

**January 1 – December 31, 2023**

## **Evidence of Coverage:**

### **Your Medicare Health Benefits and Services and Prescription Drug Coverage as a Member of PacificSource Dual Care (HMO D-SNP)**

This document gives you the details about your Medicare and Oregon Health Plan health care and prescription drug coverage from January 1 – December 31, 2023. **This is an important legal document. Please keep it in a safe place.**

**For questions about this document, please contact Customer Service at 888-863-3637 for additional information. (TTY users should call 711. We accept all relay calls.) Hours are Oct. 1 - Mar. 31: 8:00 a.m. - 8:00 p.m. local time zone, seven days a week. Apr. 1 - Sept. 30: 8:00 a.m. - 8:00 p.m. local time zone, Monday – Friday.**

This plan, PacificSource Dual Care (HMO D-SNP), is offered by PacificSource Medicare (When this *Evidence of Coverage* says “we,” “us,” or “our,” it means PacificSource Medicare. When it says “plan” or “our plan,” it means PacificSource Dual Care (HMO D-SNP).)

If you need this material in a different format such as braille, large print, or alternative formats, please call Customer Service.

Benefits, premiums, deductibles, and/or copayments/coinsurance may change on January 1, 2024.

The formulary, pharmacy network, and/or provider network may change at any time. You will receive notice when necessary. We will notify affected enrollees about changes at least 30 days in advance.

This document explains your benefits and rights. Use this document to understand about:

- Your plan premium and cost sharing;
- Your medical and prescription drug benefits;
- How to file a complaint if you are not satisfied with a service or treatment;
- How to contact us if you need further assistance; and,
- Other protections required by Medicare law.

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# CHAPTER 1:

## *Getting started as a member*

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## SECTION 1 Introduction

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<b>Section 1.1</b>	<b>You are enrolled in our plan, which is a specialized Medicare Advantage Plan (Special Needs Plan)</b>
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You are covered by both Medicare and Oregon Health Plan (Medicaid):

- **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 (kidney failure).
- **Oregon Health Plan (Medicaid)** is a joint Federal and state government program that helps with medical costs for certain people with limited incomes and resources. Oregon Health Plan (Medicaid) coverage varies depending on the state and the type of Oregon Health Plan (Medicaid) you have. Some people with Oregon Health Plan (Medicaid) get help paying for their Medicare premiums and other costs. Other people also get coverage for additional services and drugs that are not covered by Medicare.

You have chosen to get your Medicare and Medicaid health care and your prescription drug coverage through our plan, PacificSource Dual Care (HMO D-SNP). We are required to cover all Part A and Part B services. However, cost sharing and provider access in this plan differ from Original Medicare.

PacificSource Dual Care (HMO D-SNP) is a specialized Medicare Advantage Plan (a Medicare “Special Needs Plan”), which means its benefits are designed for people with special health care needs. Our plan is designed for people who have Medicare and who are also entitled to assistance from Oregon Health Plan (Medicaid).

Because you get assistance from Oregon Health Plan (Medicaid) with your Medicare Part A and B cost sharing (deductibles, copayments, and coinsurance) you may pay nothing for your Medicare health care services. Oregon Health Plan (Medicaid) also provides other benefits to you by covering health care services that are not usually covered under Medicare. You will also receive “Extra Help” from Medicare to pay for the costs of your Medicare prescription drugs. PacificSource Dual Care (HMO D-SNP) will help manage all of these benefits for you, so that you get the health care services and payment assistance that you are entitled to.

Our plan is run by a private company. Like all Medicare Advantage Plans, this Medicare Special Needs Plan is approved by Medicare. The plan also has a contract with the Oregon Health Plan (Medicaid) program to coordinate your Medicaid benefits. We are pleased to be providing your Medicare and Medicaid health care coverage, including your prescription drug coverage.

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**Coverage under this Plan qualifies as Qualifying Health Coverage (QHC)** and satisfies the Patient Protection and Affordable Care Act's (ACA) individual shared responsibility requirement. Please visit the Internal Revenue Service (IRS) website at: [www.irs.gov/Affordable-Care-Act/Individuals-and-Families](https://www.irs.gov/Affordable-Care-Act/Individuals-and-Families) for more information.

<b>Section 1.2</b>	<b>What is the <i>Evidence of Coverage</i> document about?</b>
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This *Evidence of Coverage* document tells you how to get your Medicare and Oregon Health Plan (Medicaid) medical care and prescription drugs. It explains your rights and responsibilities, what is covered, what you pay as a member of the plan, and how to file a complaint if you are not satisfied with a decision or treatment.

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

It's important for you to learn what the plan's rules are and what services are available to you. We encourage you to set aside some time to look through this *Evidence of Coverage* document.

If you are confused, concerned or just have a question, please contact Customer Service.

<b>Section 1.3</b>	<b>Legal information about the <i>Evidence of Coverage</i></b>
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This *Evidence of Coverage* is part of our contract with you about how our plan covers your care. Other parts of this contract include your enrollment form, the *List of Covered Drugs (Formulary)*, and any notices you receive from us about changes to your coverage or conditions that affect your coverage. These notices are sometimes called “riders” or “amendments.”

The contract is in effect for months in which you are enrolled in our plan between January 1, 2023 and December 31, 2023.

Each calendar year, Medicare allows us to make changes to the plans that we offer. This means we can change the costs and benefits of our plan after December 31, 2023. We can also choose to stop offering the plan in your service area, or to offer it in a different service area, after December 31, 2023.

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



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

### Section 2.1 Your eligibility requirements

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

- You have both Medicare Part A and Medicare Part B
- -- *and* -- You live in our geographic service area (Section 2.3 below describes our service area). Incarcerated individuals are not considered living in the geographic service area even if they are physically located in it.
- -- *and* -- you are a United States citizen or are lawfully present in the United States
- -- *and* -- You meet the special eligibility requirements described below.

#### Special eligibility requirements for our plan

Our plan is designed to meet the needs of people who receive certain Oregon Health Plan (Medicaid) benefits. (Oregon Health Plan (Medicaid) is a joint Federal and state government program that helps with medical costs for certain people with limited incomes and resources.) To be eligible for our plan you must be eligible for Medicare and Full Medicaid Benefits.

Please note: If you lose your eligibility but can reasonably be expected to regain eligibility within 3-month(s), then you are still eligible for membership in our plan (Chapter 4, Section 2.1 tells you about coverage and cost sharing during a period of deemed continued eligibility).

### Section 2.2 What is Oregon Health Plan (Medicaid)?

Oregon Health Plan (Medicaid) is a joint Federal and state government program that helps with medical costs for certain people who have limited incomes and resources. Each state decides what counts as income and resources, who is eligible, what services are covered, and the cost for services. States also can decide how to run their program as long as they follow the Federal guidelines.

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

- **Qualified Medicare Beneficiary (QMB):** Helps pay Medicare Part A and Part B premiums, and other cost sharing (like deductibles, coinsurance, and copayments). (Some people with QMB are also eligible for full Medicaid benefits (QMB+).)

**Chapter 1 Getting started as a member**

- **Specified Low-Income Medicare Beneficiary (SLMB):** Helps pay Part B premiums. (Some people with SLMB are also eligible for full Medicaid benefits (SLMB+).)
- **Full Benefit Dual Eligible (FBDE):** Helps pay Medicare Part A and Part B premiums and other cost sharing (like deductibles, coinsurance, and copayments). Eligible beneficiaries also receive full Oregon Health Plan (Medicaid) benefits.

**Section 2.3 Here is the plan service area for our plan**

PacificSource Dual Care (HMO D-SNP) is available only to individuals who live in our plan service area. To remain a member of our plan, you must continue to reside in the plan service area. The service area is described below.

Our service area includes these counties in Oregon: Clackamas, Crook, Deschutes, Hood River, Jefferson, Lane, Multnomah, Wasco and Washington.

Our service area includes these parts of counties in Oregon: Klamath, the following zip codes only 97731, 97733, 97737 and 97739.

If you plan to move out of the service area, you cannot remain a member of this plan. Please contact Customer Service to see if we have a plan in your new area. When you move, you will have a Special Enrollment Period that will allow you to switch to Original Medicare or enroll in a Medicare health or drug plan that is available in your new location.

It is also important that you call Social Security if you move or change your mailing address. You can find phone numbers and contact information for Social Security in Chapter 2, Section 5.



**Section 2.4 U.S. Citizen or Lawful Presence**

A member of a Medicare health plan must be a U.S. citizen or lawfully present in the United States. Medicare (the Centers for Medicare & Medicaid Services) will notify PacificSource Dual Care (HMO D-SNP) if you are not eligible to remain a member on this basis. PacificSource Dual Care (HMO D-SNP) must disenroll you if you do not meet this requirement.

**SECTION 3 Important membership materials you will receive****Section 3.1 Your plan membership card**

While you are a member of our plan, you must use your membership card whenever you get services covered by this plan and for prescription drugs you get at network pharmacies. You should also show the provider your Medicaid card. Here's a sample membership card to show you what yours will look like:

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		<b>NETWORK ID:</b> ABCD <b>PAYOR ID:</b> #XXXXX	Show this card to your provider each time you receive care.
<b>PLAN:</b> Plan Name (Type) Duals (second line if needed)		<b>CARD ISSUED:</b> XX/XX/XX <b>ISSUER:</b> 8XXXX <b>CONTRACT:</b> HXXXX_XXX	<b>CUSTOMER SERVICE:</b> (555) 555-5555; TTY 711
<b>NAME:</b> Someone W. Longname (second line if needed)		<b>RX ID:</b> R12345678 <b>MEDICAID RX ID:</b> R12345678 <b>RXBIN:</b> 123456 <b>RXGROUP:</b> RX1234 <b>RXPCN:</b> XXX	<b>PROVIDERS:</b> (555) 555-5555; TTY 711
<b>MEMBER ID:</b> 123456789 <b>MEDICAID MEMBER ID:</b> G1234567		<input checked="" type="checkbox"/> <b>MEDICAL</b> <input checked="" type="checkbox"/> <b>PART D RX</b> <input type="checkbox"/> <b>DENTAL</b>	<b>PHARMACISTS:</b> (555) 555-5555
		<b>Bill PacificSource Medicare directly, not Original Medicare.</b> Some services may require prior authorization. Medicare limiting charges apply. Contact plan for details.	
<b>PacificSource Community Health Plans</b> PO Box 7068, Springfield, OR 97475-0068   <a href="http://www.Medicare.PacificSource.com">www.Medicare.PacificSource.com</a> This card is not an authorization for services or a guarantee of payment.			

Do NOT use your red, white, and blue Medicare card for covered medical services while you are a member of this plan. If you use your Medicare card instead of your plan membership card, you may have to pay the full cost of medical services yourself. Keep your Medicare card in a safe place. You may be asked to show it if you need hospital services, hospice services, or participate in Medicare approved clinical research studies also called clinical trials.

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

### Section 3.2 Provider Directory

The *Provider Directory* lists our in-network providers and durable medical equipment suppliers. **In-network providers** are the doctors and other health care professionals, medical groups, durable medical equipment suppliers, 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.

You must use in-network providers to get your medical care and services. If you go elsewhere without proper authorization you will have to pay in full. The only exceptions are emergencies, urgently needed services when the network is not available (that is, in situations when it is unreasonable or not possible to obtain services in-network), out-of-area dialysis services, and cases in which our plan authorizes use of out-of-network providers.

The most recent list of providers and suppliers is available on our website at [www.Medicare.PacificSource.com](http://www.Medicare.PacificSource.com).

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

**Section 3.3 Pharmacy Directory**

The pharmacy directory lists our in-network pharmacies. **In-network pharmacies** are all of the pharmacies that have agreed to fill covered prescriptions for our plan members. You can use the *Pharmacy Directory* to find the in-network pharmacy you want to use. See Chapter 5, Section 2.5 for information on when you can use pharmacies that are not in the plan's network.

If you don't have the *Pharmacy Directory*, you can get a copy from Customer Service. You can also find this information on our website at [www.Medicare.PacificSource.com](http://www.Medicare.PacificSource.com).

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

The plan has a *List of Covered Drugs (Formulary)*. We call it the "Drug List" for short. It tells which Part D prescription drugs are covered under the Part D benefit included in our plan. The drugs on this list are selected by the plan with the help of a team of doctors and pharmacists. The list must meet requirements set by Medicare. Medicare has approved the PacificSource Dual Care (HMO D-SNP) Drug List.

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

We will provide you a copy of the Drug List. To get the most complete and current information about which drugs are covered, you can visit the plan's website ([www.Medicare.PacificSource.com](http://www.Medicare.PacificSource.com)) or call Customer Service.

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**SECTION 4 Your monthly costs for our plan**

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Your costs may include the following:

- Plan Premium (Section 4.1)
- Monthly Medicare Part B Premium (Section 4.2)
- Optional Supplemental Benefit Premium (Section 4.3)
- Part D Late Enrollment Penalty (Section 4.4)
- Income Related Monthly Adjusted Amount (Section 4.5)

Medicare Part B and Part D premiums differ for people with different incomes. If you have questions about these premiums review your copy of *Medicare & You 2023* handbook, the section called "2023 Medicare Costs." If you need a copy you can download it from the Medicare website ([www.medicare.gov](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.

<b>Section 4.1</b>	<b>Plan premium</b>
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You do not pay a separate monthly plan premium for PacificSource Dual Care (HMO D-SNP).

<b>Section 4.2</b>	<b>Monthly Medicare Part B Premium</b>
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**Many members are required to pay other Medicare premiums**

Some 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 Oregon Health Plan (Medicaid) as well as have both Medicare Part A and Medicare Part B. For most plan members, Oregon Health Plan (Medicaid) pays for your Part A premium (if you don't qualify for it automatically) and for your Part B premium.

**If Oregon Health Plan (Medicaid) is not paying your Medicare premiums for you, you must continue to pay your Medicare premiums to remain a member of the plan.** This includes your premium for Part B. It may also include a premium for Part A which affects members who aren't eligible for premium free Part A.

<b>Section 4.3</b>	<b>Part D Late Enrollment Penalty</b>
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Because you are dual-eligible, the LEP doesn't apply as long as you maintain your dual-eligible status, but if you lose status you may incur LEP. Some members are required to pay a Part D **late enrollment penalty**. The Part D late enrollment penalty is an additional premium that must be paid for Part D coverage if at any time after your initial enrollment period is over, there is a period of 63 days or more in a row when you did not have Part D or other creditable prescription drug coverage. "Creditable prescription drug coverage" is coverage that meets Medicare's minimum standards since it is expected to pay, on average, at least as much as Medicare's standard prescription drug coverage. The cost of the late enrollment penalty depends on how long you went without Part D or other creditable prescription drug coverage. You will have to pay this penalty for as long as you have Part D coverage.

If you do not pay your Part D late enrollment penalty, you could lose your prescription drug benefits.

You **will not** have to pay it if:

- You receive "Extra Help" from Medicare to pay for your prescription drugs.
- You have gone less than 63 days in a row without creditable coverage.
- You have had creditable drug coverage through another source such as a former employer, union, TRICARE, or Department of Veterans Affairs. Your insurer or your human resources department will tell you each year if your drug coverage is creditable coverage. This information may be sent to you in a letter or included in a newsletter from the plan. Keep this information, because you may need it if you join a Medicare drug plan later.

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- **Note:** Any notice must state that you had “creditable” prescription drug coverage that is expected to pay as much as Medicare’s standard prescription drug plan pays.
- **Note:** The following are *not* creditable prescription drug coverage: prescription drug discount cards, free clinics, and drug discount websites.

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

- First, count the number of full months that you delayed enrolling in a Medicare drug plan, after you were eligible to enroll. Or count the number of full months you did not have creditable prescription drug coverage, if the break in coverage was 63 days or more. The penalty is 1% for every month that you did not have creditable coverage. For example, if you go 14 months without coverage, the penalty will be 14%.
- Then Medicare determines the amount of the average monthly premium for Medicare drug plans in the nation from the previous year. For 2023, this average premium amount is \$32.74.
- To calculate your monthly penalty, you multiply the penalty percentage and the average monthly premium and then round it to the nearest 10 cents. In the example here, it would be 14% times \$32.74, which equals \$4.58. This rounds to \$4.60. This amount would be added **to the monthly premium for someone with a Part D late enrollment penalty**.

There are three important things to note about this monthly Part D late enrollment penalty:

- First, **the penalty may change each year**, because the average monthly premium can change each year.
- Second, **you will continue to pay a penalty** every month for as long as you are enrolled in a plan that has Medicare Part D drug benefits, even if you change plans.
- Third, if you are under 65 and currently receiving Medicare benefits, the Part D late enrollment penalty will reset when you turn 65. After age 65, your Part D late enrollment penalty will be based only on the months that you don’t have coverage after your initial enrollment period for aging into Medicare.

**If you disagree about your Part D late enrollment penalty, you or your representative can ask for a review.** Generally, you must request this review **within 60 days** from the date on the first letter you receive stating you have to pay a late enrollment penalty. However, if you were paying a penalty before joining our plan, you may not have another chance to request a review of that late enrollment penalty.



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

<b>Section 4.4</b>	<b>Income Related Monthly Adjustment Amount</b>
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Some members may be required to pay an extra charge, known as the Part D Income Related Monthly Adjustment Amount, also known as IRMAA. The extra charge is figured out using your modified adjusted gross income as reported on your IRS tax return from 2 years ago. If this amount is above a certain amount, you'll pay the standard premium amount and the additional IRMAA. For more information on the extra amount you may have to pay based on your income, visit <https://www.medicare.gov/drug-coverage-part-d/costs-for-medicare-drug-coverage/monthly-premium-for-drug-plans>.

If you have to pay an extra amount, Social Security, not your Medicare plan, will send you a letter telling you what that extra amount will be. The extra amount will be withheld from your Social Security, Railroad Retirement Board, or Office of Personnel Management benefit check, no matter how you usually pay your plan premium, unless your monthly benefit isn't enough to cover the extra amount owed. If your benefit check isn't enough to cover the extra amount, you will get a bill from Medicare. **You must pay the extra amount to the government. It cannot be paid with your monthly plan premium. If you do not pay the extra amount you will be disenrolled from the plan and lose prescription drug coverage.**

If you disagree about paying an extra amount, you can ask Social Security to review the decision. To find out more about how to do this, contact Social Security at 1-800-772-1213 (TTY 1-800-325-0778).

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<b>SECTION 5</b>	<b>More information about your monthly premium</b>
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<b>Section 5.1</b>	<b>Can we change your monthly plan premium during the year?</b>
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**No.** We are not allowed to change the amount we charge for the plan's monthly plan premium during the year. If the monthly plan premium changes for next year we will tell you in September and the change will take effect on January 1.

However, in some cases, you may be able to stop paying a late enrollment penalty, if owed. Or need to start paying a late enrollment penalty. (This could happen if you become eligible for the "Extra Help" program or if you lose your eligibility for the "Extra Help" program during the year:

- If you currently pay the Part D late enrollment penalty and become eligible for "Extra Help" during the year, you would be able to stop paying your penalty.
- If you lose Extra Help, you may be subject to the late enrollment penalty if you go 63 days or more in a row without Part D or other creditable prescription drug coverage.

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

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## **SECTION 6      Keeping your plan membership record up to date**

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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.

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

### **Let us know about these changes:**

- Changes to your name, your address, or your phone number
- Changes in any other health insurance coverage you have (such as from your employer, your spouse’s employer, workers’ compensation, or Oregon Health Plan (Medicaid))
- If you have any liability claims, such as claims from an automobile accident
- If you have been admitted to a nursing home
- If you receive care in an out-of-area or out-of-network hospital or emergency room
- If your designated responsible party (such as a caregiver) changes
- If you are participating in a clinical research study (**Note:** You are not required to tell your plan about the clinical research studies you intend to participate in but we encourage you to do so.)

If any of this information changes, please let us know by calling Customer Service.

It is also important to contact Social Security if you move or change your mailing address. You can find phone numbers and contact information for Social Security in Chapter 2, Section 5.



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## SECTION 7      How other insurance works with our plan

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### Other insurance

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. This is called **Coordination of Benefits**.

Once each year, we will send you a letter that lists any other medical or drug insurance coverage that we know about. Please read over this information carefully. If it is correct, you don't need to do anything. If the information is incorrect, or if you have other coverage that is not listed, please call Customer Service. You may need to give your plan member ID number to your other insurers (once you have confirmed their identity) so your bills are paid correctly and on time.

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

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

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

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

- No-fault insurance (including automobile insurance)

**Chapter 1 Getting started as a member**

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- Liability (including automobile insurance)
- Black lung benefits
- Workers' compensation

Oregon Health Plan (Medicaid) and TRICARE never pay first for Medicare-covered services. They only pay after Medicare and/or employer group health plans have paid.

## CHAPTER 2:

*Important phone numbers  
and resources*

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## **SECTION 1      Our Plan contacts**

(how to contact us, including how to reach Customer Service)

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### **How to contact our plan's Customer Service**

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

<b>Method</b>	<b>Customer Service – Contact Information</b>
<b>CALL</b>	<p>888-863-3637</p> <p>Calls to this number are free. Hours are: <b>October 1 – March 31:</b> 8:00 a.m. to 8:00 p.m. local time zone, seven days a week. <b>April 1 – September 30:</b> 8:00 a.m. to 8:00 p.m. local time zone, Monday – Friday.</p> <p>During this time of the year, please leave a message on weekends, holidays, and after hours. We will return your call the next business day.</p> <p>Customer Service also has free language interpreter services available for non-English speakers.</p>
<b>TTY</b>	<p>711. We accept all relay calls</p> <p>This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.</p> <p>Calls to this number are free. Hours are: <b>October 1 – March 31:</b> 8:00 a.m. to 8:00 p.m. local time zone, seven days a week. <b>April 1 – September 30:</b> 8:00 a.m. to 8:00 p.m. local time zone, Monday – Friday.</p>
<b>FAX</b>	541- 322-6423
<b>WRITE</b>	<p>PacificSource Medicare Customer Service Department PO Box 7469 Bend, Oregon 97708 MedicareCS@PacificSource.com</p>
<b>WEBSITE</b>	<a href="http://www.Medicare.PacificSource.com">www.Medicare.PacificSource.com</a>

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

A coverage decision is a decision we make about your benefits and coverage or about the amount we will pay for your medical services or Part D prescription drugs. An appeal is a formal way of asking us to review and change a coverage decision we have made. For more information on asking for coverage decisions or appeals about your medical care or Part D prescription drugs, see Chapter 9 (*What to do if you have a problem or complaint (coverage decisions, appeals, complaints)*).

<b>Method</b>	<b>Coverage Decisions For Medical Care – Contact Information</b>
<b>CALL</b>	888-863-3637  Calls to this number are free. Hours are: <b>October 1 – March 31:</b> 8:00 a.m. to 8:00 p.m. local time zone, seven days a week. <b>April 1 – September 30:</b> 8:00 a.m. to 8:00 p.m. local time zone, Monday – Friday.
<b>TTY</b>	711. We accept all relay calls  This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.  Calls to this number are free. Hours are: <b>October 1 – March 31:</b> 8:00 a.m. to 8:00 p.m. local time zone, seven days a week. <b>April 1 – September 30:</b> 8:00 a.m. to 8:00 p.m. local time zone, Monday – Friday.
<b>FAX</b>	541-322-6423
<b>WRITE</b>	PacificSource Medicare Attn: Health Services PO Box 7469 Bend, Oregon 97708
<b>WEBSITE</b>	<a href="http://www.Medicare.PacificSource.com">www.Medicare.PacificSource.com</a>

Method	Coverage Decisions for Part D Prescription Drugs – Contact Information
<b>CALL</b>	<p>888-863-3637</p> <p>Calls to this number are free. Hours are: <b>October 1 – March 31:</b> 8:00 a.m. to 8:00 p.m. local time zone, seven days a week. <b>April 1 – September 30:</b> 8:00 a.m. to 8:00 p.m. local time zone, Monday – Friday.</p> <p>For access to our 24-hour line for a standard or expedited coverage determination, call 888-437-7728. Calls to this number are free.</p>
<b>TTY</b>	<p>711. We accept all relay calls</p> <p>This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.</p> <p>Calls to this number are free. Hours are: <b>October 1 – March 31:</b> 8:00 a.m. to 8:00 p.m. local time zone, seven days a week. <b>April 1 – September 30:</b> 8:00 a.m. to 8:00 p.m. local time zone, Monday – Friday.</p>
<b>FAX</b>	800-366-4873
<b>WRITE</b>	PacificSource Medicare Attn: Pharmacy Services Department PO Box 7469 Bend, Oregon 97708
<b>WEBSITE</b>	<a href="http://www.Medicare.PacificSource.com">www.Medicare.PacificSource.com</a>

**Chapter 2 Important phone numbers and resources**

Method	Appeals For Medical Care or Part D Prescription Drugs – Contact Information
<b>CALL</b>	<p>888-863-3637</p> <p>Calls to this number are free. Hours are: <b>October 1 – March 31:</b> 8:00 a.m. to 8:00 p.m. local time zone, seven days a week. <b>April 1 – September 30:</b> 8:00 a.m. to 8:00 p.m. local time zone, Monday – Friday.</p> <p>For access to our 24-hour line for an expedited appeal call 888-863-3637.</p>
<b>TTY</b>	<p>711. We accept all relay calls</p> <p>This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.</p> <p>Calls to this number are free. Hours are: <b>October 1 – March 31:</b> 8:00 a.m. to 8:00 p.m. local time zone, seven days a week. <b>April 1 – September 30:</b> 8:00 a.m. to 8:00 p.m. local time zone, Monday – Friday.</p>
<b>FAX</b>	541-322-6424
<b>WRITE</b>	<p>PacificSource Medicare Attn: Grievance and Appeals Department PO Box 7469 Bend, Oregon 97708</p>

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

You can make a complaint about us or one of our network providers or pharmacies, including a complaint about the quality of your care. This type of complaint does not involve coverage or payment disputes. For more information on making a complaint about your medical care, see Chapter 9 (*What to do if you have a problem or complaint (coverage decisions, appeals, complaints)*).

Method	Complaints About Medical Care or Part D Prescription Drugs – Contact Information
<b>CALL</b>	<p>888-863-3637</p> <p>Calls to this number are free.  Hours are:  <b>October 1 – March 31:</b> 8:00 a.m. to 8:00 p.m. local time zone, seven days a week.  <b>April 1 – September 30:</b> 8:00 a.m. to 8:00 p.m. local time zone, Monday – Friday.</p> <p>For access to our 24-hour line for an expedited grievance, call 888-863-3637.</p>
<b>TTY</b>	<p>711. We accept all relay calls</p> <p>This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.</p> <p>Calls to this number are free.  Hours are:  <b>October 1 – March 31:</b> 8:00 a.m. to 8:00 p.m. local time zone, seven days a week.  <b>April 1 – September 30:</b> 8:00 a.m. to 8:00 p.m. local time zone, Monday – Friday.</p>
<b>FAX</b>	541-322-6424
<b>WRITE</b>	<p>PacificSource Medicare  Attn: Grievance and Appeals Department  PO Box 7469  Bend, Oregon 97708</p>
<b>MEDICARE WEBSITE</b>	<p>You can submit a complaint about our plan directly to Medicare. To submit an online complaint to Medicare, go to <a href="http://www.medicare.gov/MedicareComplaintForm/home.aspx">www.medicare.gov/MedicareComplaintForm/home.aspx</a>.</p>

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

If you have received a bill or paid for services (such as a provider bill) that you think we should pay for, you may need to ask us for reimbursement or to pay the provider bill. See Chapter 7 (*Asking us to pay a bill you have received for covered medical services or drugs*).

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



information.

Method	Payment Requests – Contact Information	
<b>CALL</b>	888-863-3637  Hours are: <b>October 1 – March 31:</b> 8:00 a.m. to 8:00 p.m. local time zone, seven days a week. <b>April 1 – September 30:</b> 8:00 a.m. to 8:00 p.m. local time zone, Monday – Friday.  Calls to this number are free.	
<b>TTY</b>	711. We accept all relay calls  This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.  Calls to this number are free. Hours are: <b>October 1 – March 31:</b> 8:00 a.m. to 8:00 p.m. local time zone, seven days a week. <b>April 1 – September 30:</b> 8:00 a.m. to 8:00 p.m. local time zone, Monday-Friday.	
<b>FAX</b>	<b>Medical</b> 541-322-6423	
<b>WRITE</b>	<b>Medical</b> PacificSource Medicare Attn: Claims Department PO Box 7469 Bend, Oregon 97708	<b>Prescription</b> CVS Caremark Attn: Claims Department PO Box 52066 Phoenix, Arizona 85072-2066
<b>WEBSITE</b>	<a href="http://www.Medicare.PacificSource.com">www.Medicare.PacificSource.com</a>	

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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.

## Chapter 2 Important phone numbers and resources

Method	Medicare – Contact Information
<b>CALL</b>	<p>1-800-MEDICARE, or 1-800-633-4227</p> <p>Calls to this number are free.</p> <p>24 hours a day, 7 days a week.</p>
<b>TTY</b>	<p>1-877-486-2048</p> <p>This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.</p> <p>Calls to this number are free.</p>
<b>WEBSITE</b>	<p><a href="http://www.medicare.gov">www.medicare.gov</a></p> <p>This is the official government website for Medicare. It gives you up-to-date information about Medicare and current Medicare issues. It also has information about hospitals, nursing homes, physicians, home health agencies, and dialysis facilities. It includes documents you can print directly from your computer. You can also find Medicare contacts in your state.</p> <p>The Medicare website also has detailed information about your Medicare eligibility and enrollment options with the following tools:</p> <ul style="list-style-type: none"> <li>• <b>Medicare Eligibility Tool:</b> Provides Medicare eligibility status information.</li> <li>• <b>Medicare Plan Finder:</b> Provides personalized information about available Medicare prescription drug plans, Medicare health plans, and Medigap (Medicare Supplement Insurance) policies in your area. These tools provide an <i>estimate</i> of what your out-of-pocket costs might be in different Medicare plans.</li> </ul>
<b>WEBSITE (continued)</b>	<p>You can also use the website to tell Medicare about any complaints you have about our plan:</p> <ul style="list-style-type: none"> <li>• <b>Tell Medicare about your complaint:</b> You can submit a complaint about our plan directly to Medicare. To submit a complaint to Medicare, go to <a href="http://www.medicare.gov/MedicareComplaintForm/home.aspx">www.medicare.gov/MedicareComplaintForm/home.aspx</a>. Medicare takes your complaints seriously and will use this information to help improve the quality of the Medicare program.</li> </ul> <p>If you don't have a computer, your local library or senior center may be able to help you visit this website using its computer. Or, you can call Medicare and tell them what information you are looking for. They will find the information on the website and review the information with you. (You can call Medicare at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.)</p>

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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 Oregon, the SHIP is called the Senior Health Insurance Benefits Assistance.

The Senior Health Insurance Benefits Assistance is an independent (not connected with any insurance company or health plan) state program that gets money from the Federal government to give free local health insurance counseling to people with Medicare.

The Senior Health Insurance Benefits Assistance counselors 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. The Senior Health Insurance Benefits Assistance counselors can also help you with Medicare questions or problems and help you understand your Medicare plan choices and answer questions about switching plans.

METHOD TO ACCESS SHIP and OTHER RESOURCES:	
<ul style="list-style-type: none"><li>▪ Visit <a href="http://www.medicare.gov">www.medicare.gov</a></li><li>▪ Click on “<b>Talk to Someone</b>” in the middle of the homepage</li><li>▪ You now have the following options<ul style="list-style-type: none"><li>○ Option #1: You can have a <b>live chat with a 1-800-MEDICARE representative</b></li><li>○ Option #2: You can select your <b>STATE</b> from the dropdown menu and click GO. This will take you to a page with phone numbers and resources specific to your state.</li></ul></li></ul>	

Method	Senior Health Insurance Benefits Assistance (Oregon SHIP) – Contact Information
<b>CALL</b>	800-722-4134
<b>TTY</b>	711  This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.
<b>WRITE</b>	Senior Health Insurance Benefits Assistance 500 Summer St. NE, E-12 Salem, OR 97301
<b>WEBSITE</b>	<a href="http://www.OregonShiba.org">www.OregonShiba.org</a>

**Chapter 2 Important phone numbers and resources****SECTION 4 Quality Improvement Organization**

There is a designated Quality Improvement Organization for serving Medicare beneficiaries in each state. For Oregon, the Quality Improvement Organization is called KEPRO.

KEPRO has a group of doctors and other health care professionals who are paid by Medicare to check on and help improve the quality of care for people with Medicare. KEPRO is an independent organization. It is not connected with our plan.

You should contact KEPRO 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.

Method	KEPRO (Oregon's Quality Improvement Organization) – Contact Information
<b>CALL</b>	888-305-6759  Available 9:00 a.m. to 5:00 p.m., Monday through Friday. Available on weekends from 11:00 a.m. to 3:00 p.m.
<b>TTY</b>	711  This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.
<b>WRITE</b>	KEPRO 5700 Lombardo Center Dr., Suite 100 Seven Hills, OH 44131
<b>WEBSITE</b>	<a href="http://www.keproqio.com">www.keproqio.com</a>

**SECTION 5 Social Security**

Social Security is responsible for determining eligibility and handling enrollment for Medicare. U.S. citizens and lawful permanent residents 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. To apply for Medicare, you can call Social Security or visit your local Social Security office.

Social Security is also responsible for determining who has to pay an extra amount for their Part D drug coverage because they have a higher income. If you got a letter from

**Chapter 2 Important phone numbers and resources**

Social Security telling you that you have to pay the extra amount and have questions about the amount or if your income went down because of a life-changing event, you can call Social Security to ask for reconsideration.

If you move or change your mailing address, it is important that you contact Social Security to let them know.

Method	Social Security – Contact Information
<b>CALL</b>	<p>1-800-772-1213</p> <p>Calls to this number are free.</p> <p>Available 8:00 am to 7:00 pm, Monday through Friday.</p> <p>You can use Social Security’s automated telephone services to get recorded information and conduct some business 24 hours a day.</p>
<b>TTY</b>	<p>1-800-325-0778</p> <p>This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.</p> <p>Calls to this number are free.</p> <p>Available 8:00 am to 7:00 pm, Monday through Friday.</p>
<b>WEBSITE</b>	<a href="http://www.ssa.gov">www.ssa.gov</a>

## **SECTION 6 Oregon Health Plan (Medicaid)**

PacificSource Dual Care (HMO D-SNP) is designed to meet the needs of people who are eligible for Medicare and full Oregon Health Plan (Medicaid) Benefits. Enrollees in these plans who meet this special eligibility requirement are dually enrolled with both Medicare and Oregon Health Plan (Medicaid).

Oregon Health Plan (Medicaid) is a joint Federal and state government program that helps with medical costs for certain people with limited incomes and resources.

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

- **Qualified Medicare Beneficiary (QMB):** Helps pay Medicare Part A and Part B premiums, and other cost sharing (like deductibles, coinsurance, and copayments). (Some people with QMB are also eligible for full Oregon Health Plan (Medicaid) benefits (QMB+).)
- **Specified Low-Income Medicare Beneficiary (SLMB):** Helps pay Part B premiums. (Some people with SLMB are also eligible for full Oregon Health Plan (Medicaid) benefits (SLMB+).)

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- **Full Benefit Dual Eligible (FBDE):** Helps pay Medicare Part A and Part B premiums and other cost-sharing (like deductibles, coinsurance, and copayments). Eligible beneficiaries also receive full Oregon Health Plan (Medicaid) benefits.

If you have questions about the assistance you get from Oregon Health Plan (Medicaid), contact the Oregon Health Plan.

Method	Oregon Health Plan – Contact Information
<b>CALL</b>	(800) 699-9075 Available 8:00 a.m. to 5:00 p.m., Monday through Friday.
<b>TTY</b>	711 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.
<b>WRITE</b>	Oregon Health Authority 500 Summer Street NE Salem, Oregon 97301
<b>WEBSITE</b>	<a href="http://www.Oregon.gov/OHA">www.Oregon.gov/OHA</a>

The OHA Ombuds Program helps people enrolled in Oregon Health Plan (Medicaid) with service or billing problems. They can help you file a grievance or appeal with our plan.

Method	OHA Ombuds Program – Contact Information
<b>CALL</b>	(800) 522-2602 Available 8:00 a.m. to 5:00 p.m., Monday through Friday.
<b>TTY</b>	711
<b>WRITE</b>	OHA Ombuds Program 500 Summer Street NE, E20 Salem, Oregon 97301
<b>WEBSITE</b>	<a href="http://www.oregon.gov/oha/ERD/Pages/Ombuds-Program.aspx">www.oregon.gov/oha/ERD/Pages/Ombuds-Program.aspx</a>

The Oregon Long-Term Care Ombudsman helps people get information about nursing homes and resolve problems between nursing homes and residents or their families.

Method	Oregon Long-Term Care Ombudsman – Contact Information
<b>CALL</b>	(800) 522-2602 Available 8:00 a.m. to 5:00 p.m., Monday through Friday.
<b>TTY</b>	711
<b>WRITE</b>	Oregon Long-Term Care Ombudsman 3855 Wolverine St NE, Suite 6 Salem, Oregon 97305

Method	Oregon Long-Term Care Ombudsman – Contact Information
WEBSITE	<a href="http://www.oltco.org">www.oltco.org</a>

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

The Medicare.gov website (<https://www.medicare.gov/drug-coverage-part-d/costs-for-medicare-drug-coverage/costs-in-the-coverage-gap/5-ways-to-get-help-with-prescription-costs>) provides information on how to lower your prescription drug costs. For people with limited incomes, there are also other programs to assist, described below.

### Medicare’s “Extra Help” Program

Because you are eligible for Oregon Health Plan (Medicaid), you qualify for and are getting “Extra Help” from Medicare to pay for your prescription drug plan costs. You do not need to do anything further to get this “Extra Help.”

If you have questions about “Extra Help,” call:

- 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048 (applications), 24 hours a day, 7 days a week;
- The Social Security Office at 1-800-772-1213, between 8 am to 7 pm, Monday through Friday. TTY users should call 1-800-325-0778; or
- Your State Medicaid Office (applications) (See Section 6 of this chapter for contact information).

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

- When we receive and verify notice from you, a pharmacy, an advocate, a representative, family member or other individual acting on your behalf who claim that you are being asked to pay the incorrect cost sharing; the plan must receive documentation to support a change to your cost sharing. One or more of the following documents will be allowed:
  - A copy of the member’s Oregon Health Plan (Medicaid) card that includes the member’s name and an eligibility date during a month after June of the previous calendar year;
  - A copy of a state document that confirms active Oregon Health Plan (Medicaid) status during a month after June of the previous calendar year;



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- A print out from the State electronic enrollment file showing Oregon Health Plan (Medicaid) status during a month after June of the previous calendar year;
  - A screen print from the State's Oregon Health Plan (Medicaid) systems showing Oregon Health Plan (Medicaid) status during a month after June of the previous calendar year;
  - Other documentation provided by the State showing Oregon Health Plan (Medicaid) status during a month after June of the previous calendar year;
  - A copy of the SSA award letter indicating qualification for Extra Help;
  - A remittance from the facility showing Oregon Health Plan (Medicaid) payment for a full calendar month for that individual during a month after June of the previous calendar year;
  - A copy of a state document that confirms Oregon Health Plan (Medicaid) payment on behalf of the individual to the facility for a full calendar month after June of the previous calendar year; or
  - A screen print from the State's Oregon Health Plan (Medicaid) system showing that individual's institutional status based on at least a full calendar month stay for Oregon Health Plan (Medicaid) payment purposes during a month after June of the previous calendar year.
- When we receive the evidence showing your copayment level, we will update our system so that you can pay the correct copayment when you get your next prescription at the pharmacy. If you overpay your copayment, we will reimburse you. Either we will forward a check to you in the amount of your overpayment or we will offset future copayments. If the pharmacy hasn't collected a copayment from you and is carrying your copayment as a debt owed by you, we may make the payment directly to the pharmacy. If a state paid on your behalf, we may make payment directly to the state. Please contact Customer Service if you have questions.

