ask for a review of that decision.
**Amendment.** If you believe that protected health information we maintain about you in a designated record set is inaccurate or incomplete, you have the right to request an amendment to correct or complete the information. You must submit your request in writing and explain the reason for the amendment. If the amendment is made, we will make reasonable efforts to inform others, including people you identify, that the information has been amended and we will use our best efforts to include the amendment with any future disclosure. We may decline to amend information under certain circumstances. This is likely to occur if we did not create the original record. If we decline to amend the information, you have the right to submit a statement of disagreement. You should know that we are allowed to attach a rebuttal statement in response to your statement of disagreement.

**Notice.** You have the right to receive a paper copy of this notice upon request.

**Accounting.** You have the right to request a list of certain disclosures of protected health information. The list will not include disclosures made for treatment, payment, or health care operations. It also will not include disclosures made pursuant to an authorization, made prior to six years before the date of the request, incidental disclosures, disclosures made for national security or intelligence, disclosures made to a correctional facility or disclosures made prior to April 14, 2003. The list will include the date of any accountable disclosure, to whom that disclosure was made, a brief description of the information disclosed, and the purpose for that disclosure (provided this information is known to us). We will supply this list free of charge once a year at your request. If you request an accounting more than once in a 12-month period, we may charge a reasonable fee.

**Special Handling.** You have the right to request restrictions on our use or disclosure of protected health information in addition to the restrictions imposed by law. We are not required to agree to your request and we may be unable to do so. If we do agree, we will comply with your request except in the case of emergency. You also have the right to request that we communicate with you in confidence. We will make every effort to accommodate your request if it is reasonable and you provide an alternate means to communicate. You should know that redirecting communication may not prevent others on your policy from discovering that you sought medical care. Accumulated deductibles and co-payment information may reveal that you obtained services. In addition, historic claims reports may include services which were obtained during the time communications were redirected.

**Complaints.** You have the right to submit a complaint if you believe we have violated your privacy rights. To submit a complaint, write to: Regence BlueCross BlueShield of Utah, Privacy Office, P.O. Box 1271, Mailstop E14A, Portland, OR 97207 or call our Customer Service department at the phone number provided at the end of this notice. You also have the right to submit a complaint to the Secretary of the U.S. Department of Public Health & Human Services. Be assured that we will not retaliate against you for submitting a complaint.
Permitted Uses and Disclosures

To administer health benefits, we collect, use and disclose protected health information for a variety of purposes:

**Treatment.** We may disclose protected health information to a health care provider in order for the provider to treat you. We may also use or disclose protected health information in an effort to provide preventive health, early detection, and case management programs.

**Payment.** We may use or disclose protected health information for payment purposes, including to adjudicate claims, issue Explanation of Benefits, or coordinate benefits with other entities responsible for paying your claims.

**Health Care Operations.** We may use or disclose protected health information to facilitate operations, including underwriting, customer service, and detection or prevention of fraud or abuse.

**Business Associates.** Occasionally, we contract with business associates to perform insurance-related functions on our behalf. We may disclose protected health information to these business associates in order to allow them to perform these functions. They also may collect, use or disclose protected health information on our behalf. We contractually obligate our business associates to provide the same privacy protections that we provide.

**Plan Sponsors and Group Health Plans.** If you are enrolled in a group health plan, we may disclose protected health information to the group health plan or plan sponsor to facilitate administration of the plan. For example, we supply enrollment lists so that premiums can be paid appropriately.

**As Permitted or Required by Law.** We use or disclose protected health information as permitted or required by law. For example, some laws require that we disclose protected health information to your personal representatives or to certain government agencies.

**Public Health Activities.** We may disclose protected health information for public health activities. These activities include prevention and control of disease, activities performed by coroners, activities performed by organ or tissue donation and transplantation services, activities performed by the Food and Drug Administration, medical research, research intended to improve the health care system, activities necessary to avert a serious threat to the health or safety of a person, and activities relating to workers’ compensation benefits.

**Health Oversight.** We may disclose protected health information to health oversight agencies. These agencies are authorized by law to conduct audits; perform inspections and investigations; license health care providers, insurers and facilities; and to enforce
regulatory requirements. These agencies include: State Commissioner of Insurance, State Board of Medicine, and the U.S. Department of Labor.

**Health Related Services.** We may use protected health information to provide information about treatment alternatives or other health related benefits or services that may be of interest to you. This may include enhancements to your health plan and health related products or services available only to health plan members that add value to, but are not a part of, your benefit plan.

**Legal Proceedings.** We may disclose protected health information in the course of a judicial or administrative proceeding, and in response to a court order, subpoena, discovery request, or other lawful process.

**Law Enforcement.** We may disclose protected health information to law enforcement officials in response to an administrative subpoena, a warrant, or an administrative request intended to identify or locate a suspect, victim, or witness. We also may disclose protected health information for the purpose of reporting a crime on our premises.

**Military and National Security.** We may disclose protected health information to armed forces personnel for military activities and to authorized federal officials for national security and intelligence activities.

**Correctional Institution.** If you are an inmate, we may disclose protected health information to your correctional institution for treatment purposes or to ensure the safety of yourself and others.

**Marketing.** We do not use or disclose protected health information for marketing purposes without your authorization. However, we may communicate with you face-to-face about products or services that may interest you or we may send you a promotional gift of nominal value.

Others Involved in Your Health Care. We may disclose protected health information to personal representatives such as appointed guardians, executors, conservators, and in many cases parents of minor children, as well as to attorneys in fact when a valid power of attorney exists. In addition, if you give us verbal permission or if your permission can be implied (for example, while you are unconscious during an emergency), we may disclose protected health information to family members or others who call on your behalf. This permission is valid only for a limited time. If you want to authorize on-going disclosures to family members or friends, you must submit written authorization.

**Authorizations.** You may give us written authorization to use protected health information or disclose protected health information about yourself to anyone for any purpose. An authorization remains valid for two years unless the authorization states otherwise or you revoke it. You may revoke an authorization at any time by submitting a written revocation, but a revocation will not affect any use or disclosure permitted by the authorization while it was in effect.
An authorization is required for us to use or disclose your protected health information for purposes other than those described in this notice.

**Future Changes**

We reserve the right to change our privacy practices and this notice at any time without advance notice. If we make a material change to our privacy practices, we will send a new, updated notice. The new notice will apply to all protected health information in our possession, including any information created or received before the revised notice became effective.

**Contacting Us**

You may reach us during regular business hours by calling our Customer Service department at (800) 541-8981. For more information about this notice or to file a written privacy-related complaint, you may write to:

Privacy Official, Regence BlueCross BlueShield of Utah, P.O. Box 1271, MS E14A, Portland, OR 97207.

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<th>Section 1.5</th>
<th>We must give you information about the plan, its network of providers, and your covered services</th>
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As a member of Regence MedAdvantage Basic, 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 electronic or other alternate formats.)

If you want any of the following kinds of information, please call Customer Service (phone numbers are printed 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.**
  - For example, you have the right to get information from us about the qualifications of the providers 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 more detailed information about our providers, you can call Customer Service (phone numbers are printed on the back cover of this booklet) or visit our website at www.regence.com/medicare.
• Information about your coverage and rules you must follow in using your coverage.
  o 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.
  o If you have questions about the rules or restrictions, please call Customer Service (phone numbers are printed on the back cover of this booklet).

• Information about why something is not covered and what you can do about it.
  o If a medical service is not covered for you, or if your coverage is restricted in some way, you can ask us for a written explanation. You have the right to this explanation even if you received the medical service from an out-of-network provider.
  o If you are not happy or if you disagree with a decision we make about what medical care 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 7 of this booklet. It gives you the details about how to make an appeal if you want us to change our decision. (Chapter 7 also tells about how to make a complaint about quality of care, waiting times, and other concerns.)
  o If you want to ask our plan to pay our share of a bill you have received for medical care, see Chapter 5 of this booklet.

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

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

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

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

• **To know about all of your choices.** This means that you have the right to be told about all of the treatment options that are recommended for your condition, no matter what they cost or whether they are covered by our plan.

• **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. Of course, if you refuse treatment, 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 7 of this booklet tells how to ask the plan for a coverage decision.

**You have the right to give instructions about what is to be done if you are not able to make medical decisions for yourself**

Sometimes people become unable to make health care decisions for themselves due to accidents or serious illness. You have the right to say what you want to happen if you are in this situation. This means that, if you want to, you can:

- Fill out a written form to give **someone the legal authority to make medical decisions for you** if you ever become unable to make decisions for yourself.

- Give your doctors **written instructions** about how you want them to handle your medical care if you become unable to make decisions for yourself.

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

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

- **Get the form.** If you want to have an advance directive, you can get a form from your lawyer, from a social worker, or from some office supply stores. You can sometimes get advance directive forms from organizations that give people information about Medicare. You can also contact Customer Service to ask for the forms (phone numbers are printed 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 did not follow the instructions in it, you may file a complaint with the Utah Department of Health at 1 (801) 538-6003.

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<th>Section 1.7</th>
<th>You have the right to make complaints and to ask us to reconsider decisions we have made</th>
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If you have any problems or concerns about your covered services or care, Chapter 7 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 7, 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 printed on the back cover of this booklet).

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<th>Section 1.8</th>
<th>What can you do if you believe you are being treated unfairly or your rights are not being respected?</th>
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If it is about discrimination, call the Office for Civil Rights

If you believe you have been treated unfairly or your rights have not been respected due to your race, disability, religion, sex, health, ethnicity, creed (beliefs), age, or national origin, you should call the Department of Health and Human Services’ Office for Civil Rights at 1-800-368-1019 or TTY 1-800-537-7697, or call your local Office for Civil Rights.
Is it about something else?

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

- You can call Customer Service (phone numbers are printed on the 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 How to get more information about your rights

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

- You can call Customer Service (phone numbers are printed on the back cover of this booklet).
- You can call the State Health Insurance Assistance Program. For details about this organization and how to contact it, go to Chapter 2, Section 3.
- You can contact Medicare.
  - You can visit the Medicare website to read or download the publication “Your Medicare Rights & Protections.” (The publication is available at: http://www.medicare.gov/Publications/Pubs/pdf/10112.pdf.)
  - Or, you can call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

SECTION 2 You have some responsibilities as a member of the plan

Section 2.1 What are your responsibilities?

Things you need to do as a member of the plan are listed below. If you have any questions, please call Customer Service (phone numbers are printed 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.

