PacificSource Medicare

PacificSource Community Health Plans
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January 1 – December 31, 2027

Evidence of Coverage for 2027:

Your Medicare Health Benefits and Services as a Member of PacificSource Medicare Oregon Basic (HMO-POS)

This document gives the details of your Medicare health coverage from January 1 – December 31, 2027. **This is an important legal document. Keep it in a safe place.**

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

- Your plan premium and cost sharing
- Your medical benefits
- How to file a complaint if you're not satisfied with a service or treatment
- How to contact us
- Other protections required by Medicare law

For questions about this document, call Customer Service at 888-863-3637 (TTY users call 711). Hours are Oct. 1 – Mar. 31: 8:00 a.m. to 8:00 p.m. local time zone, seven days a week. Apr. 1 – Sept. 30: 8:00 a.m. to 8:00 p.m. local time zone, Monday – Friday. This call is free.

This plan, PacificSource Medicare Oregon Basic (HMO-POS), 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 Medicare Oregon Basic (HMO-POS).)

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

Benefits and/or copays/coinsurance may change on January 1, 2027.

Our provider network may change at any time. You'll get notice about any changes that may affect you at least 30 days in advance.

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CHAPTER 1:

Get started as a member

SECTION 1 You're a member of our plan

Section 1.1 You're enrolled in our plan, which is a Medicare HMO Point-of-Service plan

You're covered by Medicare, and you chose to get your Medicare health coverage through our plan, PacificSource Medicare Oregon Basic (HMO-POS). Our plan covers all Part A and Part B services. However, cost sharing and provider access in this plan are different from Original Medicare.

PacificSource Medicare Oregon Basic (HMO-POS) is a Medicare Advantage HMO Plan (HMO stands for Health Maintenance Organization) with a Point-of-Service (POS) option approved by Medicare and run by a private company. Point-of-Service means you can use providers outside our plan's network for an additional cost. (Go to Chapter 3, Section 2.4 for information about using the Point-of-Service option.) This plan *doesn't* include Part D drug coverage.

Section 1.2 Legal information about the *Evidence of Coverage*

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 and any notices you get 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 the months you're enrolled in our plan between January 1, 2027, and December 31, 2027.

Medicare allows us to make changes to plans we offer each calendar year. This means we can change the costs and benefits of our plan after December 31, 2027. We can also choose to stop offering our plan in your service area, after December 31, 2027.

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

SECTION 2 Plan eligibility requirements

Section 2.1 Eligibility requirements

You're eligible for membership in our plan as long as you meet all these conditions:

- You have both Medicare Part A and Medicare Part B
- You live in our geographic service area (described in Section 2.2). People who are incarcerated aren't considered to be living in the geographic service area, even if

they're physically located in it

- You're a United States citizen or national, or an eligible noncitizen.

Section 2.2 Plan service area for our plan

PacificSource Medicare Oregon Basic (HMO-POS) is only available to people who live in our plan service area. To stay a member of our plan, you must continue to live in our plan service area. The service area is described below.

Our service area includes these counties in Oregon: Crook, Deschutes, Hood River, Jefferson, Lane, Sherman, and Wasco.
Our service area includes these parts of counties in Oregon: Klamath, the following zip codes only 97731, 97733, 97737, and 97739.

If you move out of our plan's service area, you can't stay a member of this plan. Call Customer Service at 888-863-3637 (TTY users call 711) to see if we have a plan in your new area. When you move, you'll have a Special Enrollment Period to either switch to Original Medicare or enroll in a Medicare health plan in your new location.

If you move or change your mailing address, it's also important to call Social Security. Call Social Security at 1-800-772-1213 (TTY users call 1-800-325-0778).

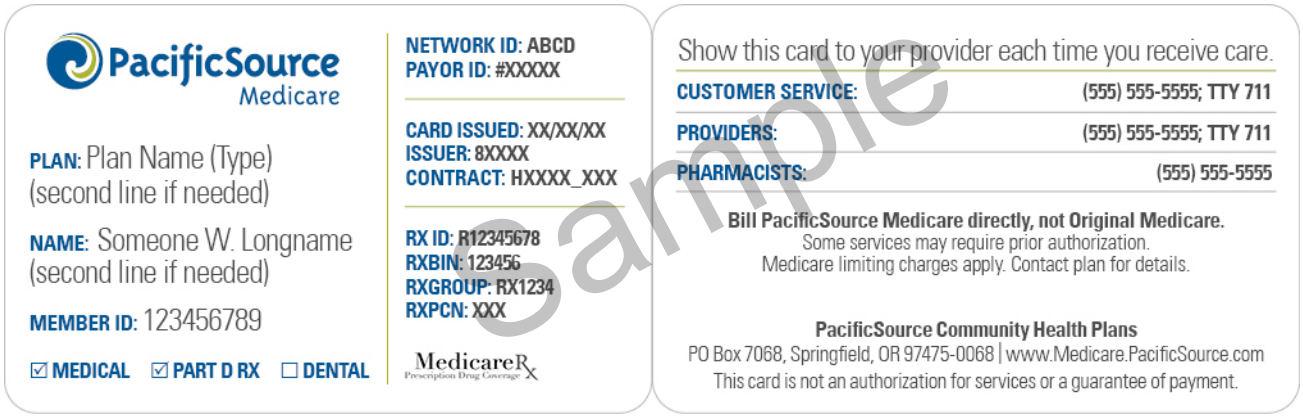
Section 2.3 U.S. citizen or national, or eligible noncitizen

You must be a U.S. citizen or national, or an eligible noncitizen to be a member of a Medicare health plan. Medicare (the Centers for Medicare & Medicaid Services) will notify our plan if you're not eligible to stay a member of our plan on this basis. Our plan must disenroll you if you don't meet this requirement.

SECTION 3 Important membership material

Section 3.1 Our plan membership card

Use your membership card whenever you get services covered by our plan. You should also show the provider your Medicaid card, if you have one. Sample membership card:



DON'T use your red, white and blue Medicare card for covered medical services while you're 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 our plan membership card is damaged, lost, or stolen, call Customer Service at 888-863-3637 (TTY users call 711) right away and we'll send you a new card.

Section 3.2 Provider Directory

The *Provider Directory* Medicare.PacificSource.com/Search/Provider lists our current 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 network providers to get your medical care and services. If you go elsewhere without proper authorization, you'll have to pay in full. The only exceptions are emergencies, urgently needed services when the network isn't available (that is, situations where it's unreasonable or not possible to get services in-network), out-of-area dialysis services, and cases when our plan authorizes use of out-of-network providers.

Our plan is a Medicare Advantage Health Maintenance Organization (HMO) with a Point-of-Service option (POS), which means you may choose to receive some covered services from out-of-network providers. Our plan covers up to $3,000 per plan year for covered services you receive from out-of-network providers. After the plan has paid $3,000 for covered out-of-network services, you pay the full cost of any additional out-of-network services you receive. See Chapter 3 (Using the plan's coverage for your medical services) for more specific information.

If you don't have a *Provider Directory*, you can ask for a copy (electronically or in paper form) from Customer Service at 888-863-3637 (TTY users call 711). Requested paper *Provider Directories* will be mailed to you within 3 business days.

SECTION 4 Summary of Important Costs for 2027

	Your Costs in 2027
Monthly plan premium* * Your premium can be higher than this amount. Go to Section 4.1 for details.	**$0**
Maximum out-of-pocket amount This is the most you'll pay out-of-pocket for covered Part A and Part B services. (Go to Chapter 4 Section 1 for details.)	**From in-network providers: $6,250** **From out-of-network providers: No limit**
Primary care office visits	**In-Network: $0 copay per visit** **Out-of-Network: $45 copay per visit**

	Your Costs in 2027
Specialist office visits	**In-Network: $20 copay per visit** **Out-of-Network: $45 copay per visit**
Inpatient hospital stays Includes various inpatient hospital stays such as acute care rehabilitation and long-term care. An inpatient hospital stay starts the day you're formally admitted with a doctor's order and ends the day before you're discharged.	**In-Network: Days 1-5:** **$450 copay per day** **Days 6+:** **$0 copay per day** **Cost sharing is charged for each inpatient stay.** **Out-of-Network: 50% coinsurance**

Your costs may include the following:

- Plan Premium (Section 4.1)
- Monthly Medicare Part B Premium (Section 4.2)

Section 4.1 Plan premium

You don't pay a separate monthly plan premium for PacificSource Medicare Oregon Basic (HMO-POS).

Medicare Part B premiums differ for people with different incomes. If you have questions about these premiums, check your copy of the *Medicare & You 2027* handbook in the section called *2027 Medicare Costs*. Download a copy from the Medicare website (Medicare.gov/medicare-and-you) or order a printed copy by phone at 1-800-MEDICARE (1-800-633-4227), TTY users call 1-877-486-2048.

Section 4.2 Monthly Medicare Part B Premium

Many members are required to pay other Medicare premiums.

You must continue paying your Medicare premiums to stay a member of our plan. This includes your premium for Part B. You may also pay a premium for Part A, if you aren't eligible for premium-free Part A.

SECTION 5 More information about your monthly plan premium

Section 5.1 Your monthly plan premium won't change during the year

We're not allowed to change your plan's monthly plan premium amount during the year. If the monthly plan premium changes for next year, we'll tell you in September and the new premium will take effect on January 1.

SECTION 6 Keep your plan membership record up to date

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

The doctors, hospitals, and other providers in your plan's network **use your membership record to know what services are covered and your cost-sharing amounts**. Because of this, it's very important to help us keep your information up to date.

If you have any of these changes, let us know:

- Changes to your name, address, or phone number
- Changes in any other health coverage you have (such as from your employer, your spouse or domestic partner's employer, workers' compensation, or Medicaid)
- Any liability claims, such as claims from an automobile accident
- If you're admitted to a nursing home
- If you get 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 participate in a clinical research study (**Note:** You're not required to tell our plan about clinical research studies you intend to participate in, but we encourage you to do so.)

If any of this information changes, let us know by calling Customer Service at 888-863-3637 (TTY users call 711).

It's also important to contact Social Security if you move or change your mailing address. Call Social Security at 1-800-772-1213 (TTY users call 1-800-325-0778).

SECTION 7 How other insurance works with our plan

Medicare requires us to collect information about any other medical or drug coverage you have so we can coordinate any other coverage with your benefits under our plan. This is called **Coordination of Benefits.**

Once a year, we'll send you a letter that lists any other medical or drug coverage we know about. Read this information carefully. If it's correct, you don't need to do anything. If the information isn't correct, or if you have other coverage that's not listed, call Customer Service at 888-863-3637 (TTY users call 711). You may need to give our plan member ID number to your other insurers (once you confirm their identity) so your bills are paid correctly and on time.

When you have other insurance (like employer group health coverage), Medicare rules decide whether our plan or your other insurance pays first. The insurance that pays first ("the primary payer") pays up to the limits of its coverage. The insurance that pays second ("the secondary payer") only pays if there are costs left uncovered by the primary coverage. The secondary payer may not pay 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) are 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 has more than 100 employees.
    - If you're over 65 and you (or your spouse or domestic partner) are 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 has more than 20 employees.
- If you have Medicare because of ESRD, your group health plan will pay first for the first 30 months after you become eligible for Medicare.

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

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

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

CHAPTER 2:

Phone numbers and resources

SECTION 1 Our plan contacts

For help with claims, billing, or member card questions, call or write to our plan. We'll be happy to help you.

Customer Service – Contact Information	
Call	888-863-3637 Calls to this number are free. Hours are: **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. • During this time of the year, please leave a message on weekends, holidays, and after hours. We will return your call the next business day. Customer Service 888-863-3637 (TTY users call 711) also has free language interpreter services for non-English speakers.
TTY	711. We accept all relay calls. This number requires special telephone equipment and is only for people who have difficulties hearing or speaking. Calls to this number are free. Hours are: **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.
Fax	541-322-6423
Write	PacificSource Medicare Customer Service Department PO Box 7469 Bend, Oregon 97708 MedicareCS@PacificSource.com
Website	Medicare.PacificSource.com

How to ask 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 pay for your medical services. An appeal is a formal way of asking us to review and change a coverage decision. For more information on how to ask for coverage decisions or appeals about your medical care, go to Chapter 7.

Coverage Decisions for Medical Care – Contact Information	
Call	888-863-3637 Calls to this number are free. Hours are: **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.
TTY	711. We accept all relay calls. This number requires special telephone equipment and is only for people who have difficulties hearing or speaking. Calls to this number are free. Hours are: **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.
Fax	541-322-6423
Write	PacificSource Medicare Attn: Health Services PO Box 7469 Bend, Oregon 97708 MedicareCS@PacificSource.com
Website	Medicare.PacificSource.com

Appeals for Medical Care – Contact Information	
Call	888-863-3637 Calls to this number are free. Hours are: **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. For access to our 24-hour line for an expedited appeal call 888-863-3637.

Appeals for Medical Care – Contact Information	
TTY	711. We accept all relay calls. This number requires special telephone equipment and is only for people who have difficulties hearing or speaking. Calls to this number are free. Hours are: **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.
Fax	541-322-6424
Write	PacificSource Medicare Attn: Grievance and Appeals Department PO Box 7469 Bend, Oregon 97708 MedicareCS@PacificSource.com
Website	Medicare.PacificSource.com

How to make a complaint about your medical care

You can make a complaint about us or one of our network providers, including a complaint about the quality of your care. This type of complaint doesn't involve coverage or payment disputes. For more information on how to make a complaint about your medical care, go to Chapter 7.

Complaints about Medical Care – Contact Information	
Call	888-863-3637 Calls to this number are free. Hours are: **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. For access to our 24-hour line for an expedited grievance call 888-863-3637.
TTY	711. We accept all relay calls. This number requires special telephone equipment and is only for people who have difficulties hearing or speaking. Calls to this number are free. Hours are: **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.