**What if you have coverage from an AIDS Drug Assistance Program (ADAP)?****What is the AIDS Drug Assistance Program (ADAP)?**

The AIDS Drug Assistance Program (ADAP) helps ADAP-eligible individuals living with HIV/AIDS have access to life-saving HIV medications. Medicare Part D prescription drugs that are also on the ADAP formulary qualify for prescription cost-sharing assistance through the Oregon CAREAssist AIDS Program. **Note:** To be eligible for the ADAP operating in your State, individuals must meet certain criteria, including proof of State residence and HIV status, low income as defined by the State, and uninsured/under-insured status. If you change plans please notify your local ADAP enrollment worker so you can continue to receive assistance. For information on eligibility criteria,



**Chapter 2 Important phone numbers and resources**

covered drugs, or how to enroll in the program, please call the Oregon CAREAssist AIDS Program at (800) 805-2313.

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**SECTION 8      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 receive your Medicare through the Railroad Retirement Board, it is important that you let them know if you move or change your mailing address. If you have questions regarding your benefits from the Railroad Retirement Board, contact the agency.

Method	Railroad Retirement Board – Contact Information
<b>CALL</b>	1-877-772-5772  Calls to this number are free.  If you press “0,” you may speak with an RRB representative from 9:00 am to 3:30 pm, Monday, Tuesday, Thursday, and Friday, and from 9:00 am to 12:00 pm on Wednesday.  If you press “1”, you may access the automated RRB HelpLine and recorded information 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://rrb.gov/">rrb.gov/</a>

## CHAPTER 3:

*Using the plan 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 explains what 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, equipment, prescription drugs, and other medical care that are covered by the plan.

For the details on what medical care is covered by our plan, use the benefits chart in the next chapter, Chapter 4 (*Medical Benefits Chart, what is covered*).

<b>Section 1.1      What are “in-network providers” and “covered services”?</b>
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- **“Providers”** are doctors and other health care professionals licensed by the state to provide medical services and care. The term “providers” also includes hospitals and other health care facilities.
- **“In-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 as payment in full. We have arranged for these providers to deliver covered services to members in our plan. The providers in our network bill us directly for care they give you. When you see an in-network provider, you pay nothing for covered services.
- **“Covered services”** include all the medical care, health care services, supplies equipment, and Prescription Drugs that are covered by our plan. Your covered services for medical care are listed in the benefits chart in Chapter 4. Your covered services for prescription drugs are discussed in Chapter 5.

<b>Section 1.2      Basic rules for getting your medical care covered by the plan</b>
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As a Medicare and Oregon Health Plan (Medicaid) health plan, PacificSource Dual Care (HMO D-SNP) must cover all services covered by Original Medicare and may offer other services in addition to those covered under Original Medicare (see Chapter 4 Section 2.1).

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

- **The care you receive is included in the plan’s Medical Benefits Chart** (this chart is in Chapter 4 of this document).
- **The care you receive is considered medically necessary.** “Medically necessary” means that the services, supplies, equipment, or drugs are needed for the prevention, diagnosis, or treatment of your medical condition and meet accepted standards of medical practice.
- **You must receive your care from an in-network provider** (for more information about this, see Section 2 in this chapter). In most cases, care you

receive from an out-of-network provider (a provider who is not part of our plan's network) will not be covered. This means that you will have to pay the provider in full for the services furnished. *Here are three exceptions:*

- The plan covers emergency care or urgently needed services that you get from an out-of-network provider. For more information about this, and to see what emergency or urgently needed services means, see Section 3 in this chapter.
- If you need medical care that Medicare or Oregon Health Plan (Medicaid) requires our plan to cover but there are no specialists in our network that provide this care, you can get this care from an out-of-network provider at the same cost sharing you normally pay in-network. You must receive prior authorization from the plan. In this situation, we will cover these services at no cost to you. For information about getting approval to see an out-of-network doctor, see Section 2.4 in this chapter.
- The plan covers kidney dialysis services that you get at a Medicare-certified dialysis facility when you are temporarily outside the plan's service area or when your provider for this service is temporarily unavailable or inaccessible. The cost sharing you pay the plan for dialysis can never exceed the cost sharing in Original Medicare. If you are outside the plan's service area and obtain the dialysis from a provider that is outside the plan's network, your cost sharing cannot exceed the cost sharing you pay in-network. However, if your usual in-network provider for dialysis is temporarily unavailable and you choose to obtain services inside the service area from a provider outside the plan's network the cost sharing for the dialysis may be higher.

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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</b>	<b>You must choose a Primary Care Provider (PCP) to provide and oversee your care</b>
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### **What is a "PCP" and what does the PCP do for you?**

When you enroll in our plan, you must choose an in-network provider to be your PCP. A PCP is a healthcare professional who meets state requirements and is trained to give you basic medical care. They can also coordinate your care with other providers. If you do not choose a PCP when you first enroll with our plan, we will assign you to a PCP in your area.

PCPs can be selected from the following specialties:

- Family Practice

**Chapter 3 Using the plan for your medical services**

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- General Practice
- Internal Medicine
- Obstetrics/Gynecology Practice
- Pediatrics

Providers in the specialties above may include: Nurse Practitioners (NP), Physicians Assistants (PA), Medical Doctors (MD), or Doctors of Osteopathy (DO).

**Services your PCP provides and coordination of your care**

Generally, you see your PCP first for most of your routine health care needs. Your PCP can also help you arrange or coordinate your covered services. This includes x-rays, laboratory tests, therapies, specialists visits, hospital admissions, and follow-up care. Doctor office visits with a PCP will cost less than visits with a specialist.

**Your PCP may help you get prior authorization for some services**

Your PCP or another Medicare-certified provider may need to get Prior Authorization (approval in advance) from the plan before providing some services. Please see the benefits chart in Chapter 4 for more information.

You can check the status of your authorizations by logging into InTouch for Members, our secure website for members that provides you with 24-hour access to plan materials and benefits, including the status of your authorizations. Click “InTouch” at the top of our website at [www.Medicare.PacificSource.com](http://www.Medicare.PacificSource.com) to register or access your account. Or, you can call Customer Service (phone numbers are printed on the back cover of this document).

**How do you choose your PCP?**

You can select a provider designated as a PCP within our *Provider Directory*. Please call Customer Service or visit [www.Medicare.PacificSource.com](http://www.Medicare.PacificSource.com) for an up-to-date list of our in-network providers. We suggest you choose a PCP close to your home so it is convenient for you to receive medical care. Your relationship with your PCP is important, so please take special care when making this selection. If you do not choose a PCP when you first enroll with our plan, we will assign you to a PCP in your area.

**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.

To change your PCP, please call or email Customer Service and we will:

- Determine whether the PCP you are requesting is designated as a PCP and accepting new patients.
- Tell you when your PCP change will take effect. Generally, the change takes

effect on the first day of the month following receipt of the request.

- Update your member record to reflect the name of your new PCP.

<b>Section 2.2</b>	<b>How to get care from specialists and other network providers</b>
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A specialist is a doctor who provides health care services for a specific disease or part of the body. There are many kinds of specialists. Here are a few examples:

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

Some procedures performed by in-network specialists require prior authorization (approval in advance) from us in order to be covered. Please see the Benefits Chart in Chapter 4 for services that require prior authorization.

### **Referrals from your PCP to Specialists**

Referrals are not required for in-network providers. However, your PCP or other providers may need to get prior authorization (approval in advance) from the plan before providing some services. Please see the Benefits Chart in Chapter 4 for more information.

### **How to Get Prior Authorization (approval in advance from the plan) for Certain Services**

Some of the services listed in the Medical Benefits Chart are covered only if your doctor or other in-network provider gets prior authorization from us. If a service requires prior authorization, you or your doctor will request the plan's approval in advance of the service being provided. This can be done online at [www.Medicare.PacificSource.com](http://www.Medicare.PacificSource.com), by faxing, or by calling Customer Service. Additionally, your provider may submit the request online.

For standard requests, we will notify you and your provider of the decision within 14 calendar days of your request for items and services unless an extension has been requested. Timeframes for Part B drugs cannot be extended.

If you would like to ask for an expedited request, please see Chapter 9, Section 5.2. For expedited requests, we will attempt to verbally notify you and your provider of the decision within 72 hours of your request for items and services and 24 hours of your request for Part B drugs. If additional information is required, or your condition does not meet criteria for an expedited review, we will attempt to verbally notify you and your provider that a decision cannot be made within the expedited timeframe. Covered services that need prior authorization are noted in the Medical Benefits Chart. Please see Chapter 4, Section 2.1 for information about which services require prior authorization.

## **How to check the status of prior authorizations**

You can check the status of your prior authorizations by logging into InTouch for Members, our secure website for members that provides you with 24-hour access to authorization requests, plan materials, and benefits. Click “InTouch” at the top of our website at [www.Medicare.PacificSource.com](http://www.Medicare.PacificSource.com) to register or access your account. Or, you can call Customer Service.

## **What if a specialist or another network provider leaves our plan?**

We may make changes to the hospitals, doctors, and specialists (providers) that are part of your plan during the year. If your doctor or specialist leaves your plan you have certain rights and protections that are summarized below:

- Even though our network of providers may change during the year, Medicare requires that we furnish you with uninterrupted access to qualified doctors and specialists.
- We will make a good faith effort to provide you with at least 30 days’ notice that your provider is leaving our plan so that you have time to select a new provider.
- We will assist you in selecting a new qualified provider to continue managing your health care needs.
- If you are undergoing medical treatment you have the right to request, and we will work with you to ensure, that the medically necessary treatment you are receiving is not interrupted.
- If our network does not have a qualified specialist for a plan-covered service, we must cover that service at in-network cost sharing. You must receive prior authorization from the plan.
- If you find out your doctor or specialist is leaving your plan, please contact us so we can assist you in finding a new provider to manage your care.
- If you believe we have not furnished you with a qualified provider to replace your previous provider or that your care is not being appropriately managed, you have the right to file a quality of care complaint to the QIO, a quality of care grievance to the plan, or both. Please see Chapter 9.

<b>Section 2.3</b>	<b>How to get care from out-of-network providers</b>
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### **You must receive your care from an in-network provider**

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. If you need medical care that Medicare requires our plan to cover and the providers in our network cannot provide this care,

**Chapter 3 Using the plan for your medical services**

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you can get this care from an out-of-network provider with prior authorization from the plan. In this situation, you will pay the same as you would pay if you got the care from an in-network provider. If a prior authorization is not requested and approved you will be responsible for paying all of the costs of the services.

You or your doctor may request prior authorization either online at [www.Medicare.PacificSource.com](http://www.Medicare.PacificSource.com), by faxing, or by calling Customer Service. See Section 2.2 above for information about how to get prior authorization from us. Please see the Benefits Chart in Chapter 4 for additional information.

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**SECTION 3      How to get services when you have an emergency or urgent need for care or during a disaster**

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<b>Section 3.1      Getting care if you have a medical emergency</b>
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**What is a “medical emergency” and what should you do if you have one?**

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

If you have a medical emergency:

- **Get help as quickly as possible.** Call 911 for help or go to the nearest emergency room or hospital. Call for an ambulance if you need it. You do *not* need to get approval or a referral first from your PCP. You do not need to use a network doctor. You may get covered emergency medical care whenever you need it, anywhere in the United States or its territories, and from any provider with an appropriate state license even if they are not part of our network.
- **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. Our phone number is listed on the back of your ID card.

**What is covered if you have a medical emergency?**

Our plan covers ambulance services in situations where getting to the emergency room in any other way could endanger your health. We also cover medical services during the emergency.

The doctors who are giving you emergency care will decide when your condition is stable and the medical emergency is over.



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After the emergency is over you are entitled to follow-up care to be sure your condition continues to be stable. Your doctors will continue to treat you until your doctors contact us and make plans for additional care. Your follow-up care will be covered by our plan. If your emergency care is provided by out-of-network providers, we will try to arrange for network providers to take over your care as soon as your medical condition and the circumstances allow.

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

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

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

- You go to a network provider to get the additional care.
- – *or* – The additional care you get is considered “urgently needed services” 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 services</b>
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**What are “urgently needed services”?**

An urgently needed service is a non-emergency situation requiring immediate medical care but, given your circumstances, it is not possible or not reasonable to obtain these services from a network provider. The plan must cover urgently needed services provided out of network. Some examples of urgently needed services are i) a severe sore throat that occurs over the weekend or ii) an unforeseen flare-up of a known condition when you are temporarily outside the service area.

**How to access urgently needed services**

If you believe you have a condition that needs urgent care services, go to the nearest urgent care center. If an urgent care center is not available, go to the nearest immediate care center or walk-in clinic. If you need advice on your condition you can call your primary care provider's (PCP) office. Someone will be available to help day and night 24-hours a day, 7 days a week. If your PCP cannot talk with you, speak to the on-call provider. They will be able to direct your care.

Our plan does not cover emergency services, urgently needed services, or any other services for care outside of the United States and its territories.

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<b>Section 3.3</b>	<b>Getting care during a disaster</b>
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If the Governor of your state, the U.S. Secretary of Health and Human Services, or the President of the United States declares a state of disaster or emergency in your geographic area, you are still entitled to care from your plan.

Please visit the following website: [www.CMS.gov/About-CMS/Agency-Information/Emergency/index.html](http://www.CMS.gov/About-CMS/Agency-Information/Emergency/index.html) for information on how to obtain needed care during a disaster.

If you cannot use a network provider during a disaster, your plan will allow you to obtain care from out-of-network providers at in-network cost sharing. If you cannot use a network pharmacy during a disaster, you may be able to fill your prescription drugs at an out-of-network pharmacy. Please see Chapter 5, Section 2.5 for more information.

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<b>SECTION 4</b>	<b>What if you are billed directly for the full cost of your services?</b>
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<b>Section 4.1</b>	<b>You can ask us to pay for covered services</b>
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If you have paid for your covered services, or if you have received a bill for covered medical services, go to Chapter 7 (*Asking us to pay a bill you have received for covered medical services or drugs*) for information about what to do.

<b>Section 4.2</b>	<b>What should you do if services are not covered by our plan?</b>
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Our plan covers all medically necessary services as listed in the Medical Benefits Chart in Chapter 4 of this document. If you receive services not covered by our plan or services obtained out-of-network and were not authorized, you are responsible for paying the full cost of services.

For covered services that have a benefit limitation, you also pay the full cost of any services you get after you have used up your benefit for that type of covered service. Costs incurred for services that are not covered by our plan or exceed the benefit limit do not count towards the annual out-of-pocket maximum. You can call Customer Service when you want to know how much of your benefit limit you have already used.

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<b>SECTION 5</b>	<b>How are your medical services covered when you are in a “clinical research study”?</b>
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<b>Section 5.1</b>	<b>What is a “clinical research study”?</b>
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A clinical research study (also called a “clinical trial”) is a way that doctors and scientists test new types of medical care, like how well a new cancer drug works. Certain clinical research studies are approved by Medicare. Clinical research studies approved by Medicare typically request volunteers to participate in the study.

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Once Medicare approves the study, and you express interest, 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. If you tell us that you are in a qualified clinical trial, then you are only responsible for the in-network cost sharing for the services in that trial. If you paid more, for example, if you already paid the Original Medicare cost-sharing amount, we will reimburse the difference between what you paid and the in-network cost sharing. However, you will need to provide documentation to show us how much you paid. When you are in a clinical research study, you may stay enrolled in our plan and continue to get the rest of your care (the care that is not related to the study) through our plan.

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

Although you do not need to get our plan's permission to be in a clinical research study, we encourage you to notify us in advance when you choose to participate in Medicare-qualified clinical trials.

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.*

<b>Section 5.2</b>	<b>When you participate in a clinical research study, who pays for what?</b>
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Once you join a Medicare-approved clinical research study, Original Medicare covers the 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

After Medicare has paid its share of the cost for these services, our plan will pay the rest. Like for all covered services, you will pay nothing for the covered services you get in the 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

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testing unless Medicare would cover the item or service even if you were *not* in a study.

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

**Do you want to know more?**

You can get more information about joining a clinical research study by visiting the Medicare website to read or download the publication “Medicare and Clinical Research Studies.” (The publication is available at: [www.medicare.gov/Pubs/pdf/02226-Medicare-and-Clinical-Research-Studies.pdf](http://www.medicare.gov/Pubs/pdf/02226-Medicare-and-Clinical-Research-Studies.pdf).) 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>
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A religious non-medical health care institution is a facility that provides care for a condition that would ordinarily be treated in a hospital or skilled nursing facility. If getting care in a hospital or a skilled nursing facility is against a member’s religious beliefs, we will instead provide coverage for care in a religious non-medical health care institution. This benefit is provided only for Part A inpatient services (non-medical health care services).

<b>Section 6.2</b>	<b>Receiving Care from a Religious Non-Medical Health Care Institution</b>
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To get care from a religious non-medical health care institution, you must sign a legal document that says you are conscientiously opposed to getting medical treatment that is “non-excepted.”

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

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 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.

There is unlimited coverage for this benefit. Please see the Benefits Chart in Chapter 4 for additional information.

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## **SECTION 7      Rules for ownership of durable medical equipment**

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<b>Section 7.1</b>	<b>Will you own the durable medical equipment after making a certain number of payments under our plan?</b>
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Durable medical equipment (DME) includes items such as oxygen equipment and supplies, wheelchairs, walkers, powered mattress systems, crutches, diabetic supplies, speech generating devices, IV infusion pumps, nebulizers, and hospital beds ordered by a provider for use in the home. The member always owns certain items, such as prosthetics. In this section, we discuss other types of DME that you must rent.

In Original Medicare, people who rent certain types of DME own the equipment after paying copayments for the item for 13 months. As a member of our plan, however, you usually will not acquire ownership of rented DME items no matter how many copayments you make for the item while a member of our plan, even if you made up to 12 consecutive payments for the DME item under Original Medicare before you joined our plan. Under certain limited circumstances, we will transfer ownership of the DME item to you. Call Customer Service for more information.

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

If you did not acquire ownership of the DME item while in our plan, you will have to make 13 new consecutive payments after you switch to Original Medicare in order to own the item. The payments made while enrolled in your plan do not count.

Example 1: You made 12 or fewer consecutive payments for the item in Original Medicare and then joined our plan. The payments you made in Original Medicare do not count. You will have to make 13 payments to our plan before owning the item.

Example 2: You made 12 or fewer consecutive payments for the item in Original Medicare and then joined our plan. You were in our plan but did not obtain ownership while in our plan. You then go back to Original Medicare. You will have to make 13 consecutive new payments to own the item once you join Original Medicare again. All previous payments (whether to our plan or to Original Medicare) do not count.

<b>Section 7.2</b>	<b>Rules for oxygen equipment, supplies, and maintenance</b>
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**What oxygen benefits are you entitled to?**

If you qualify for Medicare oxygen equipment coverage our plan will cover:

- Rental of oxygen equipment
- Delivery of oxygen and oxygen contents
- Tubing and related oxygen accessories for the delivery of oxygen and oxygen contents
- Maintenance and repairs of oxygen equipment

If you leave our plan or no longer medically require oxygen equipment, then the oxygen equipment must be returned.

**What happens if you leave your plan and return to Original Medicare?**

Original Medicare requires an oxygen supplier to provide you services for five years. During the first 36 months you rent the equipment. The remaining 24 months the supplier provides the equipment and maintenance (you are still responsible for the copayment for oxygen). After five years you may choose to stay with the same company or go to another company. At this point, the five-year cycle begins again, even if you remain with the same company, requiring you to pay copayments for the first 36 months. If you join or leave our plan, the five-year cycle starts over.

## CHAPTER 4:

*Medical Benefits Chart (what is covered)*



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## **SECTION 1      Understanding covered services**

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This chapter provides a Medical Benefits Chart that lists your covered services as a member of our plan. Later in this chapter, you can find information about medical services that are not covered. It also explains limits on certain services.

<b>Section 1.1      You pay nothing for your covered services</b>
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Because you get assistance from Oregon Health Plan (Medicaid), you pay nothing for your covered services as long as you follow the plans' rules for getting your care. (See Chapter 3 for more information about the plans' rules for getting your care.)

<b>Section 1.2      What is the most you will pay for covered medical services?</b>
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**Note:** Because our members also get assistance from Oregon Health Plan (Medicaid), very few members ever reach this out-of-pocket maximum. You are not responsible for paying any out-of-pocket costs toward the maximum out-of-pocket amount for covered Part A and Part B services.

Because you are enrolled in a Medicare Advantage Plan, there is a limit on the amount you have to pay out-of-pocket each year for medical services that are covered by our plan. This limit is called the maximum out-of-pocket amount (MOOP) for medical services. For calendar year 2023 this amount is \$8,300.

The amounts you pay for covered services count toward this maximum out-of-pocket amount. The amounts you pay for your Part D prescription drugs do not count toward your maximum out-of-pocket amount. In addition, amounts you pay for some services do not count toward your maximum out-of-pocket amount. These services are marked in bold in the Medical Benefits Chart. If you reach the maximum out-of-pocket amount of \$8,300, you will not have to pay any out-of-pocket costs for the rest of the year for covered services. However, you must continue to pay the Medicare Part B premium (unless your Part B premium is paid for you by Oregon Health Plan (Medicaid) or another third party).

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## **SECTION 2      Use the *Medical Benefits Chart* to find out what is covered**

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<b>Section 2.1      Your medical benefits as a member of the plan</b>
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The Medical Benefits Chart on the following pages lists the services our plan covers. Part D prescription drug coverage is in Chapter 5. The services listed in the Medical Benefits Chart are covered only when the following coverage requirements are met:

- Your Medicare and Oregon Health Plan (Medicaid) covered services must be provided according to the coverage guidelines established by Medicare and Oregon Health Plan (Medicaid).
- Your services (including medical care, services, supplies, equipment, and Part B prescription drugs) *must* be medically necessary. "Medically necessary" means



that the services, supplies, or drugs are needed for the prevention, diagnosis, or treatment of your medical condition and meet accepted standards of medical practice.


- You receive your care from a network provider. In most cases, care you receive from an out-of-network provider will not be covered unless it is emergent or urgent care or unless your plan or a network provider has given you a referral. This means that you will have to pay the provider in full for the services furnished.
- You have a primary care provider (a PCP) who is providing and overseeing your care.
- 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 in bold.

Other important things to know about our coverage:


- You are covered by both Medicare and Oregon Health Plan (Medicaid). Medicare covers health care and prescription drugs. Oregon Health Plan (Medicaid) covers your cost sharing for Medicare services, including coinsurances and copays. Oregon Health Plan (Medicaid) also covers services Medicare does not cover, like long-term care, transportation, over-the-counter drugs, and home and community-based services.
- Like all Medicare health plans, we cover everything that Original Medicare covers. (If you want to know more about the coverage and costs of Original Medicare, look in your *Medicare & You 2023* handbook. View it online at [www.medicare.gov](http://www.medicare.gov) or ask for a copy by calling 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.)
- For all preventive services that are covered at no cost under Original Medicare, we also cover the service at no cost to you.
- If Medicare adds coverage for any new services during 2023, either Medicare or our plan will cover those services.
- Sometimes, Oregon Health Plan (Medicaid) benefits may change during the year. If Oregon Health Plan (Medicaid) changes coverage for any benefits during 2023, we will follow their rules for coverage.
- The Medical Benefits Chart includes Medicare and full Oregon Health Plan (Medicaid) benefits covered by our plan. Benefits marked with an asterisk are not covered under Medicare, but covered directly by Oregon Health Plan (Medicaid).

- Cost shares, benefits, premiums, and deductibles in the benefits chart reflect Medicare and full Medicaid coverage. Your costs may vary if your Medicaid eligibility category and/or the level of Extra Help you receive changes.
- If you are within our plan's 3-month period of deemed continued eligibility, we will continue to provide all Medicare Advantage plan-covered Medicare benefits. However, during this period, we will not continue to cover Medicaid benefits that are included under your Oregon Health Plan (Medicaid) coverage or pay the Medicare premium or cost sharing that would be normally paid for you had you not lost your Medicaid eligibility. The amount you pay for Medicare covered services may increase during this period.

You do not pay anything for the services listed in the Benefits Chart, as long as you meet the coverage requirements described above.

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




### Medical Benefits Chart




Services that are covered for you	What you must pay when you get these services <b>In-Network</b>
 <b>Abdominal aortic aneurysm screening</b> No prior authorization required. A one-time screening ultrasound for people at risk. The plan only covers this screening if you have certain risk factors and if you get a referral for it from your physician, physician assistant, nurse practitioner, or clinical nurse specialist.	There is no coinsurance, copay, or deductible for members eligible for this preventive screening.
<b>Acupuncture for chronic low back pain</b> No prior authorization required. Covered services include: Up to 12 visits in 90 days are covered for Medicare beneficiaries under the following circumstances: For the purpose of this benefit, chronic low back pain is defined as: <ul style="list-style-type: none"> <li>• Lasting 12 weeks or longer;</li> <li>• nonspecific, in that it has no identifiable systemic cause (i.e., not associated with metastatic, inflammatory, infectious, etc. disease);</li> <li>• not associated with surgery; and</li> <li>• not associated with pregnancy.</li> </ul>	You pay nothing.

Services that are covered for you	What you must pay when you get these services <b>In-Network</b>
<p><b>Acupuncture for chronic low back pain (continued)</b></p> <p>An additional eight sessions will be covered for those patients demonstrating an improvement. No more than 20 acupuncture treatments may be administered annually. Treatment must be discontinued if the patient is not improving or is regressing.</p> <p>Provider Requirements:</p> <p>Physicians (as defined in 1861(r)(1) of the Social Security Act (the Act) may furnish acupuncture in accordance with applicable state requirements.</p> <p>Physician assistants (PAs), nurse practitioners (NPs)/ clinical nurse specialists (CNSs) (as identified in 1861(aa) (5) of the Act), and auxiliary personnel may furnish acupuncture if they meet all applicable state requirements and have:</p> <ul style="list-style-type: none"> <li>• a masters or doctoral level degree in acupuncture or Oriental Medicine from a school accredited by the Accreditation Commission on Acupuncture and Oriental Medicine (ACAOM); and,</li> <li>• a current, full, active, and unrestricted license to practice acupuncture in a State, Territory, or Commonwealth (i.e. Puerto Rico) of the United States, or District of Columbia.</li> </ul> <p>Auxiliary personnel furnishing acupuncture must be under the appropriate level of supervision of a physician, PA, or NP/CNS required by our regulations at 42 CFR §§ 410.26 and 410.27.</p>	
<ul style="list-style-type: none"> <li>• Additional acupuncture care</li> </ul>	See <b>Alternative care</b>


Services that are covered for you	What you must pay when you get these services <b>In-Network</b>
<p><b>Alternative care</b></p> <p><b>No prior authorization except as noted below. The amount you pay for services performed or ordered by an alternative care provider does not apply to your yearly maximum out-of-pocket.</b></p> <ul style="list-style-type: none"> <li>• Non-Medicare covered acupuncture, naturopathy, and non-Medicare covered chiropractic care up to a total of 24 office visits combined benefit limit per calendar year.</li> <li>• Additional visits for acupuncture, chiropractic care, massage, and yoga are covered for treatment of a covered illness or injury through your Medicaid coverage. <b>Prior authorization is required.*</b></li> </ul> <p>Covered services include:</p> <ul style="list-style-type: none"> <li>• Chiropractic care provided by a licensed Chiropractor acting within the scope of his/her license. In addition to office visits, some of the covered services include physical therapy modalities only when associated with spinal manipulation, related diagnostic laboratory (Complete Blood Count and General Panel), and x-ray services.</li> <li>• Acupuncture services provided by a licensed acupuncturists acting within the scope of his/her license. Covered services include acupuncture and electro-acupuncture.</li> <li>• Naturopathic services provided by a licensed Naturopath obtained to diagnose and treat an illness or injury.</li> <li>• Massage* <b>Prior authorization required.</b></li> <li>• Yoga* <b>Prior authorization required.</b></li> </ul> <p><u>The covered services above are not a comprehensive list. Please see table in Section 3.1 for a comprehensive list of services we do not cover.</u></p>	<p>You pay nothing.</p>
<ul style="list-style-type: none"> <li>• Manual manipulation of the spine to correct subluxation.</li> </ul>	<p><b>See Chiropractic Services</b></p>

Services that are covered for you	What you must pay when you get these services <b>In-Network</b>
<p><b>Ambulance services</b></p> <p><b>Prior authorization is required for non-emergency transportation.</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 could endanger the person's health or if authorized by the plan.</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 could endanger the person's health and that transportation by ambulance is medically required.</li> </ul> <p>We also cover non-emergent medical transportation (NEMT) ambulance service. See <b>Non-emergent medical transportation</b> for more information.*</p>	<p>You pay nothing.</p>
<p><b>Annual physical exam*</b></p> <p>No prior authorization required. <b>The amount you pay for these services do not apply to your yearly maximum out-of-pocket.</b> Limited to one exam per calendar year.</p> <p>This exam is covered in addition to the "Welcome to Medicare Exam" and "Annual Wellness Visit."</p> <ul style="list-style-type: none"> <li>Routine lab work not otherwise covered by Medicare as preventive, including: <ul style="list-style-type: none"> <li>Comprehensive Metabolic Panel</li> <li>Thyroid Stimulating Hormone</li> <li>Complete Blood Count</li> <li>Vitamin D</li> <li>A hands-on physical exam that includes inspection of the organ systems.</li> <li>A review of active medical problems, development of specific treatment plans, and an examination and evaluation of the entire person.</li> </ul> </li> </ul>	<p>You pay nothing.</p>


Services that are covered for you	What you must pay when you get these services <b>In-Network</b>
 <b>Annual wellness visit</b> No prior authorization required. If you've had Part B for longer than 12 months, you can get an annual wellness visit to develop or update a personalized prevention plan based on your current health and risk factors. This is covered once every 12 months.  <b>Note:</b> Your first annual wellness visit can't take place within 12 months of your "Welcome to Medicare" preventive visit. However, you don't need to have had a "Welcome to Medicare" visit to be covered for annual wellness visits after you've had Part B for 12 months.	There is no coinsurance, copay, or deductible for the annual wellness visit.
 <b>Bone mass measurement</b> No prior authorization required. For qualified individuals (generally, this means people at risk of losing bone mass or at risk of osteoporosis), the following services are covered every 24 months or more frequently if medically necessary: procedures to identify bone mass, detect bone loss, or determine bone quality, including a physician's interpretation of the results.	There is no coinsurance, copay, or deductible for Medicare-covered bone mass measurement.
 <b>Breast cancer screening (mammograms)</b> No prior authorization required. Covered services include: <ul style="list-style-type: none"> <li>• One baseline mammogram between the ages of 35 and 39</li> <li>• One screening mammogram every 12 months for women age 40 and older</li> <li>• Clinical breast exams once every 24 months</li> </ul>	There is no coinsurance, copay, or deductible for covered screening mammograms.
<ul style="list-style-type: none"> <li>• Additional exams are covered. Please see <b>Outpatient diagnostic tests and therapeutic services and supplies - Other outpatient diagnostic tests</b> for more information.</li> </ul>	You pay nothing.
<b>Cardiac rehabilitation services</b> No prior authorization required. Comprehensive programs of cardiac rehabilitation services that include exercise, education, and counseling are covered for members who meet certain conditions with a doctor's order. The plan also covers intensive cardiac rehabilitation programs that are typically more rigorous or more intense than cardiac rehabilitation programs.	You pay nothing.



Services that are covered for you	What you must pay when you get these services <b>In-Network</b>
 <b>Cardiovascular disease risk reduction visit (therapy for cardiovascular disease)</b> <p>No prior authorization required. We cover one visit per year with your primary care doctor to help lower your risk for cardiovascular disease. During this visit, your doctor may discuss aspirin use (if appropriate), check your blood pressure, and give you tips to make sure you're eating healthy.</p>	<p>There is no coinsurance, copay, or deductible for the intensive behavioral therapy cardiovascular disease preventive benefit.</p>
 <b>Cardiovascular disease testing</b> <p>No prior authorization required. Blood tests for the detection of cardiovascular disease (or abnormalities associated with an elevated risk of cardiovascular disease) once every 5 years (60 months).</p>	<p>There is no coinsurance, copay, or deductible for cardiovascular disease testing that is covered once every 5 years.</p>
 <b>Cervical and vaginal cancer screening</b> <p>No prior authorization required. Covered services include:</p> <ul style="list-style-type: none"> <li>• For all women: Pap tests and pelvic exams are covered once every 24 months</li> <li>• If you are at high risk of cervical or vaginal cancer or you are of childbearing age and have had an abnormal Pap test within the past 3 years: one Pap test every 12 months</li> </ul>	<p>There is no coinsurance, copay, or deductible for Medicare-covered preventive Pap and pelvic exams.</p>
<p><b>Children's care (age 20 and under)*</b></p> <p>No prior authorization required except as noted below.</p> <p>Oregon Health Plan (Medicaid) covers:</p> <ul style="list-style-type: none"> <li>• Eye exams and eyeglasses. Contact lenses for only a few conditions</li> <li>• Newborn care. Medical coverage until age 1 even if you are no longer on the Oregon Health Plan.</li> <li>• Certain shots. Shots for travel are not covered. <b>Prior authorization may be required for some shots.</b></li> <li>• Well child visits:             <ul style="list-style-type: none"> <li>○ From birth to age 36 months, limited to thirteen visits</li> <li>○ From age 3 to 18, limited to one visit a year.</li> </ul> </li> </ul>	<p>You pay nothing.</p>



Services that are covered for you	What you must pay when you get these services <b>In-Network</b>
<b>Chiropractic services</b> No prior authorization required. Covered services include: <ul style="list-style-type: none"> <li>• Manual manipulation of the spine to correct subluxation</li> </ul>	You pay nothing.
<ul style="list-style-type: none"> <li>• Additional chiropractic care</li> </ul>	See <b>Alternative Care</b>
<b>Colonoscopies</b> No prior authorization required. Covered services include: <ul style="list-style-type: none"> <li>• Diagnostic and preventive colonoscopies regardless of frequency.</li> </ul>	You pay nothing.
 <b>Colorectal cancer screening</b> No prior authorization required. For people 50 and older, the following are covered: <ul style="list-style-type: none"> <li>• Flexible sigmoidoscopy (or screening barium enema as an alternative) every 48 months</li> </ul> One of the following every 12 months: <ul style="list-style-type: none"> <li>• Guaiac-based fecal occult blood test (gFOBT)</li> <li>• Fecal immunochemical test (FIT)</li> </ul> DNA based colorectal screening every 3 years For people at high risk of colorectal cancer, we cover: <ul style="list-style-type: none"> <li>• Screening colonoscopy (or screening barium enema as an alternative) every 24 months</li> </ul> For people not at high risk of colorectal cancer, we cover: <ul style="list-style-type: none"> <li>• Screening colonoscopy every 10 years (120 months), but not within 48 months of a screening sigmoidoscopy</li> </ul>	There is no coinsurance, copay, or deductible for a Medicare-covered colorectal cancer screening exam.
<b>Death with dignity (assisted death for terminally ill)*</b> Services must be performed by an attending physician or consulting physician. Covered services include: <ul style="list-style-type: none"> <li>• Mental health evaluation and counseling</li> <li>• Prescription medications</li> </ul>	You pay nothing.