• **If you have any other health insurance coverage in addition to our plan, you are required to tell us.** Please call Customer Service to let us know (phone numbers are printed on the back cover of this booklet).
  - We are required to follow rules set by Medicare to make sure that you are using all of your coverage in combination when you get your covered services from our plan. This is called “coordination of benefits” because it involves coordinating the health benefits you get from our plan with any other health benefits available to you. We'll help you with it. (For more information about coordination of benefits, go to Chapter 1, Section 7.)

• **Tell your doctor and other health care providers that you are enrolled in our plan.** Show your plan membership card whenever you get your medical care.

• **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:
  - You must pay your plan premiums to continue being a member of our plan.
  - In order to be eligible for our plan, you must have Medicare Part A and Medicare Part B. For that reason, some plan members must pay a
premium for Medicare Part A and most plan members must pay a
premium for Medicare Part B to remain a member of the plan.

- For some of your medical services covered by the plan, you must pay your
  share of the cost when you get the service. 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.

- If you get any medical services 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,
    you can make an appeal. Please see Chapter 7 of this booklet for
    information about how to make an appeal.

- **Tell us if you move.** If you are going to move, it’s important to tell us right
  away. Call Customer Service (phone numbers are printed 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, you will have a Special Enrollment
    Period when you can join any Medicare plan available in your new area.
    We can let you know if we have a plan in your new area.

  - If you move **within** 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 printed on the
    back cover of this booklet.

  - For more information on how to reach us, including our mailing address,
    please see Chapter 2.
Chapter 7. What to do if you have a problem or complaint
(coverage decisions, appeals, complaints)

BACKGROUND

SECTION 1 Introduction ........................................................................................................ 100

Section 1.1 What to do if you have a problem or concern ............................................. 100

Section 1.2 What about the legal terms? ........................................................................ 100

SECTION 2 You can get help from government organizations that are not connected with us .......................................................................................................................... 101

Section 2.1 Where to get more information and personalized assistance ............ 101

SECTION 3 To deal with your problem, which process should you use? ........ 101

Section 3.1 Should you use the process for coverage decisions and appeals? Or should you use the process for making complaints? .... 101

COVERAGE DECISIONS AND APPEALS

SECTION 4 A guide to the basics of coverage decisions and appeals ............. 103

Section 4.1 Asking for coverage decisions and making appeals: the big picture ................................................................................................................................. 103

Section 4.2 How to get help when you are asking for a coverage decision or making an appeal ........................................................................................................ 104

Section 4.3 Which section of this chapter gives the details for your situation? .... 105

SECTION 5 Your medical care: How to ask for a coverage decision or make an appeal ....................................................................................................................... 105

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 ........................................................................... 105

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) ....................................................................................................................... 107
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) .... 110

Section 5.4  Step-by-step: How to make a Level 2 Appeal.......................... 113

Section 5.5  What if you are asking us to pay you for our share of a bill you have received for medical care?......................................................... 115

SECTION 6  How to ask us to cover a longer inpatient hospital stay if you think the doctor is discharging you too soon ..................................... 116

Section 6.1  During your inpatient hospital stay, you will get a written notice from Medicare that tells about your rights................................. 116

Section 6.2  Step-by-step: How to make a Level 1 Appeal to change your hospital discharge date................................................................. 117

Section 6.3  Step-by-step: How to make a Level 2 Appeal to change your hospital discharge date................................................................. 120

Section 6.4  What if you miss the deadline for making your Level 1 Appeal? ...... 121

SECTION 7  How to ask us to keep covering certain medical services if you think your coverage is ending too soon................................. 124

Section 7.1  This section is about three services only: Home health care, skilled nursing facility care, and Comprehensive Outpatient Rehabilitation Facility (CORF) services ........................................ 124

Section 7.2  We will tell you in advance when your coverage will be ending...... 125

Section 7.3  Step-by-step: How to make a Level 1 Appeal to have our plan cover your care for a longer time.................................................. 126

Section 7.4  Step-by-step: How to make a Level 2 Appeal to have our plan cover your care for a longer time.................................................. 128

Section 7.5  What if you miss the deadline for making your Level 1 Appeal? ...... 129

SECTION 8  Taking your appeal to Level 3 and beyond........................................ 132

Section 8.1  Levels of Appeal 3, 4, and 5 for Medical Service Appeals.............. 132
COVERAGE DECISIONS AND APPEALS

SECTION 9  How to make a complaint about quality of care, waiting times, customer service, or other concerns ................................................................. 134

Section 9.1  What kinds of problems are handled by the complaint process? ...... 134

Section 9.2  The formal name for “making a complaint” is “filing a grievance” .... 136

Section 9.3  Step-by-step: Making a complaint .......................................................... 137

Section 9.4  You can also make complaints about quality of care to the Quality Improvement Organization ................................................................. 138

Section 9.5  You can also tell Medicare about your complaint ............................. 138
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” and “Independent Review Organization” instead of “Independent Review Entity.” It also uses abbreviations as little as possible.

However, it can be helpful – and sometimes quite important – for you to know the correct legal terms for the situation you are in. Knowing which terms to use will help you communicate more clearly and accurately when you are dealing with your problem and get the right help or information for your situation. To help you know which terms to use, we include legal terms when we give the details for handling specific types of situations.
SECTION 2  You can get help from government organizations that are not connected with us

Section 2.1  Where to get more information and personalized assistance

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

Get help from an independent government organization

We are always available to help you. But in some situations you may also want help or guidance from someone who is not connected with us. You can always contact your State Health Insurance Assistance Program (SHIP). This government program has trained counselors in every state. The program is not connected with us or with any insurance company or health plan. The counselors at this program can help you understand which process you should use to handle a problem you are having. They can also answer your questions, give you more information, and offer guidance on what to do.

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

You can also get help and information from Medicare

For more information and help in handling a problem, you can also contact Medicare. Here are two ways to get information directly from Medicare:

- You can call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.
- You can visit the Medicare website (http://www.medicare.gov).

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

Section 3.1  Should you use the process for coverage decisions and appeals? Or should you use the process for making complaints?

If you have a problem or concern, you only need to read the parts of this chapter that apply to your situation. The guide that follows will help.
To figure out which part of this chapter will help with your specific problem or concern, START HERE

<table>
<thead>
<tr>
<th><strong>Is your problem or concern about your benefits or coverage?</strong></th>
<th><strong>Yes.</strong></th>
<th><strong>No.</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>My problem is about benefits or coverage.</td>
<td>My problem is not about benefits or coverage.</td>
</tr>
<tr>
<td>(This includes problems about whether particular medical care or prescription drugs are covered or not, the way in which they are covered, and problems related to payment for medical care or prescription drugs.)</td>
<td>Go on to the next section of this chapter, Section 4, “A guide to the basics of coverage decisions and making appeals.”</td>
<td>Skip ahead to Section 9 at the end of this chapter: “How to make a complaint about quality of care, waiting times, customer service or other concerns.”</td>
</tr>
</tbody>
</table>
The process for coverage decisions and making appeals deals with problems related to your benefits and coverage for medical services, 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. 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 or your doctor can also contact us and ask for a coverage decision if your doctor is unsure whether we will cover a particular medical service or refuses to provide medical care you think that you need. In other words, if you want to know if we will cover a medical service before you receive it, you can ask us to make a coverage decision for you.

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

**Making an appeal**

If we make a coverage decision and you are not satisfied with this decision, you can “appeal” the decision. An appeal is a formal way of asking us to review and change a coverage decision we have made.

When you make an appeal, we review the coverage decision we have made to check to see if we were following all of the rules properly. Your appeal is handled by different reviewers than those who made the original unfavorable decision. When we have completed the review, we give you our decision.

If we say no to all or part of your Level 1 Appeal, you can go on to a Level 2 Appeal. The Level 2 Appeal is conducted by an independent organization that is not connected to us. (In some situations, your case will be automatically sent to the independent organization for a Level 2 Appeal. If this happens, we will let you know.)
In other situations, you will need to ask for a Level 2 Appeal.) If you are not satisfied with the decision at the Level 2 Appeal, you may be able to continue through several more levels of appeal.

### Section 4.2 How to get help when you are asking for a coverage decision or making an appeal

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

- **You can call us at Customer Service** (phone numbers are printed 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).

- For medical care, a doctor can make a request for you. Your doctor can request a coverage decision or a Level 1 appeal on your behalf. If your appeal is denied at Level 1, it will be automatically forwarded to Level 2. To request any appeal after Level 2, your doctor must be appointed as your representative.

- **You can ask someone to act on your behalf.** If you want to, you can name another person to act for you as your “representative” to ask for a coverage decision or make an appeal.
  
  - There may be someone who is already legally authorized to act as your representative under State law.
  
  - If you want a friend, relative, your doctor or other provider, or other person to be your representative, call Customer Service (phone numbers are printed on the back cover of this booklet) and ask for the “Appointment of Representative” form. (The form is also available on Medicare’s website at http://www.cms.hhs.gov/cmsforms/downloads/cms1696.pdf.) The form gives that person permission to act on your behalf. It must be signed by you and by the person who you would like to act on your behalf. You must give us a copy of the signed form.

- **You also have the right to hire a lawyer to act for you.** You may contact your own lawyer, or get the name of a lawyer from your local bar association or other referral service. There are also groups that will give you free legal services if you qualify. However, **you are not required to hire a lawyer** to ask for any kind of coverage decision or appeal a decision.
There are three 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: “How to ask us to cover a longer inpatient hospital stay if you think the doctor is discharging you too soon”
- **Section 7** of this chapter: “How to ask us to keep covering certain medical services if you think your coverage is ending too soon” (*Applies to these services only*: home health care, skilled nursing facility care, and Comprehensive Outpatient Rehabilitation Facility (CORF) services)

If you’re not sure which section you should be using, please call Customer Service (phone numbers are printed on the back cover of this booklet). You can also get help or information from government organizations such as your State Health Insurance Assistance Program (Chapter 2, Section 3, of this booklet has the phone numbers for this program).

**SECTION 5**

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

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

**Section 5.1**

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

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

This section tells what you can do if you are in any of the five following situations:

1. You are not getting certain medical care you want, and you believe that this care is covered by our plan.
2. Our plan will not approve the medical care your doctor or other medical provider wants to give you, and you believe that this care is covered by the plan.

3. You have received medical care or services that you believe should be covered by the plan, but we have said we will not pay for this care.

4. You have received and paid for medical care or services that you believe should be covered by the plan, and you want to ask our plan to reimburse you for this care.

5. You are being told that coverage for certain medical care you have been getting that we previously approved will be reduced or stopped, and you believe that reducing or stopping this care could harm your health.

