



## **2011 Evidence of Coverage**

Brevard, Broward, Hillsborough, Lake, Marion,  
Miami-Dade, Orange, Osceola, Palm Beach,  
Pasco, Pinellas, Polk, Seminole, Sumter  
Counties

PUP Perks (HMO)

**January 1 – December 31, 2011**

## **Evidence of Coverage:**

### **Your Medicare Health Benefits and Services as a Member of PUP Perks (HMO)**

This booklet gives you the details about your Medicare health coverage from January 1 – December 31, 2011. It explains how to get the health care you need. This is an important legal document. Please keep it in a safe place.

#### **PUP Perks (HMO) Member Services:**

For help or information, please call Member Services or go to our plan website at [www.pupcorp.com](http://www.pupcorp.com).

1-866-571-0693 Monday – Sunday, 8:00 a.m. to 8:00 p.m. (Calls to these numbers are free.)

TTY users call: 1-800-955-8771

This plan is offered by Physicians United Plan, referred throughout the Evidence of Coverage as “we,” “us,” or “our.” PUP Perks (HMO) is referred to as “plan” or “our plan.”

A health plan with a Medicare contract

This information is available in a different format, including Spanish. Please call Member Services at the number listed above if you need plan information in another format or language.

Esta información puede ser disponible en formatos alternativos, incluyendo en español. Favor de llamar al departamento de atención al cliente al número listado anteriormente si usted necesita información acerca del plan en otro formato o idioma.

Benefits, formulary, pharmacy network, premium and/or copayments/co-insurance may change on January 1, 2012.

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## **Chapter 1. Getting started as a member of PUP Perks (HMO)**

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## SECTION 1 Introduction

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<b>Section 1.1</b>	<b>What is the <i>Evidence of Coverage</i> booklet about?</b>
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This *Evidence of Coverage* booklet tells you how to get your Medicare medical care through our plan, a Medicare Advantage Plan. This booklet explains your rights and responsibilities, what is covered, and what you pay as a member of the plan.

The *Evidence of Coverage*, 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.

Medicare is the Federal health insurance program for people 65 years of age or older, some people under age 65 with certain disabilities, and people with End-Stage Renal Disease (generally those with permanent kidney failure who need dialysis or a kidney transplant). People with Medicare can get their Medicare health coverage through Original Medicare or a Medicare Advantage plan.

A Medicare Advantage (MA) Plan, sometimes called Medicare Part C, is a plan offered by a private company that contracts with Medicare to provide you with all your Medicare Part A (Hospital) and Part B (Medical) 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. 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).

A Member (Member of our Plan, or “Plan Member”) is 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).

- You are covered by Medicare, and you have chosen to get your Medicare health care coverage through our plan, PUP Perks (HMO).
- There are different types of Medicare Advantage Plans. PUP Perks (HMO) is a Medicare Advantage HMO Plan (HMO stands for Health Maintenance Organization).

This plan is offered by Physicians United Plan, referred throughout the Evidence of Coverage as “we,” “us,” or “our.” PUP Perks (HMO) is referred to as “plan” or “our plan.”

The word “coverage” and “covered services” refers to the medical care and services available to you as a member of PUP Perks (HMO).

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<b>Section 1.2</b>	<b>What does this Chapter tell you?</b>
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Look through Chapter 1 of this *Evidence of Coverage* to learn:

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

<b>Section 1.3</b>	<b>What if you are new to PUP Perks (HMO)?</b>
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If you are a new member, then it's important for you to learn how the plan operates – what the rules are and what services are available to you. We encourage you to set aside some time to look through this *Evidence of Coverage* booklet.

*If you are confused or concerned or just have a question, please contact our plan's Member Services (contact information is on the cover of this booklet).*

Member Services is 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 Member Services.

<b>Section 1.4</b>	<b>Legal information about the <i>Evidence of Coverage</i></b>
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### **It's part of our contract with you**

This Evidence of Coverage is part of our contract with you about how PUP Perks (HMO) 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 PUP Perks (HMO) between January 1, 2011 to December 31, 2011.

### **Medicare must approve our plan each year**

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

The Centers for Medicare & Medicaid Services (CMS) is the Federal agency that runs Medicare. Chapter 2 explains how to contact CMS.

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

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### **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)

A “Service area” is the geographic area approved by the Centers for Medicare & Medicaid Services (CMS) within which an eligible individual may enroll in a certain plan, and in the case of network plans, where a network must be available to provide services.

- -- *and* -- you are entitled to Medicare Part A
- -- *and* -- you are enrolled in Medicare Part B
- -- *and* -- you do not have End Stage Renal Disease (ESRD), with limited exceptions, such as if you develop ESRD when you are already a member of a plan that we offer, or you were a member of a different plan that was terminated.

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

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

- Medicare Part A generally covers services furnished by institutional providers such as hospitals, skilled nursing facilities or home health agencies.
- Medicare Part B is for most other medical services, such as physician’s services and other outpatient services.

### **Section 2.3      Here is the plan service area for PUP Perks (HMO)**

Although Medicare is a Federal program, PUP Perks (HMO) is available only to individuals who live in our plan service area. To stay 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 Florida: Brevard, Broward, Hillsborough, Lake, Marion, Miami-Dade, Orange, Osceola, Palm Beach, Pasco, Pinellas, Polk, Seminole, Sumter Counties.

If you plan to move out of the service area, please contact Member Services.

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

### Section 3.1 Your plan membership card – Use it to get all covered medical 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 PUP Perks (HMO) 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 Member Services right away and we will send you a new card.

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

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

“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

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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.”

### **What are “network providers”?**

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

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

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

Urgently needed care is a non-emergency situation when you need medical care right away because of an illness, injury, or condition that you did not expect or anticipate, but your health is not in serious danger.

An out-of-network is 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.

If you don’t have your copy of the *Provider Directory*, you can request a copy from Member Services. You may ask Member Services for more information about our network providers, including their qualifications. You can also see the *Provider Directory* at [www.pupcorp.com](http://www.pupcorp.com), or download it from this website. Both Member Services and the website can give you the most up-to-date information about changes in our network providers.

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## **SECTION 4      Your monthly premium for PUP Perks (HMO)**

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<b>Section 4.1      How much is your plan premium?</b>
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You do not pay a separate monthly plan premium for PUP Perks (HMO). (You must continue to pay your Medicare Part B premium.)

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## 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 maintain your eligibility for Medicare Parts A and B. For that reason, some plan members will be paying a premium for Medicare Part A and most plan members will be paying a premium for Medicare Part B, in addition to paying the monthly plan premium. You must continue paying your Medicare Part B premium to remain a member of the plan. However, as a member of PUP Perks (HMO) your monthly Medicare Part B premium will be reduced by up to \$55.

- Your copy of *Medicare & You 2011* tells about these premiums in the section called “2011 Medicare Costs.” This explains how the Part B premium differs for people with different incomes.
- Everyone with Medicare receives a copy of *Medicare & You* each year in the fall. Those new to Medicare receive it within a month after first signing up. You can also download a copy of *Medicare & You 2011* 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.

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## SECTION 5 Please keep your plan membership record up to date

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<b>Section 5.1</b>	<b>How to help make sure that we have accurate information about you</b>
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Your membership record has information from your enrollment form, including your address and telephone number. It shows your specific plan coverage including your Primary Care Provider.

A Primary Care Provider (PCP) is a health care professional you select to coordinate your health care. Your PCP is responsible for providing or authorizing covered services while you are a plan member. Chapter 3 tells more about PCPs.

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 for you.** Because of this, it is very important that you help us keep your information up to date.

### Call Member Services to 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 are participating in a clinical research study

**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.

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 Member Services (phone numbers are on the cover of this booklet).

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## **SECTION 1      PUP Perks (HMO) contacts** (how to contact us, including how to reach Member Services at the plan)

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### **How to contact our plan's Member Services**

For assistance with claims, billing or member card questions, please call or write to PUP Perks (HMO) Member Services. We will be happy to help you.

<b>Member Services</b>	
<b>CALL</b>	1-866-571-0693  Calls to this number are free. Monday – Sunday, 8:00 a.m. – 8:00 p.m.
<b>TTY</b>	1-800-955-8771  This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.  Calls to this number are free. Monday – Sunday, 8:00 a.m. – 8:00 p.m.
<b>FAX</b>	407-226-1901
<b>WRITE</b>	9102 Southpark Center Loop, Suite 200 Orlando, FL 32819  Email: <a href="mailto:memberservices@pupcorp.com">memberservices@pupcorp.com</a>
<b>WEBSITE</b>	<a href="http://www.pupcorp.com">www.pupcorp.com</a>

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

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

<b>Coverage Decisions, Appeals and Complaints for Medical Care</b>	
<b>CALL</b>	1-866-429-5352  Calls to this number are free.
<b>TTY</b>	1-800-955-8771  This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.  Calls to this number are free.
<b>FAX</b>	407-226-1901
<b>WRITE</b>	9102 Southpark Center Loop, Suite 200 Orlando, FL 32819 Attn: Grievance and Appeals

For more information on asking for coverage decisions about your medical care, making an appeal or making a complaint about your medical care, see Chapter 7 (*What to do if you have a problem or complaint (coverage decisions, appeals, complaints)*).

An appeal is something you do if you disagree with a decision to deny a request for 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 a decision to stop services that you are receiving. For example, you may ask for an appeal if our plan doesn't pay for a drug, item, or service you think you should be able to receive. Chapter 9 explains appeals, including the process involved in making an appeal.

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

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## Where to send a request that asks 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 the plan for reimbursement or to pay a bill you have received from a provider, see Chapter 5 (*Asking the plan to pay its share of a bill you have received for 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	
<b>CALL</b>	1-866-571-0693  Calls to this number are free.
<b>TTY</b>	1-800-955-8771  This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.  Calls to this number are free.
<b>FAX</b>	407-226-1901
<b>WRITE</b>	For Medical Claims: Physicians United Plan Attn: Claims 9102 SouthPark Center Loop, Ste 200 Orlando, FL 32819

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

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

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

<b>Medicare</b>	
<b>CALL</b>	1-800-MEDICARE, or 1-800-633-4227  Calls to this number are free.  24 hours a day, 7 days a week.
<b>TTY</b>	1-877-486-2048  This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.  Calls to this number are free.
<b>WEBSITE</b>	<a href="http://www.medicare.gov">http://www.medicare.gov</a>  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. It has tools to help you compare Medicare Advantage Plans and Medicare drug plans in your area. You can also find Medicare contacts in your state by selecting “Help and Support” and then clicking on “Useful Phone Numbers and Websites.”  If you don’t have a computer, your local library or senior center may be able to help you visit this website using its computer. Or, you can call Medicare at the number above and tell them what information you are looking for. They will find the information on the website, print it out, and send it to you.

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

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The State Health Insurance Assistance Program (SHIP) is a government program with trained counselors in every state. In Florida, the SHIP is called SHINE (Serving Health Insurance Needs of Elders).

SHINE 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.

SHINE 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. SHINE counselors can also help you understand your Medicare plan choices and answer questions about switching plans.

<b>SHINE</b>	
<b>CALL</b>	1-800-96 ELDER (1-800-963-5337)
<b>TTY</b>	1-800-414-2001  This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.
<b>WRITE</b>	SHINE Program Department of Elder Affairs 4040 Esplanade Way, Suite 270 Tallahassee, FL 32399-7000
<b>WEBSITE</b>	<a href="http://www.floridashine.org">www.floridashine.org</a>

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

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There is a Quality Improvement Organization in each state. In Florida, the Quality Improvement Organization is called FMQAI.

Quality Improvement Organizations are Groups of practicing doctors and other health care experts that are paid by the Federal government to check and improve the care given to Medicare patients. They must review your complaints about the quality of care given by Medicare Providers. See Chapter 2, Section 4 for information about how to contact the QIO in your state and Chapter 9 for information about making complaints to the QIO.

FMQAI 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. FMQAI is an independent organization. It is not connected with our plan.

You should contact FMQAI 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.

Skilled Nursing Facility (SNF) Care is a level of care in a SNF ordered by a doctor that must be given or supervised by licensed health care professionals. It may be skilled nursing care, or skilled rehabilitation services, or both. Skilled nursing care includes services that require the skills of a licensed nurse to perform or supervise. Skilled rehabilitation services are physical therapy, speech therapy, and occupational therapy. Physical therapy includes exercise to improve the movement and strength of an area of the body, and training on how to use special equipment, such as how to use a walker or get in and out of a wheelchair. Speech therapy includes exercise to regain and strengthen speech and/or swallowing skills. Occupational therapy helps you learn how to perform usual daily activities, such as eating and dressing by yourself.

A Comprehensive Outpatient Rehabilitation Facility (CORF) is a facility that mainly provides rehabilitation services after an illness or injury, and provides a variety of services including physician's services, physical therapy, social or psychological services, and outpatient rehabilitation.

<b>FMQAI</b>	
<b>CALL</b>	1-800-844-0795
<b>WRITE</b>	5201 W. Kennedy Boulevard Suite 900 Tampa, Florida 33609-1822
<b>WEBSITE</b>	<a href="http://www.fmqai.com">www.fmqai.com</a>

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## **SECTION 5      Social Security**

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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 and pay the Part B premium. Social Security handles the enrollment process for Medicare. To apply for Medicare, you can call Social Security or visit your local Social Security office.

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

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

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Medicaid is a joint Federal and state government program that helps with medical costs for certain people with limited incomes and resources. Some people with Medicare are also eligible for Medicaid. Medicaid has programs that can help pay for your Medicare premiums and other costs, if you qualify. To find out more about Medicaid and its programs, contact The Department of Children and Families.

Medicaid is 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.