Complaints about Medical Care – Contact Information	
Fax	541-322-6424
Write	PacificSource Medicare Attn: Grievance and Appeals Department PO Box 7469 Bend, Oregon 97708 MedicareCS@PacificSource.com
Website	Medicare.PacificSource.com
Medicare website	To submit a complaint about our plan directly to Medicare, go to Medicare.gov/my/medicare-complaint.

How to ask us to pay our share of the cost for medical care you got

If you got a bill or paid for services (like a provider bill) you think we should pay for, you may need to ask us for reimbursement or to pay the provider bill. Go to Chapter 5 for more information.

If you send us a payment request and we deny any part of your request, you can appeal our decision. Go to Chapter 7 for more information.

Payment Requests – Contact Information	
Call	888-863-3637 Calls to this number are free. Hours are: **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.
TTY	711. We accept all relay calls. This number requires special telephone equipment and is only for people who have difficulties hearing or speaking. Calls to this number are free. Hours are: **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.
Fax	541-322-6423
Write	PacificSource Medicare Attn: Claims Department PO Box 7469 Bend, Oregon 97708 MedicareCS@PacificSource.com
Website	Medicare.PacificSource.com

SECTION 2 Get help from Medicare

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 (CMS). This agency contracts with Medicare Advantage organizations including our plan.

Medicare – Contact Information	
Call	1-800-MEDICARE (1-800-633-4227) Calls to this number are free. 24 hours a day, 7 days a week.
TTY	1-877-486-2048 This number requires special telephone equipment and is only for people who have difficulties hearing or speaking. Calls to this number are free.
Chat Live	Chat live at Medicare.gov/talk-to-someone.
Write	Write to Medicare at PO Box 1270, Lawrence, KS 66044
Website	Medicare.gov • Get information about the Medicare health and drug plans in your area, including what they cost and what services they provide. • Find Medicare-participating doctors or other health care providers and suppliers. • Find out what Medicare covers, including preventive services (like screenings, shots or vaccines, and yearly “Wellness” visits). • Get Medicare appeals information and forms. • Get information about the quality of care provided by plans, nursing homes, hospitals, doctors, home health agencies, dialysis facilities, hospice centers, inpatient rehabilitation facilities, and long-term care hospitals. • Look up helpful websites and phone numbers. You can also visit Medicare.gov to tell Medicare about any complaints you have about our plan. **To submit a complaint to Medicare,** go to Medicare.gov/my/medicare-complaint. Medicare takes your complaints seriously and will use this information to help improve the quality of the Medicare program.

SECTION 3 State Health Insurance Assistance Program (SHIP)

The State Health Insurance Assistance Program (SHIP) is a government program with trained counselors in every state that offers free help, information, and answers to your Medicare questions. In Oregon, the SHIP is called Senior Health Insurance Benefits Assistance.

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

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

Senior Health Insurance Benefits Assistance (Oregon SHIP) – Contact Information	
Call	800-722-4134
TTY	711 This number requires special telephone equipment and is only for people who have difficulties hearing or speaking.
Write	Senior Health Insurance Benefits Assistance 500 Summer St. NE, E-12 Salem, OR 97301
Website	shiba.oregon.gov

SECTION 4 Quality Improvement Organization (QIO)

A designated Quality Improvement Organization (QIO) serves people with Medicare in each state. For Oregon, the Quality Improvement Organization is called Acentra Health.

Acentra Health 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. Acentra Health is an independent organization. It's not connected with our plan.

Contact Acentra Health in any of these situations:

- You have a complaint about the quality of care you got. Examples of quality-of-care concerns include getting the wrong medication, unnecessary tests or procedures, or a misdiagnosis.
- 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 is ending too soon.

Acentra Health (Oregon's Quality Improvement Organization) - Contact Information	
Call	888-305-6759 Available 9:00 a.m. to 5:00 p.m., Monday through Friday. Available on weekends and holidays from 10:00 a.m. to 4:00 p.m.
TTY	711 This number requires special telephone equipment and is only for people who have difficulties hearing or speaking.
Write	Acentra 5201 West Kennedy Blvd., Suite 900 Tampa, FL 33609
Website	acentraqio.com

SECTION 5 Social Security

Social Security determines Medicare eligibility and handles Medicare enrollment.

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

Social Security - Contact Information	
Call	1-800-772-1213 Calls to this number are free. Available 8 am to 7 pm, Monday through Friday. Use Social Security's automated telephone services to get recorded information and conduct some business 24 hours a day.
TTY	1-800-325-0778 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free. Available 8 am to 7 pm, Monday through Friday.
Website	SSA.gov

SECTION 6 Medicaid

Medicaid is a joint federal and state government program that helps with medical costs for certain people with limited incomes and resources. Some people with Medicare are also eligible for Medicaid. Medicaid offers programs to help people with Medicare pay their Medicare costs, such as their Medicare premiums. These **Medicare Savings Programs** include:

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

To find out more about Medicaid and Medicare Savings Programs, contact the Oregon Health Authority.

Oregon Health Authority - Contact Information	
Call	800-699-9075 Available 8:00 a.m. to 5:00 p.m., Monday through Friday.
TTY	711 This number requires special telephone equipment and is only for people who have difficulties hearing or speaking.
Write	Oregon Health Authority 500 Summer Street NE Salem, Oregon 97301
Website	oregon.gov/oha

SECTION 7 Railroad Retirement Board (RRB)

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 get Medicare through the Railroad Retirement Board, let them know if you move or change your mailing address. For questions about your benefits from the Railroad Retirement Board, contact the agency.

Railroad Retirement Board (RRB) – Contact Information	
Call	1-877-772-5772 Calls to this number are free. Press "0" to speak with an RRB representative from 9 am to 3:30 pm, Monday, Tuesday, Thursday, and Friday, and from 9 am to 12 pm on Wednesday. Press "1" to access the automated RRB HelpLine and get recorded information 24 hours a day, including weekends and holidays.

Railroad Retirement Board (RRB) – Contact Information	
TTY	1-312-751-4701 This number requires special telephone equipment and is only for people who have difficulties hearing or speaking. Calls to this number aren't free.
Website	https://RRB.gov

SECTION 8 If you have group insurance or other health insurance from an employer

If you (or your spouse or domestic partner) get benefits from your (or your spouse or domestic partner's) employer or retiree group as part of this plan, call the employer/union benefits administrator or Customer Service at 888-863-3637 (TTY users call 711) with any questions. You can ask about your (or your spouse or domestic partner's) employer or retiree health benefits, premiums, or the enrollment period. You can call 1-800-MEDICARE (1-800-633-4227) with questions about your Medicare coverage under this plan. TTY users call 1-877-486-2048.

CHAPTER 3:

Using our plan for your medical services

SECTION 1 How to get medical care as a member of our plan

This chapter explains what you need to know about using our plan to get your medical care covered.

For details on what medical care our plan covers and how much you pay when you get care, go to the Medical Benefits Chart in Chapter 4.

Section 1.1 Network providers and covered services

- **Providers** are doctors and other health care professionals licensed by the state to provide medical services and care. The term "providers" also includes hospitals and other health care facilities.
- **Network providers** are the doctors and other health care professionals, medical groups, hospitals, and other health care facilities that have an agreement with us to accept our payment and your cost-sharing amount as payment in full. We 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 a network provider, you pay only your share of the cost for their services.
- **Covered services** include all the medical care, health care services, supplies, and equipment that are covered by our plan. Your covered services for medical care are listed in the Medical Benefits Chart in Chapter 4.

Section 1.2 Basic rules for your medical care to be covered by our plan

As a Medicare health plan, our plan must cover all services covered by Original Medicare and follow Original Medicare's coverage rules.

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

- **The care you get is included in our plan's Medical Benefits Chart** in Chapter 4.
- **The care you get 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 may get your care from an in-network or out-of-network provider** (go to Section 2). In most cases, care you get from an out-of-network provider (a provider who's not part of our plan's network) may cost more. This means you have to pay a higher cost share for out-of-network services you get. *Here are 3 exceptions:*

- Our plan covers emergency or urgently needed services you get from an out-of-network provider. For more information and to see what emergency or urgently needed services are, go to Section 3.
- If you need medical care that Medicare 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 get prior authorization from our plan. In this situation, you pay the same as you pay if you got the care from a network provider. For information about getting approval to see an out-of-network doctor, go to Section 2.4.
- Our plan covers kidney dialysis services you get at a Medicare-certified dialysis facility when you're temporarily outside our plan's service area or when your provider for this service is temporarily unavailable or inaccessible. The cost sharing you pay our plan for dialysis can never be higher than the cost sharing in Original Medicare. If you're outside our plan's service area and get dialysis from a provider outside our plan's network, your cost sharing can't be higher than the cost sharing you pay in-network. However, if your usual in-network provider for dialysis is temporarily unavailable and you choose to get services inside our service area from a provider outside our plan's network, your cost sharing for the dialysis may be higher.

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

Section 2.1 You must choose a Primary Care Provider (PCP) to provide and oversee your medical care

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

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. PCPs can be selected from the following specialties:

- Family Practice
- 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 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 to choose a PCP?

As a member of our plan, you are not required to select a PCP, however we encourage you to select a provider designated as a PCP within our *Provider Directory.* Please call Customer Service (phone numbers are printed on the back cover of this document) or visit 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.

How to change your PCP

You can change your PCP for any reason, at any time. It's also possible that your PCP might leave our plan's network of providers, and you'd need to choose a new PCP or you'll pay more for covered services.

To change your PCP, please call or email Customer Service (phone numbers and email address are printed on the back cover of this document) 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.

Section 2.2 How to get care from specialists and other network providers

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

- 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 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 Medicare.PacificSource.com to register or access your account. Or, you can call Customer Service.

When a specialist or another network provider leaves our plan

We may make changes to the hospitals, doctors and specialists (providers) in our plan's network during the year. If your doctor or specialist leaves our plan, you have these rights and protections:

- Even though our network of providers may change during the year, Medicare requires that you have uninterrupted access to qualified doctors and specialists.
- We'll notify you that your provider is leaving our plan so that you have time to choose a new provider.
    - If your primary care or behavioral health provider leaves our plan, we'll notify you if you visited that provider within the past 3 years.
    - If any of your other providers leave our plan, we'll notify you if you're assigned to the provider, currently get care from them or visited them within the past 3 months.

- We'll help you choose a new qualified in-network provider for continued care.
- If you're undergoing medical treatment or therapies with your current provider, you have the right to ask to continue getting medically necessary treatment or therapies. We'll work with you so you can continue to get care.
- We'll give you information about available enrollment periods and options you may have for changing plans.
- When an in-network provider or benefit is unavailable or inadequate to meet your medical needs, we'll arrange for any medically necessary covered benefit outside of our provider network at in-network cost sharing.
- If you find out your doctor or specialist is leaving our plan, call Customer Service at 888-863-3637 (TTY users call 711) so we can help you choose a new provider to manage your care.
- If you believe we haven't furnished you with a qualified provider to replace your previous provider, or that your care isn't being appropriately managed, you have the right to file a quality-of-care complaint to the QIO, a quality-of-care grievance to our plan, or both. (Go to Chapter 7)

Section 2.4 How to get care from out-of-network providers

As a member of our plan, you can choose to get care from out-of-network providers. However, please note providers that do not contract with us are under no obligation to treat you, except in emergency situations. Our plan will cover services from either in-network or out-of-network providers, as long as the services are covered benefits and are medically necessary. If you use an out-of-network provider, your share of the costs for your covered services may be higher. Please see the Benefits Chart in Chapter 4 for additional information. Some in-network services, such as surgeries or procedures, may require prior authorization from the plan. You or your doctor may request prior authorization either online at 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. The plan covers emergency 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. 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.

SECTION 3 How to get services in an emergency, disaster, or urgent need for care

Section 3.1 Get care if you have a medical 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're 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's 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 don't need to get approval or a referral first from your PCP. You don't need to use a network doctor. You can 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're not part of our network.
- **As soon as possible, make sure 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.

Covered services in 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 giving you emergency care will decide when your condition is stable, and when the medical emergency is over.

After the emergency is over, you're 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'll 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 wasn't an emergency, as long as you reasonably thought your health was in serious danger, we'll cover your care.

However, after the doctor says it wasn't an emergency, we'll cover additional care *only* if you get the additional care in one of these 2 ways:

- You go to a network provider to get the additional care.
- The additional care you get is considered urgently needed services and you follow the rules below for getting this urgent care.

Section 3.2 Get care when you have an urgent need for services

A service that requires immediate medical attention (but isn't an emergency) is an urgently needed service if you're either temporarily outside our plan's service area, or if it's unreasonable given your time, place, and circumstances to get this service from network providers. Examples of urgently needed services are unforeseen medical illnesses and injuries, or unexpected flare-ups of existing conditions. However, medically necessary routine provider visits such as annual checkups, aren't considered urgently needed even if you're

outside our plan's service area or our plan network is temporarily unavailable.

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 covers worldwide emergency and urgent care services outside the United States under the following circumstances:

- You can get worldwide emergency and urgently needed care anywhere in the U.S. and worldwide.

Section 3.3 Get care during a disaster

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're still entitled to care from our plan.

Visit www.CMS.gov/About-CMS/Agency-Information/Emergency/index.html for information on how to get needed care during a disaster.

If you can't use a network provider during a disaster, our plan will allow you to get care from out-of-network providers at in-network cost sharing.

SECTION 4 What if you're billed directly for the full cost of covered services?

If you paid more than our plan cost-sharing for covered services, or if you got a bill for the full cost of covered medical services, you can ask us to pay our share of the cost of covered services. Go to Chapter 5 for information about what to do.

Section 4.1 If services aren't covered by our plan, you must pay the full cost

Our plan covers all medically necessary services as listed in the Medical Benefits Chart in Chapter 4. If you get services that aren't covered by our plan or you get services out-of-network without authorization that are not emergency or urgently needed services, you're 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 use 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.