   - **NOTE:** If the coverage that will be stopped is for hospital care, home health care, skilled nursing facility care, or Comprehensive Outpatient Rehabilitation Facility (CORF) services, you need to read a separate section of this chapter because special rules apply to these types of care. Here's what to read in those situations:
     
     o Chapter 7, Section 6: *How to ask us to cover a longer inpatient hospital stay if you think the doctor is discharging you too soon.*
     
     o Chapter 7, Section 7: *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.

<table>
<thead>
<tr>
<th>Which of these situations are you in?</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>If you are in this situation:</strong></td>
</tr>
</tbody>
</table>
| 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 can send us the bill. 

   Skip ahead to **Section 5.5** of this chapter. |
Which of these situations are you in?

you have already received and paid for?

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

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

Step 1: You ask our plan to make a coverage decision on the medical care you are requesting. If your health requires a quick response, you should ask us to make a “fast coverage decision.”

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

How to request coverage for the medical care you want

- Start by calling, writing, or faxing our plan to make your request for us to provide coverage for the medical care you want. You, your doctor, or your representative can do this.

- For the details on how to contact us, go to Chapter 2, Section 1 and look for the section called, How to contact us when you are asking for a coverage decision about your medical care.

Generally we use the standard deadlines for giving you our decision

When we give you our decision, we will use the “standard” deadlines unless we have agreed to use the “fast” deadlines. A standard coverage decision means we will give you an answer within 14 days after we receive your request.

- However, we can take up to 14 more calendar days if you ask for more time, or if we need information (such as medical records from out-of-network providers) that may benefit you. If we decide to take extra days to make the decision, we will tell you in writing.

- If you believe we should not take extra days, you can file a “fast complaint” about our decision to take extra days. When you file a fast complaint, we will give you an answer to your complaint within 24 hours. (The process for making a complaint is different from the process for coverage decisions...
If your health requires it, ask us to give you a “fast coverage decision”

- **A fast coverage decision means we will answer within 72 hours.**
  - However, we can take up to 14 more calendar days if we find that some information that may benefit you is missing (such as medical records from out-of-network providers), or if you need time to get information to us for the review. If we decide to take extra days, we will tell you in writing.
  - If you believe we should not take extra days, you can file a “fast complaint” about our decision to take extra days. (For more information about the process for making complaints, including fast complaints, see Section 9 of this chapter.) We will call you as soon as we make the decision.

- **To get a fast coverage decision, you must meet two requirements:**
  - You can get a fast coverage decision only if you are asking for coverage for medical care you have not yet received. (You cannot get a fast coverage decision if your request is about payment for medical care you have already received.)
  - You can get a fast coverage decision only if using the standard deadlines could cause serious harm to your health or hurt your ability to function.

- **If your doctor tells us that your health requires a “fast coverage decision,” we will automatically agree to give you a fast coverage decision.**

- If you ask for a fast coverage decision on your own, without your doctor’s support, we will decide whether your health requires that we give you a fast coverage decision.
  - If we decide that your medical condition does not meet the requirements for a fast coverage decision, we will send you a letter that says so (and we will use the standard deadlines instead).
  - This letter will tell you that if your doctor asks for the fast coverage decision, we will automatically give a fast coverage decision.
  - The letter will also tell how you can file a “fast complaint” about our decision to give you a standard coverage decision instead of the fast coverage decision you requested. (For more information about the process for making complaints, including fast complaints, see Section 9 of this chapter.)
Step 2: We consider your request for medical care coverage and give you our answer.

Deadlines for a “fast” coverage decision

- Generally, for a fast coverage decision, we will give you our answer within 72 hours.
  - As explained above, we can take up to 14 more calendar days under certain circumstances. If we decide to take extra days to make the coverage decision, we will tell you in writing.
  - If you believe we should not take extra days, you can file a “fast complaint” about our decision to take extra days. When you file a fast complaint, we will give you an answer to your complaint within 24 hours. (For more information about the process for making complaints, including fast complaints, see Section 9 of this chapter.)
  - If we do not give you our answer within 72 hours (or if there is an extended time period, by the end of that period), you have the right to appeal. Section 5.3 below tells how to make an appeal.

- If our answer is yes to part or all of what you requested, we must authorize or provide the medical care coverage we have agreed to provide within 72 hours after we received your request. If we extended the time needed to make our coverage decision, we will provide the coverage by the end of that extended period.

- If our answer is no to part or all of what you requested, we will send you a detailed written explanation as to why we said no.

Deadlines for a “standard” coverage decision

- Generally, for a standard coverage decision, we will give you our answer within 14 days of receiving your request.
  - We can take up to 14 more calendar days (“an extended time period”) under certain circumstances. If we decide to take extra days to make the coverage decision, we will tell you in writing.
  - If you believe we should not take extra days, you can file a “fast complaint” about our decision to take extra days. When you file a fast complaint, we will give you an answer to your complaint within 24 hours. (For more information about the process for making complaints, including fast complaints, see Section 9 of this chapter.)
  - If we do not give you our answer within 14 days (or if there is an extended time period, by the end of that period), you have the right to appeal. Section 5.3 below tells how to make an appeal.

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

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

**Step 3:** If we say no to your request for coverage for medical care, you decide if you want to make an appeal.

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

### Section 5.3

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

(how to ask for a review of a medical care coverage decision made by our plan)

<table>
<thead>
<tr>
<th>Legal Terms</th>
<th>An appeal to the plan about a medical care coverage decision is called a plan “reconsideration.”</th>
</tr>
</thead>
</table>

**Step 1:** You contact us and make your appeal. If your health requires a quick response, you must ask for a “fast appeal.”

**What to do**

- **To start your appeal, you, your doctor, or your representative, must contact us.** For details on how to reach us for any purpose related to your appeal, go to Chapter 2, Section 1 look for section called, *How to contact us when you are making an appeal about your medical care.*

- **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 (phone numbers are printed on the back cover of this booklet) and ask for the “Appointment of Representative” form. It is also available on Medicare’s website at http://www.cms.hhs.gov/cmsforms/downloads/cms1696.pdf.) While we can accept an appeal request without the form, we cannot complete our review until we receive it. If we do not receive the form within 44 days after receiving your appeal request (our deadline for making a decision on your appeal), your appeal request will be sent to the Independent Review Organization for dismissal.
• If you are asking for a fast appeal, make your appeal in writing or call us at the phone number shown in Chapter 2, Section 1 (How to contact us when you are making an appeal about your medical care).

• You must make your appeal request within 60 calendar days from the date on the written notice we sent to tell you our answer to your request for a coverage decision. If you miss this deadline and have a good reason for missing it, we may give you more time to make your appeal. Examples of good cause for missing the deadline may include if you had a serious illness that prevented you from contacting us or if we provided you with incorrect or incomplete information about the deadline for requesting an appeal.

• You can ask for a copy of the information regarding your medical decision and add more information to support your appeal.
  o You have the right to ask us for a copy of the information regarding your appeal.
  o If you wish, you and your doctor may give us additional information to support your appeal.

If your health requires it, ask for a “fast appeal” (you can make a request by calling us)

| Legal Terms | A “fast appeal” is also called an “expedited reconsideration.” |

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

• The requirements and procedures for getting a “fast appeal” are the same as those for getting a “fast coverage decision.” To ask for a fast appeal, follow the instructions for asking for a fast coverage decision. (These instructions are given earlier in this section.)

• If your doctor tells us that your health requires a “fast appeal,” we will give you a fast appeal.

Step 2: We consider your appeal and we give you our answer.

• When our plan is reviewing your appeal, we take another careful look at all of the information about your request for coverage of medical care. We check to see if we were following all the rules when we said no to your request.

• We will gather more information if we need it. We may contact you or your doctor to get more information.
Deadlines for a “fast” appeal

- When we are using the fast deadlines, we must give you our answer within 72 hours after we receive your appeal. We will give you our answer sooner if your health requires us to do so.
  - However, if you ask for more time, or if we need to gather more information that may benefit you, we can take up to 14 more calendar days. If we decide to take extra days to make the decision, we will tell you in writing.
  - If we do not give you an answer within 72 hours (or by the end of the extended time period if we took extra days), we are required to automatically send your request on to Level 2 of the appeals process, where it will be reviewed by an independent organization. Later in this section, we tell you about this organization and explain what happens at Level 2 of the appeals process.

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

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

Deadlines for a “standard” appeal

- If we are using the standard deadlines, we must give you our answer within 30 calendar days after we receive your appeal if your appeal is about coverage for services you have not yet received. We will give you our decision sooner if your health condition requires us to.
  - However, if you ask for more time, or if we need to gather more information that may benefit you, we can take up to 14 more calendar days.
  - If you believe we should not take extra days, you can file a “fast complaint” about our decision to take extra days. When you file a fast complaint, we will give you an answer to your complaint within 24 hours. (For more information about the process for making complaints, including fast complaints, see Section 9 of this chapter.)
  - If we do not give you an answer by the deadline above (or by the end of the extended time period if we took extra days), we are required to send your request on to Level 2 of the appeals process, where it will be reviewed by an independent outside organization. Later in this section, we tell about this review organization and explain what happens at Level 2 of the appeals process.

- If our answer is yes to part or all of what you requested, we must authorize or provide the coverage we have agreed to provide within 30 days after we receive your appeal.
If our answer is no to part or all of what you requested, we will send you a written denial notice informing you that we have automatically sent your appeal to the Independent Review Organization for a Level 2 Appeal.

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

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

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

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

<table>
<thead>
<tr>
<th>Legal Terms</th>
<th>The formal name for the “Independent Review Organization” is the “Independent Review Entity.” It is sometimes called the “IRE.”</th>
</tr>
</thead>
</table>

**Step 1:** The Independent Review Organization reviews your appeal.

- The Independent Review Organization is an independent organization that is hired by Medicare. This organization is not connected with us and it is not a government agency. This organization is a company chosen by Medicare to handle the job of being the Independent Review Organization. Medicare oversees its work.
- We will send the information about your appeal to this organization. This information is called your “case file.” You have the right to ask us for a copy of your case file.
- You have a right to give the Independent Review Organization additional information to support your appeal.
- Reviewers at the Independent Review Organization will take a careful look at all of the information related to your appeal.

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

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

- If you had a standard appeal to our plan at Level 1, you will automatically receive a standard appeal at Level 2. The review organization must give you an answer to your Level 2 Appeal within 30 calendar days of when it receives your appeal.

- However, if the Independent Review Organization needs to gather more information that may benefit you, it can take up to 14 more calendar days.