<b><i>Florida Department of Children and Families</i></b>	
<b>CALL</b>	1-866-76ACCES (1-866-762-2237)
<b>WRITE</b>	<b><u>Brevard</u></b> Brevard County ACCESS Application Center 801 Dixon Blvd, Ste 1103

Cocoa, FL 32922

**Broward**

Central Service Center  
311 N State Road 7  
Plantation, FL 33317

**Hillsborough County**

Tampa Service Center  
1313 N. Tampa Street, 1st Floor  
Tampa, FL 33602-3392

Plant City Service Center  
307 N. Michigan Avenue  
Plant City, FL 33563

Ruskin Service Center  
201 14th Ave SE  
Ruskin, FL 33570

**Lake County**

Lake County Service Center  
1300 Duncan Drive  
Tavares, FL 32778

**Marion County**

Marion County Storefront  
1601 NE 25 Ave, Suite 900  
Ocala, FL 34470

**Miami-Dade**

Caleb Service Center  
5400 NW 22nd Avenue  
Miami, FL 33142

Central Service Center  
1490 NW 27th Avenue, 2nd Floor  
Miami, FL 33125

Coconut Grove Service Center  
3750 S. Dixie Hwy.  
Miami, FL 33133

Hialeah Service Center  
5700 NW 37th Avenue

Miami, FL 33142  
(305) 637-2605

Miami Beach Service Center  
945 Pennsylvania Avenue, S-300  
Miami Beach, FL 33139

Opa-Locka Service Center  
200 Opa-Locka Boulevard, South Building  
Opa Locka, FL 33054

Florida City Service Center  
755 W. Palm Drive  
Florida City, FL 33034

Quail Roost Service Center  
12340 Quail Roost Drive  
Miami, FL 33177

University Service Center  
1605 SW 107th Avenue, #202A  
Miami, FL 33165

**Orange County**

Orange County ACCESS Application Center  
6218 W Colonial Drive, Suite #240  
Orlando, FL 32808

**Osceola County**

Kissimmee ACCESS Service Center  
1507 N John Young Parkway  
Kissimmee, FL 34741

**Palm Beach County**

Belle Glade Service Center  
2990 North Main Street  
Belle Glade, FL 33430

Lake Worth Service Center  
4220 Lake Worth Road  
Lake Worth, FL 33461

**Pasco County**

Pasco County Service Center  
9550 US 19 Highway North, Suite 201-A

Port Richey, Florida 34668

**Pinellas County**

North Pinellas Service Center  
Mary Grizzle Building  
11351 Ulmerton Road, Suite 130  
Largo, FL 33778

South Pinellas Service Center  
Sebring Building  
525 Mirror Lake Drive, Suite 201  
St. Petersburg, FL 33701

**Polk County**

Lakeland Service Center  
4720 Old Highway 37  
Lakeland, FL 33813

**Seminole County**

Sanford ACCESS Service Center  
2674 South Orlando Drive  
Sanford, FL 32773

**Sumter County**

Sumter County Service Center  
1601 W. Gulf Atlantic Hwy  
Wildwood, FL 34785

**WEBSITE**

[www.dcf.state.fl.us/ess/](http://www.dcf.state.fl.us/ess/)

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## **SECTION 7      How to contact the Railroad Retirement Board**

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

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

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## **SECTION 8      Do you have “group insurance” or other health insurance from an employer?**

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

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

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## **Chapter 3. Using the plan's coverage for your medical services**

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

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

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

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

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

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

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

PUP Perks (HMO) 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.** It needs to be accepted treatment for your medical condition.
  - The term medically necessary is used for drugs, services, or supplies that are proper and needed for the diagnosis or treatment of your medical condition; are used for the diagnosis, direct care, and treatment of your medical condition; meet

the standards of good medical practice in the local community; and are not mainly for your convenience or that of your doctor.

- **You have a primary care provider (a PCP) who is providing and overseeing your care.** As a member of our plan, you must choose a PCP (for more information about this, see Section 2.1 in this chapter).
  - In most situations, your PCP must give you approval in advance before you can use other providers in the plan's network, such as specialists, hospitals, skilled nursing facilities, or home health care agencies. This is called giving you a "referral." For more information about this, see Section 2.2 of this chapter.
  - Referrals from your PCP are not required for emergency care or urgently needed care. There are also some other kinds of care you can get without having approval in advance from your PCP (for more information about this, see Section 2.3 of this chapter).
- Emergency Care is 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.
- **You generally must receive your care from a network provider** (for more about this, see Section 2 in this chapter). In most cases, care you receive from an out-of-network provider (a provider who is not part of our plan's network) will not be covered. *Here are two exceptions:*
  - The plan covers emergency care or urgently needed care that you get from an out-of-network provider. For more information about this, and to see what emergency or urgently needed care means, see Section 3 in this chapter.
  - If you need medical care that Medicare requires our plan to cover and the providers in our network cannot provide this care, you can get this care from an out-of-network provider. Prior authorization or approval from the plan is needed in these cases. You or your PCP can request prior authorization for you to see an out-of-network provider. In this situation, you will pay the same as you would pay if you got the care from a network provider.

Prior authorization is approval in advance to get services or certain drugs that may or may not be on our formulary. Some in-network medical services are covered only if your doctor or other network provider gets "prior authorization" from our plan. Covered services that need prior authorization are marked in the Benefits Chart in Chapter 4. Some drugs are covered only if your doctor or other network provider gets "prior authorization" from us. Covered drugs that need prior authorization are marked in the formulary.

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

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<b>Section 2.1      You must choose a Primary Care Provider (PCP) to provide and oversee your medical care</b>
--

### **What is a "PCP" and what does the PCP do for you?**

When you become a member of Physicians United Plan, you must choose a plan provider to be your PCP. Your PCP is a family practitioner, general practitioner or internist who meets state requirements and is trained to give you basic medical care. Your PCP will also coordinate the rest of the covered services you get as a plan member, including giving you referrals to see a specialist or to obtain certain tests. This includes your X-rays, laboratory tests, care from specialists, hospital admissions, and follow-up care. Coordinating your services includes checking or consulting with other plan providers about your care. For certain services, your PCP or specialist needs to get prior authorization (prior approval) from us, for example, for elective hospital admissions, outpatient surgery, MRIs, PET Scans, etc.

### **How do you choose your PCP?**

Choosing a PCP is an important decision. You should refer to the Physicians United Plan *Provider Directory* or contact Member Services if you need help choosing a PCP. When you choose your PCP, you should have all of your medical records transferred to the PCP's office. The name and office telephone number of your PCP are printed on your membership card.

Some of our plan's PCPs are part of a medical group practice that also includes specialists. Generally, these PCPs will refer their patients to specialists who are in the same medical group practice. Our *Provider Directory* identifies these PCPs and the specialists within their medical groups.

### **Changing your PCP**

You may change your PCP for any reason, at any time. Also, it's possible that your PCP might leave our plan's network of providers and you would have to find a new PCP. If you ask for a PCP change on or before the 10<sup>th</sup> day of the month, the PCP change is effective the first of the following month.

If your PCP leaves our plan's network, we will notify you, help you find a new PCP or select one for you. If you wish to select a different PCP from the one we select for you, please call or write Member Services to change your PCP.

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

- Routine women's health care, which include breast exams, mammograms (x-rays of the breast), Pap tests, and pelvic exams, as long as you get them from a network provider.
- Flu shots and pneumonia vaccinations as long as you get them from a network provider.
- Emergency services from network providers or from out-of-network providers.
- Urgently needed care from in-network providers or from out-of-network providers when network providers are temporarily unavailable or inaccessible, e.g., when you are temporarily outside of the plan's service area.
- Kidney dialysis services that you get at a Medicare-certified dialysis facility when you are temporarily outside the plan's service area. If possible, please let us know before you leave the service area where you are going to be so we can help arrange for you to have maintenance dialysis while outside the service area.
- Chiropractic care covered by this plan.

<b>Section 2.3</b>	<b>How to get care from specialists and other network providers</b>
--------------------	---

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

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

You will need a referral from your PCP to see a specialist. As described in section 2.1 above, if your PCP is part of a medical group practice that also includes specialists, your PCP will refer you to specialists within his/her medical group. Our *Provider Directory* identifies these PCPs and the specialists within their medical groups.

If your specialist recommends certain tests or procedures, your PCP or your specialist will write you a referral for that service. For certain services, your PCP or specialist needs to get prior authorization (prior approval) from us, for example, for elective hospital admissions, outpatient surgery, MRIs, PET Scans, etc. The services that require our prior approval are listed in Chapter 4, section 2.1 (Your medical benefits and costs as a member of the plan) and in the Medical Benefits Chart in that section.

**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 notify you if your PCP leaves our plan and we will find you another PCP in your area; you can always change to another PCP of your choice. We will notify you when a specialist leaves our plan if you have been seeing that specialist regularly. If you are under active treatment with that specialist we may approve continued treatment with that specialist. If an urgent situation arises please contact Member Services so we can help you access an appropriate provider.

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

---

<b>Section 3.1      Getting care if you have a medical emergency</b>
--

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

When you have a “medical emergency,” you believe that your health is in serious danger. A medical emergency can include severe pain, a bad injury, a sudden illness, or a medical condition that is quickly getting much worse.

If you have a medical emergency:

- **Get help as quickly as possible.** Call 911 for help or go to the nearest emergency room, hospital, or urgent care center. Call for an ambulance if you need it. You do *not* need to get approval or a referral first from your PCP.
- **As soon as possible, make sure that our plan has been told about your emergency.** We need to follow up on your emergency care. You or someone else should call to tell us about your emergency care, usually within 48 hours. Please call the number on the back of your Member ID card.

### **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. We provide some coverage for emergency services outside of the United States as well. 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.

We also cover emergency medical care obtained outside the country, up to a certain amount (see the Medical Benefits Chart in Chapter 4 of this booklet). We will pay up to what we would have paid if the emergency had occurred in the country. Please see the Medical Benefits Chart in Chapter 4 for details.

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. If you are in the service area, once the medical emergency is over and your condition is stable, we expect that you will return to your PCP or other network providers for follow-up care. We can arrange for network providers to take over your care if needed. If you are discharged after an emergency admission, you should return to your PCP for follow-up care, and not to the physician who treated you while you were in the hospital.

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

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

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

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

<b>Section 3.2</b>	<b>Getting care when you have an urgent need for care</b>
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### **What is “urgently needed care”?**

“Urgently needed care” is a non-emergency situation when you need medical care right away because of an illness, injury, or condition that you did not expect or anticipate, but your health is not in serious danger.

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

Whenever possible, you must use our network providers when you are in the plan's service area and you have an urgent need for care. (For more information about the plan's service area, see Chapter 1, Section 2.3 of this booklet.)

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

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

Suppose that you are temporarily outside our plan's service area, but still in the United States. If you have an urgent need for care, you probably will not be able to find or get to one of the providers in our plan's network. In this situation (when you are outside the service area and cannot get care from a network provider), our plan will cover urgently needed care that you get from any provider.

Our plan does not cover urgently needed care or any other care if you receive the care outside of the United States.

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

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<b>Section 4.1      You can ask the plan to pay our share of the cost of your covered services</b>
--

In limited instances, you may be asked to pay the full cost of the service. Other times, you may find that you have paid more than you expected under the coverage rules of the plan. In either case, you will want our plan to pay our share of the costs by reimbursing you for payments you have already made.

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 so that we can pay our share of the costs for your covered medical 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 the plan to pay its share of a bill you have received for medical services*) for information about what to do.

<b>Section 4.2      If services are not covered by our plan, you must pay the full cost</b>
---

PUP Perks (HMO) covers all medical services that are medically necessary, are covered under Medicare, and are obtained consistent with plan rules. You are responsible for paying the full cost of services that aren't covered by our plan, either because they are not plan covered services, or they were obtained out-of-network where not authorized.

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

Chapter 7 (*What to do if you have a problem or complaint*) 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 Member Services at the number on the front cover of this booklet to get more information about how to do this.

For covered services that have a benefit limitation, you pay the full cost of any services you get after you have used up your benefit for that type of covered service. These costs do not count toward the out-of-pocket maximum. You can call Members Services when you want to know how much of your benefit limit you have already used.

The out-of-pocket maximum is the maximum amount that you pay out-of-pocket during the calendar year, usually at the time services are received, for covered Part A (Hospital Insurance) and Part B (Medical Insurance) services. Plan premiums and Medicare Part A and Part B premiums do not count toward the out-of-pocket maximum.

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

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

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

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

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

Original Medicare is offered by the government, and not a private health plan like Medicare Advantage plans and prescription drug plans. Under Original Medicare, Medicare services are covered by paying doctors, hospitals, and other health care providers payment amounts established by Congress. You can see any doctor, hospital, or other health care provider that accepts Medicare. You must pay the deductible. Medicare pays its share of the Medicare-

approved amount, and you pay your share. Original Medicare has two parts: Part A (Hospital Insurance) and Part B (Medical Insurance) and is available everywhere in the United States.

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

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

1. We can let you know whether the clinical research study is Medicare-approved.
2. We can tell you what services you will get from clinical research study providers instead of from our plan.
3. We can keep track of the health care services that you receive as part of the study.

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

<b>Section 5.2</b>	<b>When you participate in a clinical research study, who pays for what?</b>
--------------------	--

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 your costs for the services you receive as part of the study will not be higher than they would be if you received these services outside of a clinical research study.

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

- Generally, Medicare will *not* pay for the new item or service that the study is testing unless Medicare would cover the item or service even if you were *not* in a study.
- Items and services the study gives you or any participant for free.

- Items or services provided only to collect data, and not used in your direct health care. For example, Medicare would not pay for monthly CT scans done as part of the study if your condition would usually require only one CT scan.

### Do you want to know more?

To find out what your coinsurance would be if you joined a Medicare-approved clinical research study, please call us at Member Services (phone numbers are on the cover of this booklet).

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

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

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

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, you must elect to have your coverage for care in a religious non-medical health care institution. You may choose to pursue medical care at any time for any reason. This benefit is provided only for Part A inpatient services (non-medical health care services). Medicare will only pay for non-medical health care services provided by religious non-medical health care institutions.

<b>Section 6.2</b>	<b>What care from a religious non-medical health care institution is covered by our plan?</b>
--------------------	---

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.

Medicare Inpatient Hospital coverage limits apply; please see the benefits chart in Chapter 4 for more information.

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## **Chapter 4. Medical Benefits Chart (what is covered and what you pay)**

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

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

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

- A **“copayment”** means that you pay a fixed amount each time you receive a medical service. You pay a copayment at the time you get the medical service.
- **“Coinsurance”** means that you pay a percent of the total cost of a medical service. You pay a coinsurance at the time you get the medical service.

Some people qualify for State Medicaid programs to help them pay their out-of-pocket costs for Medicare. 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.

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

As a member of PUP Perks (HMO), the most you will have to pay out-of-pocket for covered Part A and Part B services in 2011 is \$4,400. If you reach the maximum out-of-pocket payment amount of \$4,400, you will not have to pay any out-of-pocket costs for the remainder of the year for covered Part A and Part B services. (You will have to continue to pay the Medicare Part B premium.)

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

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<b>Section 2.1      Your medical benefits and costs as a member of the plan</b>
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The Medical Benefits Chart on the following pages lists the services PUP Perks (HMO) covers and what you pay out-of-pocket for each service. The services listed in the Medical Benefits Chart are covered only when the following coverage requirements are met:

- Your Medicare covered services must be provided according to the coverage guidelines established by Medicare.
- Except in the case of preventive services and screening tests, your services (including medical care, services, supplies, and equipment) *must* be medically necessary. Medically necessary means that the services are used for the diagnosis, direct care, and treatment of your medical condition and are not provided mainly for your convenience or that of your doctor.
- You receive your care from a network provider. In most cases, care you receive from an out-of-network provider will not be covered. Chapter 3 provides more information about requirements for using network providers and the situations when we will cover services from an out-of-network provider.
- You have a primary care provider (a PCP) who is providing and overseeing your care. In most situations, your PCP must give you approval in advance before you can see other providers in the plan's network. This is called giving you a "referral." Chapter 3 provides more information about getting a referral and the situations when you do not need a referral.
- Some of the services listed in the Medical Benefits Chart are covered *only* if your doctor or other network provider gets approval in advance (sometimes called "prior authorization") from us. Covered services that need approval in advance are marked in the Medical Benefits Chart by an asterisk. In addition, the following services not listed in the Benefits Chart require prior authorization: (the services that require prior authorization may change from time to time; your provider may obtain the most up-to-date list from our website [www.pupcorp.com](http://www.pupcorp.com)).
  - MOHS Surgery
  - PET Scans and SPECTs
  - Chemotherapy and IMRT radiation therapy
  - Sleep studies
  - Hyperbaric oxygen treatment
  - Genetic testing and counseling
- Our plan covers all Medicare-covered preventive services at no cost to you. See the

Medical Benefits Chart for information about your share of the costs for these services.