SECTION 5 Medical services in a clinical research study

Section 5.1 What is a clinical research study

A clinical research study (also called a *clinical trial*) is a way that doctors and scientists test new types of medical care, like how well a new cancer drug works. Certain clinical research studies are approved by Medicare. Clinical research studies approved by Medicare typically ask for volunteers to participate in the study. When you're in a clinical research study, you can stay enrolled in our plan and continue to get the rest of your care (care that's not related to the study) through our plan.

If you participate in a Medicare-approved study, Original Medicare pays most of the costs for covered services you get as part of the study. If you tell us you're in a qualified clinical trial, then you're 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'll reimburse the difference between what you paid and the in-network cost sharing. You'll need to provide documentation to show us how much you paid.

If you want to participate in any Medicare-approved clinical research study, you don't need to tell us or get approval from us or your PCP. The providers that deliver your care as part of the clinical research study don't need to be part of our plan's network. (This doesn't apply to covered benefits that include require a clinical trial or registry to assess the benefit, including certain benefits requiring coverage with evidence development (NCDs-CED) and investigational exemption device (IDE) studies. These benefits may also be subject to prior authorization and other plan rules.)

While you don't need 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 not approved by Medicare, you'll be responsible for paying all costs for your participation in the study.

Section 5.2 Who pays for services in a clinical research study

Once you join a Medicare-approved clinical research study, Original Medicare covers the routine items and services you get 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's part of the research study.
- Treatment of side effects and complications of the new care.

After Medicare pays its share of the cost for these services, our plan will pay the difference between the cost sharing in Original Medicare and your in-network cost sharing as a member of our plan. This means you'll pay the same amount for services you get as part of the study as you would if you got these services from our plan. However, you must submit documentation showing how much cost-sharing you paid. Go to Chapter 5 for more information on submitting requests for payments.

Example of cost sharing in a clinical trial: Let's say you have a lab test that costs $100 as part of the research study. Your share of the costs for this test is $20 under Original Medicare, but the test would be $10 under our plan. In this case, Original Medicare would pay $80 for the test, and you would pay the $20 copay required under Original Medicare. You would notify our plan that you got a qualified clinical trial service and submit documentation, (like a provider bill) to our plan. Our plan would then directly pay you $10. This makes your net payment for the test $10, the same amount you pay under our plan's benefits.

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

- Generally, Medicare won't pay for the new item or service the study is testing unless Medicare would cover the item or service even if you weren't in a study.
- Items or services provided only to collect data and not used in your direct health care. For example, Medicare won't pay for monthly CT scans done as part of a study if your medical condition would normally require only one CT scan.
- Items and services provided by the research sponsors free-of-charge for people in the trial.

Get more information about joining a clinical research study

Get more information about joining a clinical research study in the Medicare publication *Medicare and Clinical Research Studies* available at Medicare.gov/coverage/clinical-research-studies. You can also call 1-800-MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048.

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

Section 6.1 A religious non-medical health care institution

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'll instead cover care in a religious non-medical health care institution. This benefit is provided only for Part A inpatient services (non-medical health care services).

Section 6.2 How to get care from a religious non-medical health care institution

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

- **Non-excepted** medical care or treatment is any medical care or treatment that's *voluntary* and *not required* by any federal, state, or local law.
- **Excepted** medical treatment is medical care or treatment you get that's *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 only covers non-religious aspects of care.
- If you get services from this institution provided to you in a facility, the following conditions apply:
    - You must have a medical condition that would allow you to get covered services for inpatient hospital care or skilled nursing facility care;
    - – *and* – You must get approval in advance from our plan before you're admitted to the facility, or your stay won't be covered.

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

SECTION 7 Rules for ownership of durable medical equipment

Section 7.1 You won't own some durable medical equipment after making a certain number of payments under our plan

Durable medical equipment (DME) includes items like 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 members to use in the home. The member always owns some DME items, like prosthetics. Other types of DME you must rent.

In Original Medicare, people who rent certain types of DME own the equipment after paying copays for the item for 13 months. **As a member of our plan, however, you usually won't get ownership of rented DME items no matter how many copays you make for the item while a member of our plan.** You won't get ownership even if you made up to 12 consecutive payments for the DME item under Original Medicare before you joined our plan. Under some limited circumstances, we'll transfer ownership of the DME item to you. Call Customer Service at 888-863-3637 (TTY users call 711) for more information.

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

If you didn't get ownership of the DME item while in our plan, you'll have to make 13 new consecutive payments after you switch to Original Medicare to own the DME item. The payments you made while enrolled in our plan don't count towards these 13 payments.

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 don't count. You'll 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 didn't get ownership of the item while in our plan. You then go back to Original Medicare. You'll have to make 13 consecutive new payments to own the item once you rejoin Original Medicare. Any payments you already made (whether to our plan or to

Original Medicare) don't count.

Section 7.2 Rules for oxygen equipment, supplies and maintenance

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, the oxygen equipment must be returned.

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

Original Medicare requires an oxygen supplier to provide you services for 5 years. During the first 36 months, you rent the equipment. For the remaining 24 months, the supplier provides the equipment and maintenance (you're still responsible for applicable cost sharing for oxygen). After 5 years, you can choose to stay with the same company or go to another company. At this point, the 5-year cycle starts over again, even if you stay with the same company, and you're again required to pay copays for the first 36 months. If you join or leave our plan, the 5-year cycle starts over.

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

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

The Medical Benefits Chart lists your covered services and shows how much you pay for each covered service as a member of our plan. This section also gives information about medical services that aren't covered and explains limits on certain services.

Section 1.1 Out-of-pocket costs you may pay for covered services

Types of out-of-pocket costs you may pay for covered services include:

- **Copay:** the fixed amount you pay each time you get certain medical services. You pay a copay at the time you get the medical service. (The Medical Benefits Chart tells you more about your copays.)
- **Coinsurance:** the percentage you pay of the total cost of certain medical services. You pay a coinsurance at the time you get the medical service. (The Medical Benefits Chart tells you more about your coinsurance.)

Most people who qualify for Medicaid or for the Qualified Medicare Beneficiary (QMB) program don't pay deductibles, copays or coinsurance. If you're in one of these programs, be sure to show your proof of Medicaid or QMB eligibility to your provider.

Section 1.2 What's the most you'll pay for Medicare Part A and Part B covered medical services?

Medicare Advantage Plans have limits on the total amount you have to pay out of pocket each year for in-network medical services covered by our plan. This limit is called the maximum out-of-pocket (MOOP) amount for medical services.

As a member of our plan, the most you will have to pay out-of-pocket for in-network covered Part A and Part B services in 2027 is $6,250. The amounts you pay for copays, and coinsurance for in-network covered services count toward this maximum out-of-pocket amount. (The 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 $6,250, you will not have to pay any out-of-pocket costs for the rest of the year for in-network covered Part A and Part B services. However, you must continue to pay the Medicare Part B premium (unless your Part B premium is paid for you by Medicaid or another third party).

There is no maximum out-of-pocket amount for out-of-network services. Our plan will cover services from out-of-network providers, as long as the services are covered benefits and are medically necessary. Our plan covers up to $3,000 per plan year for covered services you receive from out-of-network providers. After the plan has paid $3,000 for covered out-of-network services, you pay the full cost of any additional out-of-network services you receive. Out-of-network emergency care and urgent care services do not count towards you $3,000 benefit limit. Benefits subject to this limit will be marked with an asterisk (*) in the Medical Benefits Chart in Section 2 of this chapter.

Section 1.3 Providers aren't allowed to balance bill you

As a member of our plan, you have an important protection because you only have to pay your cost-sharing amount when you get services covered by our plan. Providers can't bill you for additional separate charges, called **balance billing**. This protection applies even if we pay the provider less than the provider charges for a service, and even if there's a dispute and we don't pay certain provider charges.

Here's how protection from balance billing works:

- If your cost sharing is a copay (a set amount of dollars, for example, $15.00), you pay only that amount for any covered services from an in-network provider.
- If your cost sharing is a coinsurance (a percentage of the total charges), you never pay more than that percentage. However, your cost depends on which type of provider you see:
    - If you get covered services from an in-network provider, you pay the coinsurance percentage multiplied by our plan's reimbursement rate (this is set in the contract between the provider and our plan).
    - If you get covered services from an out-of-network provider who participates with Medicare, you pay the coinsurance percentage multiplied by the Medicare payment rate for participating providers. (Our plan covers services from out-of-network providers only in certain situations, such as when you get a referral or for emergencies or urgently needed services.)
    - If you get the covered services from an out-of-network provider who doesn't participate with Medicare, you pay the coinsurance percentage multiplied by the Medicare payment rate for non-participating providers. (Our plan covers services from out-of-network providers only in certain situations, such as when you get a referral, or for emergencies or for urgently needed services outside the service area.)
- If you think a provider has balance billed you, call Customer Service at 888-863-3637 (TTY users call 711).

SECTION 2 The Medical Benefits Chart shows your medical benefits and costs

The Medical Benefits Chart on the next pages lists the services our plan covers and what you pay out of pocket for each service. The services listed in the Medical Benefits Chart are covered only when these are met:

- Your Medicare-covered services must be provided according to the Medicare coverage guidelines.
- Your services (including medical care, services, supplies, equipment, and Part B 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.
- For new enrollees, your MA coordinated care plan must provide a minimum 90-day transition period, during which time the new MA plan can't require prior authorization for any active course of treatment, even if the course of treatment was for a service that commenced with an out-of-network provider
- You have a primary care provider (a PCP) providing and overseeing your care.
- Some services listed in the Medical Benefits Chart are covered *only* if your doctor or other in-network provider gets approval from us in advance (sometimes called prior authorization). Covered services that need approval in advance are marked in the Medical Benefits Chart in bold.

Other important things to know about our coverage:

- Like all Medicare health plans, we cover everything that Original Medicare covers. For some of these benefits, you pay *more* in our plan than you would in Original Medicare. For others, you pay *less.* (To learn more about the coverage and costs of Original Medicare, go to your *Medicare & You 2027* handbook. View it online at Medicare.gov or ask for a copy by calling 1-800-MEDICARE (1-800-633-4227) TTY users call 1-877-486-2048.)
- For preventive services covered at no cost under Original Medicare, we also cover those services at no cost to you. However, if you're also treated or monitored for an existing medical condition during the visit when you get the preventive service, a copay will apply for the care you got for the existing medical condition.
- If Medicare adds coverage for any new services during 2027, either Medicare or our plan will cover those services.

This apple shows preventive services in the Medical Benefits Chart.

Medical Benefits Chart

Covered Service	What you pay In-Network	What you pay Out-of-Network
Abdominal aortic aneurysm screening* No prior authorization required. A one-time screening ultrasound for people at risk. Our plan only covers this screening if you have certain risk factors and if you get a referral for it from your physician, physician assistant (PA), nurse practitioner (NP), or clinical nurse specialist (CNS).	There is no coinsurance or copay for members eligible for this preventive screening.	50% coinsurance
Acupuncture for chronic low back pain* No prior authorization required. Covered services include: Up to 12 visits in 90 days are covered under the following circumstances: For the purpose of this benefit, chronic low back pain is defined as: • Lasting 12 weeks or longer • Nonspecific, in that it has no identifiable systemic cause (i.e., not associated with metastatic, inflammatory, infectious disease, etc.) • Not associated with surgery • Not associated with pregnancy An additional 8 sessions will be covered for 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. **Provider Requirements:** Physicians may furnish acupuncture in accordance with applicable state requirements.	$25 copay	50% coinsurance

Covered Service	What you pay In-Network	What you pay Out-of-Network
Acupuncture for chronic low back pain* (continued) Physician assistants (PAs), nurse practitioners (NPs)/clinical nurse specialists (CNSs), and auxiliary personnel may furnish acupuncture if they meet all applicable state requirements and have: • a master's or doctoral level degree in acupuncture or Oriental Medicine from a school accredited by the Accreditation Commission on Acupuncture and Oriental Medicine (ACAOM); and, • 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. Auxiliary personnel furnishing acupuncture must be under the appropriate level of supervision of a physician, PA, or NP/CNS required by our regulations.		
• Additional acupuncture care	See **Alternative care**	
Alternative care No prior authorization required. **The amount you pay for services performed or ordered by an alternative care provider does not apply to your yearly maximum out-of-pocket.** • 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.	$10 copay per visit	

Covered Service	What you pay In-Network	What you pay Out-of-Network
Alternative care (continued) Covered services include: • Chiropractic care provided by a licensed Chiropractor acting within the scope of their 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. • Acupuncture services provided by a licensed acupuncturist acting within the scope of their license. Covered services include acupuncture and electro-acupuncture. • If you are seeing a non-participating Medicare provider, please reference Section 1.3 above as you may be Balance Billed for these services • The covered services above are not a comprehensive list. Please see table in Section 3 for a comprehensive list of services we do not cover.		
Ambulance services* **When in-network: Prior authorization is required for non-emergency transportation.** For coverage outside of the United States, see **Worldwide coverage**. Covered ambulance services, whether for an emergency or non-emergency situation, include fixed wing, rotary wing, and ground ambulance services, to the nearest appropriate facility that can provide care if they're furnished to a member whose medical condition is such that other means of transportation could endanger the person's health or if authorized by our plan. If the covered ambulance services aren't for an emergency situation, it should be 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.	$550 copay per one-way transport	

Covered Service	What you pay In-Network	What you pay Out-of-Network
Annual physical exam* No prior authorization required. **The amount you pay for these services does not apply to your yearly maximum out-of-pocket.** Limited to one exam per calendar year. This exam is covered in addition to the Welcome to Medicare Exam and Annual Wellness Visit. Routine lab work not otherwise covered by Medicare as preventive, including: • Comprehensive Metabolic Panel • Thyroid Stimulating Hormone • Complete Blood Count • Vitamin D • A hands-on physical exam that includes inspection of the organ systems. • A review of active medical problems, development of specific treatment plans, and an examination and evaluation of the entire person. **Note:** Cost sharing may apply for other services provided during the annual physical exam.	$0 copay	50% coinsurance
Annual wellness visit* 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. **Note**: 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. This benefit is administered on a calendar year basis.	There is no coinsurance or copay for the annual wellness visit.	50% coinsurance