**Step 2: The Independent Review Organization gives you their answer.**

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

- **If the review organization says yes to part or all of what you requested,** we must authorize the medical care coverage within 72 hours or provide the service within 14 calendar days after we receive the decision from the review organization.

- **If this organization says no to part or all of your appeal,** it means they agree with us that your request (or part of your request) for coverage for medical care should not be approved. (This is called “upholding the decision.” It is also called “turning down your appeal.”)
  - The written notice you get from the Independent Review Organization will tell you the dollar 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.**

- 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 8 in this chapter tells more about Levels 3, 4, and 5 of the appeals process.
Section 5.5 What if you are asking us to pay you for our share of a bill you have received for medical care?

If you want to ask us for payment for medical care, start by reading Chapter 5 of this booklet: Asking us to pay our share of a bill you have received for covered medical services. Chapter 5 describes the situations in which you may need to ask for reimbursement or to pay a bill you have received from a provider. It also tells how to send us the paperwork that asks us for payment.

Asking for reimbursement is asking for a coverage decision from us

If you send us the paperwork that asks for reimbursement, you are asking us to make a coverage decision (for more information about coverage decisions, see Section 4.1 of this chapter). To make this coverage decision, we will check to see if the medical care you paid for is a covered service (see Chapter 4: Medical Benefits Chart (what is covered and what you pay)). We will also check to see if you followed all the rules for using your coverage for medical care (these rules are given in Chapter 3 of this booklet: Using the plan’s coverage for your medical services).

We will say yes or no to your request

- If the medical care you paid for is covered and you followed all the rules, we will send you the payment for our share of the cost of your medical care within 60 calendar days after we receive your request. Or, if you haven’t paid for the services, we will send the payment directly to the provider. When we send the payment, it’s the same as saying yes to your request for a coverage decision.

- If the medical care is not covered, or you did not follow all the rules, we will not send payment. Instead, we will send you a letter that says we will not pay for the services and the reasons why in detail. (When we turn down your request for payment, it’s the same as saying no to your request for a coverage decision.)

What if you ask for payment and we say that we will not pay?

If you do not agree with our decision to turn you down, you can make an appeal. If you make an appeal, it means you are asking us to change the coverage decision we made when we turned down your request for payment.

To make this appeal, follow the process for appeals that we describe in part 5.3 of this section. Go to this part for step-by-step instructions. When you are following these instructions, please note:

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

SECTION 6 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 6.1 During your inpatient hospital stay, you will get a written notice from Medicare that tells about your rights

During your hospital stay, you will be given a written notice called An Important Message from Medicare about Your Rights. Everyone with Medicare gets a copy of this notice whenever they are admitted to a hospital. Someone at the hospital (for example, a caseworker or nurse) must give it to you within two days after you are admitted. If you do not get the notice, ask any hospital employee for it. If you need help, please call Customer Service (phone numbers are printed on the back cover of this booklet). You can also call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

1. **Read this notice carefully and ask questions if you don’t understand it.** It tells you about your rights as a hospital patient, including:

• Your right to receive Medicare-covered services during and after your hospital stay, as ordered by your doctor. This includes the right to know what these services are, who will pay for them, and where you can get them.
2013 Evidence of Coverage for Regence MedAdvantage Basic Chapter 7: What to do if you have a problem or complaint (coverage decisions, appeals, complaints) 117

- 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 6.2 below tells you how you can request an immediate review.) |

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

3. Keep your copy of the signed notice so you will have the information about making an appeal (or reporting a concern about quality of care) handy if you need it.
   - If you sign the notice more than 2 days before the day you leave the hospital, you will get another copy before you are scheduled to be discharged.
   - To look at a copy of this notice in advance, you can call Customer Service (phone numbers are printed on the back cover of this booklet) or 1-800 MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048. You can also see it online at http://www.cms.gov/BNI/12_HospitalDischargeAppealNotices.asp.

| Section 6.2 | Step-by-step: How to make a Level 1 Appeal to change your hospital discharge date |

If you want to ask for your inpatient hospital services to be covered by us for a longer time, you will need to use the appeals process to make this request. Before you start, understand what you need to do and what the deadlines are.

- Follow the process. Each step in the first two levels of the appeals process is explained below.
• **Meet the deadlines.** The deadlines are important. Be sure that you understand and follow the deadlines that apply to things you must do.

• **Ask for help if you need it.** If you have questions or need help at any time, please call Customer Service (phone numbers are printed on the back cover of this booklet). Or call your State Health Insurance Assistance Program, a government organization that provides personalized assistance (see Section 2 of this chapter).

**During a Level 1 Appeal, the Quality Improvement Organization reviews your appeal.** It checks to see if your planned discharge date is medically appropriate for you.

**Step 1: Contact the Quality Improvement Organization in your state and ask for a “fast review” of your hospital discharge. You must act quickly.**

| Legal Terms | A “fast review” is also called an “immediate review.” |

What is the Quality Improvement Organization?

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

How can you contact this organization?

• The written notice you received (*An Important Message from Medicare About Your Rights*) tells you how to reach this organization. (Or find the name, address, and phone number of the Quality Improvement Organization for your state in Chapter 2, Section 4, of this booklet.)

Act quickly:

• To make your appeal, you must contact the Quality Improvement Organization before you leave the hospital and no later than your planned discharge date. (Your “planned discharge date” is the date that has been set for you to leave the hospital.)
  
  o 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.
  
  o 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 6.4.
Ask for a “fast review”:

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

Legal Terms

A “fast review” is also called an “immediate review” or an “expedited review.”

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

What happens during this review?

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

- The reviewers will also look at your medical information, talk with your doctor, and review information that the hospital and we have given to them.

- By noon of the day after the reviewers informed our plan of your appeal, you will also get a written notice that gives your planned discharge date and explains in detail the reasons why your doctor, the hospital, and we think it is right (medically appropriate) for you to be discharged on that date.

Legal Terms

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

Step 3: Within one full day after it has all the needed information, the Quality Improvement Organization will give you its answer to your appeal.

What happens if the answer is yes?

- If the review organization says yes to your appeal, we must keep providing your covered inpatient hospital services for as long as these services are medically necessary.

- You will have to keep paying your share of the costs (such as deductibles or copayments, if these apply). In addition, there may be limitations on your covered hospital services. (See Chapter 4 of this booklet).
2013 Evidence of Coverage for Regence MedAdvantage Basic Chapter 7: What to do if you have a problem or complaint (coverage decisions, appeals, complaints)

What happens if the answer is no?

- If the review organization says no to your appeal, they are saying that your planned discharge date is medically appropriate. If this happens, our coverage for your inpatient hospital services will end at noon on the day after the Quality Improvement Organization gives you its answer to your appeal.

- If the review organization says no to your appeal and you decide to stay in the hospital, then you may have to pay the full cost of hospital care you receive after noon on the day after the Quality Improvement Organization gives you its answer to your appeal.

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

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

Section 6.3 Step-by-step: How to make a Level 2 Appeal to change your hospital discharge date

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

Here are the steps for Level 2 of the appeal process:

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

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

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

- Reviewers at the Quality Improvement Organization will take another careful look at all of the information related to your appeal.
Step 3: Within 14 calendar days, the Quality Improvement Organization reviewers will decide on your appeal and tell you their decision.

If the review organization says yes:

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

If the review organization says no:

- It means they agree with the decision they made on your Level 1 Appeal and will not change it.
- The notice you get will tell you in writing what you can do if you wish to continue with the review process. It will give you the details about how to go on to the next level of appeal, which is handled by a judge.

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

- There are three additional levels in the appeals process after Level 2 (for a total of five levels of appeal). If the review organization turns down your Level 2 Appeal, you can choose whether to accept that decision or whether to go on to Level 3 and make another appeal. At Level 3, your appeal is reviewed by a judge.
- Section 8 in this chapter tells more about Levels 3, 4, and 5 of the appeals process.

| Section 6.4 | What if you miss the deadline for making your Level 1 Appeal? |

You can appeal to us instead

As explained above in Section 6.2, you must act quickly to contact the Quality Improvement Organization to start your first appeal of your hospital discharge. (“Quickly” means before you leave the hospital and no later than your planned discharge date). If you miss the deadline for contacting this organization, there is another way to make your appeal.

If you use this other way of making your appeal, **the first two levels of appeal are different**.
Step-by-Step: How to make a Level 1 Alternate Appeal

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

**Legal Terms**

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

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

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

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

### Step 2: We do a “fast” review of your planned discharge date, checking to see if it was medically appropriate.

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

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

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

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

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

  - If you stayed in the hospital *after* your planned discharge date, then **you may have to pay the full cost** of hospital care you received after the planned discharge date.
**Step 4:** If we say *no* to your fast appeal, your case will *automatically* be sent on to the next level of the appeals process.

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

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

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

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

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

- We are required to send the information for your Level 2 Appeal to the Independent Review Organization within 24 hours of when we tell you that we are saying no to your first appeal. (If you think we are not meeting this deadline or other deadlines, you can make a complaint. The complaint process is different from the appeal process. Section 9 of this chapter tells how to make a complaint.)

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

- The Independent Review Organization is an independent organization *that is hired by Medicare.* This organization is not connected with our plan and it is not a government agency. This organization is a company chosen by Medicare to handle the job of being the Independent Review Organization. Medicare oversees its work.

- Reviewers at the Independent Review Organization will take a careful look at all of the information related to your appeal of your hospital discharge.

- *If this organization says yes to your appeal,* then we must reimburse you (pay you back) for our share of the costs of hospital care you have received since the date of your planned discharge. We must also continue the plan’s coverage of your inpatient hospital services for as long as it is medically necessary. You must continue to pay your share of the costs.
If there are coverage limitations, these could limit how much we would reimburse or how long we would continue to cover your services.

- **If this organization says *no to your appeal*,** it means they agree with us that your planned hospital discharge date was medically appropriate.
  
  o The notice you get from the Independent Review Organization will tell you in writing what you can do if you wish to continue with the review process. It will give you the details about how to go on to a Level 3 Appeal, which is handled by a judge.

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

- There are three additional levels in the appeals process after Level 2 (for a total of five levels of appeal). If reviewers say no to your Level 2 Appeal, you decide whether to accept their decision or go on to Level 3 and make a third appeal.

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

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

#### Section 7.1

*This section is about three services only:*

- Home health care, skilled nursing facility care, and Comprehensive Outpatient Rehabilitation Facility (CORF) services

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

- **Home health care services** you are getting.