Services that are covered for you	What you must pay when you get these services
<b>Inpatient Care</b>	
<p><b>Inpatient hospital care*</b></p> <p>Plan covers 90 days each benefit period.</p> <p>For both our Plan and Original Medicare, a benefit period is used to determine coverage for inpatient stays in hospitals and skilled nursing facilities. A benefit period begins on the first day you go to a Medicare-covered inpatient hospital or a skilled nursing facility. The benefit period ends when you haven't been an inpatient at any hospital or SNF for 60 days in a row. If you go to the hospital (or SNF) after one benefit period has ended, a new benefit period begins. There is no limit to the number of benefit periods you can have.</p> <p>The type of care that is covered depends on whether you are considered an <u>inpatient</u> for hospital and SNF stays. You must be admitted to the hospital as an inpatient, not just under observation. You are an inpatient in a SNF only if your care in the SNF meets certain standards for skilled level of care. Specifically, in order to be an inpatient in a SNF, you must need daily skilled-nursing or skilled-rehabilitation care, or both. Defined in Chapter 4, Section 2.1, Your medical benefits and costs as a member of the plan.</p> <p>Covered services include:</p> <ul style="list-style-type: none"><li>• Semi-private room (or a private room if medically necessary)</li><li>• Meals including special diets</li><li>• Regular nursing services</li><li>• Costs of special care units (such as intensive/coronary care units)</li><li>• Drugs and medications</li><li>• Lab tests</li><li>• X-rays and other radiology services</li><li>• Necessary surgical and medical supplies</li><li>• Use of appliances, such as wheelchairs</li></ul>	<p>For Medicare-covered hospital stays:</p> <p>Days 1 – 5: \$250 co-pay per day</p> <p>Days 6 – 90: \$0 co-pay per day</p> <p>Except in an emergency, your doctor must tell the plan that you are going to be admitted to the hospital.</p> <p>If you are readmitted for the same primary diagnosis within 30 days of discharge, you will not have to pay another inpatient hospital co-pay.</p> <p>If you get authorized inpatient care at an out-of-network hospital after your emergency condition is stabilized, your cost</p>

Services that are covered for you	What you must pay when you get these services
<ul style="list-style-type: none"><li>• Operating and recovery room costs</li><li>• Physical, occupational, and speech language therapy</li><li>• Under certain conditions, the following types of transplants are covered: corneal, kidney, kidney-pancreatic, heart, liver, lung, heart/lung, bone marrow, stem cell, and intestinal/multivisceral. If you need a transplant, we will arrange to have your case reviewed by a Medicare-approved transplant center that will decide whether you are a candidate for a transplant. If you are sent outside of your community for a transplant, we will arrange or pay for appropriate lodging and transportation costs for you and a companion.</li><li>• Blood - including storage and administration.</li><li>• Physician services</li></ul>	<p>is the cost-sharing you would pay at a network hospital.</p> <p>Cost-sharing refers to amounts that a member has to pay when services or drugs are received. It includes any combination of the following three types of payments: (1) any deductible amount a plan may impose before services or drugs are covered; (2) any fixed “copayment” amount that a plan requires when a specific service or drug is received; or (3) any “coinsurance” amount, a percentage of the total amount paid for a service or drug, that a plan requires when a specific service or drug is received.</p>

Services that are covered for you	What you must pay when you get these services
<p><b>Inpatient mental health care*</b></p> <ul style="list-style-type: none"> <li>Covered services include mental health care services that require a hospital stay.</li> </ul> <p>There is a 190-day lifetime limit for inpatient services in a psychiatric hospital. The 190-day limit does not apply to Mental Health services provided in a psychiatric unit of a general hospital.</p>	<p>For Medicare-covered hospital stays:</p> <p>Days 1 – 5: \$250 co-pay per day</p> <p>Days 6 – 90: \$0 co-pay per day</p> <p>Except in an emergency, your doctor must tell the plan that you are going to be admitted to the hospital.</p>
<p><b>Skilled nursing facility (SNF) care*</b></p> <p>(For a definition of “skilled nursing facility,” see Chapter 12 of this booklet. Skilled nursing facilities are sometimes called “SNFs.”)</p> <p><i>Plan covers up to 100 days each benefit period. No prior hospital stay is required.</i></p> <p>Covered services include:</p> <ul style="list-style-type: none"> <li>Semiprivate room (or a private room if medically necessary)</li> <li>Meals, including special diets</li> <li>Regular nursing services</li> <li>Physical therapy, occupational therapy, and speech therapy</li> <li>Drugs administered to you as part of your plan of care (This includes substances that are naturally present in the body, such as blood clotting factors.)</li> <li>Blood - including storage and administration.</li> <li>Medical and surgical supplies ordinarily provided by SNFs</li> <li>Laboratory tests ordinarily provided by SNFs</li> <li>X-rays and other radiology services ordinarily provided by SNFs</li> <li>Use of appliances such as wheelchairs ordinarily provided by</li> </ul>	<p>For SNF stays:</p> <p>Days 1 – 88: \$50 co-pay per day</p> <p>Days 89 – 100: \$0 co-pay per day</p> <p>Authorization rules may apply.</p>

Services that are covered for you	What you must pay when you get these services
<p>SNFs</p> <ul style="list-style-type: none"><li>• Physician services</li></ul> <p>Generally, you will get your SNF care from plan facilities. However, under certain conditions listed below, you may be able to pay in-network cost-sharing for a facility that isn't a plan provider, if the facility accepts our plan's amounts for payment.</p> <ul style="list-style-type: none"><li>• A nursing home or continuing care retirement community where you were living right before you went to the hospital (as long as it provides skilled nursing facility care).</li></ul> <p>A SNF where your spouse is living at the time you leave the hospital.</p>	
<p><b>Inpatient services covered when the hospital or SNF days aren't, or are no longer, covered</b></p> <p>As described above, the plan covers up to 90 days per benefit period for inpatient hospital care and up to 100 days per benefit period for skilled nursing facility (SNF) care. Once you have reached these coverage limits, the plan will no longer cover your stay in the hospital or SNF. However, we will cover certain types of services that you receive while you are still in the hospital or the SNF. Covered services include:</p> <ul style="list-style-type: none"><li>• Physician services</li><li>• Tests (like X-ray or lab tests)</li><li>• X-ray, radium, and isotope therapy including technician materials and services</li><li>• Surgical dressings, splints, casts and other devices used to reduce fractures and dislocations</li><li>• Prosthetics and orthotics devices (other than dental) that replace all or part of an internal body organ (including contiguous tissue), or all or part of the function of a permanently inoperative or malfunctioning internal body organ, including replacement or repairs of such devices</li><li>• Leg, arm, back, and neck braces; trusses, and artificial legs, arms, and eyes including adjustments, repairs, and replacements required because of breakage, wear, loss, or a change in the</li></ul>	<p>You pay 100% of the cost of services.</p>

Services that are covered for you	What you must pay when you get these services
<p>patient's physical condition</p> <ul style="list-style-type: none"> <li>Physical therapy, speech therapy, and occupational therapy</li> </ul>	
<p><b>Home health agency care*</b></p> <p>Covered services include:</p> <ul style="list-style-type: none"> <li>Part-time or intermittent skilled nursing and home health aide services (To be covered under the home health care benefit, your skilled nursing and home health aide services combined must total fewer than 8 hours per day and 35 hours per week)</li> <li>Physical therapy, occupational therapy, and speech therapy</li> <li>Medical social services</li> <li>Medical equipment and supplies</li> </ul> <p>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.</p>	<p>\$0 co-pay for Medicare-covered home health visits.</p> <p>Authorization rules may apply.</p>
<p><b>Hospice care</b></p> <p>You may receive care from any Medicare-certified hospice program. Original Medicare (rather than our Plan) will pay the hospice provider for the services you receive. Your hospice doctor can be a network provider or an out-of-network provider. You will still be a plan member and will continue to get the rest of your care that is unrelated to your terminal condition through our Plan. However, Original Medicare will pay for all of your Part A and Part B services. Your plan will bill Original Medicare while your hospice election is in force. Covered services include:</p> <ul style="list-style-type: none"> <li>Drugs for symptom control and pain relief, short-term respite care, and other services not otherwise covered by Original Medicare</li> <li>Home care</li> </ul>	<p>When you enroll in a Medicare-certified hospice program, your hospice services and your Original Medicare services are paid for by Original Medicare, not PUP Perks (HMO).</p>

Services that are covered for you	What you must pay when you get these services
<b>Outpatient Services</b>	
<b>Physician services, including doctor's office visits</b>	
<p>Covered services include:</p> <ul style="list-style-type: none"> <li>• Office visits, including medical and surgical care in a physician's office</li> <li>• Medical or surgical services furnished in a certified ambulatory surgical center or in a hospital outpatient setting*</li> <li>• Consultation, diagnosis, and treatment by a specialist</li> <li>• Hearing and balance exams, if your doctor orders it to see if you need medical treatment</li> <li>• Telehealth office visits including consultation, diagnosis and treatment by a specialist</li> <li>• Second opinion by another network provider prior to surgery</li> <li>• Outpatient hospital services*</li> <li>• Non-routine dental care (covered services are limited to surgery of the jaw or related structures, setting fractures of the jaw or facial bones, extraction of teeth to prepare the jaw for radiation treatments of neoplastic cancer disease, or services that would be covered when provided by a physician)*</li> </ul>	<p>\$0 co-pay for each primary care doctor visit for Medicare-covered benefits.</p> <p>\$35 co-pay for each in-area, network urgent care Medicare-covered visit.</p> <p>\$30 co-pay for each specialist visit for Medicare-covered benefits.</p> <p>See "Preventative Physical Exam," for more information.</p> <p>Authorization rules may apply.</p>
<b>Chiropractic services</b>	
<p>Covered services include:</p> <ul style="list-style-type: none"> <li>• Manual manipulation of the spine to correct subluxation.</li> </ul>	<p>\$30 co-pay for each Medicare-covered visit.</p>
<b>Podiatry services</b>	
<p>Covered services include:</p> <ul style="list-style-type: none"> <li>• Treatment of injuries and diseases of the feet (such as hammer toe or heel spurs).</li> <li>• Routine foot care for members with certain medical conditions</li> </ul>	<p>\$30 co-pay for each Medicare-covered visit.</p>

Services that are covered for you	What you must pay when you get these services
affecting the lower limbs	
<p><b>Outpatient mental health care*</b></p> <p>Covered services include:</p> <p>Mental health services provided by a doctor, clinical psychologist, clinical social worker, clinical nurse specialist, nurse practitioner, physician assistant, or other Medicare-qualified mental health care professional as allowed under applicable state laws.</p>	<p>\$30 co-pay for each Medicare-covered individual or group therapy visit.</p> <p>Authorization rules may apply.</p>
<p><b>Partial hospitalization services*</b></p> <p>“Partial hospitalization” is a structured program of active psychiatric treatment that is more intense than the care received in your doctor’s or therapist’s office and is an alternative to inpatient hospitalization.</p>	<p>\$250 co-pay per day</p>
<p><b>Outpatient substance abuse services*</b></p>	<p>\$30 co-pay for Medicare-covered individual or group visits.</p> <p>Authorization rules may apply.</p>
<p><b>Outpatient surgery, including services provided at hospital facilities and ambulatory surgical centers*</b></p>	<p>\$150 co-pay for each Medicare-covered ambulatory surgical center visit.</p> <p>You pay the following for services at an outpatient hospital:</p> <ul style="list-style-type: none"> <li>- \$200 per visit for surgery (including pain</li> </ul>

Services that are covered for you	What you must pay when you get these services
	<p>management procedures and biopsies)</p> <p>Authorization rules may apply.</p>
<p><b>Ambulance services</b></p> <ul style="list-style-type: none"> <li>• Covered ambulance services include fixed wing, rotary wing, and ground ambulance services, to the nearest appropriate facility that can provide care only if they are furnished to a member whose medical condition is such that other means of transportation are contraindicated (could endanger the person’s health). The member’s condition must require both the ambulance transportation itself and the level of service provided in order for the billed service to be considered medically necessary.</li> <li>• Non-emergency transportation by ambulance is appropriate if it is documented that the member’s condition is such that other means of transportation are contraindicated (could endanger the person’s health) and that transportation by ambulance is medically required. *</li> </ul>	<p>\$100 co-pay for Medicare-covered ambulance benefits.</p> <p>Authorization rules may apply.</p>
<p><b>Emergency care</b></p>	<p>\$50 co-pay for Medicare-covered emergency room visits.</p> <p>\$20,000 limit for emergency services outside U.S. every year.</p> <p>Worldwide Coverage: If you receive emergency care outside the country, we will pay</p>

Services that are covered for you	What you must pay when you get these services
	<p>up to the amount we would have paid if you had been in our service area.</p> <p>If you receive emergency care at an out-of-network hospital and need inpatient care after your emergency condition is stabilized, you must return to a network hospital in order for your care to continue to be covered or you must have your inpatient care at the out-of-network hospital authorized by the plan and your cost is the cost-sharing you would pay at a network hospital.</p>
<p><b>Urgently needed care</b>                      Coverage within the U.S.</p>	<p>\$35 co-pay for Medicare-covered urgently needed care visits.</p>
<p><b>Outpatient rehabilitation service*</b>                      Covered services include: physical therapy, occupational therapy, speech language therapy, cardiac rehabilitative therapy, intensive cardiac rehabilitation services, pulmonary rehabilitation services, and Comprehensive Outpatient Rehabilitation Facility (CORF) services.</p>	<p>\$30 co-pay for Medicare-covered Occupational Therapy visits.</p> <p>\$30 co-pay for</p>

Services that are covered for you	What you must pay when you get these services
	<p>Medicare-covered Physical and/or Speech/Language Therapy visits.</p> <p>\$30 co-pay for Medicare-covered Cardiac Rehab services</p> <p>Authorization rules may apply.</p>
<p><b>Durable medical equipment and related supplies*</b></p> <p>(For a definition of “durable medical equipment,” see Chapter 12 of this booklet.)</p> <p>Covered items include, but are not limited to: wheelchairs, crutches, hospital bed, IV infusion pump, oxygen equipment, nebulizer, and walker.</p>	<p>20% of the costs for Medicare-covered items.</p> <p>Authorization rules may apply.</p>
<p><b>Prosthetic devices and related supplies*</b></p> <p>Devices (other than dental) that replace a body part or function. These include, but are not limited to: colostomy bags and supplies directly related to colostomy care, pacemakers, braces, prosthetic shoes, artificial limbs, and breast prostheses (including a surgical brassiere after a mastectomy). Includes certain supplies related to prosthetic devices, and repair and/or replacement of prosthetic devices. Also includes some coverage following cataract removal or cataract surgery – see “Vision Care” later in this section for more detail.</p>	<p>20% of the costs for Medicare-covered items.</p> <p>Authorization rules may apply.</p>
<p><b>Diabetes self-monitoring, training, and supplies*</b></p> <p>For all people who have diabetes (insulin and non-insulin users). Covered services include:</p> <ul style="list-style-type: none"> <li>• Blood glucose monitor, blood glucose test strips, lancet devices and lancets, and glucose-control solutions for checking the accuracy of test strips and monitors.</li> </ul>	<p>\$0 co-pay for Diabetes self-monitoring training.</p> <p>\$0 co-pay for Nutrition Therapy for Diabetes.</p>