Covered Service	What you pay In-Network	What you pay Out-of-Network
Bone mass measurement* No prior authorization required. For qualified people (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 or copay for Medicare-covered bone mass measurement.	50% coinsurance
Breast cancer screening (mammograms)* No prior authorization required. Covered services include: • One baseline mammogram between the ages of 35 and 39 • One screening mammogram every 12 months for women aged 40 and older • Clinical breast exams once every 24 months	There is no coinsurance or copay for covered screening mammograms.	50% coinsurance
• One diagnostic mammography exam is covered at no cost per calendar year. Additional exams are covered with a cost share. Please see **Outpatient diagnostic tests and therapeutic services and supplies - Other outpatient diagnostic tests*** for more information.	$0 copay	50% coinsurance
Cardiac rehabilitation services* 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. Our plan covers these comprehensive programs if you've had at least one of these conditions: • Heart attack in the last 12 months • Coronary artery bypass surgery • Stable angina pectoris (chest pain)	$35 copay per visit	50% coinsurance

Covered Service	What you pay In-Network	What you pay Out-of-Network
Cardiac rehabilitation services* (continued) • Heart valve repair or replacement • Coronary angioplasty (a medical procedure used to open a blocked artery) or coronary stenting (a procedure used to keep an artery open) • Heart or heart and lung transplant • Stable chronic heart failure Coverage limitations: You can get up to 36 cardiac rehabilitation sessions. You can have 2 sessions per day (each lasting 1 hour), and the program can last up to 36 weeks. If you qualify, you may be able to get 36 more sessions that can be spread out over a longer time period.		
Cardiovascular disease risk reduction visit (therapy for cardiovascular disease)* 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.	There is no coinsurance or copay for the intensive behavioral therapy cardiovascular disease preventive benefit.	50% coinsurance
Cardiovascular disease screening tests* 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).	There is no coinsurance or copay for cardiovascular disease testing that is covered once every 5 years.	50% coinsurance
Cervical and vaginal cancer screening* No prior authorization required. Covered services include: • Pap tests and pelvic exams once every 24 months for all women • One pap test every 12 months if at high risk of cervical or vaginal cancer or if of childbearing age and have had an abnormal pap test within the past 3 years	There is no coinsurance or copay for Medicare-covered preventive Pap and pelvic exams.	50% coinsurance

Covered Service	What you pay In-Network	What you pay Out-of-Network
Chiropractic services* No prior authorization required. Covered services include: • Manual manipulation of the spine to correct a vertebral subluxation	$10 copay	50% coinsurance
• Additional chiropractic care	See **Alternative care**	
Colonoscopies* No prior authorization required. Covered services include: • Diagnostic and preventive colonoscopies regardless of frequency.	$0 copay	50% coinsurance
Colorectal cancer screening* No prior authorization required. The following screening tests are covered: • Colonoscopy has no minimum or maximum age limitation and is covered once every 120 months (10 years) for patients not at high risk, or 48 months after a previous flexible sigmoidoscopy for patients who aren't at high risk for colorectal cancer, and once every 24 months for high-risk patients after a previous screening colonoscopy. • Computed tomography colonography for patients 45 years and older who are not at high risk of colorectal cancer and is covered when at least 59 months have passed following the month in which the last screening computed tomography colonography was performed or 47 months have passed following the month in which the last screening flexible sigmoidoscopy or screening colonoscopy was performed. For patients at high risk for colorectal cancer, coverage of a screening computed tomography colonography performed after at least 23 months have passed following the month in which the last screening computed tomography colonography or the last screening colonoscopy was performed.	There is no coinsurance or copay for a Medicare-covered colorectal cancer screening exam. If your doctor finds and removes a polyp or other tissue during the colonoscopy or flexible sigmoidoscopy, the screening exam becomes a diagnostic exam.	50% coinsurance

Covered Service	What you pay In-Network	What you pay Out-of-Network
Colorectal cancer screening* (continued) • Flexible sigmoidoscopy for patients 45 years and older. Once every 120 months for patients not at high risk after the patient got a screening colonoscopy. Once every 48 months for high-risk patients from the last flexible sigmoidoscopy or computed tomography colonography. • Screening fecal-occult blood tests for patients 45 years and older. Once every 12 months. • Multitarget stool DNA for patients 45 to 85 years of age and not meeting high risk criteria. Once every 3 years. • Blood-based Biomarker Tests for patients 45 to 85 years of age and not meeting high risk criteria. Once every 3 years. • Colorectal cancer screening tests include a follow-on screening colonoscopy after a Medicare-covered non-invasive stool-based colorectal cancer screening test returns a positive result. • Colorectal cancer screening tests include a planned screening flexible sigmoidoscopy or screening colonoscopy that involves the removal of tissue or other matter, or other procedure furnished in connection with, as a result of, and in the same clinical encounter as the screening test.		

Covered Service	What you pay In-Network	What you pay Out-of-Network
Dental services No prior authorization required. **The amount you pay for these services does not apply to your yearly maximum out-of-pocket.** In general, preventive dental services (such as cleaning, routine dental exams, and dental x-rays) aren't covered by Original Medicare. However, Medicare pays for dental services in a limited number of circumstances, specifically when that service is an integral part of specific treatment of a person's primary medical condition. Examples include reconstruction of the jaw after a fracture or injury, tooth extractions done in preparation for radiation treatment for cancer involving the jaw, or oral exams prior to organ transplantation. In addition, we cover: Diagnostic (Preventive) Services: You pay a $0 copay for the following services: • Routine exams • Cleanings (prophylaxis or periodontal) • Bitewing x-rays • Full mouth x-rays, conebeam and/or panorex (1 complete series) • Topical fluoride and fluoride varnish • Periapical x-ray (limited to the dollar amount of a full mouth series) • Brush biopsy Non-Routine (Emergency) Services: You pay a $0 copay for the following services: • Problem-focused exams Restorative Services: You pay a 50% coinsurance for the following services: • Core build up (tooth requires root canal therapy) • Fillings	$0 copay for Diagnostic (Preventive) Services and Non-Routine (Emergency) Services 50% coinsurance for Restorative, Endodontics, Periodontics, Prosthodontics (Removable & Fixed), Oral/Maxillofacial Surgery, Adjunctive General Services For Medicare-covered dental benefits see **Physician/practitioner services, including doctor's office visits***	

Covered Service	What you pay In-Network	What you pay Out-of-Network
Dental services (continued) • Crowns • Inlays • Onlays • Veneers Endodontics, Periodontics, Prosthodontics (Removable & Fixed), Oral/Maxillofacial Surgery, Adjunctive General Services: You pay a 50% coinsurance for the following services: • Analgesia/Sedation (only with covered surgical procedures) • Tooth desensitization • Oral surgery (simple extractions and complicated, impacted) • Debridement • Pulpotomy (deciduous teeth only) • Pulp capping (direct) • Bridges • Bone grafting (only covered at time of extraction or at the time of a covered implant placement) • Periodontic surgery • Periodontal therapy (scaling and root planing) • Root canal therapy • Dentures and denture relines **The dental services on your plan are covered up to a combined $2,500 Annual Maximum.** See Section 3 of this chapter for exclusions and limitations. We will cover 100% up to our maximum allowable charges, minus your cost share (if there is any), for covered services. If your dentist is out of our network and the charges are more than the maximum allowable amount, you will have to pay for the excess charges.		

Covered Service	What you pay In-Network	What you pay Out-of-Network
Depression screening* 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.	There is no coinsurance or copay for an annual depression screening visit.	50% coinsurance
Diabetes screening* No prior authorization required. We cover this screening (includes fasting glucose tests) if you have any of these 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. You may be eligible for up to 2 diabetes screenings every 12 months following the date of your most recent diabetes screening test.	There is no coinsurance or copay for the Medicare-covered diabetes screening tests.	50% coinsurance
Diabetes self-management training, diabetic services, and supplies* **When in-network: Prior authorization may be required for some diabetic services and supplies.** For all people who have diabetes (insulin and non-insulin users), covered services include: • Supplies to monitor your blood glucose: blood glucose monitor, blood glucose test strips, lancet devices and lancets, and glucose-control solutions for checking the accuracy of test strips and monitors. Limited to One Touch branded products when filled through a pharmacy. For a list of covered supplies, please refer to the Part B Product List on our website at Medicare.PacificSource.com/Search/Drug.	20% coinsurance	50% coinsurance

Covered Service	What you pay In-Network	What you pay Out-of-Network
Diabetes self-management training, diabetic services, and supplies* (continued) • 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 2 additional pairs of inserts, or one pair of depth shoes and 3 pairs of inserts (not including the non-customized removable inserts provided with such shoes) including fitting		
• Diabetes self-management training under certain conditions	$0 copay	50% coinsurance
Durable medical equipment (DME) and related supplies* **When in-network: Prior authorization may be required for some Durable Medical Equipment (DME).** (For a definition of durable medical equipment, go to Chapter 10 and Chapter 3) Covered items include, but aren't 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. We cover all medically necessary DME covered by Original Medicare. If our supplier in your area doesn't carry a particular brand or manufacturer, you can ask them if they can special order it for you. The most recent list of suppliers is available on our website at Medicare.PacificSource.com.	20% coinsurance Your cost sharing for Medicare oxygen equipment coverage is 20% coinsurance every month. Your cost sharing won't change after you're enrolled for 36 months.	50% coinsurance

Covered Service	What you pay In-Network	What you pay Out-of-Network
Emergency care No prior authorization required. For coverage outside of the United States, see **Worldwide coverage**. Emergency care refers to services that are: • Furnished by a provider qualified to furnish emergency services • Needed to evaluate or stabilize an emergency medical condition A medical emergency is when you, or any other prudent layperson with an average knowledge of health and medicine, believe that you have medical symptoms that require immediate medical attention to prevent loss of life (and, if you're 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's quickly getting worse. Cost sharing for necessary emergency services you get out-of-network is the same as when you get these services in-network.	$130 copay per visit $0 copay if admitted to the hospital from the emergency room within 72 hours. If you get emergency care at an out-of-network hospital and need inpatient care after your emergency condition is stabilized, you must move to an in-network hospital for your care to continue to be covered or you must have your inpatient care at the out-of-network hospital authorized by our plan and your cost is the cost sharing you would pay at an in-network hospital.	
Health and wellness education programs* No prior authorization required. **The amount you pay for these services does not apply to your yearly maximum out-of-pocket amount.** More access. Less hassle. Keep up your current fitness routine, try out a new club, and get nutritious meals delivered right to your door. With holistic health at the center, One Pass plans are designed to give you the freedom to move freely and feel your best.	$0 fees to enroll in One Pass fitness facilities or participate in One Pass health and wellness education programs.	

Covered Service	What you pay In-Network	What you pay Out-of-Network
Health and wellness education programs* (continued) One Pass subscriptions include*: • Access to one of the largest fitness networks in the nation • Live, digital fitness classes and on-demand workouts • Online brain training made just for you to help improve your memory and focus* • Groups, clubs and social events near you so that you can meet like-minded people • Meal delivery services to make healthy eating easy *Gym network and other features vary by membership plan design. **How to get started** Getting started with One Pass is simple: • Go to YourOnePass.com • Follow prompts to set up your new account. • Get started using One Pass by using your member code • Bring your One Pass member code with you to any participating location and the staff will set up your membership for all future visits • Your One Pass member code is a single code that will get you access to any fitness location in the network. Additionally, use it for online fitness vendors and other One Pass offerings. One Pass Customer Support will be available to help you understand and use your One Pass benefits. Call 877-504-6830, TTY: 711. Hours of operation are 6:00 a.m. to 7:00 p.m. PST, Monday – Friday.		
Hearing services (Medicare covered)* 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 you get them from a physician, audiologist, or other qualified provider.	$0 copay per Medicare-covered exam	50% coinsurance

Covered Service	What you pay In-Network	What you pay Out-of-Network
Hearing services (routine)*	$0 copay per exam	Not covered
No prior authorization required. **The amounts you pay for these services do not apply to your yearly maximum out-of-pocket amount.** You must use a TruHearing provider. We cover: • One routine hearing exam per calendar year. Basic hearing evaluations performed by your provider are covered as outpatient care when furnished by a physician, audiologist, or other qualified provider.		
Up to two TruHearing-branded hearing aids every year (one per ear per year). Benefit is limited to TruHearing's Standard, Advanced and Premium hearing aids, which come in various styles and colors. Advanced and Premium Hearing aids are available in rechargeable style options for an additional $50 per aid. You must see a TruHearing provider to use this benefit. Call 844-247-6313 to schedule an appointment (for TTY, dial 711). Hearing aid purchase includes: • First year of follow-up provider visits • 60-day trial period • 3-year extended warranty • 80 batteries per aid for non-rechargeable models Benefit does not include or cover any of the following: • Additional cost for optional hearing aid rechargeability • Ear molds • Hearing aid accessories • Additional provider visits • Additional batteries; batteries when a rechargeable hearing aid is purchased	$599 per aid for Standard $799 per aid for Advanced $999 per aid for Premium	

Covered Service	What you pay In-Network	What you pay Out-of-Network
Hearing services (routine)* (continued) • Hearing aids that are not TruHearing-branded hearing aids • Costs associated with loss & damage warranty claims Costs associated with excluded items are the responsibility of the member and not covered by the plan.		
HIV screening* No prior authorization required. For people who ask for an HIV screening test or who are at increased risk for HIV infection, we cover: • One screening exam every 12 months If you are pregnant, we cover: • Up to 3 screening exams during a pregnancy	There's no coinsurance or copay for members eligible for Medicare-covered preventive HIV screening.	50% coinsurance
Home health agency care* **When in-network: Prior authorization is required after evaluation and 5 visits.** Before you get home health services, a doctor must certify that you need home health services and will order home health services to be provided by a home health agency. You must be homebound, which means leaving home is a major effort. Covered services include, but aren't limited to: • Part-time or intermittent skilled nursing and home health aide services (to be covered under the home health care benefit, your skilled nursing and home health aide services combined must total fewer than 8 hours per day and 35 hours per week) • Physical therapy, occupational therapy, and speech therapy • Medical and social services • Medical equipment and supplies	$0 copay	50% coinsurance

Covered Service	What you pay In-Network	What you pay Out-of-Network
Home infusion therapy* **When in-network: Prior authorization is required for some drugs.** Home infusion therapy involves the intravenous or subcutaneous administration of drugs or biologicals to a person 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). Covered services include, but aren't limited to: • Professional services, including nursing services, furnished in accordance with our plan of care • Patient training and education not otherwise covered under the durable medical equipment benefit • Remote monitoring • Monitoring services for the provision of home infusion therapy and home infusion drugs furnished by a qualified home infusion therapy supplier	Up to 20% coinsurance	50% coinsurance
Hospice care No prior authorization required. You're 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 can get care from any Medicare-certified hospice program. Our plan is obligated to help you find Medicare-certified hospice programs in our plan's service area, including programs we own, control, or have a financial interest in. Your hospice doctor can be a network provider or an out-of-network provider.	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.	