Services that are covered for you	What you must pay when you get these services <b>In-Network</b>
<p><b>Dental services*</b></p> <p><b>Prior authorization may be required for some services. The amount you pay for these services do not apply to your yearly maximum out-of-pocket.</b> In general, preventive dental services (such as cleaning, routine dental exams, and dental x-rays) are not covered by Original Medicare. We cover:</p> <p>Emergency Services:</p> <ul style="list-style-type: none"> <li>• Emergency Stabilization</li> </ul> <p>Preventive Services:</p> <ul style="list-style-type: none"> <li>• Exams</li> <li>• Cleanings</li> <li>• Fluoride Treatment</li> <li>• X-rays</li> <li>• Sealants - only covered for pregnant women and members under age 21</li> </ul> <p>Restorative Services:</p> <ul style="list-style-type: none"> <li>• Fillings</li> <li>• Partial Dentures - covered with limitations</li> <li>• Complete Dentures - covered with limitations</li> <li>• Crowns - covered with limitations; stainless steel</li> </ul> <p>Surgery and Endodontics:</p> <ul style="list-style-type: none"> <li>• Extractions</li> <li>• Root Canal Therapy - covered with limitations</li> </ul> <p>Dental services are provided through our partner dental care organizations (DCOs). Please see our Provider Directory for dental providers in network, or visit our website. You can also call Customer Service for more information. Your dental plan is listed on the front of your Oregon Health Plan (Medicaid) member ID card.</p>	<p>You pay nothing.</p>
<p> <b>Depression screening</b></p> <p>No prior authorization required. We cover one screening for depression per year. The screening must be done in a primary care setting that can provide follow-up treatment and/or referrals.</p>	<p>There is no coinsurance, copay, or deductible for an annual depression screening visit.</p>

Services that are covered for you	What you must pay when you get these services <b>In-Network</b>
<p><b>Diabetes prevention program*</b></p> <p>This program helps those with prediabetes to reduce the risk of Type 2 diabetes and improve overall health. This program is available online or in person in a group setting.</p>	<p>You pay nothing.</p>
<p> <b>Diabetes screening</b></p> <p>No prior authorization required. We cover this screening (includes fasting glucose tests) if you have any of the following risk factors: high blood pressure (hypertension), history of abnormal cholesterol and triglyceride levels (dyslipidemia), obesity, or a history of high blood sugar (glucose). Tests may also be covered if you meet other requirements, like being overweight and having a family history of diabetes.</p> <p>Based on the results of these tests, you may be eligible for up to two diabetes screenings every 12 months.</p>	<p>There is no coinsurance, copay, or deductible for the Medicare covered diabetes screening tests.</p>
<p> <b>Diabetes self-management training, diabetic services and supplies</b></p> <p><b>Prior authorization may be required for some diabetic services and supplies.</b> For all people who have diabetes (insulin and non-insulin users). Covered services include:</p> <ul style="list-style-type: none"> <li>Supplies to monitor your blood glucose: Blood glucose monitor, blood glucose test strips, lancet devices and lancets, and glucose-control solutions for checking the accuracy of test strips and monitors. Limited to OneTouch branded products when filled through a pharmacy. Please refer to the Diabetic Supplies List for covered services.</li> <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>Diabetes self-management training is covered under certain conditions.</li> </ul>	<p>You pay nothing.</p>


Services that are covered for you	What you must pay when you get these services <b>In-Network</b>
<p><b>Durable medical equipment (DME) and related supplies</b></p> <p><b>Prior authorization may be required for some Durable Medical Equipment (DME).</b></p> <p>(For a definition of “durable medical equipment,” see Chapter 12 as well as Chapter 3, Section 7 of this document.)</p> <p>Covered items include, but are not limited to: wheelchairs, crutches, powered mattress systems, diabetic supplies, hospital beds ordered by a provider for use in the home, IV infusion pumps, speech generating devices, oxygen equipment, nebulizers, and walkers.</p> <p>We cover all medically necessary DME covered by Original Medicare. If our supplier in your area does not carry a particular brand or manufacturer, you may ask them if they can special order it for you. The most recent list of suppliers is available on our website at <a href="http://www.Medicare.PacificSource.com">www.Medicare.PacificSource.com</a>.</p> <p>Additional DME may be available through your Oregon Health Plan (Medicaid) coverage if it is approved for treatment of a covered illness or injury.*</p>	<p>You pay nothing.</p> <p>Your cost sharing for Medicare oxygen equipment coverage is \$0 copay, every month.</p> <p>Your cost sharing will not change after being enrolled for 36 months.</p>
<p><b>Emergency care</b></p> <p>No prior authorization required. Emergency care refers to services that are:</p> <ul style="list-style-type: none"> <li>• Furnished by a provider qualified to furnish emergency services, and</li> <li>• Needed to evaluate or stabilize an emergency medical condition.</li> </ul> <p>A medical emergency is when you, or any other prudent layperson with an average knowledge of health and medicine, believe that you have medical symptoms that require immediate medical attention to prevent loss of life (and, if you are a pregnant woman, loss of an unborn child), loss of a limb, or loss of function of a limb. The medical symptoms may be an illness, injury, severe pain, or a medical condition that is quickly getting worse.</p> <p>Cost sharing for necessary emergency services furnished out-of-network is the same as for such services furnished in-network. Coverage is only within the U.S.</p>	<p>You pay nothing.</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.</p>

Services that are covered for you	What you must pay when you get these services <b>In-Network</b>
<p><b>Family planning*</b></p> <p>Family planning is a service to prevent or delay a pregnancy. We cover:</p> <ul style="list-style-type: none"> <li>• Women’s annual exam</li> <li>• Birth control education and counseling</li> <li>• Contraceptive supplies, such as patches, birth control pills, and intrauterine devices (IUDs)</li> <li>• Emergency contraception (the “morning after” pill)</li> <li>• Sterilization (tubal ligations and vasectomies) when performed by an in-network provider</li> <li>• Radiology services</li> <li>• Laboratory testing</li> </ul> <p>Related services that are also covered include:</p> <ul style="list-style-type: none"> <li>• Pregnancy tests</li> <li>• Screening and counseling for sexually transmitted diseases (STDs), including AIDS and HIV</li> <li>• Abortions (Contact OHA by visiting <a href="http://www.Oregon.gov/OHA/PH/HealthyPeopleFamilies/ReproductiveSexualHealth/OregonContraceptiveCare/pages/index.aspx#abortion">www.Oregon.gov/OHA/PH/HealthyPeopleFamilies/ReproductiveSexualHealth/OregonContraceptiveCare/pages/index.aspx#abortion</a>)</li> </ul>	<p>You pay nothing.</p>
<p><b>Flexible services*</b></p> <p>Flexible services are health related services that may be provided to improve member health. These services can include but are not limited to equipment, appliances, classes or special clothing or footwear. To find out if you are eligible and for more information about flexible services, please call (888) 675-0350. Services are limited to eligibility and funding through your Medicaid coverage.</p>	<p>You pay nothing.</p>
<p><b>Groceries</b></p>	<p>See <b>Special Supplemental Benefits for the Chronically Ill</b></p>

Services that are covered for you	What you must pay when you get these services <b>In-Network</b>
<p> <b>Health and wellness education programs</b></p> <p>No prior authorization required. <b>The amount you pay for these services do not apply to your yearly maximum out-of-pocket amount.</b></p> <p><b>The Silver&amp;Fit® Healthy Aging and Exercise Program</b></p> <p>As a Silver&amp;Fit member, you have the following options available at no cost to you:</p> <ul style="list-style-type: none"> <li>• <b>Workout Plans:</b> By answering a few online questions about your areas of interest, you will receive a customized workout plan, including instructions on how to get started and suggested digital workout videos.</li> <li>• <b>Digital Workouts:</b> You can view on-demand videos through the website and mobile app's digital workout library, including Silver&amp;Fit Signature Series Classes ®.</li> <li>• <b>Fitness Center Membership:</b> You can visit a participating fitness center or YMCA near you that takes part in the program. *You also have access to the Premium Fitness Network, which includes additional fitness center and studio choices and unique experiences like swimming centers, rock climbing gyms, and rowing centers, each with a buy-up price. Many participating fitness centers may also offer low-impact classes focused on improving and increasing muscular strength and endurance, mobility, flexibility, range of motion, balance, agility, and coordination.</li> <li>• <b>Home Fitness Kits:</b> You are eligible to receive one Home Fitness Kit per benefit year from a variety of fitness categories.</li> <li>• <b>Well-Being Club:</b> By setting your preferences for well-being topics on the website, you will see resources tailored to your interests and healthy habit goals including articles, videos, live-streaming classes, and meetups**</li> </ul>	<p>\$0 annual program fee to enroll into a Silver&amp;Fit fitness facility.</p> <p>\$0 annual fee for one kit through Silver&amp;Fit</p>

Services that are covered for you	What you must pay when you get these services <b>In-Network</b>
<p><b>Health and wellness education programs (continued)</b></p> <ul style="list-style-type: none"> <li>• Healthy Aging Coaching: You can participate in sessions by telephone with a trained coach where you can discuss topics like exercise, nutrition, social isolation, and brain health.</li> <li>• The Silver&amp;Fit Connected!™: The Silver&amp;Fit Connected! tool will assist with tracking your activity.</li> <li>• Rewards: Earn a hat and pins for reaching new milestones.</li> </ul> <p>The Silver&amp;Fit program has <b>Something for Everyone®!</b></p> <p>*Non-standard services that call for an added fee are not part of the Silver&amp;Fit program and will not be reimbursed.</p> <p>**ASH Fitness has no affiliations, interest, endorsements, or sponsorships with any of the organizations or clubs. Some clubs may require a fee to join. Such fees are not part of the Silver&amp;Fit programs and will not be reimbursed by ASH Fitness.</p> <p>The Silver&amp;Fit program is provided by American Specialty Health Fitness, Inc., a subsidiary of American Specialty Health Incorporated (ASH). Silver&amp;Fit, Silver&amp;Fit Signature Series Classes, Silver&amp;Fit Connected!, and Something for Everyone are trademarks of ASH. Limitations, and restrictions may apply. Participating facilities and fitness chains may vary by location and are subject to change. Kits and rewards are subject to change.</p> <p>For more information or to sign up for this program, visit <a href="http://www.SilverandFit.com">www.SilverandFit.com</a> or call Silver&amp;Fit toll free at (877) 427-4788. TTY users call (877) 710-2746.</p>	


Services that are covered for you	What you must pay when you get these services <b>In-Network</b>
<p><b>Health and wellness education programs (continued)</b></p> <p><b>24-Hour NurseLine*</b></p> <p><b>The amount you pay for these services do not apply to your yearly maximum out-of-pocket amount.</b> Available 24-hours, 7 days a week. You can call our 24-Hour NurseLine at (855) 834-6150 any time of the night or day to receive trusted health information and advice from the comfort of your home. TTY users should call (844) 514-3774.</p> <p>A nurse may call you back with additional advice and information based on your health questions and needs.</p>	<p>There is no coinsurance or copay for the 24-Hour NurseLine.</p>
<p><b>Hearing services (Medicare covered)</b></p> <p>No prior authorization required. Diagnostic hearing and balance evaluations performed by your provider to determine if you need medical treatment are covered as outpatient care when furnished by a physician, audiologist, or other qualified provider.</p>	<p>You pay nothing.</p>
<p><b>Hearing services (routine)*</b></p> <p>No prior authorization required. <b>The amount you pay for these services do not apply to your yearly maximum out-of-pocket amount.</b></p> <p>We cover:</p> <ul style="list-style-type: none"> <li>• One basic hearing test every 12 months</li> <li>• One comprehensive hearing test every 12 months</li> <li>• One hearing aid evaluation and selection every 12 months</li> <li>• One electroacoustic evaluation for hearing aid for one or both ears every 12 months</li> <li>• One pure tone hearing (threshold) test; air bone every 12 months</li> </ul>	<p>You pay nothing.</p>
<p><b>Hearing aids*</b></p> <p><b>Prior authorization is required for hearing aids and batteries. The amount you pay for these services do not apply to your yearly maximum out-of-pocket amount.</b></p> <ul style="list-style-type: none"> <li>• Hearing aids for adults 21 and older: One hearing aid for each ear every 5 years</li> <li>• Hearing aids for children through age 20: One hearing aid for each ear every 3 years</li> <li>• 60 batteries per year</li> </ul>	<p>You pay nothing.</p>

Services that are covered for you	What you must pay when you get these services <b>In-Network</b>
<p> <b>HIV screening</b></p> <p>No prior authorization required. 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>There is no coinsurance, copay, or deductible for members eligible for Medicare-covered preventive HIV screening.</p>
<p><b>Home health agency care</b></p> <p>No prior authorization required. Prior to receiving home health services, a doctor must certify that you need home health services and will order home health services to be provided by a home health agency. You must be homebound, which means leaving home is a major effort.</p> <p>Covered services include, but are not limited to:</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 and social services</li> <li>• Medical equipment and supplies</li> </ul>	<p>You pay nothing</p>



Services that are covered for you	What you must pay when you get these services <b>In-Network</b>
<p><b>Home infusion therapy</b></p> <p><b>Prior authorization is required for some drugs.</b> Home infusion therapy involves the intravenous or subcutaneous administration of drugs or biologicals to an individual at home. The components needed to perform home infusion include the drug (for example, antivirals, immune globulin), equipment (for example, a pump), and supplies (for example, tubing and catheters).</p> <p>Covered services include, but are not limited to:</p> <ul style="list-style-type: none"> <li>• Professional services, including nursing services, furnished in accordance with the plan of care</li> <li>• Patient training and education not otherwise covered under the durable medical equipment benefit</li> <li>• Remote monitoring</li> <li>• Monitoring services for the provision of home infusion therapy and home infusion drugs furnished by a qualified home infusion therapy supplier</li> </ul>	<p>You pay nothing.</p>
<p><b>Hospice care</b></p> <p>No prior authorization required. You are eligible for the hospice benefit when your doctor and the hospice medical director have given you a terminal prognosis certifying that you're terminally ill and have 6 months or less to live if your illness runs its normal course. You may receive care from any Medicare-certified hospice program. Your plan is obligated to help you find Medicare-certified hospice programs in the plan's service area, including those the MA organization owns, controls, or has a financial interest in. Your hospice doctor can be a network provider or an out-of-network provider. Covered services include:</p> <ul style="list-style-type: none"> <li>• Drugs for symptom control and pain relief</li> <li>• Short-term respite care</li> <li>• Home care</li> </ul>	<p>When you enroll in a Medicare-certified hospice program, your hospice services and your Part A and Part B services related to your terminal prognosis are paid for by Original Medicare, not our plan.</p>

Services that are covered for you	What you must pay when you get these services <b>In-Network</b>
<p><b>Hospice care (continued)</b></p> <p><u>For hospice services and for services that are covered by Medicare Part A or B and are related to your terminal prognosis:</u> Original Medicare (rather than our plan) will pay your hospice provider for your hospice services related to your terminal prognosis. While you are in the hospice program, your hospice provider will bill Original Medicare for the services that Original Medicare pays for. You will be billed Original Medicare cost sharing.</p> <p><u>For services that are covered by Medicare Part A or B and are not related to your terminal prognosis:</u> If you need non-emergency, non-urgently needed services that are covered under Medicare Part A or B and that are not related to your terminal prognosis, your cost for these services depends on whether you use a provider in our plan's network and follow plan rules (such as if there is a requirement to obtain prior authorization).</p> <ul style="list-style-type: none"> <li>• If you obtain the covered services from a network provider and follow plan rules for obtaining service, you only pay the plan cost-sharing amount for in-network services</li> <li>• If you obtain the covered services from an out-of-network provider, you pay the cost sharing under Fee-for-Service Medicare (Original Medicare)</li> </ul> <p><u>For services that are covered by our plan but are not covered by Medicare Part A or B:</u> our plan will continue to cover plan-covered services that are not covered under Part A or B whether or not they are related to your terminal prognosis. You pay your plan cost-sharing amount for these services.</p> <p><u>For drugs that may be covered by the plan's Part D benefit:</u> If these drugs are unrelated to your terminal hospice condition you pay cost sharing. If they are related to your terminal hospice condition then you pay Original Medicare cost sharing. Drugs are never covered by both hospice and our plan at the same time. For more information, please see Chapter 5, Section 9.4 (<i>What if you're in Medicare-certified hospice</i>).</p>	

Services that are covered for you	What you must pay when you get these services <b>In-Network</b>
<b>Hospice care (continued)</b>  <b>Note:</b> If you need non-hospice care (care that is not related to your terminal prognosis), you should contact us to arrange the services.	
Our plan covers hospice consultation services (one time only) for a terminally ill person who hasn't elected the hospice benefit.	<b>See Physician/Practitioner services, including doctor's office visits: Specialist</b>
 <b>Immunizations</b>  No prior authorization required. Covered Medicare Part B services include: <ul style="list-style-type: none"> <li>• Pneumonia vaccine</li> <li>• Flu shots, once each flu season in the fall and winter, with additional flu shots if medically necessary</li> <li>• Hepatitis B vaccine if you are at high or intermediate risk of getting Hepatitis B</li> <li>• COVID-19 vaccine</li> <li>• Other vaccines if you are at risk and they meet Medicare Part B coverage rules</li> </ul>	There is no coinsurance, copay, or deductible for the pneumonia, influenza, Hepatitis B, and COVID-19 vaccines.
We also cover some vaccines under our Part D prescription drug benefit.	<b>Please see Chapter 6 for more information about Part D prescription drug vaccines.</b>
<b>Inpatient hospital care</b>  <b>Prior authorization may be required depending on the procedure, except in urgent or emergent situations. Notification from your provider is required upon admission.</b> Includes inpatient acute, inpatient rehabilitation, long-term care hospitals and other types of inpatient hospital services. Inpatient hospital care starts the day you are formally admitted to the hospital with a doctor's order. The day before you are discharged is your last inpatient day.  You are covered for an unlimited number of medically necessary days. Each time you are admitted or transferred to a new facility type this is considered day one of your inpatient stay.	You pay nothing.  If you get authorized inpatient care at an out-of-network hospital after your emergency condition is stabilized, your cost is the cost sharing you would pay at a network hospital.


Services that are covered for you	What you must pay when you get these services <b>In-Network</b>
<p><b>Inpatient hospital care (continued)</b></p> <p>Covered services include but are not limited to:</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 care or 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> <li>• Operating and recovery room costs</li> <li>• Physical, occupational, and speech language therapy</li> <li>• Inpatient substance abuse services</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. Transplant providers may be local or outside of the service area. If our in-network transplant services are outside the community pattern of care, you may choose to go locally as long as the local transplant providers are willing to accept the Original Medicare rate. If our plan provides transplant services at a location outside the pattern of care for transplants in your community and you choose to obtain transplants at this distant location, we will arrange or pay for appropriate lodging and transportation costs for you and a companion.</li> </ul>	

Services that are covered for you	What you must pay when you get these services <b>In-Network</b>
<p><b>Inpatient hospital care (continued)</b></p> <ul style="list-style-type: none"> <li>• Blood - including storage and administration. Coverage of whole blood and packed red cells begins only with the fourth pint of blood that you need - you must either pay the costs for the first 3 pints of blood you get in a calendar year or have the blood donated by you or someone else. All other components of blood are covered beginning with the first pint used.</li> <li>• Physician services</li> </ul> <p><b>Note:</b> To be an inpatient, your provider must write an order to admit you formally as an inpatient of the hospital. Even if you stay in the hospital overnight, you might still be considered an “outpatient.” If you are not sure if you are an inpatient or an outpatient, you should ask the hospital staff.</p> <p>You can also find more information in a Medicare fact sheet called “Are You a Hospital Inpatient or Outpatient? If You Have Medicare – Ask!” This fact sheet is available on the Web at <a href="https://www.medicare.gov/sites/default/files/2021-10/11435-Inpatient-or-Outpatient.pdf">https://www.medicare.gov/sites/default/files/2021-10/11435-Inpatient-or-Outpatient.pdf</a> or by calling 1-800-MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048. You can call these numbers for free, 24 hours a day, 7 days a week.</p>	
<p><b>Inpatient services in a psychiatric hospital</b></p> <p><b>Prior authorization may be required depending on the procedure, except in urgent or emergent situations. Notification from your provider is required upon admission.</b></p> <p>Covered services include mental health care services that require a hospital stay.</p> <ul style="list-style-type: none"> <li>• There is a 190-day lifetime limit for inpatient services in a psychiatric hospital. The 190-day limit does not apply to inpatient mental health services provided in a psychiatric unit of a general hospital.</li> </ul>	<p>You pay nothing.</p>


Services that are covered for you	What you must pay when you get these services <b>In-Network</b>
<p><b>Inpatient stay: Covered services received in a hospital or SNF during a non-covered inpatient stay</b></p> <p><b>Prior authorization may be required for some services.</b> If you have exhausted your inpatient benefits or if the inpatient stay is not reasonable and necessary, we will not cover your inpatient stay. However, in some cases, we will cover certain services you receive while you are in the hospital or the skilled nursing facility (SNF). Covered services include but are not limited to:</p>	<p>For each service, see appropriate sections of this Benefits Chart for benefits, rules, and limits.</p>
<ul style="list-style-type: none"> <li>• Physician services</li> </ul>	<p>See <b>Physician/Practitioner services, PCP or Specialist office visit</b></p>
<ul style="list-style-type: none"> <li>• Diagnostic tests (like lab tests)</li> <li>• X-ray, radium, and isotope therapy including technician materials and services</li> <li>• Surgical dressings</li> <li>• Splints, casts and other devices used to reduce fractures and dislocations</li> </ul>	<p>See <b>Outpatient diagnostic tests and therapeutic services and supplies</b></p>
<ul style="list-style-type: none"> <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 patient's physical condition</li> </ul>	<p>See <b>Prosthetic devices and related supplies</b></p>
<ul style="list-style-type: none"> <li>• Physical therapy, speech therapy, and occupational therapy</li> </ul>	<p>See <b>Outpatient rehabilitation services</b></p>


Services that are covered for you	What you must pay when you get these services <b>In-Network</b>
<p><b>Intensive care coordination services (ICC)*</b></p> <p>No prior authorization required unless noted below. Coordination of special services for members who have special needs or disabilities. These services can help you:</p> <ul style="list-style-type: none"> <li>• Find a provider who can help with special healthcare needs.</li> <li>• Get an appointment with your PCP or specialist sooner.</li> <li>• Obtain equipment, supplies or services. <b>Prior authorization may be required.</b></li> <li>• Coordinate care with your providers, community support agencies, and social service agencies.</li> </ul> <p>Call Customer Service (phone numbers are listed on the back cover of this booklet) for more information about this service.</p>	<p>You pay nothing.</p>
<p><b>Interpreter services*</b></p> <p>No prior authorization required. Certified health care interpreter services are covered at your medical appointments.</p> <p>When you call to make an appointment, tell your provider's office that you need an interpreter. Tell them which language you need. If you need these services in person, you will need to call your provider at least five days before your appointment in most cases. If you need help asking for an interpreter, call Customer Service.</p>	<p>You pay nothing.</p>
<p><b>Maternity services*</b></p> <p>No prior authorization required. We cover:</p> <ul style="list-style-type: none"> <li>• Prenatal care</li> <li>• Labor and delivery</li> <li>• Postpartum care</li> <li>• Doula services</li> <li>• Care for your newborn baby until age 1</li> <li>• Eye exams and new glasses every 24 months if you are pregnant and age 21 and older</li> </ul> <p>For more information about coverage for children, see <b>Children's care (age 20 and under)*</b> benefit.</p>	<p>You pay nothing.</p>



Services that are covered for you	What you must pay when you get these services <b>In-Network</b>
<p><b>Meal benefit</b></p> <p>No prior authorization required. <b>The amounts you pay for these services do not apply to your yearly maximum out-of-pocket amount.</b></p> <p>You are able to get home-delivered precooked frozen meals within 30 days after a recent inpatient stay in a hospital or nursing facility. This service includes 2 meals per day for 14 days for a total of 28 meals at no extra cost to you.</p> <p>After you are discharged, you will receive a call from GA Foods to initiate this benefit. Once your delivery details have been confirmed, your meals will arrive within 24-72 hours.</p> <p>Special meals are available that meet heart-healthy, diabetic friendly, or low-sodium guidelines. Condition specific menus also include Renal-friendly, Pureed, Vegetarian, and Kosher options.</p> <p>For more information, please call GA Foods at (888) 308-4910.</p> <p><b>Note: All arrangements must be made through GA Foods.</b></p>	<p>You pay nothing.</p>
<p> <b>Medical nutrition therapy</b></p> <p>No prior authorization required. This benefit is for people with diabetes, renal (kidney) disease (but not on dialysis), or after a kidney transplant when ordered by your doctor.</p> <p>We cover 3 hours of one-on-one counseling services during your first year that you receive medical nutrition therapy services under Medicare (this includes our plan, any other Medicare Advantage plan, or Original Medicare), and 2 hours each year after that. If your condition, treatment, or diagnosis changes, you may be able to receive more hours of treatment with a physician's order. A physician must prescribe these services and renew their order yearly if your treatment is needed into the next calendar year.</p>	<p>There is no coinsurance, copay, or deductible for members eligible for Medicare-covered medical nutrition therapy services.</p>



Services that are covered for you	What you must pay when you get these services <b>In-Network</b>
 <b>Medicare Diabetes Prevention Program (MDPP)</b> <p>No prior authorization required. MDPP services will be covered for eligible Medicare beneficiaries under all Medicare health plans.</p> <p>MDPP is a structured health behavior change intervention that provides practical training in long-term dietary change, increased physical activity, and problem-solving strategies for overcoming challenges to sustaining weight loss and a healthy lifestyle.</p>	<p>There is no coinsurance, copay, or deductible for the MDPP benefit.</p>
<p><b>Medicare Part B prescription drugs</b></p> <p><b>Prior authorization or Step Therapy is required for some drugs.</b> These drugs are covered under Part B of Original Medicare. Members of our plan receive coverage for these drugs through our plan. Covered drugs include:</p> <ul style="list-style-type: none"> <li>• Drugs that usually aren't self-administered by the patient and are injected or infused while you are getting physician, hospital outpatient, or ambulatory surgical center services</li> <li>• Drugs you take using durable medical equipment (such as nebulizers) that were authorized by the plan</li> <li>• Clotting factors you give yourself by injection if you have hemophilia</li> <li>• Immunosuppressive drugs, if you were enrolled in Medicare Part A at the time of the organ transplant</li> <li>• 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</li> <li>• Antigens</li> <li>• Certain oral anti-cancer drugs and anti-nausea drugs</li> </ul>	<p>You pay nothing.</p> <p>The following Part B drug categories may be subject to step therapy:</p> <ul style="list-style-type: none"> <li>• Bevacizumab products (oncology)</li> <li>• Erythropoiesis stimulating agents (ESAS)</li> <li>• Filgrastim products</li> <li>• Immunologics</li> <li>• Multiple sclerosis (MS)</li> <li>• Ophthalmic</li> <li>• Osteoporosis</li> <li>• Pegfilgrastim products</li> <li>• Rituximab</li> <li>• Trastuzumab products</li> </ul>

Services that are covered for you	What you must pay when you get these services <b>In-Network</b>
<p><b>Medicare Part B prescription drugs (continued)</b></p> <ul style="list-style-type: none"> <li>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)</li> <li>Intravenous Immune Globulin for the home treatment of primary immune deficiency diseases</li> </ul> <p>The following link will take you to a list of Part B Drugs that may be subject to Step Therapy: <a href="http://www.medicare.pacificsource.com">www.medicare.pacificsource.com</a></p> <p>We also cover some vaccines under our Part B and Part D prescription drug benefit.</p> <p>Chapter 5 explains the Part D prescription drug benefit, including rules you must follow to have prescriptions covered. What you pay for your Part D prescription drugs through our plan is explained in Chapter 6.</p>	
<p><b>Non-emergent medical transportation*</b></p> <p>Non-Emergent Medical Transportation (NEMT) to and from a covered health care appointment or other health related services, not emergencies.</p> <p>You may schedule your ride in advance. Some rules may apply. For more information, call our Customer Service (phone numbers are listed on the back of this booklet) or refer to your Riders Guide at <a href="http://www.communitysolutions.pacificsource.com">www.communitysolutions.pacificsource.com</a>.</p>	<p>You pay nothing.</p>
<p> <b>Obesity screening and therapy to promote sustained weight loss</b></p> <p><b>Prior authorization is required for some drugs.</b> If you have a body mass index of 30 or more, we cover intensive counseling to help you lose weight. This counseling is covered if you get it in a primary care setting, where it can be coordinated with your comprehensive prevention plan. Talk to your primary care doctor or practitioner to find out more.</p>	<p>There is no coinsurance, copay, or deductible for preventive obesity screening and therapy.</p>

Services that are covered for you	What you must pay when you get these services <b>In-Network</b>
<p><b>Opioid treatment program services</b></p> <p>No prior authorization required. Members of our plan with opioid use disorder (OUD) can receive coverage of services to treat OUD through an Opioid Treatment Program (OTP) which includes the following services:</p> <ul style="list-style-type: none"> <li>• U.S. Food and Drug Administration (FDA)-approved opioid agonist and antagonist medication-assisted treatment (MAT) medications</li> <li>• Dispensing and administration of MAT medications (if applicable)</li> <li>• Substance use counseling</li> <li>• Individual and group therapy</li> <li>• Toxicology testing</li> <li>• Intake activities</li> <li>• Periodic assessments</li> </ul>	<p>You pay nothing.</p>
<p><b>Outpatient diagnostic tests and therapeutic services and supplies</b></p> <p>No prior authorization required except as noted below. Covered services include, but are not limited to:            (See Section 3.1 for exclusions)</p>	
<ul style="list-style-type: none"> <li>• DEXA Scans</li> </ul>	<p>You pay nothing.</p>
<ul style="list-style-type: none"> <li>• X-rays</li> </ul>	<p>You pay nothing.</p>
<ul style="list-style-type: none"> <li>• Radiation (radium and isotope) therapy including technician materials and supplies</li> </ul> <p><b>Prior authorization is required for some radiation services.</b></p>	<p>You pay nothing.</p>
<ul style="list-style-type: none"> <li>• Surgical supplies, such as dressings</li> <li>• Splints, casts and other devices used to reduce fractures and dislocations</li> </ul>	<p>You pay nothing.</p>
<ul style="list-style-type: none"> <li>• Laboratory tests</li> </ul> <p><b>Prior authorization may be required for some laboratory tests including genetic testing and analysis. Services must be ordered and administered by an in-network provider.</b></p>	<p>You pay nothing.</p>

Services that are covered for you	What you must pay when you get these services <b>In-Network</b>
<b>Outpatient diagnostic tests and therapeutic services and supplies (continued)</b> <ul style="list-style-type: none"> <li>Blood - including storage and administration. Coverage of whole blood and packed red cells begins only with the fourth pint of blood that you need - you must either pay the costs for the first 3 pints of blood you get in a calendar year or have the blood donated by you or someone else. All other components of blood are covered beginning with the first pint used.</li> </ul>	You pay nothing.
<ul style="list-style-type: none"> <li>Other outpatient diagnostic tests</li> </ul> For additional mammogram benefits, see <b>Breast cancer screening (mammograms)</b> .	You pay nothing.
<ul style="list-style-type: none"> <li>Sleep studies</li> </ul>	You pay nothing.
<ul style="list-style-type: none"> <li>Advanced/complex imaging</li> </ul> <b>Prior authorization is required for advanced/complex imaging such as:</b> CT Scan, MRI, PET Scan, Nuclear Test.	You pay nothing.
<b>Outpatient hospital observation</b>  No prior authorization required. Observation services are hospital outpatient services given to determine if you need to be admitted as an inpatient or can be discharged.  For outpatient hospital observation services to be covered, they must meet the Medicare criteria and be considered reasonable and necessary. Observation services are covered only when provided by the order of a physician or another individual authorized by state licensure law and hospital staff bylaws to admit patients to the hospital or order outpatient tests.  <b>Note:</b> Unless the provider has written an order to admit you as an inpatient to the hospital, you are an outpatient and pay the cost-sharing amounts for outpatient hospital services. Even if you stay in the hospital overnight, you might still be considered an “outpatient.” If you are not sure if you are an outpatient, you should ask the hospital staff.	You pay nothing.

Services that are covered for you	What you must pay when you get these services <b>In-Network</b>
<p><b>Outpatient hospital observation (continued)</b></p> <p>You can also find more information in a Medicare fact sheet called “Are You a Hospital Inpatient or Outpatient? If You Have Medicare – Ask!” This fact sheet is available on the Web at <a href="https://www.medicare.gov/sites/default/files/2021-10/11435-Inpatient-or-Outpatient.pdf">https://www.medicare.gov/sites/default/files/2021-10/11435-Inpatient-or-Outpatient.pdf</a> or by calling 1-800-MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048. You can call these numbers for free, 24 hours a day, 7 days a week.</p>	
<p><b>Outpatient hospital services</b></p> <p><b>Prior authorization may be required for some outpatient services.</b> We cover medically-necessary services you get in the outpatient department of a hospital for diagnosis or treatment of an illness or injury.</p> <p>Covered services include, but are not limited to:</p>	<p>For each service, see appropriate sections of the Benefits Chart for benefit rules and limits.</p>
<ul style="list-style-type: none"> <li>• Services in an emergency department</li> </ul>	<p>See <b>Emergency Care</b></p>
<ul style="list-style-type: none"> <li>• Outpatient clinic, such as observation services or outpatient surgery</li> </ul>	<p>Outpatient Clinic: See <b>Physician/Practitioner services</b></p> <p>Observation or Outpatient Surgery: See <b>Outpatient surgery</b></p>
<ul style="list-style-type: none"> <li>• Laboratory and diagnostic tests billed by the hospital</li> </ul>	<p>See <b>Outpatient diagnostic tests and therapeutic services and supplies</b></p>
<ul style="list-style-type: none"> <li>• Mental health care, including care in a partial-hospitalization program, if a doctor certifies that inpatient treatment would be required without it</li> </ul>	<p>Mental Health Care: See <b>Outpatient mental health care</b></p> <p>Partial Hospitalization: See <b>Partial hospitalization services</b></p>
<ul style="list-style-type: none"> <li>• X-rays and other radiology services billed by the hospital</li> <li>• Medical supplies such as splints and casts</li> </ul>	<p>See <b>Outpatient diagnostic tests and therapeutic services and supplies</b></p>
<ul style="list-style-type: none"> <li>• Certain drugs and biologicals that you can’t give yourself</li> </ul>	<p>See <b>Medicare Part B prescription drugs</b></p>

Services that are covered for you	What you must pay when you get these services <b>In-Network</b>
<p><b>Outpatient hospital services (continued)</b></p> <p><b>Note:</b> Unless the provider has written an order to admit you as an inpatient to the hospital, you are an outpatient and pay the cost-sharing amounts for outpatient hospital services. Even if you stay in the hospital overnight, you might still be considered an “outpatient.” If you are not sure if you are an outpatient, you should ask the hospital staff.</p> <p>You can also find more information in a Medicare fact sheet called “Are You a Hospital Inpatient or Outpatient? If You Have Medicare – Ask!” This fact sheet is available on the Web at <a href="https://www.medicare.gov/sites/default/files/2021-10/11435-Inpatient-or-Outpatient.pdf">https://www.medicare.gov/sites/default/files/2021-10/11435-Inpatient-or-Outpatient.pdf</a> or by calling 1-800-MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048. You can call these numbers for free, 24 hours a day, 7 days a week.</p>	
<p><b>Outpatient mental health care</b></p> <p>No prior authorization required. Covered services include:</p> <p>Mental health services provided by a state-licensed psychiatrist or 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> <ul style="list-style-type: none"> <li>• Oregon Health Plan (Medicaid) covers Case Management, Emergency services, Assessments, Hospitalization, Medication management, Programs to help with daily and community living, Psychiatric residential and day treatment, Counseling, Outpatient behavioral health services, Behavioral health peer delivered services, Behavioral health assessment and evaluation services (includes Assertive Community Treatment services), Medication assisted treatment of substance use disorders, Assertive Community Treatment and wraparound services.*</li> </ul>	<p>You pay nothing.</p>

Services that are covered for you	What you must pay when you get these services <b>In-Network</b>
<p><b>Outpatient rehabilitation services</b></p> <p><b>Prior authorization is required for services beyond the Medicare therapy cap limits.</b> Covered services include: physical therapy, occupational therapy, and speech language therapy.</p> <p>Outpatient rehabilitation services are provided in various outpatient settings, such as hospital outpatient departments, independent therapist offices, and Comprehensive Outpatient Rehabilitation Facilities (CORFs).</p>	<p>You pay nothing.</p>
<p><b>Outpatient substance abuse services</b></p> <p>No prior authorization required. You are covered for services and supplies to treat substance use disorders in an outpatient setting (individual or group therapy).</p>	<p>You pay nothing.</p>
<p><b>Outpatient surgery, including services provided at hospital outpatient facilities and ambulatory surgical centers</b></p> <p><b>Prior authorization is required for some services.</b> No prior authorization is required for observation services.</p> <p><b>Note:</b> If you are having surgery in a hospital facility, you should check with your provider about whether you will be an inpatient or outpatient. Unless the provider writes an order to admit you as an inpatient to the hospital, you are an outpatient and pay the cost-sharing amounts for outpatient surgery. Even if you stay in the hospital overnight, you might still be considered an “outpatient.”</p>	<p>You pay nothing.</p>


Services that are covered for you	What you must pay when you get these services <b>In-Network</b>
<p><b>Over-the-counter (OTC) allowance</b></p> <p><b>The amounts you pay for these services do not apply to your yearly maximum out-of-pocket amount.</b></p> <p>No prior authorization required. You receive a quarterly allowance of \$200 per quarter to use towards plan-approved (non-prescription) medications, and/or health-related items at NationsOTC. OTC items include the following categories plus more (please visit the website below for all categories and items):</p> <ul style="list-style-type: none"> <li>• Bath and shower safety, and fall prevention</li> <li>• Cold, flu, sinus, and allergy</li> <li>• Dental and denture care</li> <li>• Diabetes care</li> <li>• Digestive health</li> <li>• Eye and ear care</li> <li>• Feminine care</li> <li>• First aid and medical supplies</li> <li>• Foot care</li> <li>• Hemorrhoidal preparations</li> <li>• Home diagnostics, patient aids, and home health care</li> <li>• Incontinence supplies</li> <li>• Pain relief</li> <li>• Personal care</li> <li>• Rehabilitation, therapy and exercise</li> <li>• Skin care</li> <li>• Sleep aids</li> <li>• Supports and braces</li> <li>• Vitamins, minerals, and dietary supplements</li> </ul> <p>If you do not use the full amount before the end of the quarter, the remaining balance will not accumulate to the next quarter.</p> <p>You must use this benefit through NationsOTC. Order through the following:</p> <ul style="list-style-type: none"> <li>• Online - visit <a href="https://NationsOTC.com/PacificSource">NationsOTC.com/PacificSource</a></li> <li>• By Phone - call NationsOTC Member Experience Advisor at 877-281-8716</li> <li>• By Mail - fill out and return the order form in the NationsOTC/PacificSource Grocery catalog</li> </ul>	<p>Covered in full up to \$200 allowance every quarter.</p>






Services that are covered for you	What you must pay when you get these services <b>In-Network</b>
<b>Partial hospitalization services</b>  <b>Prior authorization is required for services.</b> “Partial hospitalization” is a structured program of active psychiatric treatment provided as a hospital outpatient service or by a community mental health center, that is more intense than the care received in your doctor’s or therapist’s office and is an alternative to inpatient hospitalization.	You pay nothing.
<b>Physician/Practitioner services, including doctor’s office visits</b>  No prior authorization required except as noted below.  Covered services include:	For each service, see appropriate sections of the Benefits Chart for benefit rules and limits.
<ul style="list-style-type: none"> <li>Medically-necessary medical care or surgery services furnished in a physician’s office, certified ambulatory surgical center, hospital outpatient department, or any other location</li> </ul> <b>Prior authorization may be required for surgery or treatment services.</b>	You pay nothing.  <u>In an ambulatory surgical center, hospital outpatient department, or any other location:</u> <b>See Outpatient surgery</b>
<ul style="list-style-type: none"> <li>Consultation, diagnosis, and treatment by a specialist</li> </ul> <b>Prior authorization may be required for surgery or treatment services.</b>	You pay nothing.
<ul style="list-style-type: none"> <li>Basic hearing and balance exams performed by your specialist, if your doctor orders it to see if you need medical treatment</li> </ul>	You pay nothing.
<ul style="list-style-type: none"> <li>Certain telehealth services: Many providers can connect through a telehealth appointment. This includes medical, mental health, occupational therapy, speech therapy and physical therapy.               <ul style="list-style-type: none"> <li>You have the option of getting these services through an in-person visit or by telehealth. If you choose to get one of these services by telehealth, you must use an in-network provider who offers the service by telehealth.</li> <li>These services are provided through phone and/or video. Some services may require video. Please coordinate with your provider for these services.</li> </ul> </li> </ul>	You pay nothing

Services that are covered for you	What you must pay when you get these services <b>In-Network</b>
<p><b>Physician/Practitioner services, including doctor's office visits (continued)</b></p> <ul style="list-style-type: none"> <li>• Some telehealth services including consultation, diagnosis, and treatment by a physician or practitioner, for patients in certain rural areas or other places approved by Medicare</li> <li>• Telehealth services for monthly end-stage renal disease-related visits for home dialysis members in a hospital-based or critical access hospital-based renal dialysis center, renal dialysis facility, or the member's home</li> <li>• Telehealth services to diagnose, evaluate, or treat symptoms of a stroke, regardless of your location</li> <li>• Telehealth services for members with a substance use disorder or co-occurring mental health disorder, regardless of their location</li> <li>• Telehealth services for diagnosis, evaluation, and treatment of mental health disorders if: <ul style="list-style-type: none"> <li>○ You have an in-person visit within 6 months prior to your first telehealth visit</li> <li>○ You have an in-person visit every 12 months while receiving these telehealth services</li> <li>○ Exceptions can be made to the above for certain circumstances</li> </ul> </li> <li>• Telehealth services for mental health visits provided by Rural Health Clinics and Federally Qualified Health Centers</li> <li>• Virtual check-ins (for example, by phone or video chat) with your doctor for 5-10 minutes <b>if</b>: <ul style="list-style-type: none"> <li>○ You're not a new patient <b>and</b></li> <li>○ The check-in isn't related to an office visit in the past 7 days <b>and</b></li> <li>○ The check-in doesn't lead to an office visit within 24 hours or the soonest available appointment</li> </ul> </li> </ul>	

Services that are covered for you	What you must pay when you get these services <b>In-Network</b>
<b>Physician/Practitioner services, including doctor's office visits (continued)</b> <ul style="list-style-type: none"> <li>Evaluation of video and/or images you send to your doctor, and interpretation and follow-up by your doctor within 24 hours <b>if</b>:               <ul style="list-style-type: none"> <li>You're not a new patient <b>and</b></li> <li>The evaluation isn't related to an office visit in the past 7 days <b>and</b></li> <li>The evaluation doesn't lead to an office visit within 24 hours or the soonest available appointment</li> </ul> </li> <li>Consultation your doctor has with other doctors by phone, internet, or electronic health record</li> </ul>	
<ul style="list-style-type: none"> <li>Second opinion by another in-network provider prior to surgery</li> </ul>	You pay nothing.
<ul style="list-style-type: none"> <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> <b>Prior authorization is required.</b>	You pay nothing.
<ul style="list-style-type: none"> <li>Office visits performed by other health care professionals (such as a Nurse Practitioner or Physician's Assistant)</li> </ul> <b>Prior authorization may be required for some treatment services.</b>	You pay nothing.
<ul style="list-style-type: none"> <li>Laboratory, diagnostic tests, and procedures</li> </ul>	See <b>Outpatient diagnostic tests and therapeutic services and supplies</b>
<ul style="list-style-type: none"> <li>Chronic Care Management Services: PCP or Specialist visit focusing on complex chronic care management services. These services include an assessment of medical and mental health needs, medication review, a comprehensive care plan and coordination of care</li> </ul>	You pay nothing.