Services that are covered for you	What you must pay when you get these services
<ul style="list-style-type: none"> <li>• For people with diabetes who have severe diabetic foot disease: One pair per calendar year of therapeutic custom-molded shoes (including inserts provided with such shoes) and two additional pairs of inserts, or one pair of depth shoes and three pairs of inserts (not including the non-customized removable inserts provided with such shoes). Coverage includes fitting.</li> <li>• Self-management training is covered under certain conditions.</li> <li>• For persons at risk of diabetes: Fasting plasma glucose tests. Every 12 months or more frequently if ordered by your physician.</li> </ul>	<p>0% to 20% for the cost of for Diabetes supplies.</p>
<p><b>Medical nutrition therapy*</b></p> <p>For people with diabetes, renal (kidney) disease (but not on dialysis), and after a transplant when referred by your doctor.</p>	<p>\$0 co-pay for Nutrition Therapy for Diabetes.</p>
<p><b>Kidney Disease Education Services</b></p> <p>Education to teach kidney care and help members make informed decisions about their care. For people with stage IV chronic kidney disease when referred by their doctor. We cover up to six sessions of kidney disease education services per lifetime.</p>	<p>\$0 co-pay</p>
<p><b>Outpatient diagnostic tests and therapeutic services and supplies</b></p> <p>Covered services include:</p> <ul style="list-style-type: none"> <li>• X-rays</li> <li>• Radiation therapy*</li> <li>• Surgical supplies, such as dressings</li> <li>• Supplies, such as splints and casts</li> <li>• Laboratory tests</li> <li>• Blood</li> <li>• Other outpatient diagnostic tests (e.g., ultrasound, echocardiogram, MRI/MRA, CT or PET scan, diagnostic scopic</li> </ul>	<p>You pay the following for Labs:</p> <p>-\$0 co-pay for all labs performed at a physician office during the same visit (in addition to the office visit co-pay).</p> <p>-\$5 co-pay for all labs performed at a free-standing</p>

Services that are covered for you	<b>What you must pay</b> when you get these services
<p>procedures such as colonoscopy, flexible sigmoidoscopy, endoscopy, EGD, etc., sleep study, nerve conduction study, nuclear stress test or other nuclear medicine tests.)*</p>	<p>laboratory/facility during the same visit.</p> <p>-\$15 co-pay for all labs performed at an outpatient hospital facility during the same visit.</p> <p>You pay the following for X-Rays:</p> <p>-\$0 co-pay for all X-Rays performed at a physician office during the same visit (in addition to the office visit co-pay).</p> <p>-\$30 co-pay for each X-Ray performed at a free-standing facility or outpatient hospital facility during the same visit.</p> <p>You pay the following for outpatient diagnostic procedures/tests performed at a physician office, free-standing facility or outpatient hospital facility. If they are performed at a physician office, you pay the physician office visit co-pay in</p>

Services that are covered for you	What you must pay when you get these services
	<p>addition to these co-pays:</p> <ul style="list-style-type: none"><li>- \$40 for ultrasound, echocardiogram, diagnostic scopic procedures such as a colonoscopy, flexible sigmoidoscopy, endoscopy, EGD, etc. (if the test is not part of colo-rectal screening). Note: if removal of polyps/tumor or surgery is performed during the procedure, the outpatient surgery co-pay will apply.</li><li>- \$40 per visit for sleep study, nerve conduction study, nuclear stress test or other nuclear medicine test.</li><li>- \$125 per visit for CT scan, MRI, MRA, or PET scan</li><li>- \$55 co-pay for Medicare-covered therapeutic radiology services.</li></ul> <p>You pay the following for services at an outpatient hospital:</p>

Services that are covered for you	What you must pay when you get these services
	<ul style="list-style-type: none"> <li>- \$50 per visit for chemotherapy (in addition to the 20% coinsurance for the chemotherapy drugs)</li> <li>- \$200 per visit for outpatient observation</li> <li>- \$100 per visit if no other co-pay applies</li> </ul>
<p><b>Vision care</b></p> <p>Covered services include:</p> <ul style="list-style-type: none"> <li>• Outpatient physician services for eye care.</li> <li>• For people who are at high risk of glaucoma, such as people with a family history of glaucoma, people with diabetes, and African-Americans who are age 50 and older: glaucoma screening once per year</li> <li>• One pair of eyeglasses or contact lenses after each cataract surgery that includes insertion of an intraocular lens. Corrective lenses/frames (and replacements) needed after a cataract removal without a lens implant.</li> <li>• Routine eye exam.</li> <li>• One pair of eyeglasses or contact lenses every year.</li> </ul>	<p>\$10 co-pay for one pair of eyeglasses or contact lenses after cataract surgery.</p> <p>\$0 to \$30 co-pay for exams to diagnose and treat diseases and conditions of the eye.</p> <p>You pay \$0 for annual glaucoma screenings if you are at high risk for glaucoma, have diabetes or a family</p>

Services that are covered for you	What you must pay when you get these services
	<p>history of glaucoma.</p> <p>You pay \$30 for all other Medicare-covered benefits</p> <p>\$10 co-pay for up to 1 routine eye exam every year.</p> <p>\$10 co-pay for up to 1 pair of glasses every year.</p> <p>\$10 co-pay for up to 1 pair of contacts every year.</p> <p>\$100 limit for eye wear every year.</p> <p>Eyewear is limited to a pre-determined selection from a participating provider. Contact plan for details.</p>
<p><b>Preventive Care and Screening Tests</b></p>	
<p><b>Abdominal aortic aneurysm screening</b></p> <p>A one-time screening ultrasound for people at risk. The plan only covers this screening if you get a referral for it as a result of your “Welcome to Medicare” physical exam.</p>	<p>\$0 co-pay for each ultrasound.</p>

Services that are covered for you	What you must pay when you get these services
<p><b>Bone mass measurement</b></p> <p>For qualified individuals (generally, this means people at risk of losing bone mass or at risk of osteoporosis), the following services are covered every 2 years or more frequently if medically necessary: procedures to identify bone mass, detect bone loss, or determine bone quality, including a physician’s interpretation of the results.</p>	<p>\$0 co-pay for Medicare-covered bone mass measurement.</p>
<p><b>Colorectal screening</b></p> <p>For people 50 and older, the following are covered:</p> <ul style="list-style-type: none"> <li>• Flexible sigmoidoscopy (or screening barium enema as an alternative) every 48 months</li> <li>• Fecal occult blood test, every 12 months</li> </ul> <p>For people at high risk of colorectal cancer, we cover:</p> <ul style="list-style-type: none"> <li>• Screening colonoscopy (or screening barium enema as an alternative) every 24 months</li> </ul> <p>For people not at high risk of colorectal cancer, we cover:</p> <ul style="list-style-type: none"> <li>• Screening colonoscopy every 10 years, but not within 48 months of a screening sigmoidoscopy</li> </ul>	<p>\$0 co-pay for Medicare-covered colorectal screenings.</p> <p>\$0 co-pay for screening colonoscopy. Note: if removal of polyps/tumor or surgery is performed during the procedure, the outpatient surgery co-pay will apply.</p>
<p><b>HIV screening</b></p> <p>For people who ask for an HIV screening test or who are at increased risk for HIV infection, we cover:</p> <ul style="list-style-type: none"> <li>• One screening exam every 12 months</li> </ul> <p>For women who are pregnant, we cover:</p> <ul style="list-style-type: none"> <li>• Up to three screening exams during a pregnancy</li> </ul>	<p>\$0 co-pay for HIV screenings</p>
<p><b>Immunizations</b></p>	

Services that are covered for you	What you must pay when you get these services
<p>Covered services include:</p> <ul style="list-style-type: none"> <li>• Pneumonia vaccine</li> <li>• Flu shots, once a year in the fall or winter</li> <li>• Hepatitis B vaccine if you are at high or intermediate risk of getting Hepatitis B</li> <li>• Other vaccines if you are at risk</li> </ul>	<p>\$0 co-pay for Flu and Pneumonia vaccines.</p> <p>\$0 co-pay for Hepatitis B vaccine.</p> <p>No referral needed for Flu and pneumonia vaccines.</p>
<p><b>Mammography screening</b></p> <p>Covered services include:</p> <ul style="list-style-type: none"> <li>• One baseline exam between the ages of 35 and 39</li> <li>• One screening every 12 months for women age 40 and older</li> </ul>	<p>\$0 co-pay for Medicare-covered screening mammograms.</p>
<p><b>Pap test, pelvic exams, and clinical breast exams</b></p> <p>Covered services include:</p> <ul style="list-style-type: none"> <li>• For all women, Pap tests, pelvic exams, and clinical breast exams are covered once every 24 months</li> <li>• If you are at high risk of cervical cancer or have had an abnormal Pap test and are of childbearing age: one Pap test every 12 months</li> </ul>	<p>\$0 co-pay for Medicare-covered pap smears and pelvic exams.</p>
<p><b>Prostate cancer screening exams</b></p> <p>For men age 50 and older, covered services include the following - once every 12 months:</p> <ul style="list-style-type: none"> <li>• Digital rectal exam</li> <li>• Prostate Specific Antigen (PSA) test</li> </ul>	<p>\$0 co-pay for Medicare-covered prostate cancer screening.</p>
<p><b>Cardiovascular disease testing</b></p> <p>Blood tests for the detection of cardiovascular disease (or abnormalities)</p>	

Services that are covered for you	What you must pay when you get these services
<p>associated with an elevated risk of cardiovascular disease). Once every 12 months.</p>	<p>\$0 co-pay</p>
<p><b>Preventative Physical exam (Welcome to Medicare Physical Exam)</b></p> <p>Includes measurement of height, weight, body mass index, blood pressure, visual acuity screen and other routine measurements; an electrocardiogram; education, counseling and referral with respect to covered screening and preventive services. Doesn't include lab tests.</p>	<p>\$0 co-pay for routine exams.</p> <p>Limited to 1 exam(s) every year.</p>
<p><b>Personalized Prevention Plan Services (Annual Wellness Visit)</b></p> <p>Available to members in the first 12 months that they have Medicare Part B or 12 months after the member has the Preventative Physical Exam (Welcome to Medicare Physical Exam).</p>	<p>\$0 co-pay</p>
<p><b>Other Services</b></p>	
<p><b>Dialysis (kidney)*</b></p> <p>Covered services include:</p> <ul style="list-style-type: none"> <li>• Outpatient dialysis treatments (including dialysis treatments when temporarily out of the service area, as explained in Chapter 3)</li> <li>• Inpatient dialysis treatments (if you are admitted to a hospital for special care)</li> <li>• Self-dialysis training (includes training for you and anyone helping you with your home dialysis treatments)</li> <li>• Home dialysis equipment and supplies</li> <li>• Certain home support services (such as, when necessary, visits by trained dialysis workers to check on your home dialysis, to help in emergencies, and check your dialysis equipment and water supply)</li> </ul>	<p>20% of the cost for renal dialysis.</p> <p>\$0 co-pay for Nutrition Therapy for End-Stage Renal Disease.</p>

Services that are covered for you

**What you must pay** when you get these services

**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 while you are getting physician services
- Drugs you take using durable medical equipment (such as nebulizers) that was authorized by the plan
- Clotting factors you give yourself by injection if you have hemophilia\*
- Immunosuppressive Drugs, if you were enrolled in Medicare Part A at the time of the organ transplant\*
- Injectable osteoporosis drugs, if you are homebound, have a bone fracture that a doctor certifies was related to post-menopausal osteoporosis, and cannot self-administer the drug\*
- Antigens
- Certain oral anti-cancer drugs and anti-nausea drugs
- Certain drugs for home dialysis, including heparin, the antidote for heparin when medically necessary, topical anesthetics, and erythropoiesis-stimulating agents (such as Epogen®, Procrit®, Epoetin Alfa, Aranesp®, or Darbepoetin Alfa) \*
- Intravenous Immune Globulin for the home treatment of primary immune deficiency diseases\*

20% of the cost for Part B-covered chemotherapy drugs and other Part B-covered drugs.

**Additional Benefits**

**Dental services**

\$30 co-pay for Medicare-covered dental benefits.

\$10 co-pay for an office visit that includes:

Services that are covered for you	What you must pay when you get these services
	<ul style="list-style-type: none"><li>- Up to 1 oral exam(s) every six months</li><li>- Up to 1 cleaning(s) every six months</li><li>- Up to 1 fluoride treatment(s) every year</li><li>- Up to 1 dental X-ray(s) every year</li></ul>
<p><b>Hearing services</b></p> <ul style="list-style-type: none"><li>• 1 hearing aid every two years</li><li>• Diagnostic hearing exams</li><li>• 1 routine hearing test every year</li><li>• 1 hearing aid fitting evaluation every two years</li></ul>	<p>\$0 co-pay for up to 1 hearing aid(s) every two years.</p> <p>\$30 co-pay for Medicare-covered diagnostic hearing exams.</p> <p>\$10 co-pay for up to 1 routine hearing test(s) every year.</p> <p>\$10 co-pay for up to 1 hearing aid fitting evaluation(s) every year.</p> <p>\$500 plan coverage limit for hearing aids every two years.</p>

Services that are covered for you	What you must pay when you get these services
<p><b>Health and wellness education programs</b></p> <p>These are programs focused on clinical health conditions such as high blood pressure, cholesterol, asthma, and special diets. Programs designed to enrich the health and lifestyles of members include weight management, smoking cessation, fitness, and stress management. Other health and wellness education programs include: written health education materials, including newsletters, health club membership/fitness classes, nursing hotline and other wellness benefits.</p>	<p>\$0 co-pay for each Medicare-covered smoking cessation counseling session.</p> <p>\$0 co-pay for each Medicare-covered HIV screening.</p>
<p><b>Transportation</b></p>	<p>Not covered.</p>
<p><b>Acupuncture</b></p>	<p>Not covered.</p>

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

### **Section 3.1 Types of 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 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 a covered services.
  - Experimental medical and surgical procedures, equipment and medications, unless covered by Original Medicare. However, certain services may be covered under a Medicare-approved clinical research study. See Chapter 3, Section 5 for more information on clinical research studies.
  - Surgical treatment for morbid obesity, except when it is considered medically necessary and covered under Original Medicare.
  - Private room in a hospital, except when it is considered medically necessary.
  - Private duty nurses.
  - Personal items in your room at a hospital or a skilled nursing facility, such as a telephone or a television.
  - Full-time nursing care in your home.
  - Custodial care, unless it is provided with covered skilled nursing care and/or skilled rehabilitation services. Custodial care, or non-skilled care, is care that helps you with activities of daily living, such as bathing or dressing.
    - Custodial care is care for personal needs rather than medically necessary needs. Custodial care is care that can be provided by people who don't have professional skills or training. This care includes help with walking, dressing, bathing, eating, preparation of special diets, and taking medication. Medicare does not cover custodial care unless it is provided as other care you are getting in addition to daily skilled nursing care and/or skilled rehabilitation services.
  - 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.
  - 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.
  - Outpatient prescription drugs including drugs for treatment of sexual dysfunction, including erectile dysfunction, impotence, and anorgasmia or hyporgasmia.
  - 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.
  - Any services listed above that aren't covered will remain not covered even if received at an emergency facility.