Covered Service	What you pay In-Network	What you pay Out-of-Network
Hospice care (continued) Covered services include: • Drugs for symptom control and pain relief • Short-term respite care • Home care When you're admitted to a hospice, you have the right to stay in our plan; if you stay in our plan you must continue to pay plan premiums. **For hospice services and services covered by Medicare Part A or B that are related to your terminal prognosis:** Original Medicare (rather than our plan) will pay your hospice provider for your hospice services and any Part A and Part B services related to your terminal prognosis. While you're in the hospice program, your hospice provider will bill Original Medicare for the services Original Medicare pays for. You'll be billed Original Medicare cost sharing. **For services covered by Medicare Part A or B not related to your terminal prognosis:** If you need non-emergency, non-urgently needed services covered under Medicare Part A or B that aren't 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 (like if there's a requirement to get prior authorization). • If you get the covered services from a network provider and follow plan rules for getting service, you pay only our plan cost-sharing amount for in-network services • If you get the covered services from an out-of-network provider, you pay the cost sharing under Original Medicare		

Covered Service	What you pay In-Network	What you pay Out-of-Network
Hospice care (continued) **For services covered by our plan but not covered by Medicare Part A or B:** our plan will continue to cover plan-covered services that aren't covered under Part A or B whether or not they're related to your terminal prognosis. You pay our plan cost-sharing amount for these services. **Note:** If you need non-hospice care (care that's not related to your terminal prognosis), 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.	See **Physician/practitioner services, including doctor's office visits: Specialist***	
Immunizations* No prior authorization required. Covered Medicare Part B services include: • Pneumonia vaccines • Flu/influenza shots (or vaccines), once each flu/influenza season in the fall and winter, with additional flu/influenza shots (or vaccines) if medically necessary • Hepatitis B vaccines if you've never received a complete series, you don't know your vaccination history, or you have any other condition that puts you at high or intermediate risk of getting Hepatitis B • COVID-19 vaccines • Other vaccines if you're at risk and they meet Medicare Part B coverage rules **Administration fee in the provider's office may require a cost-share.**	There is no coinsurance or copay for the pneumonia, flu/influenza, Hepatitis B, and COVID-19 vaccines.	50% coinsurance

Covered Service	What you pay In-Network	What you pay Out-of-Network
Inpatient hospital care* **When in-network: Prior authorization may be required. Notification of admission is required from the facility.** Includes inpatient acute, inpatient rehabilitation, long-term care hospitals and other types of inpatient hospital services. Inpatient hospital care starts the day you're formally admitted to the hospital with a doctor's order. The day before you're 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 and the daily copay begins again. Covered services include but aren't limited to: • Semi-private room (or a private room if medically necessary) • Meals including special diets • Regular nursing services • Costs of special care units (such as intensive care or coronary care units) • Drugs and medications • Lab tests • X-rays and other radiology services • Necessary surgical and medical supplies • Use of appliances, such as wheelchairs • Operating and recovery room costs • Physical, occupational, and speech language therapy • Inpatient substance abuse services	Days 1-5: $450 copay per day Days 6+: $0 copay per day Cost sharing is charged for each inpatient stay. 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'd pay at an in-network hospital.	50% coinsurance

Covered Service	What you pay In-Network	What you pay Out-of-Network
Inpatient hospital care* (continued) • 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'll arrange to have your case reviewed by a Medicare-approved transplant center that will decide whether you're 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 get transplants at this distant location, we'll arrange or pay for appropriate lodging and transportation costs for you and a companion. Coverage of lodging and transportation costs is a limited benefit. Call our Customer Service department for benefit rules and limitations. • Blood - including storage and administration. Coverage of whole blood and packed red cells starts only with the fourth pint of blood 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 starting with the first pint. • Physician services **Note**: 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're not sure if you're an inpatient or an outpatient, ask the hospital staff.		

Covered Service	What you pay In-Network	What you pay Out-of-Network
Inpatient hospital care* (continued) Get more information from the Medicare fact sheet *Medicare Hospital Benefits* available at Medicare.gov/ publications/11435-Medicare-Hospital-Benefits.pdf or by calling 1-800-MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048.		
Inpatient services in a psychiatric hospital* **When in-network: Prior authorization may be required. Notification of admission is required from the facility.** Covered services include mental health care services that require a hospital stay. • There is a 190-day lifetime limit for inpatient services in a psychiatric hospital. The 190-day limit does not apply to inpatient mental health services provided in a psychiatric unit of a general hospital.	Days 1-4: $450 copay per day Days 5+: $0 copay per day Cost sharing is charged for each inpatient stay.	50% coinsurance
Inpatient stay: Covered services you get in a hospital or SNF during a non-covered inpatient stay **When in-network: Prior authorization may be required for some services.** If you've used up your inpatient benefits or if the inpatient stay isn't reasonable and necessary, we won't cover your inpatient stay. In some cases, we'll cover certain services you get while you're in the hospital or the skilled nursing facility (SNF). Covered services include, but aren't limited to:	For each service, see appropriate sections of this Benefits Chart for benefits, rules, and limits. Cost sharing is charged for each inpatient stay.	
• Physician services	See **Physician/practitioner services, including doctor's office visits***	
• Diagnostic tests (like lab tests) • X-ray, radium, and isotope therapy including technician materials and services • Surgical dressings • Splints, casts, and other devices used to reduce fractures and dislocations	See **Outpatient diagnostic tests and therapeutic services and supplies***	

Covered Service	What you pay In-Network	What you pay Out-of-Network
Inpatient stay: Covered services you get in a hospital or SNF during a non-covered inpatient stay (continued) • 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 • 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	See **Prosthetic and orthotic devices and related supplies***	
• Physical therapy, speech therapy, and occupational therapy	See **Outpatient rehabilitation services***	
Medical nutrition therapy* 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. We cover 3 hours of one-on-one counseling services during the first year you get 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 get 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.	There is no coinsurance or copay for members eligible for Medicare-covered medical nutrition therapy services.	50% coinsurance

Covered Service	What you pay In-Network	What you pay Out-of-Network
Medicare Diabetes Prevention Program (MDPP)* No prior authorization required. **MDPP services are covered for eligible people under all Medicare health plans.** 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 sustain weight loss and a healthy lifestyle.	There is no coinsurance or copay for the MDPP benefit.	50% coinsurance
Medicare Part B drugs* **When in-network: Prior authorization or step therapy is required for some drugs. These drugs are covered under Part B of Original Medicare. Members of our plan get coverage for these drugs through our plan. Covered drugs include:** • Drugs that usually aren't self-administered by the patient and are injected or infused while you get physician, hospital outpatient, or ambulatory surgical center services	Up to 20% coinsurance When in-network: Part B drugs may be subject to step therapy. You pay no more than $35 for a one-month supply of Part B covered insulin. The following Part B drug categories may be subject to Step Therapy: • Bevacizumab products (oncology) • Biologics • Bortezomib • Erythropoiesis stimulating agents (ESAS) • Hyaluronic Acids • Immunologics • Infliximab • Long-acting granulocyte colony-stimulating factor • Motixafortide	50% coinsurance You pay no more than $35 for a one-month supply of Part B covered insulin.

Covered Service	What you pay In-Network	What you pay Out-of-Network
Medicare Part B drugs* (continued) • Insulin furnished through an item of durable medical equipment (such as a medically necessary insulin pump) • Other drugs you take using durable medical equipment (such as nebulizers) that were authorized by our plan • The Alzheimer's drug, Leqembi® (generic name lecanemab) is administered intravenously. In addition to medication costs, you may need additional scans and tests before and/or during treatment that could add to your overall costs. Talk to your doctor about what scans and tests you may need as part of your treatment. • Clotting factors you give yourself by injection if you have hemophilia • Transplant/immunosuppressive drugs: Medicare covers transplant drug therapy if Medicare paid for your organ transplant. You must have Part A at the time of the covered transplant, and you must have Part B at the time you get immunosuppressive drugs • Injectable osteoporosis drugs, if you're homebound, have a bone fracture that a doctor certifies was related to post-menopausal osteoporosis, and can't self-administer the drug • Some antigens: Medicare covers antigens if a doctor prepares them and a properly instructed person (who could be you, the patient) gives them under appropriate supervision • Certain oral anti-cancer drugs: Medicare covers some oral cancer drugs you take by mouth if the same drug is available in injectable form or the drug is a prodrug (an oral form of a drug that, when ingested, breaks down into the same active ingredient found in the injectable drug) of the injectable drug	• Multiple sclerosis (MS) • Ophthalmic • Pemetrexed • Prostaglandin Intracameral Implants • Rituximab • Short-acting granulocyte colony-stimulating factor • Trastuzumab • Non-Muscle Invasive Bladder Cancer (NMIBC) agents • Onapgo • Oral phosphate binders • Paliperidone palmitate implants • Testosterone	

Covered Service	What you pay In-Network	What you pay Out-of-Network
Medicare Part B drugs* (continued) • Oral anti-nausea drugs: Medicare covers oral anti-nausea drugs you use as part of an anti-cancer chemotherapeutic regimen if they're administered before, at, or within 48 hours of chemotherapy or are used as a full therapeutic replacement for an intravenous anti-nausea drug • Certain oral End-Stage Renal Disease (ESRD) drugs covered under Medicare Part B • Calcimimetic and phosphate binder medications under the ESRD payment system, including the intravenous medication Parsabiv® and the oral medication Sensipar® • Certain drugs for home dialysis, including heparin, the antidote for heparin when medically necessary and topical anesthetics • Erythropoiesis-stimulating agents: Medicare covers erythropoietin by injection if you have End-Stage Renal Disease (ESRD) or you need this drug to treat anemia related to certain other conditions (such as Epogen®, Procrit®, Retacrit®, Epoetin Alfa, Aranesp®, Darbepoetin Alfa, Mircera®, or Methoxy polyethylene glycol-epoetin beta) • Intravenous Immune Globulin for the home treatment of primary immune deficiency diseases • Parenteral and enteral nutrition (intravenous and tube feeding) This link will take you to a list of Part B drugs that may be subject to Step Therapy: Medicare.PacificSource.com We also cover some vaccines under our Part B drug benefit.		

Covered Service	What you pay In-Network	What you pay Out-of-Network
Obesity screening and therapy to promote sustained weight loss* No prior authorization required. 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.	There is no coinsurance or copay for preventive obesity screening and therapy.	50% coinsurance
Opioid treatment program services* No prior authorization required. Members of our plan with opioid use disorder (OUD) can get coverage of services to treat OUD through an Opioid Treatment Program (OTP) which includes the following services: • U.S. Food and Drug Administration (FDA)-approved opioid agonist and antagonist medication-assisted treatment (MAT) medications • Dispensing and administration of MAT medications (if applicable) • Substance use counseling • Individual and group therapy • Toxicology testing • Intake activities • Periodic assessments	$0 copay	50% coinsurance
Outpatient diagnostic tests and therapeutic services and supplies* No prior authorization required except as noted below. Covered services include, but aren't limited to: (See Section 3 for exclusions)	Cost sharing applies for each individual service and facility per day.	
• DEXA Scans	$0 copay per visit	50% coinsurance
• X-rays	$15 copay	50% coinsurance
• Radiation (radium and isotope) therapy including technician materials and supplies **When in-network: Prior authorization is required for some radiation services.**	20% coinsurance	50% coinsurance

Covered Service	What you pay In-Network	What you pay Out-of-Network
Outpatient diagnostic tests and therapeutic services and supplies* (continued) • Surgical supplies, such as dressings • Splints, casts, and other devices used to reduce fractures and dislocations	20% coinsurance	50% coinsurance
• Laboratory tests **When in-network: Prior authorization may be required for some laboratory tests including genetic testing and analysis.**	$0 copay $0 copay for Protime testing $0 copay for A1c testing 20% coinsurance for genetic testing	50% coinsurance
• 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	$0 copay	50% coinsurance
• Diagnostic non-laboratory tests such as CT scans, MRIs, EKGs, and PET scans when your doctor or other health care provider orders them to treat a medical problem **When in-network: Prior authorization is required for advanced/complex imaging such as: CT Scan, MRI, PET Scan, Nuclear Test.**	20% coinsurance	50% coinsurance
• Other outpatient diagnostic tests For additional mammogram benefits, see **Breast cancer screening (mammograms)***.	$15 copay	50% coinsurance
• Sleep studies	20% coinsurance	50% coinsurance