Services that are covered for you	What you must pay when you get these services <b>In-Network</b>
<b>Physician/Practitioner services, including doctor's office visits (continued)</b> <ul style="list-style-type: none"> <li>• Transitional Care Management Services: PCP or Specialist visit following discharge from one of these hospital settings: Inpatient Acute Care Hospital, Inpatient Psychiatric Hospital, Long Term Care Hospital, Skilled Nursing Facility, Inpatient Rehabilitation Facility, Hospital outpatient observation or partial hospitalization, Partial hospitalization at a Community Mental Health Center</li> </ul>	You pay nothing.
<ul style="list-style-type: none"> <li>• Newborn care*</li> <li>• Well Child Visits*</li> </ul>	See <b>Childrens care (age 20 and under)*</b>
<ul style="list-style-type: none"> <li>• Sexual abuse exams*</li> </ul>	You pay nothing.
<b>Podiatry services</b>  No prior authorization required. Covered services include: <ul style="list-style-type: none"> <li>• Diagnosis and the medical or surgical 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 affecting the lower limbs</li> </ul>	You pay nothing.
 <b>Prostate cancer screening exams</b>  No prior authorization required. For men age 50 and older, covered services include the following - once every 12 months: <ul style="list-style-type: none"> <li>• Digital rectal exam</li> <li>• Prostate Specific Antigen (PSA) test</li> </ul> You get a preventive PSA screening if you have no signs or symptoms (asymptomatic) of prostate cancer or related prostate conditions. If you've had a previous PSA that was elevated, or are being treated for conditions which may lead to prostate cancer which include but are not limited to prostatitis (inflammation of the prostate) or benign prostatic hyperplasia (enlargement of the prostate), or have had prostate cancer, your PSA test may be considered diagnostic.	There is no coinsurance, copay, or deductible for an annual PSA test.

Services that are covered for you	What you must pay when you get these services <b>In-Network</b>
<p><b>Prosthetic devices and related supplies</b></p> <p><b>Prior authorization is required.</b> Devices (other than dental) that replace all or part of a body part or function. These include, but are not limited to: colostomy bags and supplies directly related to colostomy care, pacemakers, braces, prosthetic shoes, artificial limbs, and breast prostheses (including a surgical brassiere after a mastectomy). Includes certain supplies related to prosthetic devices, and repair and/or replacement of prosthetic devices. Also includes some coverage following cataract removal or cataract surgery – see “Vision Care” later in this section for more detail.</p>	<p>You pay nothing.</p>
<p><b>Pulmonary rehabilitation services</b></p> <p>No prior authorization required. Comprehensive programs of pulmonary rehabilitation are covered for members who have moderate to very severe chronic obstructive pulmonary disease (COPD) and an order for pulmonary rehabilitation from the doctor treating the chronic respiratory disease.</p>	<p>You pay nothing.</p>
<p> <b>Screening and counseling to reduce alcohol misuse</b></p> <p>No prior authorization required. We cover one alcohol misuse screening for adults with Medicare (including pregnant women) who misuse alcohol, but aren’t alcohol dependent.</p> <p>If you screen positive for alcohol misuse, you can get up to 4 brief face-to-face counseling sessions per year (if you’re competent and alert during counseling) provided by a qualified primary care doctor or practitioner in a primary care setting.</p>	<p>There is no coinsurance, copay, or deductible for the Medicare-covered screening and counseling to reduce alcohol misuse preventive benefit.</p>


Services that are covered for you	What you must pay when you get these services <b>In-Network</b>
<p> <b>Screening for lung cancer with low dose computed tomography (LDCT)</b></p> <p>No prior authorization required. For qualified individuals, a LDCT is covered every 12 months.</p> <p><b>Eligible members are:</b> people aged 50 – 77 years who have no signs or symptoms of lung cancer, but who have a history of tobacco smoking of at least 20 pack-years and who currently smoke or have quit smoking within the last 15 years, who receive a written order for LDCT during a lung cancer screening counseling and shared decision making visit that meets the Medicare criteria for such visits and be furnished by a physician or qualified non-physician practitioner.</p> <p><i>For LDCT lung cancer screenings after the initial LDCT screening:</i> the member must receive a written order for LDCT lung cancer screening, which may be furnished during any appropriate visit with a physician or qualified non-physician practitioner. If a physician or qualified non-physician practitioner elects to provide a lung cancer screening counseling and shared decision-making visit for subsequent lung cancer screenings with LDCT, the visit must meet the Medicare criteria for such visits.</p>	<p>There is no coinsurance or copay for the Medicare covered counseling and shared decision-making visit or for the LDCT.</p>
<p> <b>Screening for sexually transmitted infections (STIs) and counseling to prevent STIs</b></p> <p>No prior authorization required. We cover sexually transmitted infection (STI) screenings for chlamydia, gonorrhea, syphilis, and Hepatitis B. These screenings are covered for pregnant women and for certain people who are at increased risk for an STI when the tests are ordered by a primary care provider. We cover these tests once every 12 months or at certain times during pregnancy.</p> <p>We also cover up to 2 individual 20 to 30 minute, face-to-face high-intensity behavioral counseling sessions each year for sexually active adults at increased risk for STIs. We will only cover these counseling sessions as a preventive service if they are provided by a primary care provider and take place in a primary care setting, such as a doctor's office.</p>	<p>There is no coinsurance, copay, or deductible for the Medicare-covered screening for STIs and counseling for STIs preventive benefit.</p>

Services that are covered for you	What you must pay when you get these services <b>In-Network</b>
<b>Services to treat kidney disease</b> No prior authorization required. Covered services include:	
<ul style="list-style-type: none"> <li>Kidney disease education services to teach kidney care and help members make informed decisions about their care. For members with stage IV chronic kidney disease when referred by their doctor, we cover up to six sessions of kidney disease education services per lifetime.</li> </ul>	You pay nothing.
<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, or when your provider for this service is temporarily unavailable or inaccessible)</li> </ul>	You pay nothing.
<ul style="list-style-type: none"> <li>Inpatient dialysis treatments (if you are admitted as an inpatient to a hospital for special care)</li> </ul>	See <b>Inpatient hospital care</b>
<ul style="list-style-type: none"> <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>	You pay nothing.
<ul style="list-style-type: none"> <li>Certain drugs for dialysis are covered under your Medicare Part B drug benefit. For information about coverage for Part B Drugs, please go to the section, "Medicare Part B prescription drugs."</li> </ul>	See <b>Medicare Part B prescription drugs</b>




Services that are covered for you	What you must pay when you get these services <b>In-Network</b>
<p><b>Skilled nursing facility (SNF) care</b></p> <p>(For a definition of “skilled nursing facility care,” see Chapter 12 of this document. Skilled nursing facilities are sometimes called “SNFs.”)</p> <p><b>Prior authorization is required. Limited up to 100 days per benefit period. No prior hospital stay is required.</b></p> <p>Covered services include but are not limited to:</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>• Skilled 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. Coverage of whole blood and packed red cells begins only with the fourth pint of blood that you need – you must either pay the costs for the first 3 pints of blood you get in a calendar year or have the blood donated by you or someone else. All other components of blood are covered beginning with the first pint used.</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 SNFs</li> <li>• Physician/Practitioner services</li> </ul>	<p><u>Days 1-100:</u></p> <p>You pay nothing.</p> <p>The copays above apply per benefit period.</p> <p>A benefit period begins on the day of admission. A benefit period ends when:</p> <ul style="list-style-type: none"> <li>• You have not been in a SNF for 60 days in a row, or you remain in a SNF and haven’t received care for 60 days in a row.</li> </ul> <p>If you go into a SNF after one benefit period has ended, a new benefit period begins.</p>




Services that are covered for you	What you must pay when you get these services <b>In-Network</b>
<p><b>Skilled nursing facility (SNF) care (continued)</b></p> <p>Generally, you will get your SNF care from network facilities. However, under certain conditions listed below, you may be able to get your care from a facility that isn't a network 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> <li>• A SNF where your spouse is living at the time you leave the hospital</li> </ul>	
<p> <b>Smoking and tobacco use cessation (counseling to stop smoking or tobacco use)</b></p> <p>No prior authorization required. <u>If you use tobacco, but do not have signs or symptoms of tobacco-related disease:</u> We cover two counseling quit attempts within a 12-month period as a preventive service with no cost to you. Each counseling attempt includes up to four face-to-face visits.</p> <p><u>If you use tobacco and have been diagnosed with a tobacco-related disease or are taking medicine that may be affected by tobacco:</u> We cover cessation counseling services. We cover two counseling quit attempts within a 12-month period; however, you will pay the applicable cost sharing. Each counseling attempt includes up to four face-to-face visits.</p> <p>We also cover counseling sessions over the phone, in person and in groups. For more information, call Customer Service or the Tobacco Quitline at (800) 784-8669.*</p>	<p>There is no coinsurance, copay, or deductible for the Medicare-covered smoking and tobacco use cessation preventive benefits.</p>

Services that are covered for you	What you must pay when you get these services <b>In-Network</b>
<p><b>Special Supplemental Benefits for the Chronically Ill</b></p> <p>No prior authorization required. Up to \$60 benefit limit per quarter for groceries for members with Cardiovascular disorders, Congestive Heart Failure, Diabetes and Chronic Lung disorders. Services provided through NationsOTC Food and Produce. If you do not use all your quarterly grocery benefit allowance when you order, then the remaining balance will not accumulate to the next quarter.</p> <p>Eligibility for special supplemental benefits for the chronically ill are identified based on information from claims data from your provider(s). If you are eligible, you can order:</p> <ul style="list-style-type: none"> <li>• Online - visit <a href="https://NationsOTC.com/PacificSource">NationsOTC.com/PacificSource</a></li> <li>• By Phone - call NationsOTC Member Experience Advisor at 877-281-8716</li> <li>• By Mail - fill out and return the order form in the NationsOTC/PacificSource Grocery catalog</li> </ul>	<p>Covered in full up to \$60 allowance every quarter.</p>
<p><b>Supervised Exercise Therapy (SET)</b></p> <p>No prior authorization required. SET is covered for members who have symptomatic peripheral artery disease (PAD).</p> <p>Up to 36 sessions over a 12-week period are covered if the SET program requirements are met.</p> <p>The SET program must:</p> <ul style="list-style-type: none"> <li>• Consist of sessions lasting 30-60 minutes, comprising a therapeutic exercise-training program for PAD in patients with claudication</li> <li>• Be conducted in a hospital outpatient setting or a physician's office</li> <li>• Be delivered by qualified auxiliary personnel necessary to ensure benefits exceed harms, and who are trained in exercise therapy for PAD</li> <li>• Be under the direct supervision of a physician, physician assistant, or nurse practitioner/clinical nurse specialist who must be trained in both basic and advanced life support techniques</li> </ul> <p>SET may be covered beyond 36 sessions over 12 weeks for an additional 36 sessions over an extended period of time if deemed medically necessary by a health care provider.</p>	<p>You pay nothing.</p>

Services that are covered for you	What you must pay when you get these services <b>In-Network</b>
<b>Telehealth services</b>	See <b>Physician/Practitioner services</b>
<p><b>Traditional health worker services*</b></p> <p>Traditional Health Workers (THW) are available to help connect you to a broad range of services to support your health and wellness. They provide information, tools, and support. Traditional Health Workers can be found in community-based organizations and in clinics. They have similar life experiences with the people they serve and are trained to know how to support your specific goals.</p> <p>There are seven different types of THWs that you have access to:</p> <ul style="list-style-type: none"> <li>• Birth Doulas: Assist pregnant people and their family with pre-natal, childbirth and post-partum support.</li> <li>• Personal Health Navigators (PHN): Assists a member in navigating the health care system.</li> <li>• Peer Support Specialists (PSS): Personalized peer support with shared lived experience to offer hope and recovery from addiction/mental health conditions.</li> <li>• Peer Wellness Specialists (PWS): Personalized peer support with shared lived experience to offer hope and recovery with both addiction/mental health and a physical health condition.</li> <li>• Community Health Workers (CHW): Supports individuals, families and communities to achieve their health and wellness goals.</li> <li>• Family Support Specialists (FSS): Personalized peer support with shared lived experience to families parenting a child with complex needs.</li> <li>• Youth Support Specialists (YSS): Personalized youth to youth peer support to offer hope and recovery from addiction/mental health conditions and other complex life situations.</li> </ul> <p>To be connected to THW services in the community or at your provider's office, please call Customer Service (phone numbers are listed on the back of this booklet).</p>	<p>You pay nothing.</p>

Services that are covered for you	What you must pay when you get these services <b>In-Network</b>
<p><b>Urgently needed services</b></p> <p>No prior authorization required. Urgently needed services are provided to treat a non-emergency, unforeseen medical illness, injury, or condition that requires immediate medical care but, given your circumstances, it is not possible, or it is unreasonable, to obtain services from network providers. Examples of urgently needed services that the plan must cover out of network are i) you need immediate care during the weekend, or ii) you are temporarily outside the service area of the plan. Services must be immediately needed and medically necessary. If it is unreasonable given your circumstances to immediately obtain the medical care from a network provider then your plan will cover the urgently needed services from a provider out-of-network.</p>	<p>You pay nothing.</p>
<p> <b>Vision care (Medicare covered)</b></p> <p>No prior authorization required. Covered services include:</p>	
<ul style="list-style-type: none"> <li>• Outpatient physician services for the diagnosis and treatment of diseases and injuries of the eye, including treatment for age-related macular degeneration. Original Medicare doesn't cover routine eye exams (eye refractions) for eyeglasses/contacts</li> </ul>	<p>See <b>Physician/Practitioner services, PCP or Specialist office visits</b></p>
<ul style="list-style-type: none"> <li>• For people who are at high risk of glaucoma, we will cover one glaucoma screening each year. People at high risk of glaucoma include: people with a family history of glaucoma, people with diabetes, African-Americans who are age 50 and older, and Hispanic Americans who are 65 or older</li> </ul>	<p>You pay nothing.</p>
<ul style="list-style-type: none"> <li>• For people with diabetes, screening for diabetic retinopathy is covered once per year</li> </ul>	<p>See <b>Vision care (routine)</b> for additional services</p>
<ul style="list-style-type: none"> <li>• One pair of eyeglasses or contact lenses after each cataract surgery that includes insertion of an intraocular lens (If you have two separate cataract operations, you cannot reserve the benefit after the first surgery and purchase two eyeglasses after the second surgery.)</li> <li>• This is a limited benefit and only includes basic frames, lenses or contact lenses.</li> </ul>	<p>You pay nothing.</p>

Services that are covered for you	What you must pay when you get these services <b>In-Network</b>
<p><b>Vision care (routine)</b>            No prior authorization required except as noted below.  <b>The amounts you pay for these services do not apply to your yearly maximum out-of-pocket amount.</b>            Covered services include:</p>	
<ul style="list-style-type: none"> <li>Routine (refractive) eye exams</li> </ul> <p><b>Limited to one exam every calendar year.</b></p>	You pay nothing.
<ul style="list-style-type: none"> <li>Routine prescription eyeglasses and contact lenses</li> </ul> <p>The plan covers prescription eyeglasses and/or contact lenses not related to cataract surgery or a medical condition. Limited to \$250 per year. You may receive eye hardware from an in-network provider.</p>	Total benefit for eyeglasses and/or contact lenses combined is limited to \$250 every year.
<ul style="list-style-type: none"> <li>Routine eye exams and glasses for Certain Conditions*</li> </ul> <p>Additional coverage for basic glasses and eye exams is covered every 24-months through the Oregon Health Plan (Medicaid) if you had an eye injury or are diagnosed with one of the following conditions:</p> <ul style="list-style-type: none"> <li>Aphakia</li> <li>Pseudo Aphakia</li> <li>Congenital Aphakia</li> <li>Keratoconus</li> <li>Congenital Cataracts</li> <li>Corneal Transplant</li> </ul> <p>Basic glasses are covered, but if you want to buy more expensive glasses please see <b>Vision care (routine) - Routine prescription eyeglasses and contact lenses</b> listed above.</p> <p><b>Prior authorization is required.</b> This benefit is limited to members who are not pregnant and age 21 and older.</p>	You pay nothing.
For additional vision benefits for children and during pregnancy, see <b>Maternity Services*</b> benefit and <b>Children's care (age 20 and under)*</b> benefit.	See <b>Maternity services*</b>

Services that are covered for you	What you must pay when you get these services <b>In-Network</b>
 <b>“Welcome to Medicare” preventive visit</b> No prior authorization required. The plan covers the one-time “Welcome to Medicare” preventive visit. The visit includes a review of your health, as well as education and counseling about the preventive services you need (including certain screenings and shots), and referrals for other care if needed.  <b>Important:</b> We cover the “Welcome to Medicare” preventive visit only within the first 12 months you have Medicare Part B. When you make your appointment, let your doctor’s office know you would like to schedule your “Welcome to Medicare” preventive visit.	There is no coinsurance, copay, or deductible for the “Welcome to Medicare” preventive visit.

## **SECTION 3      What services are not covered by the plan?**

### **Section 3.1      Services *not* covered by the plan (exclusions)**

This section tells you what services are “excluded”.

The chart below describes some services and items that aren’t covered by the plan under any conditions or are covered by the plan only under specific conditions.

If you get services that are excluded (not covered), you must pay for them yourself except under the specific conditions listed below. Even if you receive the excluded services at an emergency facility, the excluded services are still not covered and our plan will not pay for them. The only exception is if the service is appealed and decided: upon appeal to be a medical service that we should have paid for or covered because of your specific situation. (For information about appealing a decision we have made to not cover a medical service, go to Chapter 9, Section 6.3 in this document.)

Services not covered by Medicare	Not covered under any condition	Covered only under specific conditions
Acupuncture		See <b>Alternative care and Acupuncture for chronic low back pain</b> in the Benefits Chart
All services related to artificial insemination and conception by artificial means.	✓	

<b>Services not covered by Medicare</b>	<b>Not covered under any condition</b>	<b>Covered only under specific conditions</b>
Cosmetic surgery or procedures		<ul style="list-style-type: none"> <li>Covered in cases of an accidental injury or for improvement of the functioning of a malformed body member.</li> <li>Covered for all stages of reconstruction for a breast after a mastectomy, as well as for the unaffected breast to produce a symmetrical appearance.</li> </ul>
Court ordered treatments, testing, and special reports that are not directly related to medically-necessary treatment.	✓	
<b>Custodial care</b>  Custodial care is personal care that does not require the continuing attention of trained medical or paramedical personnel, such as care that helps you with activities of daily living, such as bathing or dressing.	✓	
Dental care to treat conditions such as a dental abscess, dental pain, and cavities.		See <b>Dental services*</b> and <b>Over-the-counter (OTC) allowance</b> in the Benefits Chart
Drugs provided to a patient during a hospital or facility stay that are considered to be self-administered.		May be covered under your Part D prescription drug benefits.
Electron Beam Tomography (EBT) calcium scoring	✓	

<b>Services not covered by Medicare</b>	<b>Not covered under any condition</b>	<b>Covered only under specific conditions</b>
Experimental medical and surgical procedures, equipment and medications  Experimental procedures and items are those items and procedures determined by Original Medicare to not be generally accepted by the medical community.		May be covered by Original Medicare under a Medicare-approved clinical research study or by our plan  (See Chapter 3, Section 5 for more information on clinical research studies.)
Fees charged for care by your immediate relatives or members of your household.	✓	
Full-time nursing care in your home.	✓	
Home-delivered meals		See <b>Meal benefit</b> in the Benefits Chart
Homemaker services including basic household assistance, such as light housekeeping or light meal preparation.	✓	
Immunizations for the sole purpose of travel	✓	
Incontinence supplies (i.e. diapers, under garments, underpads)		See <b>Over-the-counter (OTC) allowance</b> in the Benefits Chart. May also be covered under Oregon Health Plan (Medicaid).
Massage therapy and water therapy		May be covered as part of a physical therapy program in accordance with Medicare guidelines. May be covered under Oregon Health Plan (Medicaid). See <b>Alternative care</b> in the Benefits Chart
Non-routine dental care		Dental care required to treat illness or injury may be covered as inpatient or outpatient care. See <b>Dental services*</b> in the Benefits Chart



Services not covered by Medicare	Not covered under any condition	Covered only under specific conditions
Orthopedic shoes or supportive devices for the feet		Shoes that are part of a leg brace and are included in the cost of the brace. Orthopedic or therapeutic shoes for people with diabetic foot disease.  See <b>Over-the-counter (OTC) allowance</b> in the Benefits Chart for additional devices, supplies, and items.
Outpatient prescription drugs (such as self-administered or take home drugs)		May be covered under your Part D prescription drug benefits.
Personal items in your room at a hospital or a skilled nursing facility, such as a telephone or a television.	✓	
Physical exams for the following reasons: employment, licensing, insurance coverage (i.e. pilot licenses, commercial driver license, etc.)	✓	
Prescription drugs prescribed for off-label use.		See Chapter 5, Section 7.1 for coverage of this service.
Private room in a hospital.		Covered only when medically necessary.
Radial keratotomy, LASIK surgery, and other low vision aids.		Eye exam and one pair of eyeglasses (or contact lenses) are covered for people after cataract surgery.
Refractive eye exams		See <b>Vision care (routine)</b> in the Benefits Chart for information on when these services are covered.
Reversal of genital surgery or reversal of surgery to revise secondary sex characteristics; sperm preservation in advance of hormonal treatment or gender surgery or cryopreservation of fertilized embryos.	✓	

<b>Services not covered by Medicare</b>	<b>Not covered under any condition</b>	<b>Covered only under specific conditions</b>
Reversal of sterilization procedures and/or non-prescription contraceptive supplies.	✓	
Routine dental care, such as cleanings, fillings or dentures.		See <b>Dental services*</b> and <b>Over-the-counter (OTC) allowance</b> in the Benefits Chart
Routine foot care  (i.e. the cutting or removal of corns and calluses, the trimming, cutting, and clipping of nails, or hygienic or other preventive maintenance, including cleaning and soaking the feet)		Some limited coverage provided according to Medicare guidelines (e.g., if you have diabetes).  See <b>Over-the-counter (OTC) allowance</b> in the Benefits Chart
Services considered not reasonable and necessary, according to Original Medicare standards	✓	
Services covered directly by Medicaid that are not included on the Prioritized list of Health Services (below the line) at <a href="http://www.oregon.gov/oha/HPA/DSI-HERC/Pages/Prioritized-List.aspx">www.oregon.gov/oha/HPA/DSI-HERC/Pages/Prioritized-List.aspx</a>	✓	
Services provided by providers that are not licensed or certified by Medicare or providers that have opted out of Medicare.		See <b>Alternative care, Intensive care coordination services (ICC)*, Interpreter services*</b> and <b>Outpatient mental health care</b> in the Benefits Chart
Services or prescription drugs provided outside of the United States.	✓	
Supplies for home use such as gloves, gauze, dressings, bandages, tape, antiseptics, alcohol wipes, Ace-type bandages, shower/ bath chairs, commodes, and rolling walkers.		See <b>Over-the-counter (OTC) allowance</b> in the Benefits Chart

**Chapter 4 Medical Benefits Chart (what is covered)**

<b>Services not covered by Medicare</b>	<b>Not covered under any condition</b>	<b>Covered only under specific conditions</b>
TMJ surgery, services or supplies to shorten or lengthen the upper or lower jaw.	✓	
Transplant expenses beyond plan covered benefits (i.e. pre-transplant evaluations, meals, parking, utilities, child care, security deposits, cable hook-up, dry cleaning, laundry, car rental, pet care, donor services, personal items, travel benefits for donor).	✓	
Wigs, toupees, hair transplants are not covered even if they are related to a condition that is otherwise covered.		May be covered under Oregon Health Plan (Medicaid).

## CHAPTER 5:

*Using the plan's coverage for Part D  
prescription drugs*



## How can you get information about your drug costs?

Because you are eligible for Oregon Health Plan (Medicaid), you qualify for and are getting “Extra Help” from Medicare to pay for your prescription drug plan costs. Because you are in the “Extra Help” program, **some information in this *Evidence of Coverage about the costs for Part D prescription drugs* may not apply to you.** We sent you a separate insert, called the “Evidence of Coverage Rider for People Who Get Extra Help Paying for Prescription Drugs” (also known as the “Low Income Subsidy Rider” or the “LIS Rider”), which tells you about your drug coverage. If you don’t have this insert, please call Customer Service and ask for the “LIS Rider.” (Phone numbers for Customer Service are printed on the back cover of this document.)

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## SECTION 1 Introduction

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This chapter **explains rules for using your coverage for Part D drugs.** Please see Chapter 4 for Medicare Part B drug benefits and hospice drug benefits.

In addition to the drugs covered by Medicare, some prescription drugs are covered for you under your Oregon Health Plan (Medicaid) benefits. For more information about drugs covered under your Oregon Health Plan (Medicaid) benefits call Customer Service or visit the Oregon Health Plan (Medicaid) Drug List online at [www.communitysolutions.pacificsource.com](http://www.communitysolutions.pacificsource.com).

<b>Section 1.1 Basic rules for the plan's Part D drug coverage</b>
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The plan will generally cover your drugs as long as you follow these basic rules:

- You must have a provider (a doctor, dentist, or other prescriber) write you a prescription which must be valid under applicable state law.
- Your prescriber must not be on Medicare’s Exclusion or Preclusion Lists.
- You generally must use a network pharmacy to fill your prescription. (See Section 2, *Fill your prescriptions at a network pharmacy or through the plan’s mail-order service*).
- Your drug must be on the plan’s *List of Covered Drugs (Formulary)* (we call it the “Drug List” for short). (See Section 3, *Your drugs need to be on the plan’s “Drug List”*).
- Your drug must be used for a medically accepted indication. A “medically accepted indication” is a use of the drug that is either approved by the Food and Drug Administration or supported by certain reference books. (See Section 3 for more information about a medically accepted indication.)

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## **SECTION 2      Fill your prescription at a network pharmacy or through the plan's mail-order service**

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<b>Section 2.1      Use a network pharmacy</b>
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In most cases, your prescriptions are covered *only* if they are filled at the plan's network pharmacies. (See Section 2.5 for information about when we would cover prescriptions filled at out-of-network pharmacies.)

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

<b>Section 2.2      Network pharmacies</b>
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### **How do you find a network pharmacy in your area?**

To find a network pharmacy, you can look in your *Pharmacy Directory*, visit our website ([www.Medicare.PacificSource.com](http://www.Medicare.PacificSource.com)), and/or call Customer Service.

You may go to any of our network pharmacies.

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

If the pharmacy you have been using leaves the plan's network, you will have to find a new pharmacy that is in the network. To find another pharmacy in your area, you can get help from Customer Service or use the *Pharmacy Directory*. You can also find information on our website at [www.Medicare.PacificSource.com](http://www.Medicare.PacificSource.com).

### **What if you need a specialized pharmacy?**

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

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

**Chapter 5 Using the plan's coverage for Part D prescription drugs**

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

<b>Section 2.3</b>	<b>Using the plan's mail-order service</b>
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Our plan's mail-order service requires you to order **at least a 1-day supply of the drug and no more than a 90-day supply**.

To get order forms and information about filling your prescriptions by mail call Customer Service. To begin services or request a refill, you may do any of the following:

**Mail:** Ask your provider to write a prescription for up to a 90-day supply of your medication(s), and your refills for up to one year if applicable. Benefit limitations apply. Complete a mail-order form which is available at [www.Medicare.PacificSource.com](http://www.Medicare.PacificSource.com). Mail it with your written prescription(s) and copay (by credit card, debit card, or check) to:

**CVS Caremark**

PO Box 94467

Palatine, Illinois 60094-4467

They may also be reached by phone at 866-362-4009 toll-free, TTY 711. They are available 24-hours a day, 7 days a week.

Usually a mail-order pharmacy order will be delivered to you in no more than 10 days. If you follow the directions for filling a prescription with our mail-order pharmacy and that medication does not arrive on time, you can contact your doctor or other prescriber for a temporary prescription. The temporary prescription can be called in or faxed to a local in-network pharmacy.

**Please note:** When the pharmacy bills us for the temporary prescription there may be an error in processing because the prescription was recently filled at the mail-order pharmacy. This can be resolved when the pharmacy contacts our pharmacy helpdesk toll-free at 888-437-7728.

**New prescriptions the pharmacy receives directly from your doctor's office.**

After the pharmacy receives a prescription from a health care provider, it will contact you to see if you want the medication filled immediately or at a later time. It is important that you respond each time you are contacted by the pharmacy, to let them know whether to ship, delay, or stop the new prescription.

**Refills on mail-order prescriptions.** For refills of your drugs, you have the option to sign up for an automatic refill program. Under this program we will start to process your next refill automatically when our records show you should be close to running out of your drug. The pharmacy will contact you prior to shipping each refill to make sure you need more medication, and you can cancel scheduled refills if you have enough of your medication or if your medication has changed.

**Chapter 5 Using the plan's coverage for Part D prescription drugs**

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If you choose not to use our auto-refill program but still want the mail-order pharmacy to send you your prescription, please contact your pharmacy 10-14 days before your current prescription will run out. This will ensure your order is shipped to you in time.

To opt out of our program that automatically prepares mail-order refills, please contact Caremark Mail-Order Services toll-free at 866-362-4009, TTY 711.

If you receive a refill automatically by mail that you do not want, you may be eligible for a refund.

<b>Section 2.4</b>	<b>How can you get a long-term supply of drugs?</b>
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The plan offers two ways to get a long-term supply (also called an “extended supply”) of “maintenance” drugs on our plan’s Drug List. (Maintenance drugs are drugs that you take on a regular basis, for a chronic or long-term medical condition.)

1. Some retail pharmacies in our network allow you to get a long-term supply of maintenance drugs. Your *Pharmacy Directory* tells you which pharmacies in our network can give you a long-term supply of maintenance drugs. You can also call Customer Service for more information
2. You may also receive maintenance drugs through our mail-order program. Please see Section 2.3 for more information.

<b>Section 2.5</b>	<b>When can you use a pharmacy that is not in the plan's network?</b>
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**Your prescription may be covered in certain situations**

Generally, we cover drugs filled at an out-of-network pharmacy *only* when you are not able to use a network pharmacy. To help you, we have network pharmacies outside of our service area where you can get your prescriptions filled as a member of our plan. **Please check first with Customer Service** to see if there is a network pharmacy nearby. You will most likely be required to pay the difference between what you pay for the drug at the out-of-network pharmacy and the cost that we would cover at an in-network pharmacy.

Here are the circumstances when we would cover prescriptions filled at an out-of-network pharmacy:

Here are the circumstances when we would cover prescriptions filled at an out-of-network pharmacy:

- When you travel outside your Part D plan’s service area and you are unable to access an in-network pharmacy because:
  - You run out of or lose your covered Part D drug(s).
  - You become ill and need a covered Part D drug.



**Chapter 5 Using the plan's coverage for Part D prescription drugs**

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- When you cannot obtain a covered Part D drug in a timely manner within your service area.
- When you must fill a prescription for a covered Part D drug in a timely manner, and that particular covered Part D drug is not regularly stocked at an accessible in-network retail or mail-order pharmacy.
- When you get a covered Part D drug from an out-of-network institution-based pharmacy (such as a hospital pharmacy) while you are a patient and cannot get your medications filled at an in-network pharmacy. For example, you are a patient in:
  - An emergency department
  - A provider-based clinic
  - An outpatient surgery
  - Another outpatient setting
- During a Federal disaster or other public health emergency where you are evacuated or otherwise displaced from your place of residence and you cannot reasonably be expected to obtain covered Part D drugs at an in-network pharmacy.

We will cover up to three prescription fills at out-of-network pharmacies within a plan year. Our plan cannot cover a drug purchased outside the United States and its territories. In addition, all out-of-network claims are subject to the plan limitations outlined in your Evidence of Coverage and situations listed above. If you feel that your out-of-network claim should have been covered, contact Customer Service.

In these situations, **please check first with Customer Service** to see if there is an in-network pharmacy nearby. (Phone numbers for Customer Service are printed on the back cover of this document.) You may be required to pay the difference between what you pay for the drug at the out-of-network pharmacy and the cost that we would cover at an in-network pharmacy.

**How do you ask for reimbursement from the plan?**

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

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

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

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

The drugs on this list are selected by the plan with the help of a team of doctors and pharmacists. The list meets Medicare's requirements and has been approved by Medicare.

The Drug List includes the drugs covered under Medicare Part D. In addition to the drugs covered by Medicare, some prescription drugs are covered for you under your Oregon Health Plan (Medicaid) benefits. For more information about drugs covered under your Oregon Health Plan (Medicaid) benefits call Customer Service or visit the Oregon Health Plan (Medicaid) Drug List online at [www.communitysolutions.pacificsource.com](http://www.communitysolutions.pacificsource.com).

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

- Approved by the Food and Drug Administration for the diagnosis or condition for which it is being prescribed.
- *or --* Supported by certain references, such as the American Hospital Formulary Service Drug Information and the DRUGDEX Information System.

The Drug List includes brand name drugs, generic drugs, and biosimilars.

A brand name drug is a prescription drug that is sold under a trademarked name owned by the drug manufacturer. Brand name drugs that are more complex than typical drugs (for example, drugs that are based on a protein) are called biological products. On the drug list, when we refer to "drugs," this could mean a drug or a biological product.

A generic drug is a prescription drug that has the same active ingredients as the brand name drug. Since biological products are more complex than typical drugs, instead of having a generic form, they have alternatives that are called biosimilars. Generally, generics and biosimilars work just as well as the brand name drug or biological product and usually cost less. There are generic drug substitutes or biosimilar alternatives available for many brand name drugs and some biological products.

### **What is *not* on the Drug List?**

Prescription drugs covered directly by the Oregon Health Plan (Medicaid) are not included in this Drug List. For more information about drugs covered under your Oregon Health Plan (Medicaid) benefits call Customer Service (phone numbers are listed on the back of this document) or visit the Oregon Health Plan (Medicaid) Drug List online at [www.communitysolutions.pacificsource.com](http://www.communitysolutions.pacificsource.com).

**Chapter 5 Using the plan's coverage for Part D prescription drugs**

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The plan does not cover all prescription drugs.

- In some cases, the law does not allow any Medicare plan to cover certain types of drugs (for more information about this, see Section 7.1 in this chapter).
- In other cases, we have decided not to include a particular drug on the Drug List. In some cases, you may be able to obtain a drug that is not on the drug list. For more information, please see Chapter 9.

<b>Section 3.2</b>	<b>There are six “cost-sharing tiers” for drugs on the Drug List</b>
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Every drug on the plan's Drug List is in one of six cost-sharing tiers. In general, the higher the cost-sharing tier, the higher your cost for the drug:

- **Tier 1** includes **Preferred Generic drugs**.
- **Tier 2** includes **Generic drugs**.
- **Tier 3** includes **Preferred Brand drugs**.
- **Tier 4** includes **Non-Preferred drugs**.
- **Tier 5** is the highest cost sharing tier and includes **Specialty drugs**.
- **Tier 6** is the lowest cost sharing tier and includes **Select Care drugs**.

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

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

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

1. Check the most recent Drug List we provided electronically.
2. Visit the plan's website ([www.Medicare.PacificSource.com](http://www.Medicare.PacificSource.com)). The Drug List on the website is always the most current.
3. Call Customer Service to find out if a particular drug is on the plan's Drug List or to ask for a copy of the list.

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## **SECTION 4      There are restrictions on coverage for some drugs**

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<b>Section 4.1      Why do some drugs have restrictions?</b>
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For certain prescription drugs, special rules restrict how and when the plan covers them. A team of doctors and pharmacists developed these rules to encourage you and your provider to use drugs in the most effective way. To find out if any of these restrictions apply to a drug you take or want to take, check the Drug List. If a safe, lower-cost drug will work just as well medically as a higher-cost drug, the plan's rules are designed to encourage you and your provider to use that lower-cost option.

Please note that sometimes a drug may appear more than once in our drug list. This is because the same drugs can differ based on the strength, amount, or form of the drug prescribed by your health care provider, and different restrictions or cost sharing may apply to the different versions of the drug (for instance, 10 mg versus 100 mg; one per day versus two per day; tablet versus liquid).

<b>Section 4.2      What kinds of restrictions?</b>
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The sections below tell you more about the types of restrictions we use for certain drugs.

**If there is a restriction for your drug, it usually means that you or your provider will have to take extra steps in order for us to cover the drug.** Contact Customer Service to learn what you or your provider would need to do to get coverage for the drug. If you want us to waive the restriction for you, you will need to use the coverage decision process and ask us to make an exception. We may or may not agree to waive the restriction for you. (See Chapter 9)

### **Restricting brand name drugs when a generic version is available**

Generally, a “generic” drug works the same as a brand name drug and usually costs less. **When a generic version of a brand name drug is available, our network pharmacies will provide you the generic version instead of the brand name drug.** However, if your provider has told us the medical reason that neither the generic drug nor other covered drugs that treat the same condition will work for you, then we will cover the brand name drug. (Your share of the cost may be greater for the brand name drug than for the generic drug.)

### **Getting plan approval in advance**

For certain drugs, you or your provider need to get approval from the plan before we will agree to cover the drug for you. This is called “**prior authorization**.” This is put in place to ensure medication safety and help guide appropriate use of certain drugs. If you do not get this approval, your drug might not be covered by the plan.