- **Skilled nursing care** you are getting as a patient in a skilled nursing facility. (To learn about requirements for being considered a “skilled nursing facility,” see Chapter 10, *Definitions of important words.*)

- **Rehabilitation care** you are getting as an outpatient at a Medicare-approved Comprehensive Outpatient Rehabilitation Facility (CORF). Usually, this means you are getting treatment for an illness or accident, or you are recovering from a major operation. (For more information about this type of facility, see Chapter 10, *Definitions of important words.*)

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

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

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

### Section 7.2 We will tell you in advance when your coverage will be ending

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

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

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

2. **You must sign the written notice to show that you received it.**
   - You or someone who is acting on your behalf must sign the notice. (Section 4 tells how you can give written permission to someone else to act as your representative.)
   - Signing the notice shows only that you have received the information about when your coverage will stop. Signing it does not mean you agree with the plan that it’s time to stop getting the care.
If you want to ask us to cover your care for a longer period of time, you will need to use the appeals process to make this request. Before you start, understand what you need to do and what the deadlines are.

- **Follow the process.** Each step in the first two levels of the appeals process is explained below.

- **Meet the deadlines.** The deadlines are important. Be sure that you understand and follow the deadlines that apply to things you must do. There are also deadlines our plan must follow. (If you think we are not meeting our deadlines, you can file a complaint. Section 9 of this chapter tells you how to file a complaint.)

- **Ask for help if you need it.** If you have questions or need help at any time, please call Customer Service (phone numbers are printed on the back cover of this booklet). Or call your State Health Insurance Assistance Program, a government organization that provides personalized assistance (see Section 2 of this chapter).

During a Level 1 Appeal, the Quality Improvement Organization reviews your appeal and decides whether to change the decision made by our plan.

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

*What is the Quality Improvement Organization?*

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

*How can you contact this organization?*

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

*What should you ask for?*

- Ask this organization to do an independent review of whether it is medically appropriate for us to end coverage for your medical services.
Your deadline for contacting this organization.

- You must contact the Quality Improvement Organization to start your appeal no later than noon of the day after you receive the written notice telling you when we will stop covering your care.
- If you miss the deadline for contacting the Quality Improvement Organization about your appeal, you can make your appeal directly to us instead. For details about this other way to make your appeal, see Section 7.5.

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

What happens during this review?

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

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

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

What happens if the reviewers say yes to your appeal?

- If the reviewers say yes to your appeal, then we must keep providing your covered services for as long as it is medically necessary.
- You will have to keep paying your share of the costs (such as deductibles or copayments, if these apply). In addition, there may be limitations on your covered services (see Chapter 4 of this booklet).

What happens if the reviewers say no to your appeal?

- If the reviewers say no to your appeal, then your coverage will end on the date we have told you. We will stop paying its share of the costs of this care.
- If you decide to keep getting the home health care, or skilled nursing facility care, or Comprehensive Outpatient Rehabilitation Facility (CORF) services after this date when your coverage ends, then you will have to pay the full cost of this care yourself.
Step 4: If the answer to your Level 1 Appeal is no, you decide if you want to make another appeal.

- This first appeal you make is “Level 1” of the appeals process. If reviewers say no to your Level 1 Appeal – and you choose to continue getting care after your coverage for the care has ended – then you can make another appeal.
- Making another appeal means you are going on to “Level 2” of the appeals process.

| Section 7.4 Step-by-step: How to make a Level 2 Appeal to have our plan cover your care for a longer time |

If the Quality Improvement Organization has turned down your appeal and you choose to continue getting care after your coverage for the care has ended, then you can make a Level 2 Appeal. During a Level 2 Appeal, you ask the Quality Improvement Organization to take another look at the decision they made on your first appeal. If we turn down your Level 2 Appeal, you may have to pay the full cost for your home health care, or skilled nursing facility care, or Comprehensive Outpatient Rehabilitation Facility (CORF) services after the date when we said your coverage would end.

Here are the steps for Level 2 of the appeal process:

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

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

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

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

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

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

- We must reimburse you for our share of the costs of care you have received since the date when we said your coverage would end. We must continue providing coverage for the care for as long as it is medically necessary.
- You must continue to pay your share of the costs and there may be coverage limitations that apply.
What happens if the review organization says no?

- It means they agree with the decision we made to your Level 1 Appeal and will not change it.
- The notice you get will tell you in writing what you can do if you wish to continue with the review process. It will give you the details about how to go on to the next level of appeal, which is handled by a judge.

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

- There are three additional levels of appeal after Level 2, for a total of five levels of appeal. If reviewers turn down your Level 2 Appeal, you can choose whether to accept that decision or to go on to Level 3 and make another appeal. At Level 3, your appeal is reviewed by a judge.
- Section 8 in this chapter tells more about Levels 3, 4, and 5 of the appeals process.

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

You can appeal to us instead

As explained above in Section 7.3, you must act quickly to contact the Quality Improvement Organization to start your first appeal (within a day or two, at the most). If you miss the deadline for contacting this organization, there is another way to make your appeal. If you use this other way of making your appeal, the first two levels of appeal are different.

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

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

Here are the steps for a Level 1 Alternate Appeal:

Legal Terms

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

Step 1: Contact our plan and ask for a “fast review.”

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

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

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

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

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

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

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

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

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

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

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

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

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

- We are required to send the information for your Level 2 Appeal to the Independent Review Organization within 24 hours of when we tell you that we are saying no to your first appeal. (If you think we are not meeting this deadline or other deadlines, you can make a complaint. The complaint process is different from the appeal process. Section 9 of this chapter tells how to make a complaint.)

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

- The Independent Review Organization is an independent organization that is hired by Medicare. This organization is not connected with our plan and it is not a government agency. This organization is a company chosen by Medicare to handle the job of being the Independent Review Organization. Medicare oversees its work.

- Reviewers at the Independent Review Organization will take a careful look at all of the information related to your appeal.

- If this organization says yes to your appeal, then we must reimburse you (pay you back) for our share of the costs of care you have received since the date when we said your coverage would end. We must also continue to cover the care for as long as it is medically necessary. You must continue to pay your share of the costs. If there are coverage limitations, these could limit how much we would reimburse or how long we would continue to cover your services.

- If this organization says no to your appeal, it means they agree with the decision our plan made to your first appeal and will not change it.
  - The notice you get from the Independent Review Organization will tell you in writing what you can do if you wish to continue with the review process. It will give you the details about how to go on to a Level 3 Appeal.
Step 3: If the Independent Review Organization turns down your appeal, you choose whether you want to take your appeal further.

- There are three additional levels of appeal after Level 2, for a total of five levels of appeal. If reviewers say no to your Level 2 Appeal, you can choose whether to accept that decision or whether to go on to Level 3 and make another appeal. At Level 3, your appeal is reviewed by a judge.
- Section 8 in this chapter tells more about Levels 3, 4, and 5 of the appeals process.

SECTION 8 Taking your appeal to Level 3 and beyond

Section 8.1 Levels of Appeal 3, 4, and 5 for Medical Service Appeals

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

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

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

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

- If the Administrative Law Judge says yes to your appeal, the appeals process may or may not be over - We will decide whether to appeal this decision to Level 4. Unlike a decision at Level 2 (Independent Review Organization), we have the right to appeal a Level 3 decision that is favorable to you.
  - If we decide not to appeal the decision, we must authorize or provide you with the service within 60 days after receiving the judge’s decision.
  - If we decide to appeal the decision, we will send you a copy of the Level 4 Appeal request with any accompanying documents. We may wait for the Level 4 Appeal decision before authorizing or providing the service in dispute.
- If the Administrative Law Judge says no to your appeal, the appeals process may or may not be over.
2013 Evidence of Coverage for Regence MedAdvantage Basic Chapter 7: What to do if you have a problem or complaint (coverage decisions, appeals, complaints)

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

**Level 4 Appeal**

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

- If the answer is yes, or if the Medicare Appeals Council denies our request to review a favorable Level 3 Appeal decision, the appeals process *may or may not be over* - We will decide whether to appeal this decision to Level 5. Unlike a decision at Level 2 (Independent Review Organization), we have the right to appeal a Level 4 decision that is favorable to you.
  - If we decide *not* to appeal the decision, we must authorize or provide you with the service within 60 days after receiving the Medicare Appeals Council’s decision.
  - If we decide to appeal the decision, we will let you know in writing.

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

**Level 5 Appeal**

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

- This is the last step of the administrative appeals process.
MAKING COMPLAINTS

SECTION 9 How to make a complaint about quality of care, waiting times, customer service, or other concerns

<table>
<thead>
<tr>
<th>Section 9.1</th>
<th>What kinds of problems are handled by the complaint process?</th>
</tr>
</thead>
</table>

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.

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 or other health professionals? Or by our Customer Service or other staff at the plan?
    o Examples include waiting too long on the phone, in the waiting room, 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
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 4-8 of this chapter. If you are asking for a decision or making an appeal, you use that process, not the complaint process.

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

- If you have asked us to give you a “fast coverage decision” or a “fast appeal,” and we have said we will not, you can make a complaint.

- If you believe we are not meeting the deadlines for giving you a coverage decision or an answer to an appeal you have made, you can make a complaint.

- When a coverage decision we made is reviewed and we are told that we must cover or reimburse you for certain medical services, 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.

<table>
<thead>
<tr>
<th>Legal Terms</th>
<th>The formal name for “making a complaint” is “filing a grievance”</th>
</tr>
</thead>
<tbody>
<tr>
<td>What this section calls a “complaint” is also called a “grievance.”</td>
<td>Legal Terms</td>
</tr>
<tr>
<td>Another term for “making a complaint” is “filing a grievance.”</td>
<td></td>
</tr>
<tr>
<td>Another way to say “using the process for complaints” is “using the process for filing a grievance.”</td>
<td></td>
</tr>
</tbody>
</table>
Section 9.3  Step-by-step: Making a complaint

**Step 1: Contact us promptly – either by phone or in writing.**

- **Usually, calling Customer Service is the first step.** If there is anything else you need to do, Customer Service will let you know. Call Customer Service at 1 (800) 541-8981 from 8:00 a.m. to 8:00 p.m. Monday through Friday. From October 1 through February 14, our telephone hours are 8:00 a.m. to 8:00 p.m., seven days a week. (TTY/TDD Users should call 711.)

- **If you do not wish to call (or you called and were not satisfied), you can put your complaint in writing and send it to us.** If you put your complaint in writing, we will respond to your complaint in writing.