Covered Service	What you pay In-Network	What you pay Out-of-Network
Outpatient hospital observation* 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 Medicare criteria and be considered reasonable and necessary. Observation services are covered only when provided by the order of a physician or another person authorized by state licensure law and hospital staff bylaws to admit patients to the hospital or order outpatient tests. **Note**: Unless the provider has written an order to admit you as an inpatient to the hospital, you're 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 aren't sure if you're an outpatient, ask the hospital staff. Get more information from the Medicare fact sheet *Medicare Hospital Benefits* available at Medicare.gov/publications/11435-Medicare-Hospital-Benefits.pdf or by calling 1-800-MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048.	$425 copay	50% coinsurance
Outpatient hospital services **When in-network: Prior authorization may be required for some outpatient services.** We cover medically necessary services you get in the outpatient department of a hospital for diagnosis or treatment of an illness or injury. Covered services include, but aren't limited to:	For each service, see appropriate sections of the Benefits Chart for benefit rules and limits. Cost sharing may apply for each individual service and provider.	
• Services in an emergency department	See **Emergency care**	
• Outpatient clinic, such as observation services or outpatient surgery	Outpatient Clinic: See **Physician/practitioner services, including doctor's office visits*** Observation or Outpatient Surgery: See **Outpatient surgery, including services provided at hospital outpatient facilities and ambulatory surgical centers***	

Covered Service	What you pay In-Network	What you pay Out-of-Network
Outpatient hospital services (continued) • Laboratory and diagnostic tests billed by the hospital	See **Outpatient diagnostic tests and therapeutic services and supplies***	
• Mental health care, including care in a partial hospitalization program, if a doctor certifies that inpatient treatment would be required without it	Mental Health Care: See **Outpatient mental health care*** Partial Hospitalization: See **Partial hospitalization services and intensive outpatient services***	
• X-rays and other radiology services billed by the hospital • Medical supplies such as splints and casts	See **Outpatient diagnostic tests and therapeutic services and supplies***	
• Certain drugs and biologicals you can't give yourself	See **Medicare Part B drugs***	
Note: Unless the provider has written an order to admit you as an inpatient to the hospital, you're 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 aren't sure if you're an outpatient, ask the hospital staff.		
Outpatient mental health care* No prior authorization required. Covered services include: Mental health services provided by a state-licensed psychiatrist or doctor, clinical psychologist, clinical social worker (CSW), clinical nurse specialist (CNS), licensed professional counselor (LPC), licensed marriage and family therapist (LMFT), nurse practitioner (NP), physician assistant (PA), or other Medicare-qualified mental health care professional as allowed under applicable state laws.	Mental Health Specialty Services: $10 copay per each individual or group visit Psychiatric Services: $20 copay per each individual or group visit	50% coinsurance

Covered Service	What you pay In-Network	What you pay Out-of-Network
Outpatient rehabilitation services* **When in-network: Prior authorization required after the first 10 visits per therapy service.** Covered services include physical therapy, occupational therapy, and speech language therapy. Outpatient rehabilitation services are provided in various outpatient settings, such as hospital outpatient departments, independent therapist offices, and Comprehensive Outpatient Rehabilitation Facilities (CORFs).	$10 copay per visit	$45 copay per visit
Outpatient substance use disorder services* No prior authorization required. You are covered for services and supplies to treat substance use disorders in an outpatient setting (individual or group therapy).	$0 copay	50% coinsurance
Outpatient surgery, including services provided at hospital outpatient facilities and ambulatory surgical centers* **When in-network: Prior authorization is required for some services.** No prior authorization is required for observation services. **Note:** If you're having surgery in a hospital facility, you should check with your provider about whether you'll be an inpatient or outpatient. Unless the provider writes an order to admit you as an inpatient to the hospital, you're 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.	Outpatient Hospital Services: $425 copay per visit Ambulatory Surgical Center (ASC) Services: $350 copay per visit	50% coinsurance

Covered Service	What you pay In-Network	What you pay Out-of-Network
Over-the-counter (OTC) allowance **The amounts you pay for these services do not apply to your yearly maximum out-of-pocket amount.** No prior authorization required. You receive a quarterly allowance of $50 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): • Bath and shower safety, and fall prevention • Cold, flu, sinus, and allergy • Dental and denture care • Diabetes care • Digestive health • Eye and ear care • Feminine care • First aid and medical supplies • Foot care • Hemorrhoidal preparations • Home diagnostics, patient aids, and home health care • Incontinence supplies • Pain relief • Personal care • Rehabilitation, therapy and exercise • Skin care • Sleep aids • Supports and braces • Vitamins, minerals, and dietary supplements If you do not use the full amount before the end of the quarter, the remaining balance will not accumulate to the next quarter.	Covered in full up to $50 allowance every quarter through NationsOTC.	

Covered Service	What you pay In-Network	What you pay Out-of-Network
Over-the-counter (OTC) allowance (continued) You must use this benefit through NationsOTC. Order through the following: • Online – visit NationsOTC.com/PacificSource • By Phone – call NationsOTC Member Experience Advisors at 877-281-8716 • By Mail – fill out and return the order form in the NationsOTC/PacificSource Grocery catalog		
Partial hospitalization services and intensive outpatient services* **When in-network: Prior authorization required.** *Partial hospitalization* is a structured program of active psychiatric treatment provided as a hospital outpatient service or by a community mental health center that's more intense than care you get in your doctor's, therapist's, licensed marriage and family therapist's (LMFT), or licensed professional counselor's office and is an alternative to inpatient hospitalization. *Intensive outpatient service* is a structured program of active behavioral (mental) health therapy treatment provided in a hospital outpatient department, a community mental health center, a Federally Qualified Health Center, or a rural health clinic that's more intense than care you get in your doctor's, therapist's, licensed marriage and family therapist's (LMFT), or licensed professional counselor's office but less intense than partial hospitalization.	$40 copay per visit	50% coinsurance

Covered Service	What you pay In-Network	What you pay Out-of-Network
Physician/practitioner services, including doctor's office visits* 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. If other services are provided during your visit, additional cost sharing may apply, such as laboratory, diagnostic procedures and tests.	
• Medically necessary medical care or surgery services you get in a physician's office, certified ambulatory surgical center, hospital outpatient department, or any other location **When in-network: Prior authorization may be required for surgery or treatment services.**	PCP Office: $0 copay per visit Specialist Office: $20 copay per visit In an ambulatory surgical center, hospital outpatient department, or any other location: See **Outpatient surgery***	$45 copay per visit
• Consultation, diagnosis, and treatment by a specialist **When in-network: Prior authorization may be required for surgery or treatment services.**	$20 copay per visit	$45 copay per visit
• Basic hearing and balance exams performed by your specialist, if your doctor orders it to see if you need medical treatment	$20 copay per visit	$45 copay per visit

• Certain telehealth services, including: PCP visits, Specialist visits, Outpatient Rehabilitation Services (Physical Therapy, Occupational Therapy, Speech Therapy), Outpatient Mental Health, and Psychiatric Care.
  ○ 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 a network provider who offers the service by telehealth.
  ○ These services are provided through phone and/or video. Some services may require video. Please coordinate with your provider for these services.
	Telehealth services are provided at the same cost share as in the office or health care setting. Please see the appropriate sections of the Benefits chart for benefit rules, limits, prior authorization requirements and cost sharing.	Not covered

Covered Service	What you pay In-Network	What you pay Out-of-Network
Physician/practitioner services, including doctor's office visits* (continued) ○ You also have the option to schedule a telehealth visit 24 hours a day, 7 days a week via Teladoc. You can access Teladoc at www.teladochealth.com, by calling 1-800-TELADOC (1-800-835-2362) (TTY: 711) or via the mobile app at Teladoc.com/mobile. • 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 • 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 • Telehealth services to diagnose, evaluate, or treat symptoms of a stroke, regardless of your location • Telehealth services for members with a substance use disorder or co-occurring mental health disorder, regardless of their location • Telehealth services for diagnosis, evaluation, and treatment of mental health disorders • Telehealth services for mental health visits provided by Rural Health Clinics and Federally Qualified Health Centers • Virtual check-ins (for example, by phone or video chat) with your doctor for 5-10 minutes **if**: ○ You're not a new patient **and** ○ The check-in isn't related to an office visit in the past 7 days **and**		

Covered Service	What you pay In-Network	What you pay Out-of-Network
Physician/practitioner services, including doctor's office visits* (continued) ○ The check-in doesn't lead to an office visit within 24 hours or the soonest available appointment • Evaluation of video and/or images you send to your doctor, and interpretation and follow-up by your doctor within 24 hours **if**: ○ You're not a new patient **and** ○ The evaluation isn't related to an office visit in the past 7 days **and** ○ The evaluation doesn't lead to an office visit within 24 hours or the soonest available appointment • Consultation your doctor has with other doctors by phone, internet, or electronic health record		
• Second opinion by another network provider prior to surgery	$20 copay per visit	$45 copay per visit
• 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) **When in-network: Prior authorization is required.**	$40 copay per visit	50% coinsurance
• Telehealth services provided by qualified occupational therapists (OTs), physical therapists (PTs), speech-language pathologists (SLPs), and audiologists **When in-network: Prior authorization is required after the first 10 visits per therapy service.**	$10 copay per visit	$45 copay per visit
• Office visits performed by other health care professionals (such as a Nurse Practitioner or Physician's Assistant) **When in-network: Prior authorization may be required for some treatment services.**	PCP Office: $0 copay per visit Specialist Office: $20 copay per visit	$45 copay per visit

Covered Service	What you pay In-Network	What you pay Out-of-Network
Physician/practitioner services, including doctor's office visits* (continued) • Laboratory, diagnostic tests, and procedures	See **Outpatient diagnostic tests and therapeutic services and supplies***	
• 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	$0 copay per visit	$45 copay per visit
• 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	$0 copay per visit	$45 copay per visit
• Primary Care Provider (PCP) office visits for new or existing conditions when included with an annual wellness visit or annual routine physical visit	$0 copay per visit when received in conjunction with annual wellness visit or annual routine physical exam with Primary Care Provider	$45 copay per visit
Podiatry services* No prior authorization required. Covered services include: • Diagnosis and the medical or surgical treatment of injuries and diseases of the feet (such as hammer toe or heel spurs) • Routine foot care for members with certain medical conditions affecting the lower limbs	$20 copay per visit	50% coinsurance

Covered Service	What you pay In-Network	What you pay Out-of-Network
Pre-exposure prophylaxis (PrEP) for HIV prevention* No prior authorization required. If you don't have HIV, but your doctor or other health care practitioner determines you're at an increased risk for HIV, we cover pre-exposure prophylaxis (PrEP) medication and related services. If you qualify, covered services include: • FDA-approved oral or injectable PrEP medication including the fee for injecting the drug, if applicable • Up to 8 individual counseling sessions (including HIV risk assessment, HIV risk reduction, and medication adherence) every 12 months • Up to 8 HIV screenings every 12 months • A one-time hepatitis B virus screening	There is no coinsurance or copay for the PrEP benefit.	50% coinsurance
Prostate cancer screening exams* No prior authorization required. For men aged 50 and older, covered services include the following once every 12 months: • Digital rectal exam • Prostate Specific Antigen (PSA) test 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 or copay for an annual PSA test.	50% coinsurance

Covered Service	What you pay In-Network	What you pay Out-of-Network
Prosthetic and orthotic devices and related supplies* **When in-network: Prior authorization is required.** Devices (other than dental) that replace all or part of a body part or function. These include but aren't limited to testing, fitting, or training in the use of prosthetic and orthotic devices; as well as 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 and orthotic devices, and repair and/or replacement of prosthetic and orthotic devices. Also includes some coverage following cataract removal or cataract surgery – go to *Vision Care* later in this table for more detail.	$0 copay when internally implanted 20% coinsurance for all other	50% coinsurance
Pulmonary rehabilitation services* 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.	$15 copay per visit	50% coinsurance
Screening and counseling to reduce alcohol misuse* No prior authorization required. We cover one alcohol misuse screening for adults (including pregnant women) who misuse alcohol but aren't alcohol dependent. 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.	There is no coinsurance or copay for the Medicare-covered screening and counseling to reduce alcohol misuse preventive benefit.	50% coinsurance

Covered Service	What you pay In-Network	What you pay Out-of-Network
Screening for lung cancer with low dose computed tomography (LDCT)* No prior authorization required. For qualified people, an LDCT is covered every 12 months. **Eligible members are** people age 50 – 77 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 get an 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. *For LDCT lung cancer screenings after the initial LDCT screening:* the members must get an 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 lung cancer screening counseling and shared decision-making visit for later lung cancer screenings with LDCT, the visit must meet the Medicare criteria for such visits.	There is no coinsurance or copay for the Medicare-covered counseling and shared decision-making visit or for the LDCT.	50% coinsurance
Screening for Hepatitis C virus infection* No prior authorization required. We cover one Hepatitis C screening if your primary care doctor or other qualified health care provider orders one and you meet one of these conditions: • You're at high risk because you use or have used illicit injection drugs. • You had a blood transfusion before 1992. • You were born between 1945-1965.	There is no coinsurance or copay for the Medicare-covered screening for the Hepatitis C Virus.	50% coinsurance

Covered Service	What you pay In-Network	What you pay Out-of-Network
Screening for Hepatitis C virus infection* (continued) If you were born between 1945-1965 and aren't considered high risk, we cover a screening once. If you're at high risk (for example, you've continued to use illicit injection drugs since your previous negative Hepatitis C screening test), we cover yearly screenings.		
Screening for sexually transmitted infections (STIs) and counseling to prevent STIs* 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. 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 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.	There is no coinsurance or copay for the Medicare-covered screening for STIs and counseling for STIs preventive benefit.	50% coinsurance
Services to treat kidney disease* No prior authorization is required except as noted below. Kidney disease services include:		
• 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 6 sessions of kidney disease education services per lifetime	20% coinsurance	50% coinsurance

Covered Service	What you pay In-Network	What you pay Out-of-Network
Services to treat kidney disease* (continued) • 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)	20% coinsurance	50% coinsurance
• Inpatient dialysis treatments (if you're admitted as an inpatient to a hospital for special care)	See **Inpatient hospital care***	
• Self-dialysis training (includes training for you and anyone helping you with your home dialysis treatments) • Home dialysis equipment and supplies • Certain home support services (such as, when necessary, visits by trained dialysis workers to check on your home dialysis, to help in emergencies, and check your dialysis equipment and water supply)	20% coinsurance	50% coinsurance
Certain drugs for dialysis are covered under Medicare Part B. For information about coverage for Part B Drugs, go to **Medicare Part B drugs*** in this table**.** **When in-network: Prior authorization or step therapy is required for some drugs.**	See **Medicare Part B drugs***	
Skilled nursing facility (SNF) care* (For a definition of skilled nursing facility care, go to Chapter 12. Skilled nursing facilities are sometimes called SNFs.) **When in-network: Prior authorization is required. Limited up to 100 days per benefit period. No prior hospital stay is required.** Covered services include but aren't limited to: • Semiprivate room (or a private room if medically necessary) • Meals, including special diets • Skilled nursing services • Physical therapy, occupational therapy and speech therapy	Days 1-20: $0 copay per day Days 21-100: $221 copay per day The copays above apply per benefit period.	50% coinsurance

Covered Service	What you pay In-Network	What you pay Out-of-Network
Skilled nursing facility (SNF) care* (continued) • Drugs administered to you as part of our plan of care (this includes substances naturally present in the body, such as blood clotting factors) • Blood - including storage and administration. Coverage of whole blood and packed red cells begins only with the fourth pint of blood 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. • Medical and surgical supplies ordinarily provided by SNFs • Laboratory tests ordinarily provided by SNFs • X-rays and other radiology services ordinarily provided by SNFs • Use of appliances such as wheelchairs ordinarily provided by SNFs • Physician/Practitioner services Generally, you get SNF care from network facilities. Under certain conditions listed below, you may be able to pay in-network cost sharing for a facility that isn't a network provider, if the facility accepts our plan's amounts for payment. • A nursing home or continuing care retirement community where you were living right before you went to the hospital (as long as it provides skilled nursing facility care) • A SNF where your spouse or domestic partner is living at the time you leave the hospital	A benefit period begins on the day of admission. A benefit period ends when: • 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. If you go into a SNF after one benefit period has ended, a new benefit period begins.	