**Chapter 5 Using the plan's coverage for Part D prescription drugs**

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**Trying a different drug first**

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

**Quantity limits**

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

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

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<b>Section 5.1</b>	<b>There are things you can do if your drug is not covered in the way you'd like it to be covered</b>
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There are situations where there is a prescription drug you are taking, or one that you and your provider think you should be taking, that is not on our formulary or is on our formulary with restrictions. For example:

- The drug might not be covered at all. Or maybe a generic version of the drug is covered but the brand name version you want to take is not covered.
- The drug is covered, but there are extra rules or restrictions on coverage for that drug, as explained in Section 4.
- The drug is covered, but it is in a cost-sharing tier that makes your cost sharing more expensive than you think it should be.
- There are things you can do if your drug is not covered in the way that you'd like it to be covered.
- If your drug is not on the Drug List or if your drug is restricted, go to Section 5.2 to learn what you can do.
- If your drug is in a cost-sharing tier that makes your cost more expensive than you think it should be, go to Section 5.3 to learn what you can do.

<b>Section 5.2</b>	<b>What can you do if your drug is not on the Drug List or if the drug is restricted in some way?</b>
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If your drug is not on the Drug List or is restricted, here are options:

- You may be able to get a temporary supply of the drug.
- You can change to another drug.
- You can request an exception and ask the plan to cover the drug or remove restrictions from the drug.

### **You may be able to get a temporary supply**

Under certain circumstances, the plan must provide a temporary supply of a drug that you are already taking. This temporary supply gives you time to talk with your provider about the change in coverage and decide what to do.

To be eligible for a temporary supply, the drug you have been taking **must no longer be on the plan's Drug List OR is now restricted in some way.**

- **If you are a new member**, we will cover a temporary supply of your drug during the first 90 days of your membership in the plan.
- **If you were in the plan last year**, we will cover a temporary supply of your drug during the first **90 days** of the calendar year.
- This temporary supply will be for a maximum of a 30-day supply. If your prescription is written for fewer days, we will allow multiple fills to provide up to a maximum of a 30-day supply of medication. The prescription must be filled at a network pharmacy. (Please note that the long-term care pharmacy may provide the drug in smaller amounts at a time to prevent waste.)
- **For those members who have been in the plan for more than 90 days and reside in a long-term care facility and need a supply right away:**

We will cover one 31-day emergency supply of a particular drug, or less if your prescription is written for fewer days. This is in addition to the above temporary supply.

- **For current members with level of care changes:**

If you are taking a non-Formulary drug or a drug that is restricted in some way and experience a level of care change, such as when you have been discharged from a hospital, you can ask us to make an exception and cover your drug for up to a 30-day supply.

For questions about a temporary supply, call Customer Service.

During the time when you are using a temporary supply of a drug, you should talk with your provider to decide what to do when your temporary supply runs out. You have two options:

### **1) You can change to another drug**

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

### **2) You can ask for an exception**

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

If you are a current member and a drug you are taking will be removed from the formulary or restricted in some way for next year, we will tell you about any change prior to the new year. You can ask for an exception before next year and we will give you an answer within 72 hours after we receive your request (or your prescriber's supporting statement). If we approve your request, we will authorize the coverage before the change takes effect.

If you and your provider want to ask for an exception, Chapter 9, Section 7.4 tells you what to do. It explains the procedures and deadlines that have been set by Medicare to make sure your request is handled promptly and fairly.

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

#### **You can change to another drug**

If your drug is in a cost-sharing tier you think is too high, talk to your provider. There may be a different drug in a lower cost-sharing tier that might work just as well for you. Call Customer Service to ask for a list of covered drugs that treat the same medical condition. This list can help your provider find a covered drug that might work for you.

#### **You can ask for an exception**

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

If you and your provider want to ask for an exception, Chapter 9, Section 7.4 tells what to do. It explains the procedures and deadlines that have been set by Medicare to make sure your request is handled promptly and fairly.



Drugs in our Tier 5 (Specialty) tier are not eligible for this type of exception. We do not lower the cost-sharing amount for drugs in this tier.

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

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<b>Section 6.1      The Drug List can change during the year</b>
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Most of the changes in drug coverage happen at the beginning of each year (January 1). However, during the year, the plan can make some changes to the Drug List. For example, the plan might:

- **Add or remove drugs from the Drug List.**
- **Move a drug to a higher or lower cost-sharing tier.**
- **Add or remove a restriction on coverage for a drug.**
- **Replace a brand name drug with a generic drug.**

We must follow Medicare requirements before we change the plan's Drug List.

<b>Section 6.2      What happens if coverage changes for a drug you are taking?</b>
---

### **Information on changes to drug coverage**

When changes to the Drug List occur, we post information on our website about those changes. We also update our online Drug List on a regularly scheduled basis. Below we point out the times that you would get direct notice if changes are made to a drug that you are taking.

### **Changes to your drug coverage that affect you during the current plan year**

- **A new generic drug replaces a brand name drug on the Drug List (or we change the cost-sharing tier or add new restrictions to the brand name drug or both)**
  - We may immediately remove a brand name drug on our Drug List if we are replacing it with a newly approved generic version of the same drug. The generic drug will appear on the same or lower cost-sharing tier and with the same or fewer restrictions. We may decide to keep the brand name drug on our Drug List, but immediately move it to a higher cost-sharing tier or add new restrictions or both when the new generic is added.
  - We may not tell you in advance before we make that change—even if you are currently taking the brand name drug. If you are taking the brand name drug at the time we make the change, we will provide you with information about the specific change(s). This will also include information on the



steps you may take to request an exception to cover the brand name drug. You may not get this notice before we make the change.

- You or your prescriber can ask us to make an exception and continue to cover the brand name drug for you. For information on how to ask for an exception, see Chapter 9.

### **Unsafe drugs and other drugs on the Drug List that are withdrawn from the market**

- Sometimes a drug may be deemed unsafe or taken off the market for another reason. If this happens, we may immediately remove the drug from the Drug List. If you are taking that drug, we will tell you right away.
- Your prescriber will also know about this change, and can work with you to find another drug for your condition.

#### **• Other changes to drugs on the Drug List**

- We may make other changes once the year has started that affect drugs you are taking. For example, we might add a generic drug that is not new to the market to replace a brand name drug on the Drug List or change the cost-sharing tier or add new restrictions to the brand name drug or both. We also might make changes based on FDA boxed warnings or new clinical guidelines recognized by Medicare.
- For these changes, we must give you at least 30 days' advance notice of the change or give you notice of the change and a 30-day refill of the drug you are taking at a network pharmacy.
- After you receive notice of the change, you should work with your prescriber to switch to a different drug that we cover or to satisfy any new restrictions on the drug you are taking.
- You or your prescriber can ask us to make an exception and continue to cover the drug for you. For information on how to ask for an exception, see Chapter 9.

### **Changes to the Drug List that do not affect you during this plan year**

We may make certain changes to the Drug List that are not described above. In these cases, the change will not apply to you if you are taking the drug when the change is made; however, these changes will likely affect you starting January 1 of the next plan year if you stay in the same plan.

In general, changes that will not affect you during the current plan year are:

- We move your drug into a higher cost-sharing tier.

- We put a new restriction on the use of your drug.
- We remove your drug from the Drug List.

If any of these changes happen for a drug you are taking (except for market withdrawal, a generic drug replacing a brand name drug, or other change noted in the sections above), then the change won't affect your use or what you pay as your share of the cost until January 1 of the next year. Until that date, you probably won't see any increase in your payments or any added restrictions to your use of the drug.

We will not tell you about these types of changes directly during the current plan year. You will need to check the Drug List for the next plan year (when the list is available during the open enrollment period) to see if there are any changes to the drugs you are taking that will impact you during the next plan year.

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

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

If you appeal and the requested drug is found not to be excluded under Part D, we will pay for or cover it. (For information about appealing a decision, go to Chapter 9.) If the drug excluded by our plan is also excluded by Oregon Health Plan (Medicaid), you must pay for it yourself.

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

- Our plan's Part D drug coverage cannot cover a drug that would be covered under Medicare Part A or Part B.
- Our plan cannot cover a drug purchased outside the United States or its territories.
- Our plan usually cannot cover off-label use. “Off-label use” is any use of the drug other than those indicated on a drug's label as approved by the Food and Drug Administration.
- Coverage for “off-label use” is allowed only when the use is supported by certain references, such as the American Hospital Formulary Service Drug Information and the DRUGDEX Information System.

In addition, by law, the following categories of drugs listed below are not covered by Medicare. However, some of these drugs may be covered for you under your Oregon Health Plan (Medicaid) drug coverage. For more information about drugs covered under your Oregon Health Plan (Medicaid) benefits call Customer Service (phone numbers

are listed on the back of this document) or visit the Oregon Health Plan (Medicaid) Drug List online at [www.communitysolutions.pacificsource.com](http://www.communitysolutions.pacificsource.com).

- Non-prescription drugs (also called over-the-counter drugs)
  - Drugs used to promote fertility
  - Drugs used for the relief of cough or cold symptoms
  - Drugs used for cosmetic purposes or to promote hair growth
  - Prescription vitamins and mineral products, except prenatal vitamins and fluoride preparations
  - Drugs used for the treatment of sexual or erectile dysfunction
  - Drugs used for treatment of anorexia, weight loss, or weight gain
  - Outpatient drugs for which the manufacturer seeks to require that associated tests or monitoring services be purchased exclusively from the manufacturer as a condition of sale

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## **SECTION 8      Filling a prescription**

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<b>Section 8.1</b>	<b>Provide your membership information</b>
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To fill your prescription, provide your plan membership information, which can be found on your membership card, at the network pharmacy you choose. Be sure to show your Oregon Health Plan (Medicaid) membership card to fill prescription drugs covered directly under Oregon Health Plan (Medicaid). The network pharmacy will automatically bill the plan for your drug.

<b>Section 8.2</b>	<b>What if you don't have your membership information with you?</b>
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If you don't have your plan membership information with you when you fill your prescription, you or the pharmacy can call the plan to get the necessary information.

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

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## **SECTION 9      Part D drug coverage in special situations**

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<b>Section 9.1</b>	<b>What if you're in a hospital or a skilled nursing facility for a stay that is covered by the plan?</b>
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If you are admitted to a hospital or to a skilled nursing facility for a stay covered by the plan, we will generally cover the cost of your prescription drugs during your stay. Once you leave the hospital or skilled nursing facility, the plan will cover your prescription drugs as long as the drugs meet all of our rules for coverage described in this Chapter.

<b>Section 9.2</b>	<b>What if you're a resident in a long-term care (LTC) facility?</b>
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Usually, a long-term care (LTC) facility (such as a nursing home) has its own pharmacy, or uses a pharmacy that supplies drugs for all of its residents. If you are a resident of a LTC facility, you may get your prescription drugs through the facility's pharmacy or the one it uses, as long as it is part of our network.

Check your *Pharmacy Directory* to find out if your LTC facility's pharmacy or the one that it uses is part of our network. If it isn't, or if you need more information or assistance, please contact Customer Service. If you are in an LTC facility, we must ensure that you are able to routinely receive your Part D benefits through our network of LTC pharmacies.

### **What if you're a resident in a long-term care (LTC) facility and need a drug that is not on our Drug List or is restricted in some way?**

Please refer to Section 5.2 about a temporary or emergency supply.

<b>Section 9.3</b>	<b>What if you're in Medicare-certified hospice?</b>
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Hospice and our plan do not cover the same drug at the same time. If you are enrolled in Medicare hospice and require certain drugs (e.g., anti-nausea, laxative, pain medication or antianxiety drugs) that are not covered by your hospice because it is unrelated to your terminal illness and related conditions, our plan must receive notification from either the prescriber or your hospice provider that the drug is unrelated before our plan can cover the drug. To prevent delays in receiving these drugs that should be covered by our plan, ask your hospice provider or prescriber to provide notification before your prescription is filled.

In the event you either revoke your hospice election or are discharged from hospice, our plan should cover your drugs as explained in this document. To prevent any delays at a pharmacy when your Medicare hospice benefit ends, bring documentation to the pharmacy to verify your revocation or discharge.

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## **SECTION 10      Programs on drug safety and managing medications**

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<b>Section 10.1      Programs to help members use drugs safely</b>
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We conduct drug use reviews for our members to help make sure that they are getting safe and appropriate care.

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

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

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

<b>Section 10.2      Drug Management Program (DMP) to help members safely use their opioid medications</b>
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We have a program that helps make sure members safely use prescription opioids and other frequently abused medications. This program is called a Drug Management Program (DMP). If you use opioid medications that you get from several doctors or pharmacies, or if you had a recent opioid overdose, we may talk to your doctors to make sure your use of opioid medications is appropriate and medically necessary. Working with your doctors, if we decide your use of prescription opioid or benzodiazepine medications is not safe, we may limit how you can get those medications. If we place you in our DMP, the limitations may be:

- Requiring you to get all your prescriptions for opioid or benzodiazepine medications from a certain pharmacy(ies)
- Requiring you to get all your prescriptions for opioid or benzodiazepine medications from a certain doctor(s)
- Limiting the amount of opioid or benzodiazepine medications we will cover for you

If we plan on limiting how you may get these medications or how much you can get, we will send you a letter in advance. The letter will explain the limitations we think should

**Chapter 5 Using the plan's coverage for Part D prescription drugs**

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apply to you. You will have an opportunity to tell us which doctors or pharmacies you prefer to use, and about any other information you think is important for us to know. After you've had the opportunity to respond, if we decide to limit your coverage for these medications, we will send you another letter confirming the limitation. If you think we made a mistake or you disagree with our determination or with the limitation, you and your prescriber have the right to appeal. If you appeal, we will review your case and give you a decision. If we continue to deny any part of your request related to the limitations that apply to your access to medications, we will automatically send your case to an independent reviewer outside of our plan. See Chapter 9 for information about how to ask for an appeal.

You will not be placed in our DMP if you have certain medical conditions, such as active cancer-related pain or sickle cell disease, you are receiving hospice, palliative, or end-of-life care, or live in a long-term care facility.

<b>Section 10.3</b>	<b>Medication Therapy Management (MTM) program to help members manage their medications</b>
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We have a program that can help our members with complex health needs. Our program is called a Medication Therapy Management (MTM) program. This program is voluntary and free. A team of pharmacists and doctors developed the program for us to help make sure that our members get the most benefit from the drugs they take.

Some members who take medications for different medical conditions and have high drug costs, or are in a DMP to help members use their opioids safely, may be able to get services through an MTM program. A pharmacist or other health professional will give you a comprehensive review of all your medications. During the review, you can talk about your medications, your costs, and any problems or questions you have about your prescription and over-the-counter medications. You'll get a written summary which has a recommended to-do list that includes steps you should take to get the best results from your medications. You'll also get a medication list that will include all the medications you're taking, how much you take, and when and why you take them. In addition, members in the MTM program will receive information on the safe disposal of prescription medications that are controlled substances.

It's a good idea to talk to your doctor about your recommended to-do list and medication list. Bring the summary with you to your visit or anytime you talk with your doctors, pharmacists, and other health care providers. Also, keep your medication list up to date and with you (for example, with your ID) in case you go to the hospital or emergency room.

If we have a program that fits your needs, we will automatically enroll you in the program and send you information. If you decide not to participate, please notify us and we will withdraw you. If you have any questions about this program, please contact Customer Service.

## CHAPTER 6:

*What you pay for your Part D  
prescription drugs*



## How can you get information about your drug costs?

Because you are eligible for Oregon Health Plan (Medicaid), you qualify for and are getting “Extra Help” from Medicare to pay for your prescription drug plan costs. Because you are in the “Extra Help” program, **some information in this Evidence of Coverage about the costs for Part D prescription drugs may not apply to you.** We sent you a separate insert, called the “Evidence of Coverage Rider for People Who Get Extra Help Paying for Prescription Drugs” (also known as the “Low Income Subsidy Rider” or the “LIS Rider”), which tells you about your drug coverage. If you don’t have this insert, please call Customer Service and ask for the “LIS Rider.”

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## SECTION 1 Introduction

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

To understand the payment information, you need to know what drugs are covered, where to fill your prescriptions, and what rules to follow when you get your covered drugs. Chapter 5, Sections 1 through 4 explain these rules.

<b>Section 1.2</b>	<b>Types of out-of-pocket costs you may pay for covered drugs</b>
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There are different types of out-of-pocket costs for Part D drugs. The amount that you pay for a drug is called “cost sharing,” and there are three ways you may be asked to pay.

- The “**deductible**” is the amount you pay for drugs before our plan begins to pay its share.
- “**Copay**” is a fixed amount you pay each time you fill a prescription.
- “**Coinsurance**” is a percentage of the total cost you pay each time you fill a prescription.

<b>Section 1.3</b>	<b>How Medicare calculates your out-of-pocket costs</b>
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Medicare has rules about what counts and what does *not* count toward your out-of-pocket costs. Here are the rules we must follow to keep track of your out-of-pocket costs.

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### **These payments are included in your out-of-pocket costs**

**Your out-of-pocket costs include** the payments listed below (as long as they are for Part D covered drugs and you followed the rules for drug coverage that are explained in Chapter 5):

- The amount you pay for drugs when you are in any of the following drug payment stages:
  - The Initial Coverage Stage
- Any payments you made during this calendar year as a member of a different Medicare prescription drug plan before you joined our plan.

#### **It matters who pays:**

- If you make these payments **yourself**, they are included in your out-of-pocket costs.
- These payments are *also included* if they are made on your behalf by **certain other individuals or organizations**. This includes payments for your drugs made by a friend or relative, by most charities, by AIDS drug assistance programs, or by the Indian Health Service. Payments made by Medicare's "Extra Help" Program are also included.
- Some payments made by the Medicare Coverage Gap Discount Program are included. The amount the manufacturer pays for your brand name drugs is included. But the amount the plan pays for your generic drugs is not included.

#### **Moving on to the Catastrophic Coverage Stage:**

When you (or those paying on your behalf) have spent a total of \$7,400 in out-of-pocket costs within the calendar year, you will move from the Initial Coverage Stage to the Catastrophic Coverage Stage.

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### **These payments are not included in your out-of-pocket costs**

Your out-of-pocket costs **do not include** any of these types of payments:

- Drugs you buy outside the United States and its territories.
- Drugs that are not covered by our plan.
- Drugs you get at an out-of-network pharmacy that do not meet the plan's requirements for out-of-network coverage.
- Non-Part D drugs, including prescription drugs covered by Part A or Part B and other drugs excluded from coverage by Medicare.

**Chapter 6 What you pay for your Part D prescription drugs**

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- Payments you make toward prescription drugs not normally covered in a Medicare Prescription Drug Plan.
- Payments made by the plan for your brand or generic drugs while in the Coverage Gap.
- Payments for your drugs that are made by group health plans including employer health plans.
- Payments for your drugs that are made by certain insurance plans and government-funded health programs such as TRICARE and the Veterans Affairs.
- Payments for your drugs made by a third-party with a legal obligation to pay for prescription costs (for example, Workers' Compensation).

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

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

- **We will help you.** The Part D EOB report you receive includes the current amount of your out-of-pocket costs. When this amount reaches \$7,400, this report will tell you that you have left the Initial Coverage Stage and have moved on to the Catastrophic Coverage Stage.
- **Make sure we have the information we need.** Section 3.2 tells what you can do to help make sure that our records of what you have spent are complete and up to date.

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

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<b>Section 2.1</b>	<b>What are the drug payment stages for our plan members?</b>
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There are four “drug payment stages” for your Medicare Part D prescription drug coverage under our plan. How much you pay depends on what stage you are in when you get a prescription filled or refilled. Details of each stage are in Sections 4 through 7 of this chapter. The stages are:

**Stage 1: Yearly Deductible Stage****Stage 2: Initial Coverage Stage****Stage 3: Coverage Gap Stage**

## Stage 4: Catastrophic Coverage Stage

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

#### Section 3.1 We send you a monthly summary called the *Part D Explanation of Benefits* (the “Part D EOB”)

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

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

If you have had one or more prescriptions filled through the plan during the previous month we will send you a *Part D Explanation of Benefits* (“Part D EOB”). The Part D EOB includes:

- **Information for that month.** This report gives the payment details about the prescriptions you have filled during the previous month. It shows the total drug costs, what the plan paid, and what you and others on your behalf paid.
- **Totals for the year since January 1.** This is called “year-to-date” information. It shows the total drug costs and total payments for your drugs since the year began.
- **Drug price information.** This information will display the total drug price, and information about increases in price from first fill for each prescription claim of the same quantity.
- **Available lower cost alternative prescriptions.** This will include information about other available drugs with lower cost sharing for each prescription claim.

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

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

- **Show your membership card every time you get a prescription filled.** This helps us make sure we know about the prescriptions you are filling and what you

are paying.

- **Make sure we have the information we need.** There are times you may pay for the entire cost of a prescription drug. In these cases, we will not automatically get the information we need to keep track of your out-of-pocket costs. To help us keep track of your out-of-pocket costs, give us copies of your receipts. Here are examples of when you should give us copies of your drug receipts:
  - When you purchase a covered drug at a network pharmacy at a special price or using a discount card that is not part of our plan's benefit
  - When you made a copay for drugs that are provided under a drug manufacturer patient assistance program
  - Any time you have purchased covered drugs at out-of-network pharmacies or other times you have paid the full price for a covered drug under special circumstances

If you are billed for a covered drug, you can ask our plan to pay our share of the cost. For instructions on how to do this, go to Chapter 7, Section 2.

- **Send us information about the payments others have made for you.** Payments made by certain other individuals and organizations also count toward your out-of-pocket costs. For example, payments made by an AIDS drug assistance program (ADAP), the Indian Health Service, and most charities count toward your out-of-pocket costs. Keep a record of these payments and send them to us so we can track your costs.
- **Check the written report we send you.** When you receive the Part D EOB, look it over to be sure the information is complete and correct. If you think something is missing or you have any questions, please call us at Customer Service. Be sure to keep these reports.

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## **SECTION 4      There is no deductible for our plan**

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

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

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<b>Section 5.1      What you pay for a drug depends on the drug and where you fill your prescription</b>
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During the Initial Coverage Stage, the plan pays its share of the cost of your covered prescription drugs, and you pay your share (your copay). Your share of the cost will vary depending on the drug and where you fill your prescription.

**The plan has six cost-sharing tiers**

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

- **Tier 1** includes **Preferred Generic drugs**.
- **Tier 2** includes **Generic drugs**.
- **Tier 3** includes **Preferred Brand drugs**.
- **Tier 4** includes **Non-Preferred drugs**.
- **Tier 5** is the highest cost sharing tier, and includes **Specialty drugs**.
- **Tier 6** is the lowest cost sharing tier, and includes **Select Care drugs**.

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

**Your pharmacy choices**

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

- A network retail pharmacy
- A pharmacy that is not in the plan's network. We cover prescriptions filled at out-of-network pharmacies in only limited situations. Please see Chapter 5, Section 2.5 to find out when we will cover a prescription filled at an out-of-network pharmacy.
- The plan's mail-order pharmacy.

For more information about these pharmacy choices and filling your prescriptions, see Chapter 5 and the plan's *Pharmacy Directory*.

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

During the Initial Coverage Stage, your share of the cost of a covered drug will be a copay.

As shown in the table below, the amount of the copay or coinsurance depends on the cost-sharing tier. Sometimes the cost of the drug is lower than your copay. In these cases, you pay the lower price for the drug instead of the copay.

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

<b>Tier</b>	<b>Retail cost sharing (in-network)</b> (up to a 30-day supply)	<b>Mail-order cost sharing</b> (up to a 30-day supply)	<b>Long-term care (LTC) cost sharing</b> (up to a 31-day supply)	<b>Out-of-network cost sharing</b> (Coverage is limited to certain situations; see Chapter 5 for details.) (up to a 31-day supply)
<b>Cost-Sharing Tier 1</b> (Preferred Generic)	\$0	\$0	\$0	\$0
<b>Cost-Sharing Tier 2</b> (Generic)	<p>Depending on your income and institutional status, you pay the following:</p> <p>For generic drugs (including brand drugs treated as generic), either:</p> <p style="text-align: center;">\$0; \$1.45; or \$4.15</p> <p>For all other drugs, either:</p> <p style="text-align: center;">\$0; \$4.30; or \$10.35</p>			
<b>Cost-Sharing Tier 3</b> (Preferred Brand)				
<b>Cost-Sharing Tier 4</b> (Non-Preferred Drugs)				
<b>Cost-Sharing Tier 5</b> (Specialty)				
<b>Cost-Sharing Tier 6</b> (Select Care Drugs)	\$0	\$0	\$0	\$0

**Section 5.3      If your doctor prescribes less than a full month’s supply, you may not have to pay the cost of the entire month’s supply**

Typically, the amount you pay for a prescription drug covers a full month’s supply. There may be times when you or your doctor would like you to have less than a month’s supply of a drug (for example, when you are trying a medication for the first time). You can also ask your doctor to prescribe, and your pharmacist to dispense, less than a full month’s supply of your drugs, if this will help you better plan refill dates for different prescriptions.

If you receive less than a full month’s supply of certain drugs, you will not have to pay for the full month’s supply.

- If you are responsible for coinsurance, you pay a *percentage* of the total cost of the drug. Since the coinsurance is based on the total cost of the drug, your cost will be lower since the total cost for the drug will be lower.
- If you are responsible for a copay for the drug, you will only pay for the number of days of the drug that you receive instead of a whole month. We will calculate the amount you pay per day for your drug (the “daily cost-sharing rate”) and multiply it by the number of days of the drug you receive.

**Section 5.4      A table that shows your costs for a *long-term* (up to a 90-day) supply of a drug**

For some drugs, you can get a long-term supply (also called an “extended supply”). A long-term supply is up to a 90-day supply.

The table below shows what you pay when you get a long-term supply of a drug.

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

<b>Tier</b>	<b>Retail cost sharing (in-network) (90-day supply)</b>	<b>Mail-order cost sharing (90-day supply)</b>
<b>Cost-Sharing Tier 1</b> <i>(Preferred Generic)</i>	\$0	\$0

<b>Tier</b>	<b>Retail cost sharing (in-network)</b> (90-day supply)	<b>Mail-order cost sharing</b> (90-day supply)
<b>Cost-Sharing Tier 2</b> (Generic)	Depending on your income and institutional status, you pay the following:  For generic drugs (including brand drugs treated as generic), either: \$0; \$1.45; or \$4.15  For all other drugs, either: \$0; \$4.30; or \$10.35	
<b>Cost-Sharing Tier 3</b> (Preferred Brand)		
<b>Cost-Sharing Tier 4</b> (Non-Preferred Drugs)		
<b>Cost-Sharing Tier 5</b> (Specialty)	A long-term supply is not available for drugs in Tier 5.	
<b>Cost-Sharing Tier 6</b> (Select Care Drugs)	\$0	\$0

**Section 5.5      You stay in the Initial Coverage Stage until your out-of-pocket costs for the year reach \$7,400**

You stay in the Initial Coverage Stage until your total out-of-pocket costs reach \$7,400. You then move on to the Catastrophic Coverage Stage.

The Part D EOB that you receive will help you keep track of how much you, the plan, and any third parties have spent on your behalf during the year. Many people do not reach the \$7,400 limit in a year.

We will let you know if you reach this amount. If you do reach this amount, you will leave the Initial Coverage Stage and move on to the Catastrophic Coverage Stage. See Section 1.3 on how Medicare calculates your out-of-pocket costs.

**SECTION 6      There is no coverage gap for our plan**

There is no coverage gap for our plan. Once you leave the Initial Coverage Stage, you move on to the Catastrophic Coverage Stage (see Section 7).



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## **SECTION 7      During the Catastrophic Coverage Stage, the plan pays all of the costs for your drugs**

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You enter the Catastrophic Coverage Stage when your out-of-pocket costs have reached the \$7,400 limit for the calendar year. Once you are in the Catastrophic Coverage Stage, you will stay in this payment stage until the end of the calendar year.

During this stage, the plan will pay all of the costs for your drugs.

Look at the separate insert (the “LIS Rider”) for information about your costs during the Catastrophic Coverage Stage.

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## **SECTION 8      Part D Vaccines. What you pay for depends on how and where you get them**

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**Important Message About What You Pay for Vaccines** - Our plan covers most Part D vaccines at no cost to you. Call Customer Service for more information.

There are two parts to our coverage of Part D vaccinations:

- The first part of coverage is the cost of **the vaccine itself**.
- The second part of coverage is for the cost of **giving you the vaccine**. (This is sometimes called the “administration” of the vaccine.)

Your costs for a Part D vaccination depend on three things:

- 1. The type of vaccine** (what you are being vaccinated for).
  - Some vaccines are considered medical benefits. (See the *Medical Benefits Chart (what is covered and what you pay)* in Chapter 4).
  - Other vaccines are considered Part D drugs. You can find these vaccines listed in the plan’s *List of Covered Drugs (Formulary)*.
- 2. Where you get the vaccine.**
  - The vaccine itself may be dispensed by a pharmacy or provided by the doctor’s office.
- 3. Who gives you the vaccine.**
  - A pharmacist may give the vaccine in the pharmacy or another provider may give it in the doctor’s office.

**Chapter 6 What you pay for your Part D prescription drugs**

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What you pay at the time you get the Part D vaccination can vary depending on the circumstances and what Drug Stage you are in.

- Sometimes when you get a vaccination, you have to pay for the entire cost for both the vaccine itself and the cost for the provider to give you the vaccine. You can ask our plan to pay you back for our share of the cost.
- Other times, when you get a vaccination, you will pay only your share of the cost under your Part D benefit.

Below are three examples of ways you might get a Part D vaccine.

*Situation 1:* You get your vaccination at the network pharmacy. (Whether you have this choice depends on where you live. Some states do not allow pharmacies to give vaccines.)

- You will pay the pharmacy your copay for the vaccine itself which includes the cost of giving you the vaccine.
- Our plan will pay the remainder of the costs.

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

- When you get the vaccine, you will pay for the entire cost of the vaccine itself and the cost for the provider to give it to you.
- You can then ask our plan to pay our share of the cost by using the procedures that are described in Chapter 7.
- You will be reimbursed the amount you paid less your normal copay for the vaccine (including administration).

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

- You will have to pay the pharmacy your copay for the vaccine itself.
- When your doctor gives you the vaccine, you will pay the entire cost for this service. You can then ask our plan to pay our share of the cost by using the procedures described in Chapter 7.
- You will be reimbursed the amount charged by the doctor for administering the vaccine.

## CHAPTER 7:

*Asking us to pay a bill you have  
received for covered medical services  
or drugs*

**Chapter 7 Asking us to pay a bill you have received for covered medical services or drugs**

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**SECTION 1 Situations in which you should ask us to pay for your covered services or drugs**

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Our network providers bill the plan directly for your covered services and drugs – you should not receive a bill for covered services or drugs. If you get a bill for medical care or drugs you have received, you should send this bill to us so that we can pay it. When you send us the bill, 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.

**If you have already paid for a Medicare service or item covered by the plan**, 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 for medical services or drugs that are covered by our plan. There may be deadlines that you must meet to get paid back. Please see Section 2 of this chapter. When you send us a bill you have already paid, we will look at the bill and decide whether the services or drugs should be covered. If we decide they should be covered, we will pay you back for the services or drugs.

There may also be times when you get a bill from a provider for the full cost of medical care you have received or possibly for more than your share of cost sharing as discussed in the document. First try to resolve the bill with the provider. If that does not work, send the 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. If we decide not to pay it, we will notify the provider. You should never pay more than plan-allowed cost-sharing. If this provider is contracted, you still have the right to treatment.

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 or urgently needed services from any provider, whether or not the provider is a part of our network. In these cases, ask the provider to bill the plan.

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

**Chapter 7 Asking us to pay a bill you have received for covered medical services or drugs**

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- If you have already paid for the service, we will pay you back.

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

Network providers should always bill the plan directly. But sometimes they make mistakes, and ask you to pay for your services.

- Whenever you get a bill from a network provider, 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, send us the bill along with documentation of any payment you have made. You should ask us to pay you back for your covered services.

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

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

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

**4. When you use an out-of-network pharmacy to get a prescription filled**

If you go to an out-of-network pharmacy, the pharmacy may not be able to submit the claim directly to us. When that happens, you will have to pay the full cost of your prescription.

Save your receipt and send a copy to us when you ask us to pay you back. Remember that we only cover out-of-network pharmacies in limited circumstances. See Chapter 5, Section 2.5 for a discussion of these circumstances.

**5. When you pay the full cost for a prescription because you don't have your plan membership card with you**

If you do not have your plan membership card with you, you can ask the pharmacy to call the plan or to look up your plan enrollment information. However, if the pharmacy cannot get the enrollment information they need right away, you may need to pay the full cost of the prescription yourself. Save your receipt and send a copy to us when you ask us to pay you back.

**6. When you pay the full cost for a prescription in other situations**

You may pay the full cost of the prescription because you find that the drug is not covered for some reason.

## Chapter 7 Asking us to pay a bill you have received for covered medical services or drugs

- For example, the drug may not be on the plan's *List of Covered Drugs (Formulary)*; or it could have a requirement or restriction that you didn't know about or don't think should apply to you. If you decide to get the drug immediately, you may need to pay the full cost for it.
- Save your receipt and send a copy to us when you ask us to pay you back. In some situations, we may need to get more information from your doctor in order to pay you back for the drug.

When you send us a request for payment, we will review your request and decide whether the service or drug should be covered. This is called making a "coverage decision." If we decide it should be covered, we will pay for the service or drug. If we deny your request for payment, you can appeal our decision. Chapter 9 of this document 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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You may request us to pay you back by either calling us or sending us a request in writing. If you send a request in writing, send 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. **You must submit your claim to us within 1 year** of the date you received the service, item, or drug.

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

- You don't have to use the form, but it will help us process the information faster. To process your request, please provide your: name, date of birth, member ID number, date of service, item/drug/service received, a description of your illness or injury and receipt of payment.
- Either download a copy of the form from our website ([www.Medicare.PacificSource.com](http://www.Medicare.PacificSource.com)) or call Customer Service and ask for the form.

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

<p><u>Mail your request for <b>medical claim</b> reimbursement, along with any bills or receipts to:</u></p> <p>PacificSource Medicare Attn: Claims Department PO Box 7469 Bend, Oregon 97708</p>	<p><u>Mail your request for <b>prescription claim</b> reimbursement, along with any bills or receipts to:</u></p> <p>CVS Caremark Attn: Claims Department PO Box 52066 Phoenix, Arizona 85072-2066</p>
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**Chapter 7 Asking us to pay a bill you have received for covered medical services or drugs**

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

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**Section 3.1      We check to see whether we should cover the service or drug**

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

- If we decide that the medical care or drug is covered and you followed all the rules, we will pay for the service. If you have already paid for the service or drug, we will mail your reimbursement to you. If you have not paid for the service or drug yet, we will mail the payment directly to the provider.
- If we decide that the medical care or drug is *not* covered, or you did *not* follow all the rules, we will not pay for the care or drug. We will send you a letter explaining the reasons why we are not sending the payment and your rights to appeal that decision.

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

If you think we have made a mistake in turning down your request for payment or the amount we are paying, you can make an appeal. If you make an appeal, it means you are asking us to change the decision we made when we turned down your request for payment. The appeals process is a formal process with detailed procedures and important deadlines. For the details on how to make this appeal, go to Chapter 9 of this document.

# CHAPTER 8:

## *Your rights and responsibilities*



**Chapter 8 Your rights and responsibilities**

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**SECTION 1      Our plan must honor your rights and cultural sensitivities 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 and consistent with your cultural sensitivities (in languages other than English, in braille, in large print, or other alternate formats, etc.)</b>
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Your plan is required to ensure that all services, both clinical and non-clinical, are provided in a culturally competent manner and are accessible to all enrollees, including those with limited English proficiency, limited reading skills, hearing incapacity, or those with diverse cultural and ethnic backgrounds. Examples of how a plan may meet these accessibility requirements include, but are not limited to provision of translator services, interpreter services, teletypewriters, or TTY (text telephone or teletypewriter phone) connection.

Our plan has free interpreter services available to answer questions from non-English speaking members. We can also give you information in braille, in large print, or other alternate formats at no cost if you need it. We are required to give you information about the plan's benefits in a format that is accessible and appropriate for you. To get information from us in a way that works for you, please call Customer Service.

Our plan is required to give female enrollees the option of direct access to a women's health specialist within the network for women's routine and preventive health care services.

If providers in the plan's network for a specialty are not available, it is the plan's responsibility to locate specialty providers outside the network who will provide you with the necessary care. In this case, you will only pay in-network cost sharing. If you find yourself in a situation where there are no specialists in the plan's network that cover a service you need, call the plan for information on where to go to obtain this service at in-network cost sharing.

If you have any trouble getting information from our plan in a format that is accessible and appropriate for you, please call to file a grievance with Customer Service (phone numbers are printed on the back cover of this document). You may also file a complaint with Medicare by calling 1-800-MEDICARE (1-800-633-4227) or directly with the Office for Civil Rights 1-800-368-1019 or TTY 1-800-537-7697.

<b>Section 1.2</b>	<b>We must ensure that you get timely access to your covered services and drugs</b>
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You have the right to choose a provider in the plan's network to provide and arrange for your covered services. We do not require you to get referrals to go to in-network providers.

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

**Chapter 8 Your rights and responsibilities**

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services from specialists when you need that care. You also have the right to get your prescriptions filled or refilled at any of our network pharmacies without long delays.

If you think that you are not getting your medical care or Part D drugs within a reasonable amount of time, Chapter 9 tells what you can do.

<b>Section 1.3</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.
- You have rights related to your 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.
- Except for the circumstances noted below, if we intend to 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 or someone you have given legal power to make decisions for you first.*
- There are certain exceptions that do not require us to get your written permission first. These exceptions are allowed or required by law.
  - We are required to release health information to government agencies that are checking on quality of care.
  - Because you are a member of our plan through Medicare, we are required to give Medicare your health information including information about your Part D prescription drugs. If Medicare releases your information for research or other uses, this will be done according to Federal statutes and regulations; typically, this requires that information that uniquely identifies you not be shared.

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

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

**Chapter 8 Your rights and responsibilities**

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should be made.

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

If you have questions or concerns about the privacy of your personal health information, please call Customer Service.

**Notice of Privacy Practices.**

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY. THIS NOTICE IS APPLICABLE TO ALL PACIFICSOURCE ENTITIES.

Effective August 24, 2020

We are required by law to protect the privacy of your health information. We are also required to send you this notice, which explains how we may use information about you and when we can give out or “disclose” that information to others. You also have rights regarding your health information that are described in this notice. We are required by law to abide by the terms of this notice.

The terms “information” or “health information” in this notice includes any information we maintain that reasonably can be used to identify you and that relates to your physical or mental health condition, the provision of health care to you, or the payment for such health care. We will comply with the requirements of applicable privacy laws related to notifying you in the event of a breach of your health information.

We have the right to change our privacy practices and the terms of this notice. If we make a material change to our privacy practices, we will provide to you, in our next annual distribution, either a revised notice or information about the material change and how to obtain a revised notice. We will provide you with this information either by direct mail or electronically, in accordance with applicable law. In all cases, we will post the revised notice on our website, [www.PacificSource.com](http://www.PacificSource.com). We reserve the right to make any revised or changed notice effective for information we already have and for information that we receive in the future.