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**Chapter 5. Asking the plan to pay its share of a bill you have received for medical services**

**SECTION 1 Situations in which you should ask our plan to pay our share of the cost of your covered services ..... 61**

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 .....61

**SECTION 2 How to ask us to pay you back or to pay a bill you have received ..... 62**

Section 2.1 How and where to send us your request for payment.....62

**SECTION 3 We will consider your request for payment and say yes or no ..... 63**

Section 3.1 We check to see whether we should cover the service and how much we owe .....63

Section 3.2 If we tell you that we will not pay for the medical care, you can make an appeal .....63

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**SECTION 1**      **Situations in which you should ask our plan to pay our share of the cost of your covered services**

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<b>Section 1.1</b>	<b>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</b>
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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 emergency or urgently needed medical care from a provider who is not in our plan’s network**

You can receive emergency services from any provider, whether or not the provider is a part of our network. When you receive emergency or urgently needed care from a provider who is not part of our network, you are only responsible for paying your share of the cost, not for the entire cost. You should ask the provider to bill the plan for our share of the cost.

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

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

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

- Whenever you get a bill from a network provider that you think is more than you should pay, send us the bill. We will contact the provider directly and resolve the billing problem.
- If you have already paid a bill to a network provider, but you feel that you paid too much, send us the bill along with documentation of any payment you have made and ask us to pay you back the difference between the amount you paid and the amount you owed under the plan.

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.

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

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<b>Section 2.1      How and where to send us your request for payment</b>
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Send us your request for payment, along with your bill and documentation of any payment you have made. It's a good idea to make a copy of your bill and receipts for your records.

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

- You don't have to use the form, but it's helpful for our plan to process the information faster.
- Either download a copy of the form from our website ([www.pupcorp.com](http://www.pupcorp.com)) or call Member Services and ask for the form. The phone numbers for Member Services are on the cover of this booklet.

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

For Medical Claims:

Physicians United Plan

Attn: Accounts Payable

9102 SouthPark Center Loop, Ste 200

Orlando, FL 32819

Please be sure to contact Member Services if you have any questions. If you don't know what you owe, or you receive bills and you don't know what to do about those bills, we can help. You

can also call if you want to give us more information about a request for payment you have already sent to us.

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

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<b>Section 3.1      We check to see whether we should cover the service and how much we owe</b>
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When we receive your request for payment, we will let you know if we need any additional information from you. Otherwise, we will consider your request and decide whether to pay it and how much we owe.

- 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.)
- 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.

<b>Section 3.2      If we tell you that we will not pay for the medical care, you can make an appeal</b>
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If you think we have made a mistake in turning you down your request for payment, 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 legal 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 5.4 to learn how to make an appeal about getting paid back for a medical service.

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## **Chapter 6. Your rights and responsibilities**

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## **SECTION 1      Our plan must honor your rights as a member of the plan**

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<b>Section 1.1</b>	<b>We must provide information in a way that works for you (in languages other than English that are spoken in the plan service area, in Braille, in large print, or other alternate formats, etc.)</b>
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To get information from us in a way that works for you, please call Member Services (phone numbers are on the front cover).

Our plan has people and translation services available to answer questions from non-English speaking members. We can also give you information in Braille, in large print, or other alternate formats if you need it. If you are eligible for Medicare because of 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 disability, please call Medicare at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week, and tell them that you want to file a complaint. TTY users call 1-877-486-2048.

<b>Section 1.2</b>	<b>We must treat you with fairness and respect at all times</b>
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Our plan must obey laws that protect you from discrimination or unfair treatment. **We do not discriminate** based on a person's race, disability, religion, sex, health, ethnicity, creed (beliefs), age, or national origin.

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 Member Services (phone numbers are on the cover of this booklet). If you have a complaint, such as a problem with wheelchair access, Member Services can help.

<b>Section 1.3</b>	<b>We must ensure that you get timely access to your covered services</b>
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As a member of our plan, you have the right to choose a primary care provider (PCP) in the plan's network to provide and arrange for your covered services (Chapter 3 explains more about this). Call Members Services to learn which doctors are accepting new patients (phone numbers

are on the cover of this booklet). You also have the right to go to a women's health specialist (such as a gynecologist) or chiropractor without a referral.

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

If you think that you are not getting your medical care within a reasonable amount of time, Chapter 7 of this booklet tells what you can do.

<b>Section 1.4</b>	<b>We must protect the privacy of your personal health information</b>
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Federal and state laws protect the privacy of your medical records and personal health information. We protect your personal health information as required by these laws.

- Your “personal health information” includes the personal information you gave us when you enrolled in this plan as well as your medical records and other medical and health information.
- The laws that protect your privacy give you rights related to getting information and controlling how your health information is used. We give you a written notice, called a “Notice of Privacy Practice”, that tells about these rights and explains how we protect the privacy of your health information.

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

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

<b>Section 1.5</b>	<b>We must give you information about the plan, its network of providers, and your covered services</b>
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As a member of our plan, you have the right to get several kinds of information from us. (As explained above in Section 1.1, you have the right to get information from us in a way that works for you. This includes getting the information in languages other than English and in large print or other alternate formats.)

If you want any of the following kinds of information, please call Member Services (phone numbers are on the 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 Advantage 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 Member Services (phone numbers are on the cover of this booklet) or visit our website at [www.pupcorp.com](http://www.pupcorp.com).
- **Information about your coverage and rules you must follow in using your coverage.**
  - In Chapters 3 and 4 of this booklet, we explain what medical services are covered for you, any restrictions to your coverage, and what rules you must follow to get your covered medical services.

- If you have questions about the rules or restrictions, please call Member Services (phone numbers are on the cover of this booklet).
- **Information about why something is not covered and what you can do about it.**
  - 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.
  - 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. 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 ask the plan for a decision about your coverage and 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.)
  - 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.

<b>Section 1.6</b>	<b>We must support your right to make decisions about your care</b>
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### **You have the right to know your treatment options and participate in decisions about your health care**

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

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

- **To know about all of your choices.** This means that you have the right to be told about all of the treatment options that are recommended for your condition, no matter what they cost or whether they are covered by our plan.
- **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 Member Services to ask for the forms (phone numbers are on the cover of this booklet).
- **Fill it out and sign it.** Regardless of where you get this form, keep in mind that it is a legal document. You should consider having a lawyer help you prepare it.
- **Give copies to appropriate people.** You should give a copy of the form to your doctor and to the person you name on the form as the one to make decisions for you if you can't. You may want to give copies to close friends or family members as well. Be sure to keep a copy at home.

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

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

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

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

If you have signed an advance directive, and you believe that a doctor or hospital hasn't followed the instructions in it, you may file a complaint with the Florida Agency for Health Care Administration, 2727 Mahan Drive, Tallahassee, FL 32308

<b>Section 1.7</b>	<b>You have the right to make complaints and to ask us to reconsider decisions we have made</b>
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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 Member Services (phone numbers are on the cover of this booklet).

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

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

### **Is it about something else?**

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

- You can **call Member Services** (phone numbers are on the 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.

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<b>Section 1.9</b>	<b>How to get more information about your rights</b>
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There are several places where you can get more information about your rights:

- You can **call Member Services** (phone numbers are on the 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 (<http://www.medicare.gov>) to read or download the publication “Your Medicare Rights & Protections.”
  - 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.

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<b>SECTION 2</b>	<b>You have some responsibilities as a member of the plan</b>
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<b>Section 2.1</b>	<b>What are your responsibilities?</b>
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Things you need to do as a member of the plan are listed below. If you have any questions, please call Member Services (phone numbers are on the 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, or separate prescription drug coverage, you are required to tell us. Please call Member Services to let us know.***
  - We are required to follow rules set by Medicare to make sure that you are using all of your coverage in combination when you get your covered services from our plan. This is called “**coordination of benefits**” because it involves coordinating the health benefits you get from our plan with any other benefits available to you. We’ll help you with it.

- **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.
  - If you have any questions, be sure to ask. Your doctors and other health care providers are supposed to explain things in a way you can understand. If you ask a question and you don't understand the answer you are given, ask again.
- **Be considerate.** *We expect all our members to respect the rights of other patients. We also expect you to act in a way that helps the smooth running of your doctor's office, hospitals, and other offices.*
- **Pay what you owe.** *As a plan member, you are responsible for these payments:*
  - In order to be eligible for our plan, you must maintain your eligibility for Medicare Part A and 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.
- **Tell us if you move.** *If you are going to move, it's important to tell us right away. Call Member Services (phone numbers are on the cover of this booklet).*
  - **If you move *outside* of our plan service area, you cannot remain a member of our plan.** (Chapter 1 tells about our service area.) We can help you figure out whether you are moving outside our service area. If you are leaving our service area, we can let you know if we have a plan in your new area.
  - **If you move *within* our service area, we still need to know** so we can keep your membership record up to date and know how to contact you.
- **Call member services 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 Member Services are on the 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)**

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## BACKGROUND

### SECTION 1 Introduction

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

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

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

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

Which one do you use? That depends on the type of problem you are having. The guide in Section 3 will help you identify the right process to use.

#### Section 1.2 What about the legal terms?

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

To keep things simple, this chapter explains the legal rules and procedures using more common 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.

An Organization Determination means the Medicare Advantage organization has made an organization determination when it, or one of its providers, makes a decision about whether services are covered or how much you have to pay for covered services.

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

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<b>Section 2.1      Where to get more information and personalized assistance</b>
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Sometimes it can be confusing to start or follow through the process for dealing with a problem. This can be especially true if you do not feel well or have limited energy. Other times, you may not have the knowledge you need to take the next step. Perhaps both are true for you.

### **Get help from an independent government organization**

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

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

### **You can also get help and information from Medicare**

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

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

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

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<b>Section 3.1      Should you use the process for coverage decisions and appeals? Or should you use the process for making complaints?</b>
---

If you have a problem or concern and you want to do something about it, you don't need to read this whole chapter. You just need to find and 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 tells what to do for your problem or concern ,  
**START HERE**

**Is your problem or concern about your benefits and coverage?**

(This includes problems about whether particular medical care is covered or not, the way in which it is covered, and problems related to payment for medical care.)

Yes

No

Go on to the next section of this chapter, **Section 4: "A guide to the basics of coverage decisions and making appeals."**

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."**

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## COVERAGE DECISIONS AND APPEALS

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### SECTION 4      **A guide to the basics of coverage decisions and appeals**

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<b>Section 4.1</b>	<b>Asking for coverage decisions and making appeals: the big picture</b>
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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. We and/or your doctor make a coverage decision for you whenever you go to a doctor for medical care. You can also contact the plan and ask for a coverage decision. For example, 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. When we have completed the review we give you our decision.

If we say no to all or part of your Level 1 Appeal, your case will automatically go on to a Level 2 Appeal. The Level 2 Appeal is conducted by an independent organization that is not connected to our plan. If you are not satisfied with the decision at the Level 2 Appeal, you may be able to continue through several more levels of appeal.

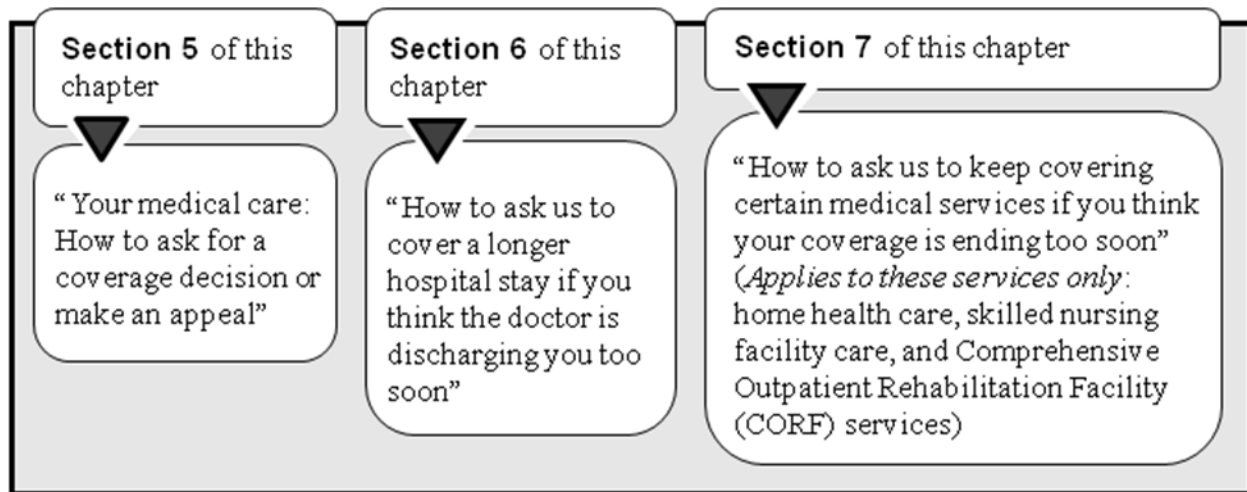
<b>Section 4.2</b>	<b>How to get help when you are asking for a coverage decision or making an appeal</b>
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Would you like some help? Here are resources you may wish to use if you decide to ask for any kind of coverage decision or appeal a decision:

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

<b>Section 4.3</b>	<b>Which section of this chapter gives the details for <u>your</u> situation?</b>
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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:



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

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

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

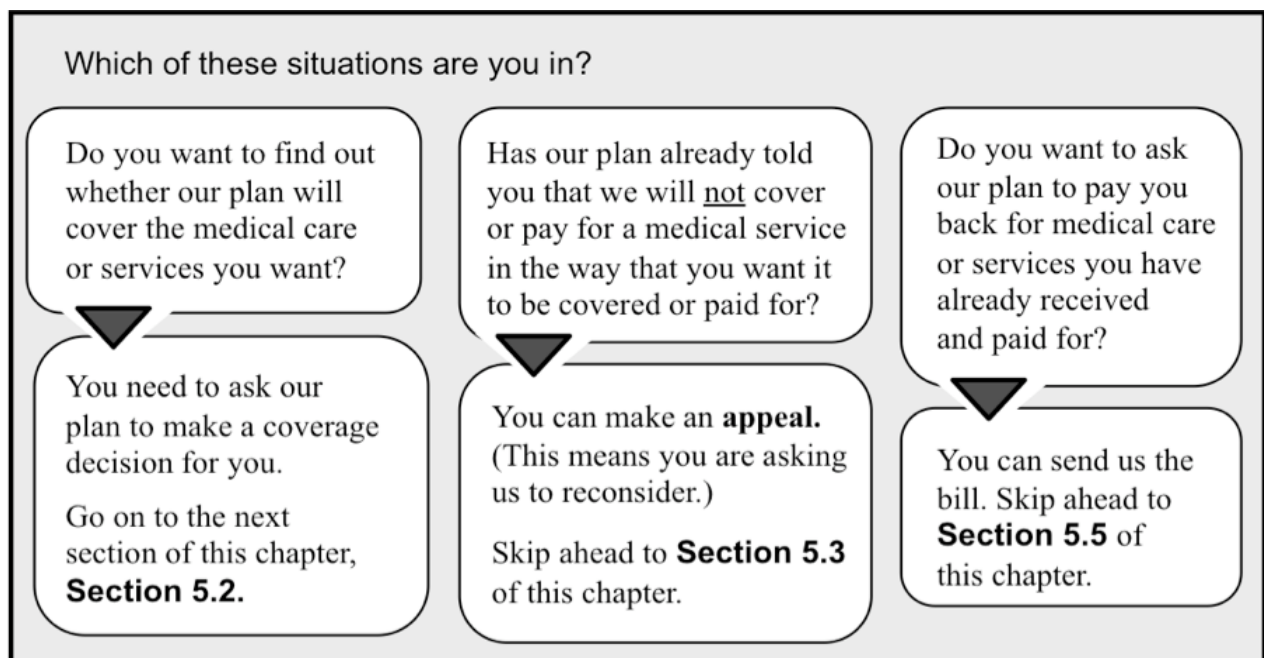
<b>Section 5.1</b>	<b>This section tells what to do if you have problems getting coverage for medical care or if you want us to pay you back for our share of the cost of your care</b>
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This section is about your benefits for medical care and services. These are the benefits 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 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 (CORF) services, you need to read a separate section of this chapter because special rules apply to these types of care. Here's what to read in those situations:**
    - Chapter 7, Section 6: *How to ask for a longer hospital stay if you think you are being asked to leave the hospital too soon.*
    - Chapter 7, Section 7: *How to ask our plan 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.