- **If we cannot resolve your complaint over the phone, we have a formal procedure to review your complaints.** To use this grievance procedure, send your grievance in writing to the address in Chapter 2. We will write to you to confirm that we have received your written grievance. If you request a fast (expedited) grievance, we will write to you within 24 hours.

- **Whether you call or write, you should contact Customer Service right away.** The complaint must be made within 60 calendar days after you had the problem you want to complain about.

- **If you are making a complaint because we denied your request for a “fast coverage decision” or a “fast appeal,” we will automatically give you a “fast” complaint.** If you have a “fast” complaint, it means we will give you an answer within 24 hours.

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

**Step 2: We look into your complaint and give you our answer.**

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

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

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

### Section 9.4 You can also make complaints about quality of care to the Quality Improvement Organization

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

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

- **You can make your complaint to the Quality Improvement Organization.**
  If you prefer, you can make your complaint about the quality of care you received directly to this organization (*without* making the complaint to us).
  - The Quality Improvement Organization is a group of practicing doctors and other health care experts paid by the Federal government to check and improve the care given to Medicare patients.
  - To find the name, address, and phone number of the Quality Improvement Organization for your state, look in Chapter 2, Section 4, of this booklet. If you make a complaint to this organization, we will work with them to resolve your complaint.

- **Or you can make your complaint to both at the same time.** If you wish, you can make your complaint about quality of care to us and also to the Quality Improvement Organization.

### Section 9.5 You can also tell Medicare about your complaint

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

If you have any other feedback or concerns, or if you feel the plan is not addressing your issue, please call 1-800-MEDICARE (1-800-633-4227). TTY/TDD users can call 1-877-486-2048.
Chapter 8. Ending your membership in the plan

SECTION 1  Introduction ........................................................................................................... 140
Section 1.1  This chapter focuses on ending your membership in our plan .......... 140

SECTION 2  When can you end your membership in our plan? ......................... 140
Section 2.1  You can end your membership during the Annual Enrollment
Period .................................................................................................................................. 140
Section 2.2  You can end your membership during the annual Medicare
Advantage Disenrollment Period, but your choices are more
limited .................................................................................................................................. 141
Section 2.3  In certain situations, you can end your membership during a
Special Enrollment Period ............................................................................................... 141
Section 2.4  Where can you get more information about when you can end
your membership? .................................................................................................................. 142

SECTION 3  How do you end your membership in our plan? ......................... 143
Section 3.1  Usually, you end your membership by enrolling in another plan ...... 143

SECTION 4  Until your membership ends, you must keep getting your
medical services through our plan .................................................................................... 144
Section 4.1  Until your membership ends, you are still a member of our plan ...... 144

SECTION 5  Regence MedAdvantage Basic must end your membership in
the plan in certain situations .............................................................................................. 144
Section 5.1  When must we end your membership in the plan? ......................... 144
Section 5.2  We cannot ask you to leave our plan for any reason related to
your health .................................................................................................................................. 145
Section 5.3  You have the right to make a complaint if we end your
membership in our plan ........................................................................................................ 146
SECTION 1  Introduction

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

Ending your membership in Regence MedAdvantage Basic may be voluntary (your own choice) or involuntary (not your own choice):

- You might leave our plan because you have decided that you want to leave.
  - There are only certain times during the year, or certain situations, when you may voluntarily end your membership in the plan. Section 2 tells you when you can end your membership in the plan.
  - The process for voluntarily ending your membership varies depending on what type of new coverage you are choosing. Section 3 tells you how to end your membership in each situation.

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

If you are leaving our plan, you must continue to get your medical care through our plan until your membership ends.

SECTION 2  When can you end your membership in our plan?

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

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

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

- When is the Annual Enrollment Period? This happens from October 15 to December 7.

- 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.
- Original Medicare without a separate Medicare prescription drug plan.

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

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

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

- **When is the annual Medicare Advantage Disenrollment Period?** This happens every year from January 1 to February 14.
- **What type of plan can you switch to during the annual Medicare Advantage Disenrollment Period?** During this time, you can cancel your Medicare Advantage Plan enrollment and switch to Original Medicare. If you choose to switch to Original Medicare during this period, you have until February 14 to join a separate Medicare prescription drug plan to add drug coverage.
- **When will your membership end?** Your membership will end on the first day of the month after we get your request to switch to Original Medicare. If you also choose to enroll in a Medicare prescription drug plan, your membership in the drug plan will begin the first day of the month after the drug plan gets your enrollment request.

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

In certain situations, members of Regence MedAdvantage Basic 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 (http://www.medicare.gov):

- Usually, when you have moved.
- If you have Medicaid.
- If we violate our contract with you.
- If you are getting care in an institution, such as a nursing home or long-term care hospital.

- **When are Special Enrollment Periods?** The enrollment periods vary depending on your situation.

- **What can you do?** To find out if you are eligible for a Special Enrollment Period, please call Medicare at 1-800-MEDICARE (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.
  - Original Medicare without a separate Medicare prescription drug plan.

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

### Section 2.4 Where can you get more information about when you can end your membership?

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

- You can call Customer Service (phone numbers are printed on the back cover of this booklet).
- You can find the information in the *Medicare & You 2013* 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

Usually, to end your membership in our plan, you simply enroll in another Medicare plan during one of the enrollment periods (see Section 2 for information about the enrollment periods). However, if you want to switch from our plan to Original Medicare without a Medicare prescription drug plan, you must ask to be disenrolled from our plan. There are two ways you can ask to be disenrolled:

- You can make a request in writing to us. Contact Customer Service if you need more information on how to do this (phone numbers are printed on the back cover of this booklet).
- --or--You can contact Medicare at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

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

<table>
<thead>
<tr>
<th>If you would like to switch from our plan to:</th>
<th>This is what you should do:</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Another Medicare health plan.</td>
<td>- Enroll in the new Medicare health plan.</td>
</tr>
<tr>
<td></td>
<td>You will automatically be disenrolled from Regence MedAdvantage Basic when your new plan’s coverage begins.</td>
</tr>
<tr>
<td>- Original Medicare with a separate Medicare prescription drug plan.</td>
<td>- Enroll in the new Medicare prescription drug plan.</td>
</tr>
<tr>
<td></td>
<td>You will automatically be disenrolled from Regence MedAdvantage Basic when your new plan’s coverage begins.</td>
</tr>
<tr>
<td>- Original Medicare without a separate Medicare prescription drug plan.</td>
<td>- Send us a written request to disenroll. Contact Customer Service if you need more information on how to do this (phone numbers are printed on the back cover of this booklet).</td>
</tr>
<tr>
<td></td>
<td>- You can also contact Medicare, at 1-</td>
</tr>
</tbody>
</table>
If you would like to switch from our plan to:

<table>
<thead>
<tr>
<th>This is what you should do:</th>
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<tbody>
<tr>
<td>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.</td>
</tr>
<tr>
<td>• You will be disenrolled from Regence MedAdvantage Basic when your coverage in Original Medicare begins.</td>
</tr>
</tbody>
</table>

SECTION 4  Until your membership ends, you must keep getting your medical services through our plan

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

If you leave Regence MedAdvantage Basic, it may take time before your membership ends and your new Medicare coverage goes into effect. (See Section 2 for information on when your new coverage begins.) During this time, you must continue to get your medical care through our plan.

• If you are hospitalized on the day that your membership ends, your hospital stay will usually be covered by our plan until you are discharged (even if you are discharged after your new health coverage begins).

SECTION 5  Regence MedAdvantage Basic must end your membership in the plan in certain situations

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

Regence MedAdvantage Basic must end your membership in the plan if any of the following happen:

• If you do not stay continuously enrolled in Medicare Part A and Part B.
• If you move out of our service area.
• If you are away from our service area for more than twelve months.
If you move or take a long trip, you need to call Customer Service to find out if the place you are moving or traveling to is in our plan’s area. (Phone numbers for Customer Service are printed on the back cover of this booklet.)

Go to Chapter 4, Section 2.2 for information on getting care when you are away from the service area through our plan’s visitor/traveler benefit.

- If you become incarcerated (go to prison).
- If you intentionally give us incorrect information when you are enrolling in our plan and that information affects your eligibility for our plan. (We cannot make you leave our plan for this reason unless we get permission from Medicare first.)
- If you continuously behave in a way that is disruptive and makes it difficult for us to provide medical care for you and other members of our plan. (We cannot make you leave our plan for this reason unless we get permission from Medicare first.)
- If you let someone else use your membership card to get medical care. (We cannot make you leave our plan for this reason unless we get permission from Medicare first.)
  - If we end your membership because of this reason, Medicare may have your case investigated by the Inspector General.
- If you do not pay the plan premiums for two calendar months.
  - We must notify you in writing that you have two calendar months to pay the plan premium before we end your membership.

Where can you get more information?

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

- You can call Customer Service for more information (phone numbers are printed on the back cover of this booklet).

Where can you get more information?

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

- You can call Customer Service for more information (phone numbers are printed on the back cover of this booklet).

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

What should you do if this happens?

If you feel that you are being asked to leave our plan because of a health-related reason, you should call Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048. You may call 24 hours a day, 7 days a week.
If we end your membership in our plan, we must tell you our reasons in writing for ending your membership. We must also explain how you can make a complaint about our decision to end your membership. You can also look in Chapter 7, Section 9 for information about how to make a complaint.
Chapter 9. Legal notices

SECTION 1  Notice about governing law................................................................. 148
SECTION 2  Notice about nondiscrimination......................................................... 148
SECTION 3  Notice about Medicare Secondary Payer subrogation rights .......... 148
SECTION 4  Events Beyond Our Control ................................................................. 148
SECTION 5  Liability of Member in the Event of Nonpayment ......................... 149
SECTION 6  Third Party Liability............................................................................ 149
SECTION 7  Relationship to the Blue Cross and Blue Shield Association........ 150
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  Notice about Medicare Secondary Payer subrogation rights

We have the right and responsibility to collect for covered Medicare services for which Medicare is not the primary payer. According to CMS regulations at 42 CFR sections 422.108 and 423.462, Regence MedAdvantage Basic, as a Medicare Advantage Organization, will exercise the same rights of recovery that the Secretary exercises under CMS regulations in subparts B through D of part 411 of 42 CFR and the rules established in this section supersede any State laws.

SECTION 4

Events Beyond Our Control

Regence BlueCross BlueShield of Utah is not liable if events beyond our control, such as, war, riot, complete or partial destruction of facilities, civil insurrection, public health emergency or natural disaster, cause delay or failure to furnish covered services to you. Regence BlueCross BlueShield of Utah will make a good faith effort to furnish health care or arrange for health care to be furnished in these situations.
SECTION 5
Liability of Member in the Event of Nonpayment

Unless otherwise required by law, you are responsible for any applicable coinsurance and copayments when covered services are provided by a plan provider.