PacificSource collects and maintains oral, written and electronic information to administer our business and to provide products, services and information of importance to our enrollees. We maintain physical, electronic and procedural security safeguards in the handling and maintenance of our enrollees’ information, in accordance with applicable state and federal standards, to protect against risks such as loss, destruction or misuse.

**How We Use or Disclose Information**

We must use and disclose your health information to provide that information:

- To you or someone who has the legal right to act for you (your personal representative) in order to administer your rights as described in this notice; and

**Chapter 8 Your rights and responsibilities**

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- To the Secretary of the Department of Health and Human Services, if necessary, to make sure your privacy is protected.

We have the right to use and disclose health information for your treatment, to pay for your health care and to operate our business. For example, we may use or disclose your health information:

- **For Payment** of premiums due to us, to determine your coverage, and to process claims for health care services you receive, including for subrogation or coordination of other benefits you may have. For example, we may tell a doctor whether you are eligible for coverage and what percentage of the bill may be covered.
- **For Treatment.** We may use or disclose health information to aid in your treatment or the coordination of your care. For example, we may disclose information to your physicians or hospitals to help them provide medical care to you.
- **For Health Care Operations.** We may use or disclose health information as necessary to operate and manage our business activities related to providing and managing your health care coverage. For example, we might talk to your physician to suggest a disease management or wellness program that could help improve your health or we may analyze data to determine how we can improve our services. We may use or disclose health information when the use or disclosure is in the form of face-to-face communication made by a covered entity to an individual or a promotional gift of nominal value provided by the covered entity. We may use or disclose health information to participants in the organized health care arrangement for any health care operations activities of the organized health care arrangement.
- **To Provide You Information on Health Related Programs or Products** such as alternative medical treatments and programs or about health-related products and services, subject to limits imposed by law.
- **For Plan Sponsors.** If your coverage is through an employer sponsored group health plan, we may share summary health information and enrollment and disenrollment information with the plan sponsor. In addition, we may share other health information with the plan sponsor for plan administration purposes if the plan sponsor agrees to special restrictions on its use and disclosure of the information in accordance with federal law.
- **For Underwriting Purposes.** We may use or disclose your health information for underwriting purposes; however, we will not use or disclose your genetic health information for such purposes.
- **For Reminders.** We may use or disclose health information to send you reminders about your benefits or care, such as appointment reminders with providers who provide medical care to you.

We may use or disclose your health information for the following purposes under limited circumstances:

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- **As Required by Law.** We may disclose information when required to do so by law.
- **To Persons Involved With Your Care.** We may use or disclose your health information to a person involved in your care or who helps pay for your care, such as a family member, when you are incapacitated or in an emergency, or when you agree or fail to object when given the opportunity. If you are unavailable or unable to object, we will use our best judgement to decide if the disclosure is in your best interests. Special rules apply regarding when we may disclose health information to family members and others involved in a deceased individual's care. We may disclose health information to any persons involved, prior to death, in the care or payment for care of a deceased individual, unless we are aware that doing so would be inconsistent with a preference previously expressed by the deceased.
- **For Public Health Activities** such as reporting or preventing disease outbreaks to a public health authority.
- **For Reporting Victims of Abuse, Neglect or Domestic Violence** to government authorities that are authorized by law to receive such information, including a social service or protective service agency.
- **For Health Oversight Activities** to a health oversight agency for activities authorized by law, such as licensure, governmental audits and fraud and abuse investigations.
- **For Judicial or Administrative Proceedings** such as in response to a court order, search warrant or subpoena.
- **For Law Enforcement Purposes.** We may disclose your health information to a law enforcement official for purposes such as providing limited information to locate a missing person or report a crime.
- **To Avoid a Serious Threat to Health or Safety** to you, another person, or the public by, for example, disclosing information to public health agencies or law enforcement authorities, or in the event of an emergency or natural disaster.
- **For Specialized Government Functions** such as military and veteran activities, national security and intelligence activities, and the protective services for the President and others.
- **For Workers' Compensation** as authorized by, or to the extent necessary to comply with, state workers compensation laws that govern job-related injuries or illness.
- **For Research Purposes** such as research related to the evaluation of certain treatments or the prevention of disease or disability, if the research study meets federal privacy law requirements.
- **To Provide Information Regarding Decedents.** We may disclose information to a coroner or medical examiner to identify a deceased person, determine a cause of death, or as authorized by law. We may also disclose information to funeral directors

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as necessary to carry out their duties.

- **For Organ Procurement Purposes.** We may use or disclose information to entities that handle procurement, banking or transplantation of organs, eyes or tissue to facilitate donation and transplantation.
- **To Correctional Institutions or Law Enforcement Officials** if you are an inmate of a correctional institution or under the custody of a law enforcement official, but only if necessary (1) for the institution to provide you with health care; (2) to protect your health and safety or the health and safety of others; or (3) for the safety and security of the correctional institution.
- **To Business Associates** that perform functions on our behalf or provide us with services if the information is necessary for such functions or services. Our business associates are required, under contract with us and pursuant to federal law, to protect the privacy of your information and are not allowed to use or disclose any information other than as specified in our contract and as permitted by federal law.
- **Additional Restrictions on Use and Disclosure.** Certain federal and state laws may require special privacy protections that restrict the use and disclosure of certain health information, including highly confidential information about you. “Highly confidential information” may include confidential information under Federal laws governing alcohol and drug abuse information and genetic information as well as state laws that often protect the following types of information:
  1. HIV/AIDS
  2. Mental health
  3. Genetic tests
  4. Alcohol and drug abuse
  5. Sexually transmitted diseases and reproductive health information
  6. Child or adult abuse or neglect, including sexual assault

If a use or disclosure of health information described above in this notice is prohibited or materially limited by other laws that apply to us, it is our intent to meet the requirements of the more stringent law.

Except for uses and disclosures described and limited as set forth in this notice, we will use and disclose your health information only with a written authorization from you. This includes, except for limited circumstances allowed by federal privacy law, not using or disclosing psychotherapy notes about you, selling your health information to others, or using or disclosing your health information for certain promotional communications that are prohibited marketing communications under federal law, without your written authorization. Once you give us authorization to release your health information, we cannot guarantee that the recipient to whom the information is provided will not disclose the information. You may take back or “revoke” your written authorization at any time in writing, except if we have already acted based on your authorization. To find out where to mail your written authorization and how to revoke an authorization, contact the Customer Service phone number listed on your ID card.



**Chapter 8 Your rights and responsibilities**

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**What Are Your Rights**

The following are your rights with respect to your health information:

- **You have the right to ask to restrict** uses or disclosures of your information for treatment, payment, or health care operations. You also have the right to ask to restrict disclosures to family members or to others who are involved in your health care or payment for your health care. We may also have policies on dependent access that authorize your dependents to request certain restrictions. Please note that while we will try to honor your request and will permit requests consistent with our policies, we are not required to agree to any restriction.
- **You have the right to ask to receive confidential communications** of information in a different manner or at a different place (for example, by sending information to a P.O. Box instead of your home address). We will accommodate reasonable requests where a disclosure of all or part of your health information otherwise could endanger you. In certain circumstances, we will accept your verbal request to receive confidential communications, however, we may also require you confirm your request in writing. In addition, any requests to modify or cancel a previous confidential communication request must be made in writing. Mail your request to the address listed below.
- **You have the right to see and obtain a copy** of certain health information we maintain about you such as claims and case or medical management records. If we maintain your health information electronically, you will have the right to request that we send a copy of your health information in an electronic format to you. You can also request that we provide a copy of your information to a third party that you identify. In some cases you may receive a summary of this health information or have your information sent to a third party. Mail your request to the address listed below. In certain limited circumstances, we may deny your request to inspect and copy your health information. If we deny your request, you may have the right to have the denial reviewed. We may charge a reasonable fee for any copies.
- **You have the right to ask to amend** certain health information we maintain about you such as claims and case or medical management records, if you believe the health information about you is wrong or incomplete. Your request must be in writing and provide the reasons for the requested amendment. Mail your request to the address listed below. If we deny your request, you may have a statement of your disagreement added to your health information.
- **You have the right to receive an accounting** of certain disclosures of your information made by us during the six years prior to your request. This accounting will not include disclosures of information made: (i) for treatment, payment, and health care operations purposes; (ii) to you or pursuant to your authorization; and (iii) to correctional institutions or law enforcement officials; and (iv) other disclosures for which federal law does not require us to provide an accounting.

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- **You have the right to a paper copy of this notice.** You may ask for a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice. You may also obtain a copy of this notice on our website, [www.PacificSource.com](http://www.PacificSource.com).

**Exercising Your Rights**

- **Contacting your Health Plan.** If you have any questions about this notice or want information about exercising your rights, please call the toll-free member phone number on your health plan ID card or you may contact a PacificSource Customer Call Center Representative for your plan:

<b>PacificSource Community Health Plans (Medicare Advantage Plan)</b>	<b>PacificSource Community Solutions (Medicaid Plan)</b>	<b>PacificSource Health Plans</b>
Toll Free 888-863-3637	Toll Free 800-431-4135	Toll Free 888-977-9299
TTY 711		

- **Submitting a Written Request.** Mail to us your written requests to exercise any of your rights, including modifying or cancelling a confidential communication, requesting copies of your records, or requesting amendments to your record, at the address for your plan:

<b>PacificSource Community Health Plans (Medicare Advantage Plan)</b>	<b>PacificSource Community Solutions (Medicaid Plan)</b>	<b>PacificSource Health Plans</b>
PO Box 7469 Bend, OR 97708	PO Box 5729 Bend, OR 97708	555 International Way Springfield, OR 97477

- **Filing a Complaint.** If you believe your privacy rights have been violated, you may file a complaint with us at the address listed above.

You may also notify the Secretary of the U.S. Department of Health and Human Services of your complaint. We will not take any action against you for filing a complaint.

Please send your complaint to:  PacificSource Medicare Attn: Grievance/Appeals Department PO Box 7469 Bend, Oregon 97708	You may also send your complaints to the U.S. Department of Health and Human Services:  U.S. Department of Health and Human Services 200 Independence Avenue SW Room 509F, HHH Building Washington D.C. 20201
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**Website Privacy Information**

This portion of the privacy policy discloses the privacy practices for [www.PacificSource.com](http://www.PacificSource.com). This portion of the privacy policy applies solely to information collected by this web site. It will notify you of the following:

- What personally identifiable information is collected from you through the web site, how it is used, and with whom it may be shared.
- What choices are available to you regarding the use of your data.
- The security procedures in place to protect the misuse of your information.
- How you can correct any inaccuracies in the information.

**Information Collection, Use, and Sharing**

We are the sole owners of the information collected on this site. We only have access to/collect information that you voluntarily give us via email or other direct contact from you. We will not sell or rent this information to anyone.

We will use your information to respond to you, regarding the reason you contacted us. We will not share your information with any third party outside of our organization, other than necessary to fulfill your request, e.g. to ship an order.

Unless you ask us not to, we may contact you via email in the future to tell you about specials, new products or services, or changes to the website privacy policy.

We use “cookies” on this site. A cookie is a piece of data stored on a site visitor’s hard drive to help us improve your access to our site and identify repeat visitors to our site. For instance, when we use a cookie to identify you, you would not have to log in a password more than once, thereby saving time while on our site. Cookies can also enable us to track and target the interests of our users to enhance the experience on our site. Usage of a cookie is in no way linked to any personally identifiable information on our site.

**Electronic Communications**

An electronic submission has the same force and effect as if you had submitted a paper application to PacificSource with your signature. You can receive secured electronic communications from PacificSource regarding your application and/or enrollment status, changes in insurance coverage, and termination of coverage. An electronic communication can also be used to keep PacificSource informed of your current email address so we may continue to correspond with you. Your consent continues while the plan you enroll in is effective. You may, at any time, opt out of electronic communications. You may request a free paper copy of your application and/or enrollment information by contacting our Customer Service Department. Electronic communications are offered as a convenience only. Your decision to not receive electronic communications will not affect your enrollment. There is no charge associated with switching to paper.

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<b>Section 1.4</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.

If you want any of the following kinds of information, please call Customer Service:

- **Information about our plan.** This includes, for example, information about the plan's financial condition.
- **Information about our network providers and pharmacies.** You have the right to get information about the qualifications of the providers and pharmacies in our network and how we pay the providers in our network.
- **Information about your coverage and the rules you must follow when using your coverage.** Chapters 3 and 4 provide information regarding medical services. Chapters 5 and 6 provide information about Part D prescription drug coverage.
- **Information about why something is not covered and what you can do about it.** Chapter 9 provides information on asking for a written explanation on why a medical service or Part D drug is not covered or if your coverage is restricted. Chapter 9 also provides information on asking us to change a decision, also called an appeal.

<b>Section 1.5</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. 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.** You have the right to be told about all of the treatment options that are recommended for your condition, no matter what they cost or whether they are covered by our plan. It also includes being told about programs our plan offers to help members manage their medications and use drugs safely.
- **To know about the risks.** You have the right to be told about any risks involved in your care. You must be told in advance if any proposed medical care or treatment is part of a research experiment. You always have the choice to refuse any experimental treatments.

**Chapter 8 Your rights and responsibilities**

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- **The right to say “no.”** You have the right to refuse any recommended treatment. This includes the right to leave a hospital or other medical facility, even if your doctor advises you not to leave. You also have the right to stop taking your medication. Of course, if you refuse treatment or stop taking medication, you accept full responsibility for what happens to your body as a result.

**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.** You can get an advance directive form from your lawyer, from a social worker, or from some office supply stores. You can sometimes get advance directive forms from organizations that give people information about Medicare. You can also contact Customer Service to ask for the forms.
- **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 who can make decisions for you if you can’t. You may want to give copies to close friends or family members. 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.**

- The hospital 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

**Chapter 8 Your rights and responsibilities**

one can deny you care or discriminate against you based on whether or not you have signed an advance directive.

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

If you have signed an advance directive, and you believe that a doctor or hospital did not follow the instructions in it, you may file a complaint with:

State	Agency	Phone
Oregon	Oregon Department of Human Services	(503) 945-5944

<b>Section 1.6</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, concerns, or complaints and need to request coverage, or make an appeal, Chapter 9 of this document tells what you can do. Whatever you do – ask for a coverage decision, make an appeal, or make a complaint – **we are required to treat you fairly.**

<b>Section 1.7</b>	<b>What can you do if you believe 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 believe you have been treated unfairly or your rights have not been respected due to your race, disability, religion, sex, health, ethnicity, creed (beliefs), age, sexual orientation, or national origin, you should call the Department of Health and Human Services' **Office for Civil Rights** at 1-800-368-1019 or TTY 1-800-537-7697, or call your local Office for Civil Rights.

**Is it about something else?**

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

- You can **call Customer Service**.
- You can **call the SHIP**. For details, go to Chapter 2, Section 3.
- Or, **you can call Medicare** at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week (TTY 1-877-486-2048).

**Section 1.8      How to get more information about your rights**

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

- You can **call Customer Service**.
- You can **call the SHIP**. For details, go to Chapter 2, Section 3.
- You can contact **Medicare**.
  - You can visit the Medicare website to read or download the publication “Medicare Rights & Protections.” (The publication is available at: [www.medicare.gov/Pubs/pdf/11534-Medicare-Rights-and-Protections.pdf](http://www.medicare.gov/Pubs/pdf/11534-Medicare-Rights-and-Protections.pdf).)
  - Or, you can call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week (TTY 1-877-486-2048).

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

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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 Customer Service.

- **Get familiar with your covered services and the rules you must follow to get these covered services.** Use this Evidence of Coverage 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.
  - Chapters 5 and 6 give the details about your Part D prescription drug coverage.
- **If you have any other health insurance coverage or prescription drug coverage in addition to our plan, you are required to tell us.** Chapter 1 tells you about coordinating these benefits.
- **Tell your doctor and other health care providers that you are enrolled in our plan.** Show your plan membership card and your Oregon Health Plan (Medicaid) card whenever you get your medical care or Part D prescription drugs.
- **Help your doctors and other providers help you by giving them information, asking questions, and following through on your care.**
  - To help get the best care, tell your doctors and other health providers about your health problems. Follow the treatment plans and instructions that you and your doctors agree upon.
  - Make sure your doctors know all of the drugs you are taking, including over-the-counter drugs, vitamins, and supplements.

**Chapter 8 Your rights and responsibilities**

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- If you have any questions, be sure to ask and get an answer you can understand.
- **Be considerate.** We expect all our members to respect the rights of other patients. We also expect you to act in a way that helps the smooth running of your doctor's office, hospitals, and other offices.
- **Pay what you owe.** As a plan member, you are responsible for these payments:
  - You must continue to pay your Medicare premiums to remain a member of the plan.
  - For most of your drugs covered by the plan, you must pay your share of the cost when you get the drug.
  - If you are required to pay the extra amount for Part D because of your higher income (as reported on your last tax return), you must continue to pay the extra amount directly to the government to remain a member of the plan.
- **If you move *within* our service area, we need to know** so we can keep your membership record up to date and know how to contact you.
- **If you move *outside* of our plan service area, you cannot remain a member of our plan.**
- If you move, it is also important to tell Social Security (or the Railroad Retirement Board).

## CHAPTER 9:

*What to do if you have a problem  
or complaint (coverage decisions,  
appeals, complaints)*

**Chapter 9 What to do if you have a problem or complaint (coverage decisions, appeals, complaints)**

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**SECTION 1 Introduction**

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

This chapter explains the processes for handling problems and concerns. The process you use to handle your problem depends on the type of problem you are having:

- For some problems, you need to use the **process for coverage decisions and appeals**.
- For other problems, you need to use the **process for making complaints**; also called grievances.

Each process has a set of rules, procedures, and deadlines that must be followed by us and by you.

**Section 3** will help you identify the right process to use and what you should do.

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

There are 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 make things easier, this chapter:

- Uses simpler words in place of certain legal terms. For example, this chapter generally says “making a complaint” rather than “filing a grievance,” “coverage decision” rather than “integrated organization determination” or “coverage determination” or “at-risk 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. Knowing which terms to use will help you communicate more accurately to 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.

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**SECTION 2 Where to get more information and personalized assistance**

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We are always available to help you. Even if you have a complaint about our treatment of you, we are obligated to honor your right to complain. Therefore, you should always reach out to customer service for help. But in some situations, you may also want help or guidance from someone who is not connected with us. Below are two entities that can assist you.



## Chapter 9 What to do if you have a problem or complaint (coverage decisions, appeals, complaints)

### State Health Insurance Assistance Program (SHIP)

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

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

### Medicare

You can also contact Medicare to get help. To contact 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 also can visit the Medicare website ([www.medicare.gov](http://www.medicare.gov)).

### You can get help and information from Oregon Health Plan (Medicaid)

Method	Oregon Health Plan (Medicaid) – Contact Information
<b>CALL</b>	(800) 699-9075 Available 8:00 a.m. to 5:00 p.m., Monday through Friday.
<b>TTY</b>	711 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.
<b>WRITE</b>	Oregon Health Authority 500 Summer Street NE Salem, Oregon 97301
<b>WEBSITE</b>	<a href="http://www.Oregon.gov/OHA">www.Oregon.gov/OHA</a>

## SECTION 3 Understanding Medicare and Oregon Health Plan (Medicaid) complaints and appeals in our plan

You have Medicare and get assistance from Oregon Health Plan (Medicaid). Information in this chapter applies to **all** of your Medicare and Oregon Health Plan (Medicaid) benefits. This is sometimes called an “integrated process” because it combines, or integrates, Medicare and Oregon Health Plan (Medicaid) processes.

Sometimes the Medicare and Oregon Health Plan (Medicaid) processes are not combined. In those situations, you use a Medicare process for a benefit covered by Medicare and a Oregon Health Plan (Medicaid) process for a benefit covered by Oregon Health Plan (Medicaid). These situations are explained in **Section 6.4** of this chapter, “Step-by-step: How a Level 2 appeal is done.”

**Chapter 9 What to do if you have a problem or complaint (coverage decisions, appeals, complaints)**

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**PROBLEMS ABOUT YOUR BENEFITS**

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**SECTION 4 Coverage decisions and appeals**

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If you have a problem or concern, you only need to read the parts of this chapter that apply to your situation. The information below will help you find the right section of this chapter for problems or complaints about **benefits covered by Medicare or Oregon Health Plan (Medicaid)**.

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

(This includes problems about whether medical care or prescription drugs are covered or not, the way they are covered, and problems related to payment for medical care or prescription drugs.)

**Yes.**

Go on to the next section of this chapter, **Section 5, “A guide to the basics of coverage decisions and appeals.”**

**No.**

Skip ahead to **Section 11** 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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**SECTION 5 A guide to the basics of coverage decisions and appeals**

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<b>Section 5.1</b>	<b>Asking for coverage decisions and making appeals: the big picture</b>
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Coverage decisions and appeals deal with problems related to your benefits and coverage, including 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 prior to receiving services**

A coverage decision is a decision we make about your benefits and coverage or about the amount we will pay for your medical services or drugs. We are making a coverage decision whenever we decide what is covered for you and how much we pay. For example, your plan network doctor makes a (favorable) coverage decision for you whenever you receive medical care from him or her or if your network doctor refers you to a medical specialist. You or your doctor can also contact us and ask for a coverage decision if your doctor is unsure whether we will cover a particular medical service or refuses to provide medical care you think that you need. In other words, if you want to

**Chapter 9 What to do if you have a problem or complaint (coverage decisions, appeals, complaints)**

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know if we will cover a medical service before you receive it, you can ask us to make a coverage decision for you. In limited circumstances a request for a coverage decision will be dismissed, which means we won't review the request. Examples of when a request will be dismissed include if the request is incomplete, if someone makes the request on your behalf but isn't legally authorized to do so or if you ask for your request to be withdrawn. If we dismiss a request for a coverage decision, we will send a notice explaining why the request was dismissed and how to ask for a review of the dismissal.

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

**Making an appeal**

If we make a coverage decision, whether before or after a service is received, and you are not satisfied, you can "appeal" the decision. An appeal is a formal way of asking us to review and change a coverage decision we have made. Under certain circumstances, which we discuss later, you can request an expedited or "fast appeal" of a coverage decision. Your appeal is handled by different reviewers than those who made the original decision.

When you appeal a decision for the first time, this is called a Level 1 appeal. In this appeal, we review the coverage decision we made to check to see if we were properly following the rules. When we have completed the review, we give you our decision.

In limited circumstances, a request for a Level 1 appeal will be dismissed, which means we won't review the request. Examples of when a request will be dismissed include if the request is incomplete, if someone makes the request on your behalf but isn't legally authorized to do so or if you ask for your request to be withdrawn. If we dismiss a request for a Level 1 appeal, we will send a notice explaining why the request was dismissed and how to ask for a review of the dismissal.

If we do not dismiss your case but say no to all or part of your Level 1 appeal, your appeal will automatically go on to Level 2. The Level 2 appeal is conducted by an Independent Review Entity that is not connected to us.

- Your case will be automatically sent to the independent review organization for a Level 2 appeal – you do not have to do anything. The independent review organization will mail you a notice to confirm they received your Level 2 appeal.
- See **Section 6.4** of this chapter for more information about Level 2 appeals.

If you are not satisfied with the Level 2 appeal decision, you may be able to continue through additional levels of appeal (Section 10 in this chapter explains the Level 3, 4, and 5 appeals processes).

**Chapter 9 What to do if you have a problem or complaint (coverage decisions, appeals, complaints)****Section 5.2 How to get help when you are asking for a coverage decision or making an appeal**

Here are resources if you decide to ask for any kind of coverage decision or appeal a decision:

- You **can call us at Customer Service**.
- You **can get free help** from your State Health Insurance Assistance Program.
- **Your doctor or other health care provider can make a request for you.** If your doctor helps with an appeal past Level 2, they will need to be appointed as your representative. Please call Customer Service and ask for the “Appointment of Representative” form. (The form is also available on Medicare’s website at [www.cms.gov/Medicare/CMS-Forms/CMS-Forms/downloads/cms1696.pdf](http://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/downloads/cms1696.pdf).)
  - For medical care, your doctor or other health care provider can request a coverage decision or a Level 1 appeal on your behalf. If your appeal is denied at Level 1, it will be automatically forwarded to Level 2.
  - If your doctor or other health provider asks that a service or item that you are already getting be continued during your appeal, you **may** need to name your doctor or other prescriber as your representative to act on your behalf.
  - For Part D prescription drugs, your doctor or other prescriber can request a coverage decision or a Level 1 appeal on your behalf. If your Level 1 appeal is denied your doctor or prescriber can request a Level 2 appeal.
- **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.
  - If you want a friend, relative, or other person to be your representative, call Customer Service and ask for the “Appointment of Representative” form. (The form is also available on Medicare’s website at [www.cms.gov/Medicare/CMS-Forms/CMS-Forms/downloads/cms1696.pdf](http://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/downloads/cms1696.pdf).) The form gives that person permission to act on your behalf. It must be signed by you and by the person you would like to act on your behalf. You must give us a copy of the signed form.
  - While we can accept an appeal request without the form, we cannot begin or complete our review until we receive it. If we do not receive the form within 44 calendar days after receiving your appeal request (our deadline for making a decision on your appeal), your appeal request will be dismissed. If this happens, we will send you a written notice explaining your right to ask the independent review organization to review our decision to dismiss your appeal.

**Chapter 9 What to do if you have a problem or complaint (coverage decisions, appeals, complaints)**

- **You also have the right to hire a lawyer.** 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 5.3</b>	<b>Which section of this chapter gives the details for your situation?</b>
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There are four different situations that involve coverage decisions and appeals. Since each situation has different rules and deadlines, we give the details for each one in a separate section:

- **Section 6** of this chapter, “Your medical care: How to ask for a coverage decision or make an appeal”
- **Section 7** of this chapter, “Your Part D prescription drugs: How to ask for a coverage decision or make an appeal”
- **Section 8** of this chapter, “How to ask us to cover a longer inpatient hospital stay if you think the doctor is discharging you too soon”
- **Section 9** of this chapter, “How to ask us to keep covering certain medical services if you think your coverage is ending too soon” (This section only applies to these services: home health care, skilled nursing facility care, and Comprehensive Outpatient Rehabilitation Facility (CORF) services)

If you're not sure which section you should be using, call Customer Service. You can also get help or information from government organizations such as your SHIP.

<b>SECTION 6</b>	<b>Your medical care: How to ask for a coverage decision or make an appeal of a coverage decision</b>
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<b>Section 6.1</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 your care</b>
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This section is about your benefits for medical care and services. These benefits are described in Chapter 4 of this document: *Medical Benefits Chart (what is covered)*. To keep things simple, we generally refer to “medical care coverage” or “medical care” which includes medical items and services as well as Medicare Part B prescription drugs. In some cases, different rules apply to a request for a Part B prescription drug. In those cases, we will explain how the rules for Part B prescription drugs are different from the rules for medical items and services.

**Chapter 9 What to do if you have a problem or complaint (coverage decisions, appeals, complaints)**

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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 our plan covers this care. **Ask for a coverage decision. Section 6.2.**
2. Our plan will not approve the medical care your doctor or other health care provider wants to give you, and you believe that our plan covers this care. **Ask for a coverage decision. Section 6.2.**
3. You have received medical care that you believe our plan should cover, but we have said we will not pay for this care. **Make an appeal. Section 6.3.**
4. You have received and paid for medical care that you believe our plan should cover, and you want to ask our plan to reimburse you for this care. **Send us the bill. Section 6.5.**
5. You are being told that coverage for certain medical care you have been getting (that we previously approved) will be reduced or stopped, and you believe that reducing or stopping this care could harm your health. **Make an appeal. Section 6.3.**

**Note:** If the coverage that will be stopped is for hospital care, home health care, skilled nursing facility care, or Comprehensive Outpatient Rehabilitation Facility (CORF) services, you need to read Sections 8 and 9 of this chapter. Special rules apply to these types of care.

<b>Section 6.2</b>	<b>Step-by-step: How to ask for a coverage decision</b>
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<b>Legal Terms</b>
When a coverage decision involves your medical care, it is called an “ <b>organization determination</b> .”
A “fast coverage decision” is called an “ <b>expedited determination</b> .”

**Step 1:** Decide if you need a “standard coverage decision” or a “fast coverage decision.”

A “standard coverage decision” is usually made within 14 days or 72 hours for Part B drugs. A “fast coverage decision” is generally made within 72 hours, for medical services, or 24 hours for Part B drugs. In order to get a fast coverage decision, you must meet two requirements:

- You may *only* ask for coverage for medical care *you have not yet received*.



**Chapter 9 What to do if you have a problem or complaint (coverage decisions, appeals, complaints)**

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- You can get a fast coverage decision *only* if using the standard deadlines could *cause serious harm to your health or hurt your ability to function*.
- **If your doctor tells us that your health requires a “fast coverage decision,” we will automatically agree to give you a fast coverage decision.**
- **If you ask for a fast coverage decision on your own, without your doctor’s support, we will decide whether your health requires that we give you a fast coverage decision.** If we do not approve a fast coverage decision, we will send you a letter that:
  - Explains that we will use the standard deadlines
  - Explains if your doctor asks for the fast coverage decision, we will automatically give you a fast coverage decision
  - Explains that you can file a “fast complaint” about our decision to give you a standard coverage decision instead of the fast coverage decision you requested.

**Step 2: Ask our plan to make a coverage decision or fast coverage decision.**

- Start by calling, writing, or faxing our plan to make your request for us to authorize or provide coverage for the medical care you want. You, your doctor, or your representative can do this. Chapter 2 has contact information.

**Step 3: We consider your request for medical care coverage and give you our answer.**

***For standard coverage decisions we use the standard deadlines.***

**This means we will give you an answer within 14 calendar days** after we receive your request **for a medical item or service**. If your request is for a **Medicare Part B prescription drug**, we will give you an answer **within 72 hours** after we receive your request.

- **However**, if you ask for more time, or if we need more information that may benefit you **we can take up to 14 more days** if your request is for a medical item or service. If we take extra days, we will tell you in writing. We can’t take extra time to make a decision if your request is for a Medicare Part B prescription drug.
- If you believe we should *not* take extra days, you can file a “fast complaint.” We will give you an answer to your complaint as soon as we make the decision. (The process for making a complaint is different from the process for coverage decisions and appeals. See Section 11 of this chapter for

**Chapter 9 What to do if you have a problem or complaint (coverage decisions, appeals, complaints)**

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information on complaints.)

***For Fast Coverage decisions we use an expedited timeframe***

**A fast coverage decision means we will answer within 72 hours if your request is for a medical item or service. If your request is for a Medicare Part B prescription drug, we will answer within 24 hours.**

- **However**, if you ask for more time, or if we need more that may benefit you **we can take up to 14 more days**. If we take extra days, we will tell you in writing. We can't take extra time to make a decision if your request is for a Medicare Part B prescription drug.
- If you believe we should *not* take extra days, you can file a "fast complaint". (See Section 11 of this chapter for information on complaints.) We will call you as soon as we make the decision.
- **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 4: If we say no to your request for coverage for medical care, you can appeal.**

- If we say no, you have the right to ask us to reconsider this decision by making an appeal. This means asking again to get the medical care coverage you want. If you make an appeal, it means you are going on to Level 1 of the appeals process.

<b>Section 6.3</b>	<b>Step-by-step: How to make a Level 1 appeal</b>
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<b>Legal Terms</b>
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An appeal to the plan about a medical care coverage decision is called a plan <b>"reconsideration."</b>
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A "fast appeal" is also called an <b>"expedited reconsideration."</b>
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**Step 1: Decide if you need a "standard appeal" or a "fast appeal."**

**A "standard appeal" is usually made within 30 days. A "fast appeal" is generally made within 72 hours.**

- If you are appealing a decision we made about coverage for care that you have not yet received, you and/or your doctor will need to decide if you need a "fast appeal." If your doctor tells us that your health requires a "fast appeal," we will give you a fast appeal.



**Chapter 9 What to do if you have a problem or complaint (coverage decisions, appeals, complaints)**

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- The requirements for getting a “fast appeal” are the same as those for getting a “fast coverage decision” in Section 6.2 of this chapter.

**Step 2: Ask our plan for an appeal or a fast appeal**

- **If you are asking for a standard appeal, submit your standard appeal in writing.** You may also ask for an appeal by calling us. Chapter 2 has contact information.
- **If you are asking for a fast appeal, make your appeal in writing or call us.** Chapter 2 has contact information.
- **You must make your appeal request within 60 calendar days** from the date on the written notice we sent to tell you our answer on the coverage decision. If you miss this deadline and have a good reason for missing it, explain the reason your appeal is late when you make your appeal. We may give you more time to make your appeal. Examples of good cause may include a serious illness that prevented you from contacting us or if we provided you with incorrect or incomplete information about the deadline for requesting an appeal.
- **You can ask for a free copy of the information regarding your medical decision. You and your doctor may add more information to support your appeal.**

***If we told you we were going to stop or reduce services or items that you were already getting, you may be able to keep those services or items during your appeal.***

- If we decided to change or stop coverage for a service or item that you currently get, we will send you a notice before taking the proposed action.
- If you disagree with the action, you can file a Level 1 appeal. We will continue covering the service or item if you ask for a Level 1 appeal within 10 calendar days of the postmark date on our letter or by the intended effective date of the action, whichever is later.
- If you meet this deadline, you can keep getting the service or item with no changes while your Level 1 appeal is pending. You will also keep getting all other services or items (that are not the subject of your appeal) with no changes.

**Step 3: We consider your appeal and we give you our answer.**

- When we are reviewing your appeal, we take a careful look at all of the information. We check to see if we were following all the rules when we said no to your request.

**Chapter 9 What to do if you have a problem or complaint (coverage decisions, appeals, complaints)**

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- We will gather more information if needed, possibly contacting you or your doctor.

***Deadlines for a “fast appeal”***

- For fast appeals, 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.
  - However, if you ask for more time, or if we need more information that may benefit you, we **can take up to 14 more calendar days** if your request is for a medical item or service. If we take extra days, we will tell you in writing. We can't take extra time if your request is for a Medicare Part B prescription drug.
  - 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 review organization. Section 6.4 explains the Level 2 appeal 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 our decision in writing and automatically forward your appeal to the independent review organization for a Level 2 appeal. The independent review organization will notify you in writing when it receives your appeal.

***Deadlines for a “standard” appeal***

- For standard appeals, we must give you our answer **within 30 calendar days** after we receive your appeal. If your request is for a Medicare Part B prescription drug you have not yet received, we will give you our answer **within 7 calendar days** after we receive your appeal. 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 more information that may benefit you, **we can take up to 14 more calendar days** if your request is for a medical item or service. If we take extra days, we will tell you in writing. We can't take extra time to make a decision if your request is for a Medicare Part B prescription drug.
  - If you believe we should **not** take extra days, you can file a “fast complaint.” When you file a fast complaint, we will give you an answer to your complaint within 24 hours. (For more information about the process for making complaints, including fast complaints, see **Section 11** of this chapter.)

## Chapter 9 What to do if you have a problem or complaint (coverage decisions, appeals, complaints)

- If we do not give you an answer by the deadline (or by the end of the extended time period), we will send your request to a Level 2 appeal where an independent review organization will review the appeal. Section 6.4 explains the Level 2 appeal process.
- **If our answer is yes to part or all of what you requested**, we must authorize or provide the coverage within **30 calendar days**, or **within 7 calendar days** if your request is for a Medicare Part B prescription drug, after we receive your appeal.
- **If our plan says no to part or all of your appeal, you have additional appeal rights.**
- If we say no to part or all of what you asked for, we will send you a letter.
  - If your problem is about coverage of a Medicare service or item, the letter will tell you that we sent your case to the independent review organization for a Level 2 appeal.
  - If your problem is about coverage of a Oregon Health Plan (Medicaid) service or item, the letter will tell you how to file a Level 2 appeal yourself.

<b>Section 6.4</b>	<b>Step-by-step: How a Level 2 appeal is done</b>
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<b>Legal Term</b>
The formal name for the “independent review organization” is the “ <b>Independent Review Entity.</b> ” It is sometimes called the “ <b>IRE.</b> ”

The **independent review organization** is an independent organization hired by **Medicare**. It is not connected with us and is not a government agency. This organization decides whether the decision we made is correct or if it should be changed. Medicare oversees its work.

- If your problem is about a service or item that is usually **covered by Medicare**, we will automatically send your case to Level 2 of the appeals process as soon as the Level 1 appeal is complete.
- If your problem is about a service or item that is usually **covered by Oregon Health Plan (Medicaid)**, you can file a Level 2 appeal yourself. The letter will tell you how to do this. Information is also below.
- If your problem is about a service or item that could be **covered by both Medicare and Oregon Health Plan (Medicaid)**, you will automatically get a Level 2 appeal with the independent review organization. You can also ask for a Fair Hearing with the state.

**Chapter 9 What to do if you have a problem or complaint (coverage decisions, appeals, complaints)**

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If you qualified for continuation of benefits when you filed your Level 1 appeal, your benefits for the service, item, or drug under appeal may also continue during Level 2. Go to page 161 for information about continuing your benefits during Level 1 appeals.

- If your problem is about a service that is usually covered by Medicare only, your benefits for that service will not continue during the Level 2 appeals process with the independent review organization.
- If your problem is about a service that is usually covered by Oregon Health Plan (Medicaid), your benefits for that service will continue if you submit a Level 2 appeal within 10 calendar days after receiving the plan's decision letter.

**If your problem is about a service or item Medicare usually covers:**

**Step 1: The independent review organization reviews your appeal.**

- 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 free copy of your case file.**
- You have a right to give the independent review organization additional information to support your appeal.
- Reviewers at the independent review organization will take a careful look at all of the information related to your appeal.

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

- For the “fast appeal” the review organization must give you an answer to your Level 2 appeal **within 72 hours** of when it receives your appeal.
- If your request is for a medical item or service and the independent review organization needs to gather more information that may benefit you, **it can take up to 14 more calendar days**. The independent review organization can't take extra time to make a decision if your request is for a Medicare Part B prescription drug.

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

- For the “standard appeal” if your request is for a medical item or service, the review organization must give you an answer to your Level 2 appeal **within 30 calendar days** of when it receives your appeal.

**Chapter 9 What to do if you have a problem or complaint (coverage decisions, appeals, complaints)**

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- If your request is for a Medicare Part B prescription drug, the review organization must give you an answer to your Level 2 appeal **within 7 calendar days** of when it receives your appeal.
- However, if your request is for a medical item or service and the independent review organization needs to gather more information that may benefit you, **it can take up to 14 more calendar days**. The independent review organization can't take extra time to make a decision if your request is for a Medicare Part B prescription drug.