<b>Section 5.2</b>	<b>Step-by-step: How to ask for a coverage decision</b> (how to ask our plan to authorize or provide the medical care coverage you want)
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<b>Legal Terms</b>	When a coverage decision involves your medical care, it is called an “ <b>organization determination.</b> ”
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**Step 1: You ask our plan to make a coverage decision on the medical care you are requesting.** If your health requires a quick response, you should ask us to make a “**fast decision.**”

<b>Legal Terms</b>	A “fast decision” is called an “ <b>expedited decision.</b> ”
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*How to request coverage for the medical care you want*

- Start by calling, writing, or faxing our plan to make your request for us to provide coverage for the medical care you want. You, or your doctor, or your representative can do this.
- For the details on how to contact us, go to Chapter 2, Section 1 and look for the section called, *How to contact our plan when you are asking for a coverage decision about your medical care.*

*Generally we use the standard deadlines for giving you our decision*

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

- **However, we can take up to 14 more days** if you ask for more time, or if we need information (such as medical records) that may benefit you. If we decide to take extra days to make the decision, we will tell you in writing.
- If you believe we should *not* take extra days, you can file a “fast complaint” about our decision to take extra days. When you file a fast complaint, we will give you an answer to your complaint within 24 hours. (The process for making a complaint is different from the process for coverage decisions and appeals. For more information about the process for making complaints, including fast complaints, see Section 9 of this chapter.)

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

- **A fast decision means we will answer within 72 hours.**

- **However, we can take up to 14 more days** if we find that some information is missing that may benefit you, 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 decision, you must meet two requirements:**
  - You can get a fast decision only if you are asking for coverage for medical care *you have not yet received*. (You cannot get a fast decision if your request is about payment for medical care you have already received.)
  - You can get a fast decision *only* if using the standard deadlines could *cause serious harm to your health or hurt your ability to function*.
- **If your doctor tells us that your health requires a “fast decision,” we will automatically agree to give you a fast decision.**
- If you ask for a fast decision on your own, without your doctor’s support, our plan will decide whether your health requires that we give you a fast decision.
  - If we decide that your medical condition does not meet the requirements for a fast decision, we will send you a letter that says so (and we will use the standard deadlines instead).
  - This letter will tell you that if your doctor asks for the fast decision, we will automatically give a fast decision.
  - The letter will also tell how you can file a “fast complaint” about our decision to give you a standard decision instead of the fast decision you requested. (For more information about the process for making complaints, including fast complaints, see Section 9 of this chapter.)

**Step 2: Our plan considers your request for medical care coverage and we give you our answer.**

*Deadlines for a “fast” coverage decision*

- Generally, for a fast decision, we will give you our answer **within 72 hours**.
  - As explained above, we can take up to 14 more days under certain circumstances. If we decide to take extra days to make the decision, we will tell you in writing. If we take extra days, it is called “an extended time period.”
  - If we do not give you our answer within 72 hours (or if there is an extended time period, by the end of that period), you have the right to appeal. Section 5.3 below tells how to make an appeal.
- **If our answer is yes to part or all of what you requested**, we must authorize or provide the medical care coverage we have agreed to provide within 72 hours after

we received your request. If we extended the time needed to make our decision, we will provide the coverage by the end of that extended period.

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

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

- Generally, for a standard decision, we will give you our answer **within 14 days of receiving your request**.
  - We can take up to 14 more days (“an extended time period”) under certain circumstances. If we decide to take extra days to make the decision, we will tell you in writing.
  - If we do not give you our answer within 14 days (or if there is an extended time period, by the end of that period), you have the right to appeal. Section 5.3 below tells how to make an appeal.
- **If our answer is yes to part or all of what you requested**, we must authorize or provide the coverage we have agreed to provide within 14 days after we received your request. If we extended the time needed to make our decision, we will provide the coverage by the end of that extended period.
- **If our answer is no to part or all of what you requested**, we will send you a written statement that explains why we said no.

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

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

#### **Section 5.3**

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

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

**Legal Terms** When you start the appeal process by making an appeal, it is called the “first level of appeal” or a “Level 1 Appeal.”

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

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

*What to do*

- **To start an appeal you, your representative, or in some cases your doctor must contact our plan.** For details on how to reach us for any purpose related to your appeal, go to Chapter 2, Section 1 look for section called, *How to contact our plan 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.** You may also ask for an appeal by calling us at the phone number shown in Chapter 2, Section 1 (*How to contact our plan when you are making an appeal about your medical care.*).
- **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 our plan 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.
- **You can ask for a copy of the information regarding your medical decision and add more information to support your appeal.**
  - You have the right to ask us for a copy of the information regarding your appeal. We are allowed to charge a fee for copying and sending this information to you.
  - If you wish, you and your doctor may give us additional information to support your appeal.

*If your health requires it, ask for a “fast appeal” (you can make an oral request)*

<b>Legal Terms</b>	A “fast appeal” is also called an “ <b>expedited appeal.</b> ”
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- If you are appealing a decision our plan made about coverage for care you have not yet received, you and/or your doctor will need to decide if you need a “fast appeal.”
- The requirements and procedures for getting a “fast appeal” are the same as those for getting a “fast decision.” To ask for a fast appeal, follow the instructions for asking for a fast decision. (These instructions are given earlier in this section.)
- If your doctor tells us that your health requires a “fast appeal,” we will give you a fast appeal.

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

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

#### *Deadlines for a “fast” appeal*

- When we are using the fast deadlines, we must give you our answer **within 72 hours after we receive your appeal**. We will give you our answer sooner if your health requires us to do so.
  - However, if you ask for more time, or if we need to gather more information that may benefit you, we **can take up to 14 more calendar days**. If we decide to take extra days to make the decision, we will tell you in writing.
  - If we do not give you an answer within 72 hours (or by the end of the extended time period 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 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, **our plan is required to send your appeal to the “Independent Review Organization.”** When we do this, it means that your appeal is going on to the next level of the appeals process, which is Level 2.

<b>Section 5.4</b>	<b>Step-by-step: How to make a Level 2 Appeal</b>
--------------------	---

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

<b>Legal Terms</b>	The formal name for the “Independent Review Organization” is the “ <b>Independent Review Entity.</b> ” It is sometimes called the “ <b>IRE.</b> ”
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**Step 1: The Independent Review Organization reviews your appeal.**

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

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

- If you had a fast appeal to our plan at Level 1, you will automatically receive a fast appeal at Level 2. The review organization must give you an answer to your Level 2 Appeal **within 72 hours** of when it receives your appeal.

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

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

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

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

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

- **If the review organization says yes to part or all of what you requested**, we must authorize the medical care coverage within 72 hours or provide the service within 14 calendar days after we receive the decision from the review organization.
- **If this organization says no to part or all of your appeal**, it means they agree with our plan that your request (or part of your request) for coverage for medical care should not be approved. (This is called “upholding the decision.” It is also called “turning down your appeal.”)
  - The notice you get from the Independent Review Organization will tell you in writing if your case meets the requirements for continuing with the appeals process. For example, to continue and make another appeal at Level 3, the dollar value of the medical care coverage you are requesting must meet a certain minimum. If the dollar value of the coverage you are requesting is too low, you cannot make another appeal, which means that the decision at Level 2 is final.

### **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.

<b>Section 5.5</b>	<b>What if you are asking our plan to pay you for our share of a bill you have received for medical care?</b>
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If you want to ask our plan for payment for medical care, start by reading Chapter 5 of this booklet: *Asking the plan to pay its share of a bill you have received for 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 our plan**

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

### **We will say yes or no to your request**

- If the medical care you paid for is covered and you followed all the rules, we will send you the payment for our share of the cost of your medical care within 60 calendar days after we receive your request. Or, if you haven't paid for the services, we will send the payment directly to the provider. When we send the payment, it's the same as saying *yes* to your request for a coverage decision.)
- If the medical care is *not* covered, or you did *not* follow all the rules, we will not send payment. Instead, we will send you a letter that says we will not pay for the services and the reasons why. (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.

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

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When you are admitted to a hospital, you have the right to get all of your covered hospital services that are necessary to diagnose and treat your illness or injury. For more information about our coverage for your hospital care, including any limitations on this coverage, see Chapter 4 of this booklet: *Medical Benefits Chart (what is covered and what you pay)*.

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

- The day you leave the hospital is called your “**discharge date.**” Our plan’s coverage of your hospital stay ends on this date.
- When your discharge date has been decided, your doctor or the hospital staff will let you know.
- If you think you are being asked to leave the hospital too soon, you can ask for a longer hospital stay and your request will be considered. This section tells you how to ask.

<b>Section 6.1      During your hospital stay, you will get a written notice from Medicare that tells about your rights</b>
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During your hospital stay, you will be given a written notice called *An Important Message from Medicare about Your Rights*. Everyone with Medicare gets a copy of this notice whenever they are admitted to a hospital. Someone at the hospital is supposed to give it to you within two days after you are admitted.

- 1. Read this notice carefully and ask questions if you don’t understand it.** It tells you about your rights as a hospital patient, including:
  - Your right to receive Medicare-covered services during and after your hospital stay, as ordered by your doctor. This includes the right to know what these services are, who will pay for them, and where you can get them.
  - Your right to be involved in any decisions about your hospital stay, and know who will pay for it.
  - Where to report any concerns you have about quality of your hospital care.
  - What to do if you think you are being discharged from the hospital too soon.

<b>Legal Terms</b>	The written notice from Medicare tells you how you can “ <b>make an appeal.</b> ” Making an appeal is a formal, legal way to ask for a delay in your discharge date so that your hospital care will be covered for a longer time. (Section 7.2 below tells how to make this appeal.)
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**2. You must sign the written notice to show that you received it and understand your rights.**

- You or someone who is acting on your behalf must sign the notice. (Section 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 Member Services 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.hhs.gov>.

<b>Section 6.2</b>	<b>Step-by-step: How to make a Level 1 Appeal to change your hospital discharge date</b>
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If you want to ask for your hospital services to be covered by our plan for a longer time, you will need to use the appeals process to make this request. Before you start, understand what you need to do and what the deadlines are.

- **Follow the process.** Each step in the first two levels of the appeals process is explained below.
- **Meet the deadlines.** The deadlines are important. Be sure that you understand and follow the deadlines that apply to things you must do.
- **Ask for help if you need it.** If you have questions or need help at any time, please call Member Services (phone numbers are on the front cover of this booklet). Or call your State Health Insurance Assistance Program, a government organization that provides personalized assistance (see Section 2 of this chapter).

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

<b>Legal Terms</b>	When you start the appeal process by making an appeal, it is called the “first level of appeal” or a “Level 1 Appeal.”
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**Step 1: Contact the Quality Improvement Organization in your state and ask for a “fast review” of your hospital discharge. You must act quickly.**

<b>Legal Terms</b>	A “fast review” is also called an “ <b>immediate review</b> ” or an “ <b>expedited review.</b> ”
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*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*) tells you how to reach this organization. (Or find the name, address, and phone number of the Quality Improvement Organization for your state in Chapter 2, Section 4, of this booklet.)

*Act quickly:*

- To make your appeal, you must contact the Quality Improvement Organization *before* you leave the hospital and **no later than your planned discharge date.** (Your “planned discharge date” is the date that has been set for you to leave the hospital.)
  - If you meet this deadline, you are allowed to stay in the hospital *after* your discharge date *without paying for it* while you wait to get the decision on your appeal from the Quality Improvement Organization.
  - If you do *not* meet this deadline, and you decide to stay in the hospital after your planned discharge date, *you may have to pay all of the costs* for hospital care you receive after your planned discharge date.
- If you miss the deadline for contacting the Quality Improvement Organization about your appeal, you can make your appeal directly to our plan instead. For details about this other way to make your appeal, see Section 6.4.

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

*What happens during this review?*

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

<b>Legal Terms</b>	This written explanation is called the “ <b>Detailed Notice of Discharge.</b> ” You can get a sample of this notice by calling Member Services 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 get see a sample notice online at <a href="http://www.cms.hhs.gov/BNI/">http://www.cms.hhs.gov/BNI/</a>
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**Step 3: Within one full day after it has all the needed information, the Quality Improvement Organization will give you its answer to your appeal.***What happens if the answer is yes?*

- If the review organization says *yes* to your appeal, **our plan must keep providing your covered hospital services for as long as these services are medically necessary.**
- You will have to keep paying your share of the costs (such as deductibles or copayments, if these apply). In addition, there may be limitations on your covered hospital services. (See Chapter 4 of this booklet).

*What happens if the answer is no?*

- If the review organization says *no* to your appeal, they are saying that your planned discharge date is medically appropriate. (Saying *no* to your appeal is also called *turning down* your appeal.) If this happens, **our plan’s coverage for your hospital services will end** at noon on the day *after* the Quality Improvement Organization gives you its answer to your appeal.
- If the review organization says *no* to your appeal and you decide to stay in the hospital, then **you may have to pay the full cost** of hospital care you receive after noon on the day after the Quality Improvement Organization gives you its answer to your appeal.