Covered Service	What you pay In-Network	What you pay Out-of-Network
Smoking and tobacco use cessation (counseling to stop smoking or tobacco use)* No prior authorization required. Smoking and tobacco use cessation counseling is covered for outpatient and hospitalized patients who meet these criteria: • Use tobacco, regardless of whether they exhibit signs or symptoms of tobacco-related disease • Are competent and alert during counseling • A qualified physician or other Medicare-recognized practitioner provides counseling We cover 2 cessation attempts per year (each attempt may include a maximum of 4 intermediate or intensive sessions, with the patient getting up to 8 sessions per year.)	There is no coinsurance or copay for the Medicare-covered smoking and tobacco use cessation preventive benefits.	50% coinsurance
Supervised exercise therapy (SET)* No prior authorization required. SET is covered for members who have symptomatic peripheral artery disease (PAD) Up to 36 sessions over a 12-week period are covered if the SET program requirements are met. The SET program must: • Consist of sessions lasting 30-60 minutes, comprising a therapeutic exercise-training program for PAD in patients with claudication • Be conducted in a hospital outpatient setting or a physician's office • Be delivered by qualified auxiliary personnel necessary to ensure benefits exceed harms and who are trained in exercise therapy for PAD	$25 copay per visit	50% coinsurance

Covered Service	What you pay In-Network	What you pay Out-of-Network
Supervised exercise therapy (SET)* (continued) • Be under the direct supervision of a physician, physician assistant (PA), or nurse practitioner (NP)/clinical nurse specialist (CNS) who must be trained in both basic and advanced life support techniques 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.		
Telehealth services	See **Physician/practitioner services, including doctor's office visits***	
Urgently needed services For coverage outside of the United States, see **Worldwide coverage**. No prior authorization required. A plan-covered service requiring immediate medical attention that's not an emergency is an urgently needed service if either you're temporarily outside our plan's service area, or, even if you're inside our plan's service area, it's unreasonable given your time, place, and circumstances to get this service from network providers. Our plan must cover urgently needed services and only charge you in-network cost sharing. Examples of urgently needed services are unforeseen medical illnesses and injuries, or unexpected flare-ups of existing conditions. Medically necessary routine provider visits (like annual checkups) aren't considered urgently needed even if you're outside our plan's service area or our plan network is temporarily unavailable.	$50 copay per visit	
Vision care (Medicare covered)* No prior authorization required. Covered services include:		
• 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	See **Physician/practitioner services, including doctor's office visits***	

Covered Service	What you pay In-Network	What you pay Out-of-Network
Vision care (Medicare covered)* (continued) • For people who are at high risk for glaucoma, we 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	$0 copay per exam See **Vision care (routine)*** for additional services	50% coinsurance See **Vision care (routine)*** for additional services
• For people with diabetes, screening for diabetic retinopathy is covered once per year	See **Vision care (routine)*** for additional services	
• One pair of eyeglasses or contact lenses after each cataract surgery that includes insertion of an intraocular lens. If you have 2 separate cataract operations, you can't reserve the benefit after the first surgery and purchase 2 eyeglasses after the second surgery There is a limited benefit and only includes basic frames, lenses or contact lenses.	$0 copay after each cataract surgery	
Vision care (routine)* No prior authorization required. **The amounts you pay for these services do not apply to your yearly maximum out-of-pocket amount.** Covered services include:		
• Routine (refractive) eye exams **Limited to one exam every calendar year.**	$0 copay per exam	
• Routine prescription eyeglasses and contact lenses The plan covers prescription eyeglasses and/or contact lenses not related to cataract surgery or a medical condition. You may purchase eye hardware from any licensed, qualified provider.	Total reimbursement for eyeglasses and/or contact lenses combined is limited to $200 every calendar year.	
• Diabetic Retinopathy and Glaucoma screenings are allowed for an unlimited number of screenings	$0 copay per exam	50% coinsurance

Covered Service	What you pay In-Network	What you pay Out-of-Network
Welcome to Medicare preventive visit* No prior authorization required. Our 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 preventive services you need (including certain screenings and shots (and vaccines)), and referrals for other care if needed. **Important:** We cover the *Welcome to Medicare* preventive visit only within the first 12 months you have Medicare Part B. When you make your appointment, let your doctor's office know you want to schedule your *Welcome to Medicare* preventive visit.	There is no coinsurance or copay for the *Welcome to Medicare* preventive visit.	50% coinsurance
Worldwide coverage **When in-network: Prior authorization is required for non-urgent or emergent follow up care. The amounts you pay for worldwide services do not apply to your yearly maximum out-of-pocket amount.** **Worldwide emergency and urgently needed services are subject to a combined annual maximum coverage limit of $20,000.** Worldwide emergency coverage for emergency department services outside of the United States: • This includes emergency or urgently needed care and emergency ambulance transportation only from the scene of an emergency to the nearest medical treatment facility. • Transportation back to the United States from another country is not covered, regardless of whether that transportation is via ambulance or some other method of transportation.	Worldwide ambulance: $300 per one way trip Worldwide emergency care and urgently needed care: $130 copay per visit	

Covered Service	What you pay In-Network	What you pay Out-of-Network
Worldwide coverage (continued) • Any pre-scheduled services, scheduled appointments, pre-planned treatments (including dialysis for an ongoing condition) and/or elective procedures that are not covered outside of the United States, even if those services are related to a previous emergency. • Services provided by a dentist are not covered. • Provider access fees, appointment fees and administrative fees are not covered. • Prescription drugs purchased outside of the United States will be reimbursed only if they are directly related to urgent or emergent services and considered medically necessary. • We will not cover drugs purchased outside of the United States that are unrelated to urgent or emergent services. • Generally, you will pay the full cost of emergency services received outside of the United States at the time you receive services and then will request reimbursement from us. Payment requests we receive from intermediaries, claims management companies or third-party billers for services received outside of the United States are not reimbursable. **Foreign taxes and fees are not covered.**		

SECTION 3 Services that aren't covered by our plan (exclusions)

This section tells you what services are *excluded* from Medicare coverage and therefore, aren't covered by this plan.

The chart below lists services and items that either aren't covered under any condition or are covered 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 get the excluded services at an emergency facility, the excluded services are still not covered, and our plan won't 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 made to not cover a medical service, go to Chapter 7, Section 5.3.)

Services not covered by Medicare	Covered only under specific conditions
Acupuncture	See **Alternative care** and **Acupuncture for chronic low back pain*** in the Benefits Chart
All services related to artificial insemination and conception by artificial means	Not covered under any condition
Ambulance triage services without transportation	Not covered under any condition
Charges for missed appointments	Not covered under any condition
Cosmetic surgery or procedures	Covered in cases of an accidental injury or for improvement of the functioning of a malformed body member Covered for all stages of reconstruction for a breast after a mastectomy, as well as for the unaffected breast to produce a symmetrical appearance
Court ordered treatments, testing, and special reports that are not directly related to medically-necessary treatment	Not covered under any condition
Custodial care Custodial care is personal care that doesn't 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	Not covered under any condition
Dental care to treat conditions such as a dental abscess, dental pain, and cavities	See **Dental services** and **Over-the-counter (OTC) allowance** in the Benefits Chart. See Chapter 4, Section 3 for more information about additional limitations.
Drugs provided to a patient during a hospital or facility stay that are considered to be self-administered	Not covered under any condition
Electron Beam Tomography (EBT) calcium scoring	Not covered under any condition
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 (Go to Chapter 3, Section 5 for more information on clinical research studies)

Services not covered by Medicare	Covered only under specific conditions
Family planning, contraceptives, and contraceptive devices	Not covered under any condition
Fees charged for care by your immediate relatives or members of your household	Not covered under any condition
Full-time nursing care in your home	Not covered under any condition
Hearing aids and provider visits to service hearing aids (except as noted in the Covered Benefits), ear molds, hearing aid accessories, warranty claim fees, and hearing aid batteries (beyond the 80 free batteries per non-rechargeable aid purchased).	Hearing aid services are limited to TruHearing. See **Hearing services (routine)*** in the Benefits Chart for information on when these services are covered.
Home-delivered meals	Not covered under any condition
Home health services	Medicare covers medically necessary part-time or intermittent skilled nursing care.
Homemaker services include basic household help, including light housekeeping or light meal preparation.	Not covered under any condition
Immunizations for the sole purpose of travel	Not covered under any condition
Incontinence supplies (such as diapers, under garments, underpads)	See **Over-the-counter (OTC) allowance** in the Benefits Chart
Massage therapy and water therapy	May be covered as part of a physical therapy program in accordance with Medicare guidelines.
Naturopath services (uses natural or alternative treatments)	See **Alternative care** 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 **Dental services** in the Benefits Chart.
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
Outpatient prescription drugs (such as self-administered or take home drugs)	Not covered under any condition
Personal items in your room at a hospital or a skilled nursing facility, such as a telephone or a television	Not covered under any condition

Services not covered by Medicare	Covered only under specific conditions
Physical exams for the following reasons: employment, licensing, insurance coverage (such as pilot's license, commercial driver's license)	Not covered under any condition
Prescription drugs prescribed for off-label use	Part B drugs may be covered when supported by Medicare recognized compendium
Private room in a hospital	Covered only when medically necessary.
Refractive eye exams	See **Vision services (routine)*** in the Benefits Chart for information on when these services are covered.
Reversal of sterilization procedures and or non-prescription contraceptive supplies	Not covered under any condition
Routine dental care, such as cleanings, fillings, or dentures	See **Dental services** and **Over-the-counter (OTC) allowance** in the Benefits Chart. See Chapter 4, Section 3 for more information about additional limitations.
Routine eye examinations, eyeglasses, radial keratotomy, LASIK surgery, and other low vision aids	One pair of eyeglasses with standard frames (or one set of contact lenses) covered after each cataract surgery that implants an intraocular lens. See **Vision care (routine)*** in the Benefits Chart.
Routine foot care (such as 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 **Over-the-counter (OTC) allowance** in the Benefits Chart.
Services considered not reasonable and necessary, according to Original Medicare standards	Not covered under any condition
Services provided by providers that are not licensed or certified by Medicare or providers that have opted out of Medicare	See **Alternative care** in the Benefits Chart
Services or prescription drugs provided outside of the United States	See **Worldwide coverage** in the Benefits Chart for coverage of services 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 **Over-the-counter (OTC) allowance** in the Benefits Chart

Services not covered by Medicare	Covered only under specific conditions
TMJ surgery, services or supplies to shorten or lengthen the upper or lower jaw.	Not covered under any condition
Transplant expenses beyond plan covered benefits (such as 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).	Not covered under any condition
Wigs, toupees, hair transplants are not covered even if they are related to a condition that is otherwise covered	Not covered under any condition

Dental Limitations and Exclusions

This section includes dental limitations and exclusions for dental coverage included on your plan.

Payment will not be made for:

- Services not considered reasonable and necessary
- Services you are entitled under any Workers' Compensation Law or Act or any other insurance plan, even if you did not claim those benefits
- Charges in excess of our maximum allowable charge (minus your member cost sharing, if there is any).
- Treatment, services, or expenses in connection with any dental procedure started prior to your effective date of this plan or after termination of your coverage
- Treatment by anyone other than a dentist, except where performed by a duly qualified hygienist under the direction of a dentist
- Services and supplies not specifically covered by the plan as defined within this document
- Localized delivery of antimicrobial agents into diseased crevicular tissue via a controlled release vehicle
- A separate charge for a biopsy of oral tissue or histopathologic exam
- Charges for missed appointments
- Collection of cultures and specimens
- Core build-ups unless used to restore a tooth that has been treated endodontically (root canal)
- Procedures, appliances, restorations, supplies, or other services that are primarily for cosmetic or aesthetic purposes (including, but not limited to, peg laterals, maxillary and mandibular (upper and lower jaw) malformations, enamel hypoplasia, veneers, and fluorosis (discoloration of teeth), bleaching of teeth and labial veneers). However,

the replacement of congenitally missing teeth is covered. (Congenital anomalies are not considered cosmetic.)