**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 independent review organization says yes to part or all of a request for a medical item or service**, we must authorize the medical care coverage **within 72 hours** or provide the service within **14 calendar days** after we receive the independent review organization's decision for **standard requests** or provide the service **within 72 hours** from the date we receive the independent review organization's decision for **expedited requests**.
- **If the independent review organization says yes to part or all of a request for a Medicare Part B prescription drug**, we must authorize or provide the Medicare Part B prescription drug **within 72 hours** after we receive the independent review organization's decision for **standard requests** or **within 24 hours** from the date we receive the independent review organization's decision for **expedited requests**.
- **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" or "turning down your appeal.") In this case, the independent review organization will send you a letter:
  - Explaining its decision.
  - Notifying you of the right to a Level 3 appeal if the dollar value of the medical care coverage meets a certain minimum. The written notice you get from the independent review organization will tell you the dollar amount you must meet to continue the appeals process.
  - Telling you how to file a Level 3 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

**Chapter 9 What to do if you have a problem or complaint (coverage decisions, appeals, complaints)**

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on to Level 3 and make a third appeal. The details on how to do this are in the written notice you get after your Level 2 appeal.

- The Level 3 appeal is handled by an Administrative Law Judge or attorney adjudicator. **Section 10** in this chapter explains the process for Level 3, 4, and 5 appeals.

**If your problem is about a service or item Oregon Health Plan (Medicaid) usually covers:****Step 1: You can ask for a Fair Hearing with the state.**

- Level 2 of the appeals process for services that are usually covered by Oregon Health Plan (Medicaid) is a Fair Hearing with the state. You must ask for a Fair Hearing in writing or over the phone **within 120 calendar days** of the date that we sent the decision letter on your Level 1 appeal. The letter you get from us will tell you where to submit your hearing request.

If you do not agree with the Level 1 Appeal decision for services that are usually covered by Oregon Health Plan (Medicaid), ask the state to review it. You or someone with permission to speak for you can ask for a hearing. This could be your provider or authorized representative. They don't need permission in writing to ask for a hearing on your behalf.

**Step 2: The Fair Hearing office gives you their answer.**

The Fair Hearing office will tell you their decision in writing and explain the reasons for it.

- **If the Fair Hearing office says yes to part or all of a request for a medical item or service**, we must authorize or provide the service or item within 72 hours after we receive the decision from the Fair Hearing office.
- **If the Fair Hearing office says no to part or all of your appeal**, 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" or "turning down your appeal.")

**If the decision is no for all or part of what I asked for, can I make another appeal?**

If the independent review organization or Fair Hearing office decision is no for all or part of what you asked for, you have **additional appeal rights**.

The letter you get from the Fair Hearing office will describe this next appeal option.



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See **Section 10** of this chapter for more information on your appeal rights after Level 2.

<b>Section 6.5</b>	<b>What if you are asking us to pay you back for a bill you have received for medical care?</b>
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If you have already paid for a Oregon Health Plan (Medicaid) service or item covered by the plan, 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 for medical services or drugs that are covered by our plan. When you send us a bill you have already paid, we will look at the bill and decide whether the services or drugs should be covered. If we decide they should be covered, we will pay you back for the services or drugs.

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

If you send us the paperwork asking for reimbursement, you are asking for a coverage decision. To make this decision, we will check to see if the medical care you paid for is a covered service. We will also check to see if you followed all the rules for using your coverage for medical care.

If you want us to reimburse you for a **Medicare** service or item or you are asking us to pay a health care provider for a Oregon Health Plan (Medicaid) service or item you paid for, you will ask us to make this coverage decision. We will check to see if the medical care you paid for is a covered service. We will also check to see if you followed all the rules for using your coverage for medical care.

- **If we say yes to your request:** If the medical care is covered and you followed all the rules, we will send you the payment for the cost within 60 calendar days after we receive your request.
- **If we say no to your request:** 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.

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 Section 5.3.** For appeals concerning reimbursement, please note:

- We must give you our answer within 30 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, you are not allowed to ask for a fast appeal.
- If the independent review organization decides we should pay, we must send you or the provider the payment 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

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payment you requested to you or to the health care provider within 60 calendar days.

### SECTION 7 Your Part D prescription drugs: How to ask for a coverage decision or make an appeal

#### Section 7.1 This section tells you what to do if you have problems getting a Part D drug or you want us to pay you back for a Part D drug

Your benefits include coverage for many prescription drugs. To be covered, the drug must be used for a medically accepted indication. (See Chapter 5 for more information about a medically accepted indication.) For details about Part D drugs, rules, restrictions, and costs please see Chapters 5 and 6.

- **This section is about your Part D drugs only.** To keep things simple, we generally say “drug” in the rest of this section, instead of repeating “covered outpatient prescription drug” or “Part D drug” every time. We also use the term “drug list” instead of “List of Covered Drugs” or “Formulary.”
- If you do not know if a drug is covered or if you meet the rules, you can ask us. Some drugs require that you get approval from us before we will cover it.
- If your pharmacy tells you that your prescription cannot be filled as written, the pharmacy will give you a written notice explaining how to contact us to ask for a coverage decision.

#### Part D coverage decisions and appeals

Legal Term
An initial coverage decision about your Part D drugs is called a “ <b>coverage determination.</b> ”

A coverage decision is a decision we make about your benefits and coverage or about the amount we will pay for your drugs. This section tells what you can do if you are in any of the following situations:

- Asking to cover a Part D drug that is not on the plan’s *List of Covered Drugs*. **Ask for an exception. Section 7.2.**
- Asking to waive a restriction on the plan’s coverage for a drug (such as limits on the amount of the drug you can get). **Ask for an exception. Section 7.2.**
- Asking to pay a lower cost-sharing amount for a covered drug on a higher cost-sharing tier. **Ask for an exception. Section 7.2.**
- Asking to get pre-approval for a drug. **Ask for a coverage decision. Section 7.4.**



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- Pay for a prescription drug you already bought. **Ask us to pay you back. Section 7.4.**

If you disagree with a coverage decision we have made, you can appeal our decision.

This section tells you both how to ask for coverage decisions and how to request an appeal.

### Section 7.2 What is an exception?

#### Legal Terms

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

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

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

If a drug is not covered in the way you would like it to be covered, you can ask us to make an “exception.” An exception is a type of coverage decision.

For us to consider your exception request, your doctor or other prescriber will need to explain the medical reasons why you need the exception approved. Here are three examples of exceptions that you or your doctor or other prescriber can ask us to make:

1. **Covering a Part D drug for you that is not on our Drug List.** If we agree to cover a drug not on the Drug List, you will need to pay the cost-sharing amount that applies to drugs in Tier 5 (Specialty). You cannot ask for an exception to the cost-sharing amount we require you to pay for the drug.
2. **Removing a restriction for a covered drug.** Chapter 5 describes the extra rules or restrictions that apply to certain drugs on our Drug List. If we agree to make an exception and waive a restriction for you, you can ask for an exception to the copayment or coinsurance amount we require you to pay for the drug.
3. **Changing coverage of a drug to a lower cost-sharing tier.** Every drug on our Drug List is in one of six cost-sharing tiers. In general, the lower the cost-sharing tier number, the less you will pay as your share of the cost of the drug.
  - If our drug list contains alternative drug(s) for treating your medical condition that are in a lower cost-sharing tier than your drug, you can ask us to cover your drug at the cost-sharing amount that applies to the alternative drug(s).

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- If the drug you're taking is a brand name drug, you can ask us to cover your drug at the cost-sharing amount that applies to the lowest tier that contains brand name alternatives for treating your condition.
- If the drug you're taking is a generic drug, you can ask us to cover your drug at the cost-sharing amount that applies to the lowest tier that contains either brand or generic alternatives for treating your condition.
- You cannot ask us to change the cost-sharing tier for any drug in Tier 5 (Specialty).
- If we approve your tiering exception request and there is more than one lower cost-sharing tier with alternative drugs you can't take, you will usually pay the lowest amount.

<b>Section 7.3</b>	<b>Important things to know about asking for exceptions</b>
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**Your doctor must tell us the medical reasons**

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

Typically, our Drug List includes more than one drug for treating a particular condition. These different possibilities are called "alternative" drugs. If an alternative drug would be just as effective as the drug you are requesting and would not cause more side effects or other health problems, we will generally **not** approve your request for an exception. If you ask us for a tiering exception, we will generally **not** approve your request for an exception unless all the alternative drugs in the lower cost-sharing tier(s) won't work as well for you or are likely to cause an adverse reaction or other harm.

**We can say yes or no to your request**

- If we approve your request for an exception, our approval usually is valid until the end of the plan year. This is true as long as your doctor continues to prescribe the drug for you and that drug continues to be safe and effective for treating your condition.
- If we say no to your request, you can ask for another review by making an appeal.

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<b>Section 7.4</b>	<b>Step-by-step: How to ask for a coverage decision, including an exception</b>
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<b>Legal Term</b>
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A “fast coverage decision” is called an <b>“expedited coverage determination.”</b>
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### **Step 1: Decide if you need a “standard coverage decision” or a “fast coverage decision.”**

“**Standard coverage decisions**” are made within **72 hours** after we receive your doctor’s statement. “**Fast coverage decisions**” are made within **24 hours** after we receive your doctor’s statement.

***If your health requires it, ask us to give you a “fast coverage decision.” To get a fast coverage decision, you must meet two requirements:***

- You must be asking for a *drug you have not yet received*. (You cannot ask for fast coverage decision to be paid back for a drug you have already bought.)
- Using the standard deadlines could *cause serious harm to your health or hurt your ability to function*.
- **If your doctor or other prescriber tells us that your health requires a “fast coverage decision,” we will automatically give you a fast coverage decision.**
- **If you ask for a fast coverage decision on your own, without your doctor or prescriber’s support, we will decide whether your health requires that we give you a fast coverage decision.** If we do not approve a fast coverage decision, we will send you a letter that:
  - Explains that we will use the standard deadlines.
  - Explains if your doctor or other prescriber asks for the fast coverage decision, we will automatically give you a fast coverage decision.
  - Tells you how you can file a “fast complaint” about our decision to give you a standard coverage decision instead of the fast coverage decision you requested. We will answer your complaint within 24 hours of receipt.

### **Step 2: Request a “standard coverage decision” or a “fast coverage decision.”**

Start by calling, writing, or faxing our plan to make your request for us to authorize or provide coverage for the medical care you want. You can also access the coverage decision process through our website. We must accept any

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written request, including a request submitted on the CMS Model Coverage Determination Request Form, which is available on our website. Chapter 2 has contact information. To assist us in processing your request, please be sure to include your name, contact information, and information identifying which denied claim is being appealed.

You, your doctor, (or other prescriber) or your representative can do this. You can also have a lawyer act on your behalf. Section 4 of this chapter tells how you can give written permission to someone else to act as your representative.

- **If you are requesting an exception, provide the “supporting statement,** which is the medical reasons for the exception. Your doctor or other prescriber can fax or mail the statement to us. Or your doctor or other prescriber can tell us on the phone and follow up by faxing or mailing a written statement if necessary.

**Step 3: We consider your request and give you our answer.*****Deadlines for a “fast coverage decision”***

- We must generally give you our answer **within 24 hours** after we receive your request.
  - For exceptions, we will give you our answer within 24 hours after we receive your doctor’s supporting statement. We will give you our answer sooner if your health requires us to.
  - If we do not meet this deadline, we are required to send your request on to Level 2 of the appeals process, where it will be reviewed by an independent review organization.
- **If our answer is yes to part or all of what you requested,** we must provide the coverage we have agreed to provide within 24 hours after we receive your request or doctor’s statement supporting your request.
- **If our answer is no to part or all of what you requested,** we will send you a written statement that explains why we said no. We will also tell you how you can appeal.

***Deadlines for a “standard” coverage decision about a drug you have not yet received***

- We must give you our answer **within 72 hours** after we receive your request.
  - For exceptions, we will give you our answer within 72 hours after we receive your doctor’s supporting statement. We will give you our answer sooner if your health requires us to.

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- If we do not meet this deadline, we are required to send your request on to Level 2 of the appeals process, where it will be reviewed by an independent review organization.
- **If our answer is yes to part or all of what you requested**, we must **provide the coverage** we have agreed to provide **within 72 hours** after we receive your request or doctor's statement supporting your request.
- **If our answer is no to part or all of what you requested**, we will send you a written statement that explains why we said no. We will also tell you how you can appeal.

***Deadlines for a "standard" coverage decision about payment for a drug you have already bought***

- We must give you our answer **within 14 calendar days** after we receive your request.
  - If we do not meet this deadline, we are required to send your request on to Level 2 of the appeals process, where it will be reviewed by an independent review organization
- **If our answer is yes to part or all of what you requested**, we are also required to make payment to you within 14 calendar days after we receive your request.
- **If our answer is no to part or all of what you requested**, we will send you a written statement that explains why we said no. We will also tell you how you can appeal.

**Step 4: If we say no to your coverage request, you can make an appeal.**

- If we say no, you have the right to ask us to reconsider this decision by making an appeal. This means asking again to get the drug coverage you want. If you make an appeal, it means you are going on to Level 1 of the appeals process.

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### Section 7.5 Step-by-step: How to make a Level 1 appeal

#### Legal Term

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

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

#### **Step 1:** Decide if you need a “standard appeal” or a “fast appeal.”

***A “standard appeal” is usually made within 7 days. A “fast appeal” is generally made within 72 hours. If your health requires it, ask for a “fast appeal”.***

- If you are appealing a decision we made about a drug you have not yet received, you and your doctor or other prescriber will need to decide if you need a “fast appeal.”
- The requirements for getting a “fast appeal” are the same as those for getting a “fast coverage decision” in Section 6.4 of this chapter.

#### **Step 2:** You, your representative, doctor or other prescriber must contact us and make your Level 1 appeal. If your health requires a quick response, you must ask for a “fast appeal.”

- **For standard appeals, submit a written request**, or call us. Chapter 2 has contact information.
- **For fast appeals either submit your appeal in writing or call us at 888-863-3637. TTY users should call 711.** Chapter 2 has contact information.
- **We must accept any written request**, including a request submitted on the CMS Model Coverage Determination Request Form, which is available on our website. Please be sure to include your name, contact information, and information regarding your claim to assist us in processing your request.
- **You can also submit an appeal through our secure website for members, InTouch.** Click “InTouch Login” at the top of our plan website ([www.Medicare.PacificSource.com](http://www.Medicare.PacificSource.com)) to register or access your account. There are two ways you can access our online appeal and grievance forms (1) From the **Tools** menu, choose “File Appeal or Grievance” (2) From the **Quick Links** box, choose “File Appeal or Grievance”.
  - An online form will appear for you to fill out. The form has two sections, one is for appeals (Tab 1) and the other is for grievances (Tab 2). Fill out the section that applies to your situation. After you have completed

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the form(s) click “Submit” to submit your request to the plan for review. Follow up notices will be sent to you by mail (or phone call for expedited reviews).

- **You must make your appeal request within 60 calendar days** from the date on the written notice we sent to tell you our answer on the coverage decision. If you miss this deadline and have a good reason for missing it, explain the reason your appeal is late when you make your appeal. We may give you more time to make your appeal. Examples of good cause may include a serious illness that prevented you from contacting us or if we provided you with incorrect or incomplete information about the deadline for requesting an appeal.
- **You can ask for a copy of the information in your appeal and add more information.** You and your doctor may add more information to support your appeal.

**Step 3: We consider your appeal and we give you our answer.**

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

***Deadlines for a “fast appeal”***

- For fast appeals, 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.
  - If we do not give you an answer within 72 hours, we are required to send your request on to Level 2 of the appeals process, where it will be reviewed by an independent review organization. **Section 7.6** explains the Level 2 appeal process.
- **If our answer is yes to part or all of what you requested**, we must provide the coverage we have agreed to provide within 72 hours after we receive your appeal.
- **If our answer is no to part or all of what you requested**, we will send you a written statement that explains why we said no and how you can appeal our decision.

***Deadlines for a “standard” appeal for a drug you have not yet received***

- For standard appeals, we must give you our answer **within 7 calendar days** after we receive your appeal. We will give you our decision sooner if you have



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not received the drug yet and your health condition requires us to do so.

- If we do not give you a decision within 7 calendar days, we are required to send your request on to Level 2 of the appeals process, where it will be reviewed by an independent review organization.

**Section 7.6** explains the Level 2 appeal process.

- **If our answer is yes to part or all of what you requested**, we must provide the coverage as quickly as your health requires, but no later than **7 calendar 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 statement that explains why we said no and how you can appeal our decision.

### ***Deadlines for a “standard appeal” about payment for a drug you have already bought***

- We must give you our answer **within 14 calendar days** after we receive your request.
  - If we do not meet this deadline, we are required to send your request on to Level 2 of the appeals process, where it will be reviewed by an independent review organization.
- **If our answer is yes to part or all of what you requested**, we are also required to make payment to you within 30 calendar days after we receive your request.
- **If our answer is no to part or all of what you requested**, we will send you a written statement that explains why we said no. We will also tell you how you can appeal.

### **Step 4: If we say no to your appeal, you decide if you want to continue with the appeals process and make another appeal.**

- If you decide to make another appeal, it means your appeal is going on to Level 2 of the appeals process.

<b>Section 7.6</b>	<b>Step-by-step: How to make a Level 2 appeal</b>
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<b>Legal Term</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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The **independent review organization is an independent organization hired by Medicare**. It is not connected with us and is not a government agency. This organization decides whether the decision we made is correct or if it should be changed. Medicare oversees its work.

**Step 1: You (or your representative or your doctor or other prescriber) must contact the independent review organization and ask for a review of your case.**

- If we say no to your Level 1 appeal, the written notice we send you will include **instructions on how to make a Level 2 appeal** with the independent review organization. These instructions will tell who can make this Level 2 appeal, what deadlines you must follow, and how to reach the review organization. If, however, we did not complete our review within the applicable timeframe, or make an unfavorable decision regarding “at-risk” determination under our drug management program, we will automatically forward your claim to the IRE.
- We will send the information about your appeal to this organization. This information is called your “case file.” **You have the right to ask us for a copy of your case file.**
- You have a right to give the independent review organization additional information to support your appeal.

**Step 2: The independent review organization reviews your appeal.**

Reviewers at the independent review organization will take a careful look at all of the information related to your appeal.

***Deadlines for “fast appeal”***

- If your health requires it, ask the independent review organization for a “fast appeal.”
- If the organization agrees to give you a “fast appeal,” the organization must give you an answer to your Level 2 appeal **within 72 hours** after it receives your appeal request.

***Deadlines for “standard appeal”***

- For standard appeals, the review organization must give you an answer to your Level 2 appeal **within 7 calendar days** after it receives your appeal if it is for a drug you have not yet received. If you are requesting that we pay you back for a drug you have already bought, the review organization must give you an answer to your Level 2 appeal **within 14 calendar days** after it receives your request.

**Chapter 9 What to do if you have a problem or complaint (coverage decisions, appeals, complaints)****Step 3: The independent review organization gives you their answer.*****For “fast appeals”:***

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

***For “standard appeals”:***

- **If the independent review organization says yes to part or all of your request for coverage**, we must **provide the drug coverage** that was approved by the review organization **within 72 hours** after we receive the decision from the review organization.
- **If the independent review organization says yes to part or all of your request to pay you back** for a drug you already bought, we are required to **send payment to you within 30 calendar days** after we receive the decision from the review organization.

**What if the review organization says no to your appeal?**

**If this organization says no to part or all of your appeal**, it means they agree with our decision not to approve your request (or part of your request). (This is called “upholding the decision” or “turning down your appeal.”) In this case, the independent review organization will send you a letter:

- Explaining its decision.
- Notifying you of the right to a Level 3 appeal if the dollar value of the drug coverage you are requesting meets a certain minimum. If the dollar value of the drug coverage you are requesting is too low, you cannot make another appeal and the decision at Level 2 is final.
- Telling you the dollar value that must be in dispute to continue with the appeals process.

**Step 4: 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 you want to go on to a Level 3 appeal, the details on how to do this are in the written notice you get after your Level 2 appeal decision.
- The Level 3 appeal is handled by an Administrative Law Judge or attorney adjudicator. **Section 10** of this chapter tells more about the process for Level 3, 4, and 5 appeals.

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**SECTION 8      How to ask us to cover a longer inpatient 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.

During your covered 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 help arrange for care you may need after you leave.

- The day you leave the hospital is called your “**discharge date.**”
- When your discharge date is decided, your doctor or the hospital staff will tell you.
- 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.

<b>Section 8.1      During your inpatient hospital stay, you will get a written notice from Medicare that tells about your rights</b>
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Within two days of being admitted to the hospital, 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.

If you do not get the notice from someone at the hospital (for example, a caseworker or nurse), ask any hospital employee for it. If you need help, call Customer Service or 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week (TTY 1-877-486-2048).

1. **Read this notice carefully and ask questions if you don’t understand it.** It tells you:
  - 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.
  - Where to report any concerns you have about the quality of your hospital care.
  - Your right to **request an immediate review** of the decision to discharge you if you think you are being discharged from the hospital too soon. This is a formal, legal way to ask for a delay in your discharge date so that we will cover your hospital care for a longer time.

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**2. You will be asked to sign the written notice to show that you received it and understand your rights.**

- You or someone who is acting on your behalf will be asked to sign the notice.
- Signing the notice shows **only** that you have received the information about your rights. The notice does not give your discharge date. Signing the notice **does not mean** you are agreeing on a discharge date.

**3. Keep your copy** of the notice handy so you will have the information about making an appeal (or reporting a concern about quality of care) if you need it.

- If you sign the notice more than two days before your discharge date, you will get another copy before you are scheduled to be discharged.
- To look at a copy of this notice in advance, you can call Customer Service or 1-800 MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048. You can also see the notice online at [www.cms.gov/Medicare/Medicare-General-Information/BNH/HospitalDischargeAppealNotices](http://www.cms.gov/Medicare/Medicare-General-Information/BNH/HospitalDischargeAppealNotices).

**Section 8.2****Step-by-step: How to make a Level 1 appeal to change your hospital discharge date**

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

- **Follow the process.**
- **Meet the deadlines.**
- **Ask for help if you need it.** If you have questions or need help at any time, call Customer Service. Or call your State Health Insurance Assistance Program, a government organization that provides personalized assistance.

**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.

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

**Chapter 9 What to do if you have a problem or complaint (coverage decisions, appeals, complaints)**

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**Step 1: Contact the Quality Improvement Organization for your state and ask for an immediate review of your hospital discharge. You must act quickly.**

***How can you contact this organization?***

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

***Act quickly:***

- To make your appeal, you must contact the Quality Improvement Organization **before** you leave the hospital and **no later than midnight the day of your discharge**.
  - If you meet this deadline, you may stay in the hospital **after** your discharge date **without paying for it** while you wait to get the decision 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, and you still wish to appeal, you must make an appeal directly to our plan instead. For details about this other way to make your appeal, see **Section 8.4** of this chapter.

Once you request an immediate review of your hospital discharge the Quality Improvement Organization will contact us. By noon of the day after we are contacted we will give you a **Detailed Notice of Discharge**. This notice gives your planned discharge date and explains in detail the reasons why your doctor, the hospital, and we think it is right (medically appropriate) for you to be discharged on that date.

You can get a sample of the **Detailed Notice of Discharge** by calling Customer Service or 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. (TTY users should call 1-877-486-2048.) Or you can see a sample notice online at [www.cms.gov/Medicare/Medicare-General-Information/BNH/HospitalDischargeappealNotices](http://www.cms.gov/Medicare/Medicare-General-Information/BNH/HospitalDischargeappealNotices).

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

- Health professionals at the Quality Improvement Organization (“the reviewers”) 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.

**Chapter 9 What to do if you have a problem or complaint (coverage decisions, appeals, complaints)**

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- The reviewers will also look at your medical information, talk with your doctor, and review information that the hospital and we have given to them.
- By noon of the day after the reviewers told us of your appeal, you will get a written notice from us that gives your planned discharge date. This notice also explains in detail the reasons why your doctor, the hospital, and we think it is right (medically appropriate) for you to be discharged on that date.

**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, **we must keep providing your covered inpatient hospital services for as long as these services are medically necessary.**
- You will have to keep paying your share of the costs (such as deductibles or copayments, if these apply). In addition, there may be limitations on your covered hospital services.

***What happens if the answer is no?***

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

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

- If the Quality Improvement Organization has said *no* to 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.



**Chapter 9 What to do if you have a problem or complaint (coverage decisions, appeals, complaints)****Section 8.3 Step-by-step: How to make a Level 2 appeal to change your hospital discharge date**

During a Level 2 appeal, you ask the Quality Improvement Organization to take another look at their decision on your first appeal. If the Quality Improvement Organization turns down your Level 2 appeal, you may have to pay the full cost for your stay after your planned discharge date.

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

- You must ask for this review **within 60 calendar days** after the day the Quality Improvement Organization said no to your Level 1 appeal. You can ask for this review only if you stay 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 of receipt of your request for a Level 2 appeal, the reviewers will decide on your appeal and tell you their decision.*****If the review organization says yes:***

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

***If the review organization says no:***

- It means they agree with the decision they made on your Level 1 appeal.
- The notice you get will tell you in writing what you can do if you wish to continue with the review process.

**Chapter 9 What to do if you have a problem or complaint (coverage decisions, appeals, complaints)**

**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 you want to go to a Level 3 appeal, the details on how to do this are in the written notice you get after your Level 2 appeal decision.
- The Level 3 appeal is handled by an Administrative Law Judge or attorney adjudicator. **Section 10** of this chapter tells more about Levels 3, 4, and 5 of the appeals process.

<b>Section 8.4</b>	<b>What if you miss the deadline for making your Level 1 appeal?</b>
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<b>Legal Term</b>
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A “fast review” (or “fast appeal”) is also called an “ <b>expedited appeal</b> .”
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**You can appeal to us instead**

As explained above, you must act quickly to start your Level 1 appeal of your hospital discharge. If you miss the deadline for contacting the Quality Improvement 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****Step 1: Contact us and ask for a “fast review.”**

- **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. Chapter 2 has contact information.

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

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

## Chapter 9 What to do if you have a problem or complaint (coverage decisions, appeals, complaints)

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

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

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

### **Step-by-Step: Level 2 *Alternate* appeal Process**

Legal Term
The formal name for the “independent review organization” is the “ <b>Independent Review Entity</b> .” It is sometimes called the “ <b>IRE</b> .”

**The independent review organization is an independent organization hired by Medicare.** It is not connected with our plan and is not a government agency. This organization decides whether the decision we made is correct or if it should be changed. Medicare oversees its work.

**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. **Section 11** of this chapter tells how to make a complaint.)

**Chapter 9 What to do if you have a problem or complaint (coverage decisions, appeals, complaints)**

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

- Reviewers at the independent review organization will take a careful look at all of the information related to your appeal of your hospital discharge.
- **If this organization says yes to your appeal**, then we must pay you back for our share of the costs of hospital care you received since the date of your planned discharge. We must also continue the plan’s coverage of your inpatient hospital services for as long as it is medically necessary. You must continue to pay your share of the costs. If there are coverage limitations, these could limit how much we would reimburse or how long we would continue to cover your services.
- **If this organization says no to your appeal**, it means they agree that your planned hospital discharge date was medically appropriate.
  - The written notice you get from the independent review organization will tell you how to start a Level 3 appeal, which is handled by an Administrative Law Judge or attorney adjudicator.

**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 appeal.
- **Section 10** of this chapter tells more about the process for Level 3, 4, and 5 appeals.

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<b>SECTION 9</b>	<b>How to ask us to keep covering certain medical services if you think your coverage is ending too soon</b>
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<b>Section 9.1</b>	<b>This section is only about three services: Home health care, skilled nursing facility care, and Comprehensive Outpatient Rehabilitation Facility (CORF) services</b>
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When you are getting **home health services, skilled nursing care, or rehabilitation care (Comprehensive Outpatient Rehabilitation Facility)**, 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.

**Chapter 9 What to do if you have a problem or complaint (coverage decisions, appeals, complaints)**

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

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

**Section 9.2 We will tell you in advance when your coverage will be ending****Legal Term**

**“Notice of Medicare Non-Coverage.”** It tells you how you can request a **“fast-track appeal.”** Requesting a fast-track appeal is a formal, legal way to request a change to our coverage decision about when to stop your care.

1. **You receive a notice in writing** at least two days before our plan is going to stop covering your care. The notice tells you:
  - The date when we will stop covering the care for you.
  - How to request a “fast track appeal” to request us to keep covering your care for a longer period of time.
2. **You, or someone who is acting on your behalf, will be asked to sign the written notice to show that you received it.** 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’s decision to stop care.

**Section 9.3 Step-by-step: How to make a Level 1 appeal to have our plan cover your care for a longer time**

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

- **Follow the process.**
- **Meet the deadlines.**
- **Ask for help if you need it.** If you have questions or need help at any time, call Customer Service. Or call your State Health Insurance Assistance Program, a government organization that provides personalized assistance.

**During a Level 1 appeal, the Quality Improvement Organization reviews your appeal.** It decides if the end date for your care is medically appropriate.

**Chapter 9 What to do if you have a problem or complaint (coverage decisions, appeals, complaints)**

The **Quality Improvement Organization** is a group of doctors and other health care experts paid by the Federal government to check on and help improve the quality of care for people with Medicare. This includes reviewing plan decisions about when it's time to stop covering certain kinds of medical care. These experts are not part of our plan.

**Step 1: Make your Level 1 appeal: contact the Quality Improvement Organization and ask for a *fast-track appeal*. You must act quickly.*****How can you contact this organization?***

- The written notice you received (*Notice of Medicare Non-Coverage*) 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.

***Act quickly:***

- You must contact the Quality Improvement Organization to start your appeal **by noon of the day before the effective date** on the Notice of Medicare Non-Coverage.

***Your deadline for contacting this organization.***

- If you miss the deadline for contacting the Quality Improvement Organization, and you still wish to file an appeal, you must make an appeal directly to us instead. For details about this other way to make your appeal, see **Section 9.5** of this chapter.

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

Legal Term
<b>“Detailed Explanation of Non-Coverage.”</b> Notice that provides details on reasons for ending coverage.

***What happens during this review?***

- Health professionals at the Quality Improvement Organization (“the reviewers”) 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 told us of your appeal, you will get the **Detailed Explanation of Non-Coverage** from us that explains in detail our reasons for ending our coverage for your services.

**Chapter 9 What to do if you have a problem or complaint (coverage decisions, appeals, complaints)**

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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?***

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

***What happens if the reviewers say no?***

- If the reviewers say no, then **your coverage will end on the date we have told you.**
- 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.

- 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 a Level 2 appeal.

<b>Section 9.4</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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During a Level 2 appeal, you ask the Quality Improvement Organization to take another look at the decision on your first appeal. If the Quality Improvement Organization turns down your Level 2 appeal, you may have to pay the full cost for your home health care, or skilled nursing facility care, or Comprehensive Outpatient Rehabilitation Facility (CORF) services **after** the date when we said your coverage would end.

**Step 1:** 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.



**Chapter 9 What to do if you have a problem or complaint (coverage decisions, appeals, complaints)**

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**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 of receipt of your appeal request, reviewers will decide on your appeal and tell you their decision.*****What happens if the review organization says yes?***

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

***What happens if the review organization says no?***

- It means they agree with the decision made to your Level 1 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 an Administrative Law Judge or attorney adjudicator.

**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 you want to go on to a Level 3 appeal, the details on how to do this are in the written notice you get after your Level 2 appeal decision.
- The Level 3 appeal is handled by an Administrative Law Judge or attorney adjudicator. **Section 10** of this chapter tells more about the process for Level 3, 4, and 5 appeals.

**Chapter 9 What to do if you have a problem or complaint (coverage decisions, appeals, complaints)****Section 9.5 What if you miss the deadline for making your Level 1 appeal?****You can appeal to us instead**

As explained above, 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**

Legal Term
A “fast review” (or “fast appeal”) is also called an <b>“expedited appeal.”</b>

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

- **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. Chapter 2 has contact information.

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

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

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

- **If we say yes to your appeal,** it means we have agreed with you that you need services longer, and we will keep providing your covered services for as long as it is medically necessary. It also means that we have agreed to reimburse you for our share of the costs of care you have received since the date when we said your coverage would end. (You must pay your share of the costs, and there may be coverage limitations that apply.)
- **If we say no to your appeal,** then your coverage will end on the date we told you and we will not pay any share of the costs after this date.
- 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.

**Chapter 9 What to do if you have a problem or complaint (coverage decisions, appeals, complaints)**

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

Legal Term
The formal name for the “independent review organization” is the “ <b>Independent Review Entity.</b> ” It is sometimes called the “ <b>IRE.</b> ”

**Step-by-Step: Level 2 Alternate appeal Process**

During the Level 2 appeal, the **independent review organization** reviews the decision we made to your “fast appeal.” This organization decides whether the decision should be changed. **The independent review organization is an independent organization that is hired by Medicare.** This organization is not connected with our plan and it is not a government agency. This organization is a company chosen by Medicare to handle the job of being the independent review organization. Medicare oversees its work.

**Step 1: We 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. **Section 11** 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.**

- Reviewers at the independent review organization will take a careful look at all of the information related to your appeal.
- **If this organization says yes to your appeal,** then we must 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 services.
- **If this organization says no to your appeal,** it means they agree with the decision our plan made to your first appeal and will not change it.
  - The notice you get from the independent review organization will tell you in writing what you can do if you wish to go on to a Level 3 appeal.

**Chapter 9 What to do if you have a problem or complaint (coverage decisions, appeals, complaints)**

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**Step 3: If the independent review organization says no to 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 you want to go on to a Level 3 appeal, the details on how to do this are in the written notice you get after your Level 2 appeal decision.
- A Level 3 appeal is reviewed by an Administrative Law Judge or attorney adjudicator. **Section 10** of this chapter tells more about the process for Level 3, 4, and 5 appeals.

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**SECTION 10 Taking your appeal to Level 3 and beyond**

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**Section 10.1 Appeal Levels 3, 4 and 5 for Medical Service Requests**

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. The written response you receive to your Level 2 appeal will explain how to make 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** An Administrative Law Judge or an attorney adjudicator who works for the Federal government will review your appeal and give you an answer.

- **If the Administrative Law Judge or attorney adjudicator says yes to your appeal, the appeals process may or may not be over.** Unlike a decision at a Level 2 appeal, we have the right to appeal a Level 3 decision that is favorable to you. If we decide to appeal it will go to a Level 4 appeal.
  - If we decide not to appeal, we must authorize or provide you with the service within 60 calendar days after receiving the Administrative Law Judge's or attorney adjudicator'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.

**Chapter 9 What to do if you have a problem or complaint (coverage decisions, appeals, complaints)**

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- **If the Administrative Law Judge or attorney adjudicator 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. The notice you get will tell you what to do for a Level 4 appeal.

**Level 4 appeal** The **Medicare Appeals Council** (Council) will review your appeal and give you an answer. The Council is part of the Federal government.

- **If the answer is yes, or if the Council denies our request to review a favorable Level 3 appeal decision, the appeals process may or may not be over.** Unlike a decision at Level 2, we have the right to appeal a Level 4 decision that is favorable to you. We will decide whether to appeal this decision to Level 5.

- If we decide **not** to appeal the decision, we must authorize or provide you with the service within 60 calendar days after receiving the 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 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 may be able to continue to the next level of the review process. If the 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 and how to continue with a Level 5 appeal.

**Level 5 appeal** A judge at the **Federal District Court** will review your appeal.

- A judge will review all of the information and decide *yes* or *no* to your request. This is a final answer. There are no more appeal levels after the Federal District Court.

<b>Section 10.2</b>	<b>Additional Oregon Health Plan (Medicaid) appeals</b>
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You also have other appeal rights if your appeal is about services or items that Oregon Health Plan (Medicaid) usually covers. The letter you get from the Fair Hearing office will tell you what to do if you wish to continue the appeals process.

**Chapter 9 What to do if you have a problem or complaint (coverage decisions, appeals, complaints)****Section 10.3 Appeal Levels 3, 4 and 5 for Part D Drug Requests**

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 value of the drug you have appealed meets a certain dollar amount, you may be able to go on to additional levels of appeal. If the dollar amount is less, you cannot appeal any further. 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** An **Administrative Law Judge or attorney adjudicator who works for the Federal** government will review your appeal and give you an answer.

- **If the answer is yes, the appeals process is over.** We must **authorize or provide the drug coverage** that was approved by the Administrative Law Judge or attorney adjudicator **within 72 hours (24 hours for expedited appeals) or make payment no later than 30 calendar days** after we receive the decision.
- **If the answer is no, the appeals process may or may not be over.**
  - If you decide to accept this decision that turns down your appeal, the appeals process is over.
  - If you do not want to accept the decision, you can continue to the next level of the review process. The notice you get will tell you what to do for a Level 4 appeal.

**Level 4 appeal** The **Medicare Appeals Council** (Council) will review your appeal and give you an answer. The Council is part of the Federal government.

- **If the answer is yes, the appeals process is over.** We must **authorize or provide the drug coverage** that was approved by the Council **within 72 hours (24 hours for expedited appeals) or make payment no later than 30 calendar days** after we receive the decision.
- **If the answer is no, the appeals process may or may not be over.**
  - If you decide to accept this decision that turns down your appeal, the appeals process is over.
  - If you do not want to accept the decision, you may be able to continue to the next level of the review process. If the Council says no to your appeal or denies your request to review the appeal, the notice will tell you whether the rules allow you to go on to a Level 5 appeal. It will also

## Chapter 9 What to do if you have a problem or complaint (coverage decisions, appeals, complaints)

tell you who to contact and what to do next if you choose to continue with your appeal.

**Level 5 appeal** A judge at the **Federal District Court** will review your appeal.

- A judge will review all of the information and decide *yes* or *no* to your request. This is a final answer. There are no more appeal levels after the Federal District Court.