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

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

<b>Section 6.3</b>	<b>Step-by-step: How to make a Level 2 Appeal to change your hospital discharge date</b>
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If the Quality Improvement Organization has turned down your appeal, *and* you stay in the hospital after your planned discharge date, then you can make a Level 2 Appeal. During a Level 2 Appeal, you ask the Quality Improvement Organization to take another look at the decision they made on your first appeal.

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

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

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

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

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

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

*If the review organization says yes:*

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

*If the review organization says no:*

- It means they agree with the decision they made to your Level 1 Appeal and will not change it. This is called “upholding the decision.” It is also called “turning down your appeal.”
- 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.

<b>Section 6.4</b>	<b>What if you miss the deadline for making your Level 1 Appeal?</b>
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**You can appeal to our plan instead**

As explained above in Section 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 our plan, asking for a “fast review.” A fast review is an appeal that uses the fast deadlines instead of the standard deadlines.

<b>Legal Terms</b>	A “fast” review (or “fast appeal”) is also called an “ <b>expedited</b> ” review (or “ <b>expedited appeal</b> ”).
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**Step 1: Contact our plan and ask for a “fast review.”**

- For details on how to contact our plan, go to Chapter 2, Section 1 and look for the section called, *How to contact 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: Our plan does a “fast” review of your planned discharge date, checking to see if it was medically appropriate.**

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

**Step 3: Our plan gives you our decision within 72 hours after you ask for a “fast review” (“fast appeal”).**

- **If our plan says yes to your fast appeal**, it means we have agreed with you that you still need to be in the hospital after the discharge date, and will keep providing your covered services for as long as it is medically necessary. It also means that we have agreed to reimburse you for our share of the costs of care you have received since the date when we said your coverage would end. (You must pay your share of the costs and there may be coverage limitations that apply.)
- **If our plan says no to your fast appeal**, we are saying that your planned discharge date was medically appropriate. Our coverage for your hospital services ends as of the day we said coverage would end.
- If you stayed in the hospital *after* your planned discharge date, then **you may have to pay the full cost** of hospital care you received after the planned discharge date. You will be responsible for the cost of care starting from noon on the day after our plan says no to your appeal.

**Step 4: If our plan says *no* to your fast appeal, your case will *automatically* be sent on to the next level of the appeals process.**

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

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

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

<b>Legal Terms</b>	The formal name for the “Independent Review Organization” is the <b>“Independent Review</b>
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**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 outside, independent organization that is hired by Medicare.** This organization is not connected with our plan and it is not a government agency. This organization is a company chosen by Medicare to handle the job of being the Independent Review Organization. Medicare oversees its work.
- Reviewers at the Independent Review Organization will take a careful look at all of the information related to your appeal of your hospital discharge.
- **If this organization says *yes* to your appeal,** then our plan must reimburse you (pay you back) for our share of the costs of hospital care you have received since the date of your planned discharge. We must also continue the plan’s coverage of your hospital services for as long as it is medically necessary. You must continue to pay your share of the costs. If there are coverage limitations, these could limit how much we would reimburse or how long we would continue to cover your services.
- **If this organization says *no* to your appeal,** it means they agree with our plan that your planned hospital discharge date was medically appropriate. (This is called “upholding the decision.” It is also called “turning down your appeal.”)
  - The notice you get from the Independent Review Organization will tell you in writing 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.

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

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<b>Section 7.1</b>	<i>This section is about three services <u>only</u>:</i> <b>Home health care, skilled nursing facility care, and Comprehensive Outpatient Rehabilitation Facility (CORF) services</b>
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This section is about the following types of care *only*:

- **Home health care services** you are getting.
- **Skilled nursing care** you are getting as a patient in a skilled nursing facility. (To learn about requirements for being considered a “skilled nursing facility,” see Chapter 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 our plan decides it is time to stop covering any of the three types of care for you, we are required to tell you in advance. When your coverage for that care ends, *our plan will stop paying its share of the cost for your care*.

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

<b>Section 7.2</b>	<b>We will tell you in advance when your coverage will be ending</b>
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1. **You receive a notice in writing.** At least two days before our plan is going to stop covering your care, the agency or facility that is providing your care will give you a notice.
  - The written notice tells you the date when our plan will stop covering the care for you.

<b>Legal Terms</b>	In this written notice, we are telling you about a “ <b>coverage decision</b> ” we have made about when to stop covering your care. (For more information about coverage decisions, see Section 4 in this chapter.)
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- 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.

<b>Legal Terms</b>	In telling what you can do, the written notice is telling how you can “ <b>make an appeal.</b> ” Making an appeal is a formal, legal way to ask our plan to change the coverage decision we have made about when to stop your care. (Section 8.3 below tells how you can make an appeal.)
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<b>Legal Terms</b>	The written notice is called the “ <b>Notice of Medicare Non-Coverage.</b> ” To get a sample copy, call Member Services 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 <a href="http://www.cms.hhs.gov/BNI/">http://www.cms.hhs.gov/BNI/</a>
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## 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.

<b>Section 7.3</b>	<b>Step-by-step: How to make a Level 1 Appeal to have our plan cover your care for a longer time</b>
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If you want to ask us to cover your care for a longer period of time, you will need to use the appeals process to make this request. Before you start, understand what you need to do and what the deadlines are.

- **Follow the process.** Each step in the first two levels of the appeals process is explained below.
- **Meet the deadlines.** The deadlines are important. Be sure that you understand and follow the deadlines that apply to things you must do. There are also deadlines our plan must follow. (If you think we are not meeting our deadlines, you can file a complaint. Section 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 Member Services (phone numbers are on the front cover of this booklet). Or call your State Health Insurance Assistance Program, a government organization that provides personalized assistance (see Section 2 of this chapter).

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

<b>Legal Terms</b>	When you start the appeal process by making an appeal, it is called the “first level of appeal” or “Level 1 Appeal.”
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**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 our plan to end coverage for your medical services.

*Your deadline for contacting this organization.*

- You must contact the Quality Improvement Organization to start your appeal *no later than noon of the day after you receive the written notice telling you when we will stop covering your care.*
- If you miss the deadline for contacting the Quality Improvement Organization about your appeal, you can make your appeal directly to our plan instead. For details about this other way to make your appeal, see Section 8.4.

**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 our plan of your appeal, you will also get a written notice from the plan that gives our reasons for wanting to end the plan’s coverage for your services.

<b>Legal Terms</b>	This notice explanation is called the “ <b>Detailed Explanation of Non-Coverage.</b> ”
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**Step 3: Within one full day after they have all the information they need, the reviewers will tell you their decision.**

*What happens if the reviewers say yes to your appeal?*

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

*What happens if the reviewers say no to your appeal?*

- If the reviewers say *no* to your appeal, then **your coverage will end on the date we have told you.** Our plan will stop paying its share of the costs of this care.
- If you decide to keep getting the home health care, or skilled nursing facility care, or Comprehensive Outpatient Rehabilitation Facility (CORF) services *after* this date when your coverage ends, then **you will have to pay the full cost** of this care yourself.

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

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

<b>Section 7.4</b>	<b>Step-by-step: How to make a Level 2 Appeal to have our plan cover your care for a longer time</b>
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If the Quality Improvement Organization has turned down your appeal and you choose to continue getting care after your coverage for the care has ended, then you can make a Level 2 Appeal. During a Level 2 Appeal, you ask the Quality Improvement Organization to take another look at the decision they made on your first appeal.

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?*

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

*What happens if the review organization says no?*

- It means they agree with the decision they made to your Level 1 Appeal and will not change it. (This is called “upholding the decision.” It is also called “turning down your appeal.”)
- 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 our plan 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 our plan, asking for a “fast review.” A fast review is an appeal that uses the fast deadlines instead of the standard deadlines.

Here are the steps for a Level 1 Alternate Appeal:

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

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

- For details on how to contact our plan, go to Chapter 2, Section 1 and look for the section called, *How to contact 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: Our plan does a “fast” review of the decision we made about when to end coverage for your services.**

- During this review, our plan takes another look at all of the information about your case. We check to see if we were following all the rules when we set the date for ending the plan’s coverage for services you were receiving.
- We will use the “fast” deadlines rather than the standard deadlines for giving you the answer to this review. (Usually, if you make an appeal to our plan and ask for a “fast review,” we are allowed to decide whether to agree to your request and give you a

“fast review.” But in this situation, the rules require us to give you a fast response if you ask for it.)

**Step 3: Our plan gives you our decision within 72 hours after you ask for a “fast review” (“fast appeal”).**

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

**Step 4: If our plan says *no* to your fast appeal, your case will *automatically* go on to the next level of the appeals process.**

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

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

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

<b>Legal Terms</b>	The formal name for the “Independent Review Organization” is the <b>“Independent Review Entity.”</b> It is sometimes called the <b>“IRE.”</b>
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**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 outside, independent organization that is hired by Medicare.** This organization is not connected with our plan and it is not a government agency. This organization is a company chosen by Medicare to handle the job of being the Independent Review Organization. Medicare oversees its work.
- Reviewers at the Independent Review Organization will take a careful look at all of the information related to your appeal.
- **If this organization says *yes* to your appeal,** then our plan must reimburse you (pay you back) for our share of the costs of care you have received since the date when we said your coverage would end. We must also continue to cover the care for as long as it is medically necessary. You must continue to pay your share of the costs. If there are coverage limitations, these could limit how much we would reimburse or how long we would continue to cover your services.
- **If this organization says *no* to your appeal,** it means they agree with the decision our plan made to your first appeal and will not change it. (This is called “upholding the decision.” It is also called “turning down your appeal.”)
  - The notice you get from the Independent Review Organization will tell you in writing what you can do if you wish to continue with the review process. It will give you the details about how to go on to a Level 3 Appeal.

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

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

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## **SECTION 8      Taking your appeal to Level 3 and beyond**

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

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

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

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

- **If the Administrative Law Judge says yes to your appeal, the appeals process *may* or *may not* be over** - We will decide whether to appeal this decision to Level 4. Unlike a decision at Level 2 (Independent Review Organization), we have the right to appeal a Level 3 decision that is favorable to you.
  - If we decide *not* to appeal the decision, we must authorize or provide you with the service within 60 days after receiving the judge’s decision.
  - If we decide to appeal the decision, we will send you a copy of the Level 4 Appeal request with any accompanying documents. We may wait for the Level 4 Appeal decision before authorizing or providing the service in dispute.
- **If the Administrative Law Judge says no to your appeal, the appeals process *may* or *may not* be over.**
  - If you decide to accept this decision that turns down your appeal, the appeals process is over.
  - If you do not want to accept the decision, you can continue to the next level of the review process. If the administrative law judge says no to your appeal, the notice you get will tell you what to do next if you choose to continue with your appeal.

**Level 4 Appeal** The Medicare Appeals Council will review your appeal and give you an answer. The Medicare Appeals Council works for the Federal government.

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

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

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

## MAKING COMPLAINTS

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

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

<b>Section 9.1</b>	<b>What kinds of problems are handled by the complaint process?</b>
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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 Member Services has dealt with you?
- Do you feel you are being encouraged to leave our 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 Member Services or other staff at our plan?
- 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 our plan**

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

*The next page has more examples of possible reasons for making a complaint*

### **Possible complaints (continued)**

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

The process of asking for a coverage decision and making appeals is explained in sections 4-8 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 for a coverage decision or made an appeal, and you think that our plan is not responding quickly enough, you can also make a complaint about our slowness. Here are examples:

- If you have asked us to give you a “fast response” for a coverage decision or appeal, and we have said we will not, you can make a complaint.
- If you believe our plan is 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 our plan is 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 our plan does 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.

<b>Section 9.2</b>	<b>The formal name for “making a complaint” is “filing a grievance”</b>
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<b>Legal Terms</b>	<ul style="list-style-type: none"><li>• What this section calls a “<b>complaint</b>” is also called a “<b>grievance.</b>”</li><li>• Another term for “<b>making a complaint</b>” is “<b>filing a grievance.</b>”</li><li>• Another way to say “<b>using the process for complaints</b>” is “<b>using the process for filing a grievance.</b>”</li></ul>
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<b>Section 9.3</b>	<b>Step-by-step: Making a complaint</b>
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**Step 1: Contact us promptly – either by phone or in writing.**

- **Usually, calling Member Services is the first step.** If there is anything else you need to do, Member Services will let you know. 1-866-571-0693. TTY users call: 1-800-955-8771 Monday – Sunday, 8:00 a.m. to 8:00 p.m.
- **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 do this, it means that we will use our *formal procedure* for answering grievances. Here’s how it works:
- A Grievance & Appeals coordinator will acknowledge your grievance in writing, investigate your case and send you a response in writing. The grievance must be submitted within 60 days of the event or incident. We must address your grievance as quickly as your case requires based on your health status, but no later than 30 days after receiving your complaint. We may extend the time frame by up to 14 days if you ask for the extension, or if we justify a need for additional information and the delay is in your best interest. You may also file an expedited or fast grievance when we deny your request for a fast (expedited) decision about your request for a service or for a fast (expedited) appeal for a service, or because we take extra days (an extension) to decide on your request for a service or your appeal. If you file an expedited or fast grievance, we must decide within 24 hours if our decision to deny or delay making an expedited decision puts your life or health at risk.
- **Whether you call or write, you should contact Member Services right away.** The complaint must be made within 60 calendar days after you had the problem you want to complain about.

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

<b>Legal Terms</b>	What this section calls a “fast complaint” is also called a “fast grievance.”
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### **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 days (44 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.

<b>Section 9.4</b>	<b>You can also make complaints about quality of care to the Quality Improvement Organization</b>
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You can make your complaint about the quality of care you received to our plan by using the step-by-step process outlined above.

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

- **You can make your complaint to the Quality Improvement Organization.** If you prefer, you can make your complaint about the quality of care you received directly to this organization (*without* making the complaint to our plan). To find the name, address, and phone number of the Quality Improvement Organization in your state, look in Chapter 2, Section 4, of this booklet. If you make a complaint to this organization, we will work with them to resolve your complaint.
- **Or, you can make your complaint to both at the same time.** If you wish, you can make your complaint about quality of care to our plan and also to the Quality Improvement Organization.

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## **Chapter 8. Ending your membership in the plan**

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## SECTION 1 Introduction

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<b>Section 1.1</b>	<b>This chapter focuses on ending your membership in our plan</b>
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Ending your membership in PUP Perks (HMO) may be **voluntary** (your own choice) or **involuntary** (not your own choice):

- You might leave our plan because you have decided that you *want* to leave.
  - There are only certain times during the year, or certain situations, when you may voluntarily end your membership in the plan. Section 2 tells you *when* you can end your membership in the plan.
  - The process for voluntarily ending your membership varies depending on what type of new coverage you are choosing. Section 3 tells you *how* to end your membership in each situation.
- There are also limited situations where you do not choose to leave, but we are required to end your membership. Section 5 tells you about situations when we must end your membership.

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

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

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

Disenrollment is the process of ending your membership in our plan. Disenrollment may be voluntary (your own choice) or involuntary (not your own choice).

<b>Section 2.1</b>	<b>You can end your membership during the Annual Enrollment Period</b>
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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 November 15 to December 31 of 2010.