You are responsible for any services for which there is a fee if the benefit is not included in the Schedule of Benefits. In the event Regence BlueCross BlueShield of Utah fails to pay a contracting or non-contracting provider for covered services, you are not liable to the provider for any sums owed by Regence BlueCross BlueShield of Utah.

However, if you enter into a private contract with a non-contracting medical provider, neither Regence BlueCross BlueShield of Utah nor Medicare will pay for those services.

SECTION 6
Third Party Liability

If you are injured through the actions of a third party and are entitled to recovery from the third party or as a result of your injury for medical expenses, you are obligated to reimburse Regence BlueCross BlueShield of Utah for the reasonable value of the medical services received as a result of your injury.

If automobile medical, no-fault or liability insurance is available to you, then benefits under that plan must be used before there is coverage by Regence BlueCross BlueShield of Utah. Regence BlueCross BlueShield of Utah will pay only after the other coverage has been exhausted.

Payment of funds may be made directly between insurance and other providers of benefits. If benefits are provided in the form of service rather than cash payments, the reasonable cash value of each service rendered should be deemed both an allowable expense and a benefit paid.

In the case of injuries caused by an act or omission of a third party, and complications incident to that act, Regence BlueCross BlueShield of Utah will arrange for the provision of covered services and other benefits. You must notify Regence BlueCross BlueShield of Utah when there is a possibility that a third party may be liable for the injuries. Regence BlueCross BlueShield of Utah will have a first-party lien against any such accident-related settlement, even if the settlement does not specifically include payment for medical costs. Upon settlement, Regence BlueCross BlueShield of Utah will be reimbursed at the prevailing rates for the cost of services and benefits provided as a result of the injury. In the event the third party does not satisfy Regence BlueCross BlueShield of Utah’s lien by direct payment, you agree to reimburse Regence
BlueCross BlueShield of Utah any amounts it has paid in connection with treatment of the injury or any complications, but not to exceed the amount of the recovery.

If you incur health care expenses for treatment of the illness or injury after receiving a recovery, we will exclude benefits for otherwise covered expenses until the total amount of health care expenses incurred after the recovery exceeds the net recovery amount. You must agree to cooperate in protecting the interests of Regence BlueCross BlueShield of Utah under this provision and to execute and deliver to Regence BlueCross BlueShield of Utah, or its nominee, any and all assignments or other documents that may be necessary or proper to fully and completely carry out and protect the rights of Regence BlueCross BlueShield of Utah or its nominee.

SECTION 7
Relationship to the Blue Cross and Blue Shield Association

You hereby expressly acknowledge your understanding that this Evidence of Coverage is a contract solely between you and Regence BlueCross BlueShield of Utah. Regence BlueCross BlueShield of Utah is an independent corporation operating under a license from the Blue Cross and BlueShield Association (the “Association”), an association of independent Blue Cross and Blue Shield Plans, permitting Regence BlueCross BlueShield of Utah to use the Blue Cross and Blue Shield Service Marks in Utah. Regence BlueCross BlueShield of Utah is not contracting as an agent of the Association.

You further acknowledge and agree that you have not entered into this Plan based upon representations by any person other than Regence BlueCross BlueShield of Utah and that no person, entity, or organization other than Regence BlueCross BlueShield of Utah shall be held accountable or liable to you for any of Regence BlueCross BlueShield of Utah’s obligations to you created under this Evidence of Coverage. This paragraph shall not create any additional obligations whatsoever on the part of Regence BlueCross BlueShield of Utah other than those obligations created under other provisions of this Evidence of Coverage.
Chapter 10. Definitions of important words

**Ambulatory Surgical Center** – An Ambulatory Surgical Center is an entity that operates exclusively for the purpose of furnishing outpatient surgical services to patients not requiring hospitalization and whose expected stay in the center does not exceed 24 hours.

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

**Appeal** – An appeal is something you do if you disagree with our decision to deny a request for coverage of health care services or prescription drugs or payment for services or drugs you already received. You may also make an appeal if you disagree with our decision to stop services that you are receiving. For example, you may ask for an appeal if we don’t pay for a drug, item, or service you think you should be able to receive. Chapter 7 explains appeals, including the process involved in making an appeal.

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

**Benefit Period** – The way that both our plan and Original Medicare measures your use of hospital and skilled nursing facility (SNF) services. A benefit period begins the day you go into a hospital or skilled nursing facility. The benefit period ends when you haven’t received any inpatient hospital care (or skilled care in a SNF) for 60 days in a row. If you go into a hospital or a skilled nursing facility after one benefit period has ended, a new benefit period begins. There is no limit to the number of benefit periods.

**Centers for Medicare & Medicaid Services (CMS)** – The Federal agency that administers Medicare. Chapter 2 explains how to contact CMS.

**Coinsurance** – An amount you may be required to pay as your share of the cost for services after you pay any deductibles. Coinsurance is usually a percentage (for example, 20%).

**Combined Maximum Out-of-Pocket Amount** – This is the most you will pay in a year for all Part A and Part B services from both network (preferred) providers and out-of-network (non-preferred) providers. See Chapter 4, Section 1.3 for information about your combined maximum out-of-pocket amount.
Comprehensive Outpatient Rehabilitation Facility (CORF) – A facility that mainly provides rehabilitation services after an illness or injury, and provides a variety of services including physical therapy, social or psychological services, respiratory therapy, occupational therapy and speech-language pathology services, and home environment evaluation services.

Copayment – An amount you may be required to pay as your share of the cost for a medical service or supply, like a doctor’s visit, hospital outpatient visit, or a prescription. 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.

Cost Sharing – Cost sharing refers to amounts that a member has to pay when services are received. (This is in addition to the plan’s monthly premium.) Cost sharing includes any combination of the following three types of payments: (1) any deductible amount a plan may impose before services are covered; (2) any fixed “copayment” amount that a plan requires when a specific service is received; or (3) any “coinsurance” amount, a percentage of the total amount paid for a service, that a plan requires when a specific service is received.

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

Creditable Prescription Drug Coverage – Prescription drug coverage (for example, from an employer or union) that is expected to pay, on average, at least as much as Medicare’s standard prescription drug coverage. People who have this kind of coverage when they become eligible for Medicare can generally keep that coverage without paying a penalty, if they decide to enroll in Medicare prescription drug coverage later.

Custodial Care – Custodial care is personal care provided in a nursing home, hospice, or other facility setting when you do not need skilled medical care or skilled nursing care. Custodial care is personal care that can be provided by people who don’t have professional skills or training, such as help with activities of daily living like bathing, dressing, eating, getting in or out of a bed or chair, moving around, and using the bathroom. It may also include the kind of health-related care that most people do themselves, like using eye drops. Medicare doesn’t pay for custodial care.

Customer Service – A department within our plan responsible for answering your questions about your membership, benefits, grievances, and appeals. See Chapter 2 for information about how to contact Customer Service.

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

Disenroll or Disenrollment – The process of ending your membership in our plan. Disenrollment may be voluntary (your own choice) or involuntary (not your own choice).
Durable Medical Equipment – Certain medical equipment that is ordered by your doctor for use at home. Examples are walkers, wheelchairs, or hospital beds.

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

Emergency Care – Covered services that are: 1) rendered by a provider qualified to furnish emergency services; and 2) needed to evaluate or stabilize an emergency medical condition.

Evidence of Coverage (EOC) and Disclosure Information – This document, along with your enrollment form and any other attachments, riders, or other optional coverage selected, which explains your coverage, what we must do, your rights, and what you have to do as a member of our plan.

Extra Help – A Medicare program to help people with limited income and resources pay Medicare prescription drug program costs, such as premiums, deductibles, and coinsurance.

Grievance – A type of complaint you make about us or one of our network providers, 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.

Hospital Inpatient Stay – A hospital stay when you have been formally admitted to the hospital for skilled medical services. Even if you stay in the hospital overnight, you might still be considered an “outpatient.”

Initial Enrollment Period – When you are first eligible for Medicare, the period of time when you can sign up for Medicare Part B. For example, if you’re eligible for Part B when you turn 65, your Initial Enrollment Period is the 7-month period that begins 3 months before the month you turn 65, includes the month you turn 65, and ends 3 months after the month you turn 65.

In-Network Maximum Out-of-Pocket Amount – The most you will pay for covered Part A and Part B services received from network (preferred) providers. After you have reached this limit, you will not have to pay anything when you get covered services from network providers for the rest of the contract year. However, until you reach your combined out-of-pocket amount, you must continue to pay your share of the costs when
you seek care from an out-of-network (non-preferred) provider. See Chapter 4, Section 1.3 for information about your in-network maximum out-of-pocket amount.

**Low Income Subsidy (LIS)** – See “Extra Help.”

**Medicaid (or Medical Assistance)** – A joint Federal and state program that helps with medical costs for some people with low incomes and limited resources. Medicaid programs vary from state to state, but most health care costs are covered if you qualify for both Medicare and Medicaid. See Chapter 2, Section 6 for information about how to contact Medicaid in your state.

**Medically Accepted Indication** – A use of a drug that is either approved by the Food and Drug Administration or supported by certain reference books.

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

**Medicare** – The Federal health insurance program for people 65 years of age or older, some people under age 65 with certain disabilities, and people with End-Stage Renal Disease (generally those with permanent kidney failure who need dialysis or a kidney transplant). People with Medicare can get their Medicare health coverage through Original Medicare, a Medicare Cost Plan, 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, 2013.

**Medicare Advantage (MA) Plan** – Sometimes called Medicare Part C. A plan offered by a private company that contracts with Medicare to provide you with all your Medicare Part A and Part B benefits. A Medicare Advantage Plan can be an HMO, PPO, a Private Fee-for-Service (PFFS) plan, or a Medicare Medical Savings Account (MSA) plan. When you are enrolled in a Medicare Advantage Plan, Medicare services are covered through the plan, and are not paid for under Original Medicare. In most cases, Medicare Advantage Plans also offer Medicare Part D (prescription drug coverage). These plans are called **Medicare Advantage Plans with Prescription Drug Coverage**. Everyone who has Medicare Part A and Part B is eligible to join any Medicare health plan that is offered in their area, except people with End-Stage Renal Disease (unless certain exceptions apply).