## SECTION 11 How to make a complaint about quality of care, waiting times, customer service, or other concerns

### Section 11.1 What kinds of problems are handled by the complaint process?

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

Complaint	Example
<b>Quality of your medical care</b>	<ul style="list-style-type: none"> <li>• Are you unhappy with the quality of the care you have received (including care in the hospital)?</li> </ul>
<b>Respecting your privacy</b>	<ul style="list-style-type: none"> <li>• Did someone not respect your right to privacy or share confidential information?</li> </ul>
<b>Disrespect, poor customer service, or other negative behaviors</b>	<ul style="list-style-type: none"> <li>• Has someone been rude or disrespectful to you?</li> <li>• Are you unhappy with our Customer Service?</li> <li>• Do you feel you are being encouraged to leave the plan?</li> </ul>
<b>Waiting times</b>	<ul style="list-style-type: none"> <li>• Are you having trouble getting an appointment, or waiting too long to get it?</li> <li>• Have you been kept waiting too long by doctors, pharmacists, or other health professionals? Or by our Customer Service or other staff at the plan? <ul style="list-style-type: none"> <li>◦ Examples include waiting too long on the phone, in the waiting or exam room, or getting a prescription.</li> </ul> </li> </ul>
<b>Cleanliness</b>	<ul style="list-style-type: none"> <li>• Are you unhappy with the cleanliness or condition of a clinic, hospital, or doctor's office?</li> </ul>
<b>Information you get from us</b>	<ul style="list-style-type: none"> <li>• Did we fail to give you a required notice?</li> <li>• Is our written information hard to understand?</li> </ul>



## Chapter 9 What to do if you have a problem or complaint (coverage decisions, appeals, complaints)

Complaint	Example
<b>Timeliness</b> (These types of complaints are all related to the timeliness of our actions related to coverage decisions and appeals)	<p>If you have asked for a coverage decision or made an appeal and you think that we are not responding quickly enough, you can make a complaint about our slowness. Here are examples:</p> <ul style="list-style-type: none"> <li>• You asked us for a “fast coverage decision” or a “fast appeal,” and we have said no; you can make a complaint.</li> <li>• You believe we are not meeting the deadlines for coverage decisions or appeals; you can make a complaint.</li> <li>• You believe we are not meeting deadlines for covering or reimbursing you for certain medical services or drugs that were approved; you can make a complaint.</li> <li>• You believe we failed to meet required deadlines for forwarding your case to the independent review organization; you can make a complaint.</li> </ul>

### Section 11.2 How to make a complaint

Legal Terms
<ul style="list-style-type: none"> <li>• A “<b>Complaint</b>” is also called a “<b>grievance.</b>”</li> <li>• “<b>Making a complaint</b>” is also called “<b>filing a grievance.</b>”</li> <li>• “<b>Using the process for complaints</b>” is also called “<b>using the process for filing a grievance.</b>”</li> <li>• A “<b>fast complaint</b>” is also called an “<b>expedited grievance.</b>”</li> </ul>

### Section 11.3 Step-by-step: Making a complaint

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

- **Usually, calling Customer Service is the first step.** If there is anything else you need to do, Customer Service will let you know.
- If you do not wish to call (or you called and were not satisfied), you can put your complaint in writing and send it to us. If you put your complaint in writing, we will respond to your complaint in writing.
- **If you do this, it means that we will use our formal procedure for answering grievances.** Here’s how it works:

**Chapter 9 What to do if you have a problem or complaint (coverage decisions, appeals, complaints)**

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- You or your legal representative may file the grievance. Your representative may be a friend, lawyer, advocate, doctor, or anyone else you formally name as your representative. If your representative is not someone who is already authorized by a Court or under State law to act for you, then you and that person must sign and date a statement that gives the person legal permission to be your representative. To learn how to name your representative, you may contact Customer Service at the numbers listed above.
  - If you file your grievance in writing, please send it to the address listed in Chapter 2. We will write you or your representative and let you know how we have addressed your concerns within 30 calendar days of receiving your grievance. In some instances we may need additional time to research and address your concern. If this is the case, we may extend the 30 day timeframe by up to 14 calendar days, and keep you informed of how your grievance is being handled. The 14 day extension may also be applied upon your request.
  - If your grievance is related to the denial of an expedited (fast) Organizational Determination or reconsideration, then you will be entitled to an expedited (fast) grievance. We will also expedite your grievance if it relates to a Plan decision to extend the 14 day timeframe for an Organizational Determination or the 30 day timeframe for a reconsideration request. We will respond to expedited reasons for this answer. We must respond whether we agree with the complaint or not.
  - You can also submit a grievance through our secure website for members, InTouch. Click “InTouch Login” at the top of our plan website ([www.Medicare.PacificSource.com](http://www.Medicare.PacificSource.com)) to register or access your account. There are two ways you can access our online appeal and grievance forms (1) From the **Tools** menu, choose “File Appeal or Grievance” (2) From the **Quick Links** box, choose “File Appeal or Grievance”.
  - An online form will appear for you to fill out. The form has two sections, one is for appeals (Tab 1) and the other is for grievances (Tab 2). Fill out the section that applies to your situation. After you have completed the form(s) click “Submit” to submit your request to the plan for review. Follow up notices will be sent to you by mail (or phone call for expedited reviews).
- The **deadline** for making a complaint is 60 calendar days from the time you had the problem you want to complain about.
  - **Whether you call or write, you should contact Customer Service right away.** You can make the complaint at any time after you had the problem you want to complain about.

**Chapter 9 What to do if you have a problem or complaint (coverage decisions, appeals, complaints)****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.
- **Most complaints are answered within 30 calendar days.** If we need more information and the delay is in your best interest or if you ask for more time, we can take up to 14 more calendar days (44 calendar days total) to answer your complaint. If we decide to take extra days, we will tell you in writing.
- **If you are making a complaint because we denied your request for a “fast coverage decision” or a “fast appeal,” we will automatically give you a “fast complaint.”** If you have a “fast complaint,” it means we will give you **an answer within 24 hours.**
- **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 include our reasons in our response to you.

<b>Section 11.4</b>	<b>You can also make complaints about quality of care to the Quality Improvement Organization</b>
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When your complaint is about **quality of care**, you also have two extra options:

- **You can make your complaint directly to the Quality Improvement Organization.** The Quality Improvement Organization is a group of practicing doctors and other health care experts paid by the Federal government to check and improve the care given to Medicare patients. Chapter 2 has contact information.

*Or*

- **You can make your complaint to both the Quality Improvement Organization and us at the same time.**

<b>Section 11.5</b>	<b>You can also tell Medicare and Oregon Health Plan (Medicaid) about your complaint</b>
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You can submit a complaint about our plan directly to Medicare. To submit a complaint to Medicare, go to [www.medicare.gov/MedicareComplaintForm/home.aspx](http://www.medicare.gov/MedicareComplaintForm/home.aspx). You may also call 1-800-MEDICARE (1-800-633-4227). TTY/TDD users can call 1-877-486-2048.

The OHA Ombuds Program helps people enrolled in Oregon Health Plan (Medicaid) with complaints. They can help you file a complaint with our plan.

**Chapter 9 What to do if you have a problem or complaint (coverage decisions, appeals, complaints)**

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Method	OHA Ombuds Program – Contact Information
<b>CALL</b>	(800) 522-2602 Available 8:00 a.m. to 5:00 p.m., Monday through Friday.
<b>TTY</b>	711
<b>WRITE</b>	OHA Ombuds Program 500 Summer Street NE, E20 Salem, Oregon 97301
<b>WEBSITE</b>	<a href="http://www.oregon.gov/oha/ERD/Pages/Ombuds-Program.aspx">www.oregon.gov/oha/ERD/Pages/Ombuds-Program.aspx</a>

## CHAPTER 10:

*Ending your membership in the plan*

**Chapter 10 Ending your membership in the plan**

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**SECTION 1 Introduction to ending your membership in our plan**

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Ending your membership in our plan may be **voluntary** (your own choice) or **involuntary** (not your own choice):

- You might leave our plan because you have decided that you *want* to leave. Sections 2 and 3 provide information on ending your membership voluntarily.
- 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, our plan must continue to provide your medical care and prescription drugs and you will continue to pay your cost share until your membership ends.

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

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<b>Section 2.1</b>	<b>You may be able to end your membership because you have Medicare and Oregon Health Plan (Medicaid)</b>
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Most people with Medicare can end their membership only during certain times of the year. Because you have Oregon Health Plan (Medicaid), you may be able to end your membership in our plan or switch to a different plan one time during each of the following Special Enrollment Periods:

- January to March
- April to June
- July to September

If you joined our plan during one of these periods, you'll have to wait for the next period to end your membership or switch to a different plan. You can't use this Special Enrollment Period to end your membership in our plan between October and December. However, all people with Medicare can make changes from October 15 – December 7 during the Annual Enrollment Period. Section 2.2 tells you more about the Annual Enrollment Period.

- Choose any of the following types of Medicare plans:
  - Another Medicare health plan, with or without prescription drug coverage
  - Original Medicare *with* a separate Medicare prescription drug plan
  - Original Medicare without a separate Medicare prescription drug plan
    - If you choose this option, Medicare may enroll you in a drug plan, unless you have opted out of automatic enrollment.

**Chapter 10 Ending your membership in the plan**

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**Note:** If you disenroll from Medicare prescription drug coverage and go without “creditable” prescription drug coverage for a continuous period of 63 days or more, you may have to pay a Part D late enrollment penalty if you join a Medicare drug plan later.

Contact your State Oregon Health Plan (Medicaid) Office to learn about your Oregon Health Plan (Medicaid) plan options (telephone numbers are in Chapter 2, Section 6 of this document).

- **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 plans. Your enrollment in your new plan will also begin on this day.

<b>Section 2.2</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 Open Enrollment Period”). During this time, review your health and drug coverage and decide about coverage for the upcoming year.

- The **Annual Enrollment Period** is from **October 15 to December 7**.
- **Choose to keep your current coverage or make changes to your coverage for the upcoming year.** If you decide to change to a new plan, you can choose any of the following types of plans:
  - Another Medicare health plan, with or without prescription drug coverage.
  - Original Medicare *with* a separate Medicare prescription drug plan

OR

- Original Medicare *without* a separate Medicare prescription drug plan.
- **Your membership will end in our plan** when your new plan’s coverage begins on January 1.

**If you receive “Extra Help” from Medicare to pay for your prescription drugs:** If you switch to Original Medicare and do not enroll in a separate Medicare prescription drug plan, Medicare may enroll you in a drug plan, unless you have opted out of automatic enrollment.

**Note:** If you disenroll from Medicare prescription drug coverage and go without creditable prescription drug coverage for 63 days or more in a row, you may have to pay a Part D late enrollment penalty if you join a Medicare drug plan later.



**Section 2.3      You can end your membership during the Medicare Advantage Open Enrollment Period**

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

- **The annual Medicare Advantage Open Enrollment Period** is from January 1 to March 31.
- **During the annual Medicare Advantage Open Enrollment Period** you can:
  - Switch to another Medicare Advantage Plan with or without prescription drug coverage.
  - Disenroll from our plan and obtain coverage through Original Medicare. If you choose to switch to Original Medicare during this period, you can also join a separate Medicare prescription drug plan at that time.
- **Your membership will end** on the first day of the month after you enroll in a different Medicare Advantage plan or we get your request to switch to Original Medicare. If you also choose to enroll in a Medicare prescription drug plan, your membership in the drug plan will begin the first day of the month after the drug plan gets your enrollment request.

**Section 2.4      In certain situations, you can end your membership during a Special Enrollment Period**

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

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

- Usually, when you have moved.
- If you have Oregon Health Plan (Medicaid).
- If you are eligible for “Extra Help” with paying for your Medicare prescriptions.
- If we violate our contract with you.
- If you are getting care in an institution, such as a nursing home or long-term care (LTC) hospital.
- If you enroll in the Program of All-inclusive Care for the Elderly (PACE).

**Note:** If you’re in a drug management program, you may not be able

**Chapter 10 Ending your membership in the plan**

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to change plans. Chapter 5, Section 10 tells you more about drug management programs.

**Note:** Section 2.1 tells you more about the special enrollment period for people with Oregon Health Plan (Medicaid).

- **The enrollment time periods vary** depending on your situation.
- **To find out if you are eligible for a Special Enrollment Period**, please call Medicare at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users call 1-877-486-2048. If you are eligible to end your membership because of a special situation, you can choose to change both your Medicare health coverage and prescription drug coverage. You can choose:
  - Another Medicare health plan with or without prescription drug coverage.
    - Original Medicare *with* a separate Medicare prescription drug plan

OR

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

**Note:** If you disenroll from Medicare prescription drug coverage and go without creditable prescription drug coverage for 63 days or more in a row, you may have to pay a Part D late enrollment penalty if you join a Medicare drug plan later.

**If you receive “Extra Help” from Medicare to pay for your prescription drugs:** If you switch to Original Medicare and do not enroll in a separate Medicare prescription drug plan, Medicare may enroll you in a drug plan, unless you have opted out of automatic enrollment.

**Your membership will usually end** on the first day of the month after your request to change your plan is received.

**Note:** Sections 2.1 and 2.2 tell you more about the special enrollment period for people with Oregon Health Plan (Medicaid) and Extra Help.

<b>Section 2.5</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 about ending your membership you can:

- **Call Customer Service.**
- Find the information in the ***Medicare & You 2023*** handbook.
- Contact **Medicare** at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. (TTY 1-877-486-2048).

**Chapter 10 Ending your membership in the plan****SECTION 3      How do you end your membership in our plan?**

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

<b>If you would like to switch from our plan to:</b>	<b>This is what you should do:</b>
Another Medicare health plan	<ul style="list-style-type: none"> <li>• Enroll in the new Medicare health plan. Your new coverage will begin on the first day of the following month.</li> <li>• You will automatically be disenrolled from our plan when your new plan's coverage begins.</li> </ul>
Original Medicare <i>with</i> a separate Medicare prescription drug plan	<ul style="list-style-type: none"> <li>• Enroll in the new Medicare prescription drug plan. Your new coverage will begin on the first day of the following month.</li> <li>• You will automatically be disenrolled from our plan when your new plan's coverage begins.</li> </ul>
Original Medicare <i>without</i> a separate Medicare prescription drug plan <ul style="list-style-type: none"> <li>○ If you switch to Original Medicare and do not enroll in a separate Medicare prescription drug plan, Medicare may enroll you in a drug plan, unless you have opted out of automatic enrollment.</li> <li>○ If you disenroll from Medicare prescription drug coverage and go 63 days or more in a row without creditable prescription drug coverage, you may have to pay a late enrollment penalty if you join a Medicare drug plan later.</li> </ul>	<ul style="list-style-type: none"> <li>• <b>Send us a written request to disenroll.</b> Contact Customer Service if you need more information on how to do this.</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> <li>• You will be disenrolled from our plan when your coverage in Original Medicare begins.</li> </ul>

**Note:** If you disenroll from Medicare prescription drug coverage and go without creditable prescription drug coverage for 63 days or more in a row, you may have to pay a Part D late enrollment penalty if you join a Medicare drug plan later.

For questions about your Oregon Health Plan (Medicaid) benefits, contact Oregon Health Plan toll-free at (800) 699-9075, 8:00 a.m. to 5:00 p.m., Monday through Friday. TTY users should call 711. Ask how joining another plan or returning to Original Medicare affects how you get your Oregon Health Plan (Medicaid) coverage.

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

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Until your membership in our plan ends, and your new Medicare and Oregon Health Plan (Medicaid) coverage begins, you must continue to get your medical care and prescription drugs through our plan.

- **Continue to use our network providers to receive medical care.**
- **Continue to use our network pharmacies or mail order to get your prescriptions filled.**
- **If you are hospitalized on the day that your membership ends, your hospital stay will 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      Our plan 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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**Our plan must end your membership in the plan if any of the following happen:**

- If you no longer have Medicare Part A and Part B
- If you are no longer eligible for Oregon Health Plan (Medicaid). As stated in Chapter 1, Section 2.1, our plan is for people who are eligible for both Medicare and Oregon Health Plan (Medicaid). Please note: If you lose your eligibility but can reasonably be expected to regain eligibility within 3-month(s), then you are still eligible for membership in our plan (Chapter 4, Section 2.1 tells you about coverage and cost sharing during a period of deemed continued eligibility).
- If you move out of our service area
- If you are away from our service area for more than six months
  - If you move or take a long trip, call Customer Service to find out if the place you are moving or traveling to is in our plan's area.
- If you become incarcerated (go to prison)
- If you are no longer a United States citizen or lawfully present in the United States
- If you lie or withhold information about other insurance you have that provides prescription drug coverage

**Chapter 10 Ending your membership in the plan**

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- If you intentionally give us incorrect information when you are enrolling in our plan and that information affects your eligibility for our plan. (We cannot make you leave our plan for this reason unless we get permission from Medicare first.)
- If you continuously behave in a way that is disruptive and makes it difficult for us to provide medical care for you and other members of our plan. (We cannot make you leave our plan for this reason unless we get permission from Medicare first.)
- If you let someone else use your membership card to get medical care. (We cannot make you leave our plan for this reason unless we get permission from Medicare first.)
  - If we end your membership because of this reason, Medicare may have your case investigated by the Inspector General.
- If you are required to pay the extra Part D amount because of your income and you do not pay it, Medicare will disenroll you from our plan.

**Where can you get more information?**

If you have questions or would like more information on when we can end your membership call Customer Service.

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

Our plan is not allowed to ask you to leave our plan for any health-related reason.

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

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

If we end your membership in our plan, we must tell you our reasons in writing for ending your membership. We must also explain how you can file a grievance or make a complaint about our decision to end your membership.

# CHAPTER 11:

## *Legal notices*

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**SECTION 1 Notice about governing law**

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The principal law that applies to this *Evidence of Coverage* 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. This may affect your rights and responsibilities even if the laws are not included or explained in this document.

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**SECTION 2 Notice about nondiscrimination**

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**We don't discriminate** based on race, ethnicity, national origin, color, religion, sex, gender, age, sexual orientation, mental or physical disability, health status, claims experience, medical history, genetic information, evidence of insurability, or geographic location within the service area. 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, Section 1557 of the Affordable Care Act, all other laws that apply to organizations that get Federal funding, and any other laws and rules that apply for any other reason.

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** at 1-800-368-1019 (TTY 1-800-537-7697) or your local Office for Civil Rights. You can also review information from the Department of Health and Human Services' Office for Civil Rights at <https://www.hhs.gov/ocr/index>.

If you have a disability and need help with access to care, please call us at Customer Service. If you have a complaint, such as a problem with wheelchair access, Customer Service can help.

**Discrimination is Against the Law**

PacificSource Community Health Plans complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. PacificSource Community Health Plans does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

PacificSource Community Health Plans:

Provides free aids and services to people with disabilities to communicate effectively with us, such as:

- Qualified sign language interpreters
- Written information in other formats (large print, audio, accessible electronic formats, other formats)



**Chapter 11 Legal notices**

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Provides free language services to people whose primary language is not English, such as:

- Qualified interpreters
- Information written in other languages

If you need services, contact Customer Service at 888-863-3637 or, for TTY users, 711. We accept all relay calls.

- **October 1 – March 31:** 8:00 a.m. to 8:00 p.m. local time zone, seven days a week
- **April 1 – September 30:** 8:00 a.m. to 8:00 p.m. local time zone, Monday – Friday

If you believe that PacificSource Community Health Plans has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with: Civil Rights Coordinator, PO Box 7068, Springfield, OR 97475-0068, 888-977-9299, TTY 771, fax (541) 684-5264, or email [crc@pacificsource.com](mailto:crc@pacificsource.com). Please indicate you wish to file a civil rights grievance. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, our Customer Service Department is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at [OCRPortal.hhs.gov/ocr/portal/lobby.jsf](https://ocrportal.hhs.gov/ocr/portal/lobby.jsf), or by mail or phone at:

U.S. Department of Health and Human Services  
200 Independence Avenue, SW  
Room 509F, HHH Building  
Washington, D.C. 20201

800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at [HHS.gov/ocr/office/file/index.html](https://HHS.gov/ocr/office/file/index.html).

Arabic	PacificSource Community Health Plans، لكي تلفح ال اي ف لوص حلال ع ددعاس مالت امولعمالو ث تحلل عمج رتلص تائب 863-3637 (888). ن إن الكي دل وأب مل ص خش دهعلت قلئس أصوص كب ث لفلفذا يهؤو نم نب لغتك يفورولا ض
Cambodian-Mon-Khmer	បស្ចិមឫទ្ធិភាព បួន មុខកំរើជលអនកក់ពងដឹងជួយ មនុស្សណូ PacificSource Community Health Plans បេង, អនកមនុស្សណូពីចំណែកផ្ទៃក្នុងយ៉ាងណាម៉េច នន បេងដែកនិង សីវា របស់អនក បេងហាយមនុស្សអស់ប៉ុណ្ណាក៏។ បេងបេងបេងយាយ មួយអនកកដប សូម (888) 863-3637.
Chinese	如果您，或是您正在協助的對象，有關於[插入SBM 項目的名稱 PacificSource Community Health Plans 方面的問題，您 有權利免費以您的母語得到幫助和訊息。洽詢一位翻譯員，請撥電話[在此插入數字(888) 863-3637]
Cushite-Oromo	Isin yookan namni biraa isin deeggartan PacificSource Community Health Plans irratti gaaffii yo qabaattan, kaffaltii irraa bilisa haala ta'een afaan keessaniin odeeffannoo argachuu fi deeggarsa argachuuf mirga ni qabdu. Nama isiniif ibsu argachuuf, lakkoofsa bilbilaa (888) 863-3637 tiin bilbilaa.
French	Si vous, ou quelqu'un que vous êtes en train d'aider, a des questions à propos de PacificSource Community Health Plans, vous avez le droit d'obtenir de l'aide et l'information dans votre langue à aucun coût. Pour parler à un interprète, appelez (888) 863-3637.
German	Falls Sie oder jemand, dem Sie helfen, Fragen zum PacificSource Community Health Plans haben, haben Sie das Recht, kostenlose Hilfe und Informationen in Ihrer Sprache zu erhalten. Um mit einem Dolmetscher zu sprechen, rufen Sie bitte die Nummer (888) 863-3637 an.
Japanese	ご本人様、またはお客様の身の回りの方でもPacificSource Community Health Plansについてご質問がございましたら、ご希望の言語でサポートを受けたり、情報を入手したりすることができます。料金は かかりません。通訳とお話される場合、(888) 863-3637 までお電話ください。
Korean	만약 귀하 또는 귀하가 돕고 있는 어떤 사람이 PacificSource Community Health Plans 에 관해서 질문이 있다면 귀하는 그러한 도움과 정보를 귀하의 언어로 비용 부담없이 얻을 수 있는 권리가 있습니다. 그렇게 통역사와 얘기하기 위해서는 (888) 863-3637로 전화하십시오.
Persian-Farsi	م ، الوسرد دروم PacificSource Community Health Plans، ش هدیش اباق حنی ار دی رادکه کم ک بهروطنگی ار تف ایرداپی یذ.(888) 863-3637 س امتلص احی پی امن.گ ار اهش، ای س کی که امشه ویا کم کشینی وتاعلط ایهن ایزوخار
Romanian	Dacă dumneavoastră sau persoana pe care o asistați aveți întrebări privind PacificSource Community Health Plans, aveți dreptul de a obține gratuit ajutor și informații în limba dumneavoastră. Pentru a vorbi cu un interpret, sunați la (888) 863-3637.
Russian	Если у вас или лица, которому вы помогаете, имеются вопросы по поводу PacificSource Community Health Plans, то вы имеете право на бесплатное получение помощи и информации на вашем языке. Для разговора с переводчиком позвоните по телефону (888) 863-3637.
Spanish	Si usted, o alguien a quien usted está ayudando, tiene preguntas acerca de PacificSource Community Health Plans, tiene derecho a obtener ayuda e información en su idioma sin costo alguno. Para hablar con un intérprete, llame al (888) 863-3637.
Thai	หากคุณ หรือ คนที่ คุณ กำลังช่วยเหลื อมืค ถาถามเกือ ยวากนั PacificSource Community Health Plans คณอื สิทธอื ที่ีจะได้อรับความช่วยเหลอื และช่ออมลในภาษาของคุณได้อโดยไมอมีคาใช้อจ่าย พดคมุ กบลาม โทร (888) 863-3637.

**Chapter 11 Legal notices**

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Ukrainian	Якщо у Вас чи у когось, хто отримує Вашу допомогу, виникають питання про PacificSource Community Health Plans, у Вас є право отримати безкоштовну допомогу та інформацію на Вашій рідній мові. Щоб зв'язатись з перекладачем, задзвоніть на (888) 863-3637.
Vietnamese	Nếu quý vị, hay người mà quý vị đang giúp đỡ, có câu hỏi về PacificSource Community Health Plans, quý vị sẽ có quyền được giúp và có thêm thông tin bằng ngôn ngữ của mình miễn phí. Để nói chuyện với một thông dịch viên, xin gọi (888) 863-3637.

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### **SECTION 3      Notice about Medicare Secondary Payer subrogation rights**

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

## CHAPTER 12:

*Definitions of important words*

**Chapter 12 Definitions of important words**

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

**Annual Enrollment Period** – The time period of October 15 until December 7 of each year when members can change their health or drug plans or switch to Original Medicare.

**Appeal** – An appeal is something you do if you disagree with our decision to deny a request for coverage of health care services or prescription drugs or payment for services or drugs you already received. You may also make an appeal if you disagree with our decision to stop services that you are receiving.

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

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

**Catastrophic Coverage Stage** – The stage in the Part D Drug Benefit where you pay no copayment or coinsurance for your drugs after you or other qualified parties on your behalf have spent \$7,400 in covered drugs during the covered year.

**Centers for Medicare & Oregon Health Plan (Medicaid) Services (CMS)** – The Federal agency that administers Medicare.

**Coinsurance** – An amount you may be required to pay, expressed as a percentage (for example 20%) as your share of the cost for services or prescription drugs.

**Complaint** — The formal name for “making a complaint” is “filing a grievance.” The complaint process is used *only* for certain types of problems. This includes problems related to quality of care, waiting times, and the customer service you receive. It also includes complaints if your plan does not follow the time periods in the appeal process.

**Comprehensive Outpatient Rehabilitation Facility (CORF)** – A facility that mainly provides rehabilitation services after an illness or injury, including physical therapy, social or psychological services, respiratory therapy, occupational therapy and speech-language pathology services, and home environment evaluation services.

**Copayment (or “copay”)** – An amount you may be required to pay as your share of the cost for a medical service or supply, like a doctor’s visit, hospital outpatient visit, or a prescription drug. A copayment is a set amount (for example \$10), rather than a

**Chapter 12 Definitions of important words**

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percentage.

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

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

**Coverage Determination** – A decision about whether a drug prescribed for you is covered by the plan and the amount, if any, you are required to pay for the prescription. In general, if you bring your prescription to a pharmacy and the pharmacy tells you the prescription isn’t covered under your plan, that isn’t a coverage determination. You need to call or write to your plan to ask for a formal decision about the coverage. Coverage determinations are called “coverage decisions” in this document.

**Covered Drugs** – The term we use to mean all of the prescription drugs covered by our plan.

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

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

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

**Customer Service** – A department within our plan responsible for answering your questions about your membership, benefits, grievances, and appeals.

**Daily cost-sharing rate** – A “daily cost-sharing rate” may apply when your doctor prescribes less than a full month’s supply of certain drugs for you and you are required to pay a copayment. A daily cost-sharing rate is the copayment divided by the number of days in a month’s supply. Here is an example: If your copayment for a one-month supply of a drug is \$30, and a one-month’s supply in your plan is 30 days, then your “daily cost-sharing rate” is \$1 per day.

**Chapter 12 Definitions of important words**

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

**Disenroll or Disenrollment** – The process of ending your membership in our plan.

**Dispensing Fee** – A fee charged each time a covered drug is dispensed to pay for the cost of filling a prescription, such as the pharmacist's time to prepare and package the prescription.

**Dual Eligible Special Needs Plans (D-SNP)** – D-SNPs enroll individuals who are entitled to both Medicare (title XVIII of the Social Security Act) and medical assistance from a state plan under Oregon Health Plan (Medicaid) (title XIX). States cover some Medicare costs, depending on the state and the individual's eligibility.

**Dual Eligible Individual** – A person who qualifies for Medicare and Oregon Health Plan (Medicaid) coverage.

**Durable Medical Equipment (DME)** – Certain medical equipment that is ordered by your doctor for medical reasons. Examples include walkers, wheelchairs, crutches, powered mattress systems, diabetic supplies, IV infusion pumps, speech generating devices, oxygen equipment, nebulizers, or hospital beds ordered by a provider for use in the home.

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

**Emergency Care** – Covered services that are: (1) provided by a provider qualified to furnish emergency services; and (2) needed to treat, evaluate, or stabilize an emergency medical condition.

**Evidence of Coverage (EOC) and Disclosure Information** – This document, along with your enrollment form and any other attachments, riders, or other optional coverage selected, which explains your coverage, what we must do, your rights, and what you have to do as a member of our plan.

**Exception** – A type of coverage decision that, if approved, allows you to get a drug that is not on our formulary (a formulary exception), or get a non-preferred drug at a lower cost-sharing level (a tiering exception). You may also request an exception if our plan requires you to try another drug before receiving the drug you are requesting, or if our plan limits the quantity or dosage of the drug you are requesting (a formulary exception).

**Extra Help** – A Medicare or a State program to help people with limited income and resources pay Medicare prescription drug program costs, such as premiums, deductibles, and coinsurance.

**Generic Drug** – A prescription drug that is approved by the Food and Drug



**Chapter 12 Definitions of important words**

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Administration (FDA) as having the same active ingredient(s) as the brand name drug. Generally, a “generic” drug works the same as a brand name drug and usually costs less.

**Home Health Aide** – A person who provides services that do not 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).

**Hospice** – A benefit that provides special treatment for a member who has been medically certified as terminally ill, meaning having a life expectancy of 6 months or less. We, your plan, must provide you with a list of hospices in your geographic area. If you elect hospice and continue to pay premiums you are still a member of our plan. You can still obtain all medically necessary services as well as the supplemental benefits we offer.

**Hospital Inpatient Stay** – A hospital stay when you have been formally admitted to the hospital for skilled medical services. Even if you stay in the hospital overnight, you might still be considered an “outpatient.”

**Income Related Monthly Adjustment Amount (IRMAA)** –If your modified adjusted gross income as reported on your IRS tax return from 2 years ago is above a certain amount, you’ll pay the standard premium amount and an Income Related Monthly Adjustment Amount, also known as IRMAA. IRMAA is an extra charge added to your premium. Less than 5% of people with Medicare are affected, so most people will not pay a higher premium.

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

**Initial Coverage Stage** – This is the stage before your total drug costs including amounts you have paid and what your plan has paid on your behalf for the year have reached \$7,400.

**Initial Enrollment Period** – When you are first eligible for Medicare, the period of time when you can sign up for Medicare Part A and Part B. If you’re eligible for Medicare when you turn 65, your Initial Enrollment Period is the 7-month period that begins 3 months before the month you turn 65, includes the month you turn 65, and ends 3 months after the month you turn 65.

**In-Network Pharmacy** –A pharmacy that contracts with our plan where members of our plan can get their prescription drug benefits. In most cases, your prescriptions are covered only if they are filled at one of our in-network pharmacies.

**In-Network Provider** – “Provider” is the general term 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. “**In-Network providers**” 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. In-network providers are also called “plan providers.”

**Chapter 12 Definitions of important words**

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**Institutional Special Needs Plan (SNP)** – A plan that enrolls eligible individuals who continuously reside or are expected to continuously reside for 90 days or longer in a long-term care (LTC) facility. These facilities may include a skilled nursing facility (SNF), nursing facility (NF), (SNF/NF), an Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID), an inpatient psychiatric facility, and/or facilities approved by CMS that furnishes similar long-term, healthcare services that are covered under Medicare Part A, Medicare Part B, or Oregon Health Plan (Medicaid); and whose residents have similar needs and healthcare status to the other named facility types. An institutional Special Needs Plan must have a contractual arrangement with (or own and operate) the specific LTC facility(ies).

**Institutional Equivalent Special Needs Plan (SNP)** – A plan that enrolls eligible individuals living in the community but requiring an institutional level of care based on the State assessment. The assessment must be performed using the same respective State level of care assessment tool and administered by an entity other than the organization offering the plan. This type of Special Needs Plan may restrict enrollment to individuals that reside in a contracted assisted living facility (ALF) if necessary to ensure uniform delivery of specialized care.

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

**Integrated Organization Determination** – A decision our plan makes about whether items or services are covered or how much you have to pay for covered items or services. Organization determinations are called “coverage decisions” in this document.

**List of Covered Drugs (Formulary or “Drug List”)** – A list of prescription drugs covered by the plan.

**Low Income Subsidy (LIS)** – See “Extra Help.”

**Maximum Out-of-Pocket Amount** – The most that you pay out-of-pocket during the calendar year for covered Part A and Part B services. Amounts you pay for your prescription drugs do not count toward the maximum out-of-pocket amount. (**Note:** Because our members also get assistance from Oregon Health Plan (Medicaid), very few members ever reach this out-of-pocket maximum.)

**Medically Accepted Indication** – A use of a drug that is either approved by the Food and Drug Administration or supported by certain reference books.

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

**Medicare** – The Federal health insurance program for people 65 years of age or older, some people under age 65 with certain disabilities, and people with End-Stage Renal Disease (generally those with permanent kidney failure who need dialysis or a kidney transplant).

**Chapter 12 Definitions of important words**

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**Medicare Advantage Open Enrollment Period** – The time period from January 1 until March 31 when members in a Medicare Advantage plan can cancel their plan enrollment and switch to another Medicare Advantage plan, or obtain coverage through Original Medicare. If you choose to switch to Original Medicare during this period, you can also join a separate Medicare prescription drug plan at that time. The Medicare Advantage Open Enrollment Period is also available for a 3-month period after an individual is first eligible for Medicare.

**Medicare Advantage (MA) Plan** – Sometimes called Medicare Part C. A plan offered by a private company that contracts with Medicare to provide you with all your Medicare Part A and Part B benefits. A Medicare Advantage Plan can be an i) HMO, ii) PPO, a iii) Private Fee-for-Service (PFFS) plan, or a iv) Medicare Medical Savings Account (MSA) plan. Besides choosing from these types of plans, a Medicare Advantage HMO or PPO plan can also be a Special Needs Plan (SNP). 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**.

**Medicare Coverage Gap Discount Program** – A program that provides discounts on most covered Part D brand name drugs to Part D members who have reached the Coverage Gap Stage and who are not already receiving “Extra Help.” Discounts are based on agreements between the Federal government and certain drug manufacturers.

**Medicare-Covered Services** – Services covered by Medicare Part A and Part B. All Medicare health plans must cover all of the services that are covered by Medicare Part A and B. The term Medicare-Covered Services does not include the extra benefits, such as vision, dental, or hearing, that a Medicare Advantage plan may offer.

**Medicare Health Plan** – A Medicare health plan is offered by a private company that contracts with Medicare to provide Part A and Part B benefits to people with Medicare who enroll in the plan. This term includes all Medicare Advantage Plans, Medicare Cost Plans, Special Needs Plans, Demonstration/Pilot Programs, and Programs of All-inclusive Care for the Elderly (PACE).

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

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

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

**Chapter 12 Definitions of important words**

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**Oregon Health 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. State Oregon Health Plan (Medicaid) programs vary, but most health care costs are covered if you qualify for both Medicare and Oregon Health Plan (Medicaid).

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

**Out-of-Network Pharmacy** – A pharmacy that does not have a contract with our plan to coordinate or provide covered drugs to members of our plan. Most drugs you get from out-of-network pharmacies are not covered by our plan unless certain conditions apply.

**Out-of-Network Provider or Out-of-Network Facility** – A provider or facility that does not have a contract with our plan 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.

**Out-of-Pocket Costs** – See the definition for “cost sharing” above. A member’s cost-sharing requirement to pay for a portion of services or drugs received is also referred to as the member’s “out-of-pocket” cost requirement.

**PACE plan** – A PACE (Program of All-Inclusive Care for the Elderly) plan combines medical, social, and long-term care (LTC) services for frail people to help people stay independent and living in their community (instead of moving to a nursing home) as long as possible. People enrolled in PACE plans receive both their Medicare and Oregon Health Plan (Medicaid) benefits through the plan.

**Part C** – see “Medicare Advantage (MA) Plan.”

**Part D** – The voluntary Medicare Prescription Drug Benefit Program.

**Part D Drugs** – Drugs that can be covered under Part D. We may or may not offer all Part D drugs. Certain categories of drugs have been excluded from Part D coverage by Congress. Certain categories of Part D drugs must be covered by every plan.

**Part D Late Enrollment Penalty** – An amount added to your monthly premium for Medicare drug coverage if you go without creditable coverage (coverage that is expected to pay, on average, at least as much as standard Medicare prescription drug coverage) for a continuous period of 63 days or more after you are first eligible to join a Part D plan. If you lose Extra Help, you may be subject to the late enrollment penalty if you go 63 days or more in a row without Part D or other creditable prescription drug coverage.

**Chapter 12 Definitions of important words**

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

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

**Primary Care Provider (PCP)** – The doctor or other provider you see first for most health problems. In many Medicare health plans, you must see your primary care provider before you see any other health care provider.

**Prior Authorization** – Approval in advance to get services or certain drugs. Covered services that need prior authorization are marked in the Medical Benefits Chart in Chapter 4. Covered drugs that need prior authorization are marked in the formulary.

**Prosthetics and Orthotics** – Medical devices including, but not limited to, arm, back, and neck braces; artificial limbs; artificial eyes; and devices needed to replace an internal body part or function, including ostomy supplies and enteral and parenteral nutrition therapy.

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

**Quantity Limits** – A management tool that is designed to limit the use of selected drugs for quality, safety, or utilization reasons. Limits may be on the amount of the drug that we cover per prescription or for a defined period of time.

**Rehabilitation Services** – These services include physical therapy, speech and language therapy, and occupational therapy.

**Service Area** – A geographic area where you must live to join a particular health plan. For plans that limit which doctors and hospitals you may use, it's also generally the area where you can get routine (non-emergency) services. The plan must disenroll you if you permanently move out of the plan's service area.

**Skilled Nursing Facility (SNF) Care** – Skilled nursing care and rehabilitation services provided on a continuous, daily basis, in a skilled nursing facility. Examples of care include physical therapy or intravenous injections that can only be given by a registered nurse or doctor.

**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 Oregon Health Plan (Medicaid), who reside in a nursing home, or who

**Chapter 12 Definitions of important words**

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have certain chronic medical conditions.

**Step Therapy** – A utilization tool that requires you to first try another drug to treat your medical condition before we will cover the drug your physician may have initially prescribed.

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

**Urgently Needed Services** – Covered services that are not emergency services, provided when the network providers are temporarily unavailable or inaccessible or when the enrollee is out of the service area. For example, you need immediate care during the weekend. Services must be immediately needed and medically necessary.



## PacificSource Medicare Customer Service

Method	Customer Service – Contact Information
<b>CALL</b>	<p>888-863-3637</p> <p>Calls to this number are free. Hours are: <b>October 1 – March 31:</b> 8:00 a.m. to 8:00 p.m. local time zone, seven days a week. <b>April 1 – September 30:</b> 8:00 a.m. to 8:00 p.m. local time zone, Monday – Friday.</p> <p>During this time of the year, please leave a message on weekends, holidays, and after hours. We will return your call the next business day.</p> <p>Customer Service also has free language interpreter services available for non-English speakers.</p>
<b>TTY</b>	<p>711. We accept all relay calls</p> <p>This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.</p> <p>Calls to this number are free. Hours are: <b>October 1 – March 31:</b> 8:00 a.m. to 8:00 p.m. local time zone, seven days a week. <b>April 1 – September 30:</b> 8:00 a.m. to 8:00 p.m. local time zone, Monday – Friday.</p>
<b>FAX</b>	541-322-6423
<b>WRITE</b>	<p>PacificSource Medicare Customer Service Department PO Box 7469 Bend, Oregon 97708 MedicareCS@PacificSource.com</p>
<b>WEBSITE</b>	<a href="http://www.Medicare.PacificSource.com">www.Medicare.PacificSource.com</a>

## Senior Health Insurance Benefits Assistance (Oregon SHIP)

Senior Health Insurance Benefits Assistance is a state program that gets money from the Federal government to give free local health insurance counseling to people with Medicare.



**Chapter 12 Definitions of important words**

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Method	Senior Health Insurance Benefits Assistance (Oregon SHIP) – Contact Information
<b>CALL</b>	800-722-4134
<b>TTY</b>	711  This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.
<b>WRITE</b>	Senior Health Insurance Benefits Assistance 500 Summer St. NE, E-12 Salem, OR 97301
<b>WEBSITE</b>	<a href="http://www.OregonShiba.org">www.OregonShiba.org</a>

**PRA Disclosure Statement** According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1051. If you have comments or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.