- **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 Advantage plan. (You can choose a plan that covers prescription drugs or one that does not cover prescription drugs.)
  - Original Medicare *with* a separate Medicare prescription drug plan.
  - – *or* – Original Medicare *without* a separate Medicare prescription drug plan.
- **When will your membership end?** Your membership will end when your new plan's coverage begins on January 1.

<b>Section 2.2</b>	<b>You can end your membership during the Medicare Advantage Annual Disenrollment Period, but your choices are more limited</b>
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You have the opportunity to make *one* change to your health coverage during the **Medicare Advantage Annual Disenrollment Period**.

- **When is the Medicare Advantage Annual Disenrollment Period?** This happens every year from January 1 to February 14.
- **What type of plan can you switch to during the Medicare Advantage Annual Disenrollment Period?** During this time, you can cancel your Medicare Advantage enrollment and switch to Original Medicare. If you choose to switch to Original Medicare, you may also choose a separate Medicare prescription drug plan at the same time.
- **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 at the same time.

<b>Section 2.3</b>	<b>In certain situations, you can end your membership during a Special Enrollment Period</b>
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In certain situations, members of PUP Perks (HMO) 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 you live in a facility, such as a nursing home.
- **When are Special Enrollment Periods?** The enrollment periods vary depending on your situation.
- **What can you do?** 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 Advantage plan. (You can choose a plan that covers prescription drugs or one that does not cover prescription drugs.)
  - Original Medicare *with* a separate Medicare prescription drug plan.
  - – *or* – Original Medicare *without* a separate Medicare prescription drug plan.
- **When will your membership end?** Your membership will usually end on the first day of the month after we receive your request to change your plan.

<b>Section 2.4</b>	<b>Where can you get more information about when you can end your membership?</b>
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If you have any questions or would like more information on when you can end your membership:

- You can **call Member Services** (phone numbers are on the cover of this booklet).
- You can find the information in the *Medicare & You 2011* 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 health plan during one of the enrollment periods (see Section 2 for information about the enrollment periods). One exception is when you want to switch from our plan to Original Medicare *without* a Medicare prescription drug plan. In this situation, you must contact PUP Perks (HMO) Member Services and ask to be disenrolled from our plan.

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

If you would like to switch from our plan to:	This is what you should do:
<ul style="list-style-type: none"> <li>Another Medicare Advantage plan.</li> </ul>	<ul style="list-style-type: none"> <li>Enroll in the new Medicare Advantage plan.</li> </ul> <p>You will automatically be disenrolled from PUP Perks (HMO) when your new plan's coverage begins.</p>
<ul style="list-style-type: none"> <li>Original Medicare <i>with</i> a separate Medicare prescription drug plan.</li> </ul>	<ul style="list-style-type: none"> <li>Enroll in the new Medicare prescription drug plan.</li> </ul> <p>You will automatically be disenrolled from PUP Perks (HMO) when your new plan's coverage begins.</p>
<ul style="list-style-type: none"> <li>Original Medicare <i>without</i> a separate Medicare prescription drug plan.</li> </ul>	<ul style="list-style-type: none"> <li><b>Contact Member Services and ask to be disenrolled from the plan (phone numbers are on the cover of this booklet).</b></li> <li>You can also contact <b>Medicare</b> at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week, and ask to be disenrolled. TTY users should call 1-877-486-2048.</li> </ul>

**If you would like to switch from our plan to:**

**This is what you should do:**

- You will be disenrolled from PUP Perks (HMO) when your coverage in Original Medicare begins.

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

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<b>Section 4.1      Until your membership ends, you are still a member of our plan</b>
--

If you leave PUP Perks (HMO), 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, you will usually be covered by our plan until you are discharged** (even if you are discharged after your new health coverage begins).

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## **SECTION 5      PUP Perks (HMO) must end your membership in the plan in certain situations**

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<b>Section 5.1      When must we end your membership in the plan?</b>
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**PUP Perks (HMO) must end your membership in the plan if any of the following happen:**

- If you do not stay continuously enrolled in Medicare Part A and Part B.
- If you move out of our service area for more than six months.
  - If you move or take a long trip, you need to call Member Services to find out if the place you are moving or traveling to is in our plan's area.
- If you become incarcerated.
- If you intentionally give us incorrect information when you are enrolling in our plan and that information affects your eligibility for our plan.

- If you continuously behave in a way that is disruptive and makes it difficult for us to provide medical care for you and other members of our plan.
  - We cannot make you leave our plan for this reason unless we get permission from Medicare first.
- If you let someone else use your membership card to get medical care.
  - If we end your membership because of this reason, Medicare may have your case investigated by the Inspector General.

### **Where can you get more information?**

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

- You can call **Member Services** for more information (phone numbers are on the cover of this booklet).

<b>Section 5.2</b> <b>We <u>cannot</u> ask you to leave our plan for any reason related to your health</b>
--

### **What should you do if this happens?**

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

<b>Section 5.3</b> <b>You have the right to make a complaint if we end your membership in our plan</b>
--

If we end your membership in our plan, we must tell you our reasons in writing for ending your membership. We must also explain how you can make a complaint about our decision to end your membership. You can also look in Chapter 7, Section 9 for information about how to make a complaint.

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## **Chapter 9. Legal notices**

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<b>SECTION 2</b>	<b>Notice about nondiscrimination .....</b>	<b>123</b>
<b>SECTION 3</b>	<b>Notice about third party liability .....</b>	<b>123</b>
<b>SECTION 4</b>	<b>Notice about our access to your medical records .....</b>	<b>123</b>

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## **SECTION 1      Notice about governing law**

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

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## **SECTION 2      Notice about nondiscrimination**

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

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## **SECTION 3      Notice about third party liability**

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If we pay for medical care or prescription drugs for you as a result of an automobile accident or an illness or injury that is caused, or alleged to be caused, by a third party(ies), and you or your estate obtains a judgment or settlement from the third party(ies) or from any insurance company, we have the right to recover the amount we paid on your behalf from any monies you receive from that judgment or settlement. You agree to notify us of any claim or lawsuit that you or your representative may file.

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## **SECTION 4      Notice about our access to your medical records**

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By enrolling with us, you automatically authorize us to obtain any medical information we need from your health care providers if we need this information for treatment, payment or healthcare operations purposes, as defined by the Health Insurance Portability and Accountability Act of 1996 ("HIPAA").

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

**Appeal** – An appeal is something you do if you disagree with a decision to deny a request for health care services or payment for services you already received. You may also make an appeal if you disagree with a decision to stop services that you are receiving. For example, you may ask for an appeal if our plan doesn't pay for an item or service you think you should be able to receive. Chapter 7 explains appeals, including the process involved in making an appeal. Defined in Chapter 2, Section 1, PUP Perks (HMO) Contacts.

**Benefit Period** – For both our plan and Original Medicare, a benefit period is used to determine coverage for inpatient stays in hospitals and skilled nursing facilities. A benefit period begins on the first day you go to a Medicare-covered inpatient hospital or a skilled nursing facility. The benefit period ends when you haven't been an inpatient at any hospital or SNF for 60 days in a row. If you go to the hospital (or SNF) after one benefit period has ended, a new benefit period begins. There is no limit to the number of benefit periods you can have.

The type of care that is covered depends on whether you are considered an inpatient for hospital and SNF stays. You must be admitted to the hospital as an inpatient, not just under observation. You are an inpatient in a SNF only if your care in the SNF meets certain standards for skilled level of care. Specifically, in order to be an inpatient in a SNF, you must need daily skilled-nursing or skilled-rehabilitation care, or both. Defined in Chapter 4, Section 2.1, Your medical benefits and costs as a member of the plan.

**Centers for Medicare & Medicaid Services (CMS)** – The Federal agency that runs Medicare. Chapter 2 explains how to contact CMS. Defined in Chapter 1, Section 1.4, Legal information about the *Evidence of Coverage*.

**Comprehensive Outpatient Rehabilitation Facility (CORF)** – A facility that mainly provides rehabilitation services after an illness or injury, and provides a variety of services including physician's services, physical therapy, social or psychological services, and outpatient rehabilitation. Defined in Chapter 2, Section 4, Quality Improvement Organization.

**Cost Sharing** – Cost-sharing refers to amounts that a member has to pay when services are received. It 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 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 cover, on average, at least as much as Medicare's standard prescription drug coverage. People who have this kind of coverage when they become eligible

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for Medicare can generally keep that coverage without paying a penalty, if they decide to enroll in Medicare prescription drug coverage later.

**Custodial Care** – Care for personal needs rather than medically necessary needs. Custodial care is care that can be provided by people who don't have professional skills or training. This care includes help with walking, dressing, bathing, eating, preparation of special diets, and taking medication. Medicare does not cover custodial care unless it is provided as other care you are getting in addition to daily skilled nursing care and/or skilled rehabilitation services. Defined in Chapter 4, Section 3.1, Types of benefits we do *not* cover (exclusions)

**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). Defined in Chapter 8, Section 2, When can you end your membership in our plan?

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

**Emergency Care** – Covered services that are: 1) rendered by a provider qualified to furnish emergency services; and 2) needed to evaluate or stabilize an emergency medical condition. Defined in Chapter 3, Section 1.2, Basic rules for getting your medical care that is covered by the plan.

**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. Defined in Chapter 1, Section 1.1, What is the *Evidence of Coverage* booklet about?

**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. Defined in Chapter 2, Section 1, PUP Perks (HMO) contacts (how to contact us, including how to reach Member Services.)

**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. Defined in Chapter 4, Section 2.1, Your medical benefits and costs as a member of the plan.

**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 Necessary** – Drugs, services, or supplies that are proper and needed for the diagnosis or treatment of your medical condition; are used for the diagnosis, direct care, and treatment of

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your medical condition; meet the standards of good medical practice in the local community; and are not mainly for your convenience or that of your doctor. Defined in Chapter 3, Section 1.2, Basic rules for getting your medical care that is covered by the plan.

**Medicare** – The Federal health insurance program for people 65 years of age or older, some people under age 65 with certain disabilities, and people with End-Stage Renal Disease (generally those with permanent kidney failure who need dialysis or a kidney transplant). People with Medicare can get their Medicare health coverage through Original Medicare or a Medicare Advantage plan. Defined in Chapter 1, Section 1.1, What is the *Evidence of Coverage* booklet about?

**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 (Hospital) and Part B (Medical) 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. 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**. PUP Perks (HMO) does not offer Medicare 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). Defined in Chapter 1, Section 1.1, What is the *Evidence of Coverage* booklet about?

**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). Defined in Chapter 1, Section 1.1, What is the *Evidence of Coverage* booklet about?

**Member Services** – 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 Member Services. Defined in Chapter 1, Section 1.3, What if you are new to PUP Perks (HMO)?

**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.” Defined in Chapter 1, Section 3.2, *The Provider Directory*: your guide to all providers in the plan’s network.

**Organization Determination** – The Medicare Advantage organization has made an organization determination when it, or one of its providers, makes a decision about whether services are covered and how much you have to be paid for covered services. Defined in Chapter 7, Section 1.2, What about the legal terms?

**Original Medicare** (“Traditional Medicare” or “Fee-for-service” Medicare) – Original Medicare is offered by the government, and not a private health plan like Medicare Advantage plans and prescription drug plans. Under Original Medicare, Medicare services are covered by paying doctors, hospitals, and other health care providers payment amounts established by Congress. You can see any doctor, hospital, or other health care provider that accepts Medicare. You must pay the deductible. Medicare pays its share of the Medicare-approved amount, and you pay your share. Original Medicare has two parts: Part A (Hospital Insurance) and Part B (Medical Insurance) and is available everywhere in the United States. Defined in Chapter 3, Section 5.1, What is a “clinical research study”?

**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. Defined in Chapter 1, Section 3.2, *The Provider Directory*: your guide to all providers in the plan’s network

**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.

**Out-of-Pocket Maximum** – The maximum amount that you pay out-of-pocket during the calendar year, usually at the time services are received, for covered Part A (Hospital Insurance) and Part B (Medical Insurance) services. Plan premiums and Medicare Part A and Part B premiums do not count toward the out-of-pocket maximum. Defined in Chapter 3, Section 4.2, If services are not covered by our plan, you must pay the full cost.

**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.)

**Primary Care Provider (PCP)** – A health care professional you select to coordinate your health care. Your PCP is responsible for providing or authorizing covered services while you are a plan

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member. Chapter 3 tells more about PCPs. Defined in Chapter 1, Section 5.1, How to help make sure that we have accurate information about you.

**Prior Authorization** – Approval in advance to get services. Some in-network medical services are covered only if your doctor or other network provider gets “prior authorization” from our plan. Covered services that need prior authorization are marked in the Benefits Chart in Chapter 4. Defined in Chapter 3, Section 1.2, Basic rules for getting your medical care that is covered by the plan.

**Quality Improvement Organization (QIO)** – Groups of practicing doctors and other health care experts that are paid by the Federal government to check and improve the care given to Medicare patients. They must review your complaints about the quality of care given by Medicare Providers. See Chapter 2, Section 4 for information about how to contact the QIO in your state and Chapter 7 for information about making complaints to the QIO. Defined in Chapter 2, Section 4, Quality Improvement Organization (paid by Medicare to check on the quality of care for people with Medicare)

**Rehabilitation Services** – These services include physical therapy, speech and language therapy, and occupational therapy. Defined in Chapter 2, Section 4, Quality Improvement Organization (paid by Medicare to check on the quality of care for people with Medicare)

**Service Area** – “Service area” is the geographic area approved by the Centers for Medicare & Medicaid Services (CMS) within which an eligible individual may enroll in a certain plan, and in the case of network plans, where a network must be available to provide services. Defined in Chapter 1, Section 2.1, Your three eligibility requirements.

**Skilled Nursing Facility (SNF) Care** – A level of care in a SNF ordered by a doctor that must be given or supervised by licensed health care professionals. It may be skilled nursing care, or skilled rehabilitation services, or both. Skilled nursing care includes services that require the skills of a licensed nurse to perform or supervise. Skilled rehabilitation services are physical therapy, speech therapy, and occupational therapy. Physical therapy includes exercise to improve the movement and strength of an area of the body, and training on how to use special equipment, such as how to use a walker or get in and out of a wheelchair. Speech therapy includes exercise to regain and strengthen speech and/or swallowing skills. Occupational therapy helps you learn how to perform usual daily activities, such as eating and dressing by yourself. Chapter 2, Section 4, Quality Improvement Organization (paid by Medicare to check on the quality of care for people with Medicare)

**Special Needs Plan** – A special type of Medicare Advantage plan that provides more focused health care for specific groups of people, such as those who have both Medicare and Medicaid, who reside in a nursing home, or who have certain chronic medical conditions.

**Supplemental Security Income (SSI)** – A monthly benefit paid by the Social Security Administration to people with limited income and resources who are disabled, blind, or age 65 and older. SSI benefits are not the same as Social Security benefits.

**Urgently Needed Care** – Urgently needed care is a non-emergency situation when you need medical care right away because of an illness, injury, or condition that you did not expect or anticipate, but your health is not in serious danger. Defined in Chapter 1, Section 3.2, *The Provider Directory*: your guide to all providers in the plan’s network.