**Medicare Cost Plan** – A Medicare Cost Plan is a plan operated by a Health Maintenance Organization (HMO) or Competitive Medical Plan (CMP) in accordance with a cost-reimbursed contract under section 1876(h) of the Act.
Medicare-Covered Services – Services covered by Medicare Part A and Part B. All Medicare health plans, including our plan, must cover all of the services that are covered by Medicare Part A and B.

Medicare Health Plan – A Medicare health plan is offered by a private company that contracts with Medicare to provide Part A and Part B benefits to people with Medicare who enroll in the plan. This term includes all Medicare Advantage Plans, Medicare Cost Plans, Demonstration/Pilot Programs, and Programs of All-inclusive Care for the Elderly (PACE).

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

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

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

Network 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 makes a decision about whether items or services are covered or how much you have to pay for covered items or services. The Medicare Advantage organization’s network provider or facility has also made an organization determination when it provides you with an item or service, or refers you to an out-of-network provider for an item or service. Organization determinations are called “coverage decisions” in this booklet. Chapter 7 explains how to ask us for a coverage decision.

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

**Out-of-Network Provider or Out-of-Network Facility** – A provider or facility with which we have not arranged to coordinate or provide covered services to members of our plan. Out-of-network providers are providers that are not employed, owned, or operated by our plan or are not under contract to deliver covered services to you. Using out-of-network providers or facilities is explained in this booklet in Chapter 3.

**Out-of-Pocket Costs** – See the definition for “cost sharing” above. A member’s cost-sharing requirement to pay for a portion of services received is also referred to as the member’s “out-of-pocket” cost requirement.

**Part C** – see “Medicare Advantage (MA) Plan.”

**Part D** – The voluntary Medicare Prescription Drug Benefit Program. (For ease of reference, we will refer to the prescription drug benefit program as Part D.)

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

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

**Prior Authorization** – Approval in advance to get covered services. In the network portion of a PPO, some in-network medical services are covered only if your doctor or other network provider gets “prior authorization” from our plan. In a PPO, you do not need prior authorization to obtain out-of-network services. Covered services that need prior authorization are marked in the Benefits Chart in Chapter 4. Some drugs are covered only if your doctor or other network provider gets “prior authorization” from us. Covered drugs that need prior authorization are marked in the formulary.

**Quality Improvement Organization (QIO)** – A group of practicing doctors and other health care experts paid by the Federal government to check and improve the care given to Medicare patients. See Chapter 2, Section 4 for information about how to contact the QIO for your state.
Rehabilitation Services – These services include physical therapy, speech and language therapy, and occupational therapy.

Service Area – A geographic area where a health plan accepts members if it limits membership based on where people live. For plans that limit which doctors and hospitals you may use, it’s also generally the area where you can get routine (non-emergency) services. The plan may disenroll you if you move out of the plan’s service area.

Skilled Nursing Facility (SNF) Care – Skilled nursing care and rehabilitation services provided on a continuous, daily basis, in a skilled nursing facility. Examples of skilled nursing facility care include physical therapy or intravenous injections that can only be given by a registered nurse or doctor.

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

Special Needs Plan – A special type of Medicare Advantage Plan that provides more focused health care for specific groups of people, such as those who have both Medicare and Medicaid, who reside in a nursing home, or who have certain chronic medical conditions.

Supplemental Security Income (SSI) – A monthly benefit paid by Social Security to people with limited income and resources who are disabled, blind, or age 65 and older. SSI benefits are not the same as Social Security benefits.

Urgently Needed Care – Urgently needed care is care provided to treat a non-emergency, unforeseen medical illness, injury, or condition, that requires immediate medical care. Urgently needed care may be furnished by network providers or by out-of-network providers when network providers are temporarily unavailable or inaccessible.
Multi-language Interpreter Services

English: We have free interpreter services to answer any questions you may have about our health or drug plan. To get an interpreter, just call us at 1 (800) 541-8981. Someone who speaks English/Language can help you. This is a free service.

Spanish: Tenemos servicios de intérprete sin costo alguno para responder cualquier pregunta que pueda tener sobre nuestro plan de salud o medicamentos. Para hablar con un intérprete, por favor llame al 1 (800) 541-8981. Alguien que hable español le podrá ayudar. Este es un servicio gratuito.

Chinese Mandarin: 我们提供免费的翻译服务，帮助您解答关于健康或药物保险的任何疑问。如果您需要此翻译服务，请致电1 (800) 541-8981。我们的中文工作人员很乐意帮助您。这是一项免费服务。

Chinese Cantonese: 您對我們的健康或藥物保險可能存有疑問，為此我們提供免費的翻譯服務。如需翻譯服務，請致電 1 (800) 541-8981。我們講中文的人員將樂意為您提供幫助。這是一項免費服務。

Tagalog: Mayroon kaming libreng serbisyo sa pagsasaling-wika upang masagot ang anumang mga katanungan ninyo hinggil sa aming planong pangkalusugan o pangamot. Upang makakuha ng tagasaling-wika, tawagan lamang kami sa 1 (800) 541-8981. Maaari kayong tulungan ng isang nakakapagsalita ng Tagalog. Ito ay libreng serbisyo.

French: Nous proposons des services gratuits d'interprétation pour répondre à toutes vos questions relatives à notre régime de santé ou d'assurance-médicaments. Pour accéder au service d'interprétation, il vous suffit de nous appeler au 1 (800) 541-8981. Un interlocuteur parlant Français pourra vous aider. Ce service est gratuit.

Vietnamese: Chúng tôi có dịch vụ thông dịch miễn phí để trả lời các câu hỏi về chương sức khỏe và chương trình thuốc men. Nếu quý vị cần thông dịch viên xin gọi 1 (800) 541-8981 sẽ có nhân viên nói tiếng Việt giúp đỡ quý vị. Đây là dịch vụ miễn phí.


Korean: 당사는 의료 보험 또는 약품 보험에 관한 질문에 답해 드리고자 무료 통역 서비스를 제공하고 있습니다. 통역 서비스를 이용하려면 전화 1 (800) 541-8981번으로 문의해 주십시오. 한국어를 하는 담당자가 도와드릴 것입니다. 이 서비스는 무료로 운영됩니다.

Russian: Если у вас возникнут вопросы относительно страхового или медикаментного плана, вы можете воспользоваться нашими бесплатными услугами переводчиков. Чтобы воспользоваться услугами переводчика, позвоните
нам по телефону 1 (800) 541-8981. Вам окажет помощь сотрудник, который говорит по-русски. Данная услуга бесплатная.

Arabic: إننا نقدم خدمات المتجم الفوري المجانية للإجابة عن أي أسئلة تتعلق بالصحة أو جدول الأدوية لدينا. للحصول

Italian: È disponibile un servizio di interpretariato gratuito per rispondere a eventuali domande sul nostro piano sanitario e farmaceutico. Per un interprete, contattare il numero 1 (800) 541-8981. Un nostro incaricato che parla Italiano fornirà l'assistenza necessaria. È un servizio gratuito.

Português: Dispomos de serviços de interpretação gratuitos para responder a qualquer questão que tenha acerca do nosso plano de saúde ou de medicação. Para obter um intérprete, contacte-nos através do número 1 (800) 541-8981. Irá encontrar alguém que fale o idioma Português para o ajudar. Este serviço é gratuito.

French Creole: Nou genyen sèvis entèprèt gratis pou reppon tout keshon ou ta genyen konsènan plan medikal oswa dwòg nou an. Pou jwenn yon entèprèt, jis rele nou nan 1 (800) 541-8981. Yon moun ki pale Kreyòl kapab ede w. Sa a se yon sèvis ki gratis.

Polish: Umożliwiamy bezpłatne skorzystanie z usług tłumacza ustnego, który pomoże w uzyskaniu odpowiedzi na temat planu zdrowotnego lub dawkowania leków. Aby skorzystać z pomocy tłumacza znającego język polski, należy zadzwonić pod numer 1 (800) 541-8981. Ta usługa jest bezpłatna.

Hindi: हमारे स्वास््थ्य या दवा की योजना के बारे में आपके किसी भी प्रश्न के जवाब देने के लिए हमारे पास मुफ्त दुभाषिया सेवाएं उपलब्ध हैं. एक दुभाषिया प्राप्त करने के लिए, बस हमें 1 (800) 541-8981 पर फोन करें. कोई व्यक्ति जो हिंदी बोलता है आपकी मदद कर सकता है. यह एक मुफ्त सेवा है.

Japanese: 当社の健康 健康保険と薬品 処方薬プランに関するご質問にお答えするために、無料の通訳サービスがございます。通訳をご用命になるには、1 (800) 541-8981にお電話ください。日本語を話す人者 が支援いたします。これは無料のサー ビスです。
Regence MedAdvantage Basic (PPO) Customer Service

<table>
<thead>
<tr>
<th>CALL</th>
<th>1 (800) 541-8981</th>
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<tbody>
<tr>
<td></td>
<td>Calls to this number are free. Our telephone hours are 8:00 a.m. to 8:00 p.m., Monday through Friday. From October 1 through February 14, our telephone hours are 8:00 a.m. to 8:00 p.m., seven days a week. Customer Service also has free language interpreter services available for non-English speakers.</td>
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<tr>
<td>TTY</td>
<td>711</td>
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<td>Calls to this number are free. Our telephone hours are 8:00 a.m. to 8:00 p.m., Monday through Friday. From October 1 through February 14, our telephone hours are 8:00 a.m. to 8:00 p.m., seven days a week.</td>
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<tr>
<td>FAX</td>
<td>1 (888) 335-2985</td>
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<tr>
<td>WRITE</td>
<td>P.O. Box 12625</td>
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<tr>
<td></td>
<td>Salem, OR 97309-0625</td>
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<tr>
<td></td>
<td><a href="mailto:medicarecustomerservice@regence.com">medicarecustomerservice@regence.com</a></td>
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<tr>
<td>WEBSITE</td>
<td><a href="http://www.regence.com/medicare">www.regence.com/medicare</a></td>
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Health Insurance Information Program (Utah SHIP)
Health Insurance Information Program is a state program that gets money from the Federal government to give free local health insurance counseling to people with Medicare.

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<tr>
<th>CALL</th>
<th>1 (800) 541-7735</th>
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<tr>
<td>WRITE</td>
<td>195 North 1950 West</td>
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<td></td>
<td>Salt Lake City, UT  84116</td>
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<td>WEBSITE</td>
<td><a href="http://www.hxdaas.utah.gov/insurance_programs.htm">www.hxdaas.utah.gov/insurance_programs.htm</a></td>
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