- Diagnostic casts (study models) and occlusal appliances
- Gnathological recordings, occlusal equilibration procedures, or similar procedures
- Drugs and medications that are prescribed and take-home medicine or supplies distributed by a provider. As well as premedication drugs, analgesics (for example, nitrous oxide or non-intravenous sedation), and any other euphoric drugs
- Instructions and/or training in plaque control and oral hygiene
- Services, supplies, protocols, procedures, devices, drugs or medicines that are experimental or investigational for diagnosis and treatment.
- Surgery, services, and supplies provided in connection with the treatment of simple or compound fractures of the maxilla or mandible
- General anesthesia except when administered by a dentist in connection with oral surgery in their office
- Gingivectomy, gingivoplasty, or crown lengthening in conjunction with crown preparation or fixed bridge services done on the same date of service
- Hospital charges or additional fees charged by the dentist for hospital treatment
- Hypnosis
- Indirect pulp caps are to be included in the restoration process, and are not a separate covered benefit
- A separate charge for infection control or sterilization
- Devices and procedures for intra and extra coronal splinting to stabilize mobile teeth
- Mail order or Internet/web-based providers are not eligible providers
- Repair or replacement of orthodontic appliances furnished under this plan
- Treatment of misalignment of teeth and/or jaws, or any ancillary services expressly performed because of orthodontic treatment
- Surgery to manipulate facial bones, including the jaw, in patients with facial bone abnormalities performed to restore the proper anatomic and functional relationship to the facial bones
- Periodontal probing, charting, and re-evaluations
- Photographic images
- Pin retention in addition to restoration
- Precision attachments
- Pulpotomies on permanent teeth
- Removal of clinically serviceable amalgam restorations to be replaced by other materials free of mercury, except with proof of allergy to mercury
- Services covered by the member's medical plan
- Services for rebuilding or maintaining chewing surfaces due to teeth out of alignment or occlusion, or for stabilizing the teeth
- Services for which no charge is normally made in the absence of insurance
- Services or supplies provided by or payable under any plan or program established

by a domestic or foreign government or political subdivision, unless such exclusion is prohibited by law

- Services or supplies with no charge, or the member is not legally required to pay, or a provider or facility is not licensed to provide even though the service or supply may otherwise be eligible (including any services provided by the member, or any licensed professional that is directly related to the member by blood or marriage)
- Services or supplies provided outside of the United States
- Sinus lift grafts to prepare sinus site for implants
- Services or supplies for treatment of any disturbance of the temporomandibular joint
- Services and supplies provided in connection with tooth transplantation, including re-implantation from one site to another, splinting, and/or stabilization (except re-implantation of a tooth into its original socket after it has been avulsed)
- Treatment of any illness, injury, or disease arising out of an illegal act or occupation or participation in a felony
- Charges for services or supplies for which you are unwilling to release dental or eligibility information necessary to determine the benefits payable under this plan
- The treatment of any condition caused by or arising out of any act of war, or any war declared or undeclared, or while in the service of the armed forces

CHAPTER 5:
Asking us to pay our share of a bill for covered medical services

SECTION 1 Situations when you should ask us to pay our share for covered services

Sometimes when you get medical care, you may need to pay the full cost. Other times, you may find you pay more than you expected under the coverage rules of our plan, or you may get a bill from a provider. In these cases, you can ask our plan to pay you back (reimburse you). It's your right to be paid back by our plan whenever you've paid more than your share of the cost for medical services covered by our plan. There may be deadlines that you must meet to get paid back. Go to Section 2 of this chapter.

There may also be times when you get a bill from a provider for the full cost of medical care you got or for more than your share of cost sharing as discussed in this material. First try to resolve the bill with the provider. If that doesn't work, send the bill to us instead of paying it. We'll look at the bill and decide whether the services should be covered. If we decide they should be covered, we'll pay the provider directly. If we decide not to pay it, we'll 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.

Examples of situations in which you may need to ask our plan to pay you back or to pay a bill you got:

1. **When you've got emergency or urgently needed medical care from a provider who's not in our plan's network**

   Outside the service area, you can get emergency or urgently needed services from any provider, whether or not the provider is a part of our network. In these cases,

   - You're only responsible for paying your share of the cost for emergency or urgently needed services. Emergency providers are legally required to provide emergency care.
   - If you pay the entire amount yourself at the time you get the care, ask us to pay you back for our share of the cost. Send us the bill, along with documentation of any payments you made.
   - You may get a bill from the provider asking for payment you think you don't owe. Send us this bill, along with documentation of any payments you already made.
     - If the provider is owed anything, we'll pay the provider directly.
     - If you already paid more than your share of the cost of the service, we'll

determine how much you owed and pay you back for our share of the cost.

2. **When a network provider sends you a bill you think you shouldn't pay**

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

   - You only have to pay your cost-sharing amount when you get covered services. We don't allow providers to add additional separate charges, called **balance billing**. This protection (that you never pay more than your cost-sharing amount) applies even if we pay the provider less than the provider charges for a service and even if there's a dispute and we don't pay certain provider charges.
   - Whenever you get a bill from a network provider you think is more than you should pay, send us the bill. We'll contact the provider directly and resolve the billing problem.
   - If you already paid a bill to a network provider, but feel you paid too much, send us the bill along with documentation of any payment you made and ask us to pay you back the difference between the amount you paid and the amount you owed under our plan.

3. **If you're retroactively enrolled in our plan**

   Sometimes a person's enrollment in our 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 covered services after your enrollment date, you can ask us to pay you back for our share of the costs. You need to submit paperwork such as receipts and bills for us to handle the reimbursement.

When you send us a request for payment, we'll 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'll pay for our share of the cost for the service or drug. If we deny your request for payment, you can appeal our decision. Chapter 7 has information about how to make an appeal.

SECTION 2 How to ask us to pay you back or pay a bill you got

You can ask us to pay you back by either calling us o*r* sending us a request in writing. If you send a request in writing, send your bill and documentation of any payment you've 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 got the service or item.

To make sure you're 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'll 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.

- Download a copy of the form from our website (www.Medicare.PacificSource.com) or call Customer Service at 888-863-3637 (TTY users call 711) and ask for the form.

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

PacificSource Medicare
Attn: Claims Department
PO Box 7469
Bend, OR 97708

SECTION 3 We'll consider your request for payment and say yes or no

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

- If we decide the medical care is covered and you followed all the rules, we'll pay for our share of the cost. If you already paid for the service, we'll mail your reimbursement of our share of the cost to you. If you haven't paid for the service yet, we'll mail the payment directly to the provider.
- If we decide the medical care is *not* covered, or you did *not* follow all the rules, we won't pay for our share of the cost. We'll send you a letter explaining the reasons why we aren't sending the payment and your rights to appeal that decision.

Section 3.1 If we tell you that we won't pay for all or part of the medical care or drug, you can make an appeal

If you think we made a mistake in turning down your request for payment or the amount we're paying, you can make an appeal. If you make an appeal, it means you're 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 7.

CHAPTER 6:
Your rights and responsibilities

SECTION 1 Our plan must honor your rights and cultural sensitivities

Section 1.1 We must provide information in a way that works for you and consistent with your cultural sensitivities (in languages other than English, braille, large print, or other alternate formats, etc.)

Our 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 our plan may meet these accessibility requirements include, but aren't 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 materials in braille, in large print, or other alternate formats at no cost if you need it. We're required to give you information about our plan's benefits in a format that's accessible and appropriate for you. To get information from us in a way that works for you, call Customer Service at 888-863-3637 (TTY users call 711).

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

If you have any trouble getting information from our plan in a format that's accessible and appropriate for you, seeing a women's health specialist or finding a network specialist, call to file a grievance with Customer Service at 888-863-3637 (TTY users call 711). You can 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.

Section 1.2 We must ensure you get timely access to covered services

You have the right to choose a provider in our plan's network to provide and arrange for your covered services. We don't require you to get referrals to go to network providers.

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

If you think you aren't getting your medical care within a reasonable amount of time, Chapter 7 tells what you can do.

Section 1.3 We must protect the privacy of your personal health information

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

- Your personal health information includes the personal information you gave us when you enrolled in this plan as well as your medical records and other medical and health information.
- 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've given legal power to make decisions for you first.*
- There are certain exceptions that don't require us to get your written permission first. These exceptions are allowed or required by law.
    - We're required to release health information to government agencies that are checking on quality of care.
    - Because you're a member of our plan through Medicare, we're required to give Medicare your health information. If Medicare releases your information for research or other uses, this will be done according to federal statutes and regulations; typically, this requires that information that uniquely identifies you not be shared.

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

You have the right to look at your medical records held by our plan, and to get a copy of your records. We're 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'll work with your healthcare provider to decide whether the changes should be made.

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

If you have questions or concerns about the privacy of your personal health information, call Customer Service at 888-863-3637 (TTY users call 711).

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.

Effective August 2024

Your rights

You have the right to:

- We make sure that unauthorized people don't see or change your records.
- Get a copy of your health and claims records
- Correct your records
- Request confidential communication
- Ask us to limit the information we share
- Get a list of those with whom we've shared your information
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated

Your choices

You have choices regarding how we use and share information as we:

- Answer coverage questions from your family and friends
- Help with disaster relief
- Market our services and sell your information

Our uses and disclosures

We may use and share your information as we:

- Help manage your treatment
- Run our organization
- Pay for your health services
- Administer your health plan
- Help with public health and safety issues
- Do research
- Comply with the law
- Respond to organ and tissue donation requests and work with a medical examiner or funeral director
- Address workers' compensation, law enforcement, and other government requests
- Respond to lawsuits and legal actions

When it comes to your health information, you have certain rights.

This section explains your rights and our responsibilities to help you.

- Get a copy of your health and claims records
  - You can ask to get a copy of your health and claims records and other health information we have about you. Ask us how.
  - We will provide a copy or a summary of your health and claims records, usually within 30 days of your request. We may charge a fee.
- Ask us to correct health and claims records
  - You can ask us to correct your health and claims records. Ask us how.
  - If we say “no,” we’ll tell you why within 60 days.
- Request confidential communications
  - You can ask us to contact you in a specific way or to send mail to a different address.
  - We will consider all reasonable requests. We must say “yes” if you would be in danger if we do not.
- Ask us to limit what we use or share
  - You can ask us not to use or share certain information for treatment, payment, or our operations.
  - We don’t have to agree, and we can say “no” if it would affect your care.
- Get a list of those with whom we’ve shared information
  - You can ask for a list of the times we’ve shared your health information for six years prior to the date you ask, who we shared it with, and why.
  - We will include all disclosures except those about treatment, payment, and healthcare operations, and certain other disclosures. We’ll do this once a year for free.
- Get a copy of this privacy notice
  - You can ask for a paper copy of this notice. We will send you a paper copy quickly.
- Choose someone to act for you
  - If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
  - We will make sure the person has this authority and can act for you before we take any action.
- File a complaint if you feel your rights are violated
  - Please contact us if you feel we have violated your rights.

- File a complaint with the Department of Health and Human Services Office for Civil Rights by:
  - Sending a letter to 200 Independence Avenue SW, Washington DC 20201
  - Calling 877-696-6775
  - Or visiting HHS.gov/hipaa/filing-a-complaint/what-to-expect
- We will not retaliate against you.

For certain health information, you can make choices about what we share.

If you have a clear preference for how we share your information, let us know.

- In these cases, you can tell us to:
  - Share information with your family or others paying for your care
  - Share information in a disaster-relief situation
  - If you can't tell us your preference, we may share your information if it is in your best interest. We may also share information to lessen a health or safety threat.
- In these cases, we never share your information unless you give us written permission:
  - Marketing
  - Selling your information

How do we use or share your health information?

We typically use or share your health information in the following ways.

- Help manage your healthcare treatment
  - We can use your health information and share it with people who are treating you.
  - Example: A doctor sends us information about your diagnosis and treatment plan so we can set up services.
- Run our organization
  - We can use and disclose your information to run our organization and contact you when necessary.
  - We do not use genetic information to decide whether we will give you coverage and the price of that coverage. This does not apply to long-term care plans.
  - Example: We use your health information to develop better services for you.
- Pay for your health services
  - We can use and disclose your health information as we pay for your health services.
  - Example: We share information about you with your dental plan to coordinate payment for your dental work.

- Administer your plan
  - We may share your health information to your health plan sponsor for plan administration.
  - Example: Your company contracts with us, and we give your company information to explain premiums.

How else can we use or share your health information?

We also share your information in other ways. Usually these ways contribute to the public good, such as public health and research. We must meet certain conditions to do this. Visit HHS.gov/hipaa/for-individuals/guidance-materials-for-consumers.

- Help with public health and safety issues
  - We can share your health information for situations such as:
    - Preventing disease
    - Helping with product recalls
    - Reporting adverse reactions to medications
    - Reporting abuse, neglect, or domestic violence
    - Preventing a serious health or safety threat
- Do research
  - We can share your information for health research.
- Obey the law
  - We will share information if laws require it, including with the Department of Health and Human Services if it wants to see we're following privacy laws.
- Respond to organ and tissue donation requests and work with a medical examiner or funeral director
  - We can share health information about you with organ procurement organizations.
  - We can share health information with a coroner, medical examiner, or funeral director when someone dies.
- Address workers' compensation, law enforcement, and other government requests
  - We can use or share health information about you:
    - For workers' compensation claims
    - For law enforcement purposes
    - With health oversight agencies for activities authorized by law
    - For government functions such as military, national security, and presidential protective services
- Respond to lawsuits and legal actions
  - We can share health information about you in response to lawsuits or legal actions.

Our responsibilities

- We are required to keep your protected health information private and secure.
- We will let you know if a breach may have compromised the privacy or security of your information.
- We must follow the practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you change your mind, tell us in writing.

For more information, see HHS.gov/hipaa/for-individuals/notice-privacy-practices.

Changes to the terms of this notice

If we change the terms, the changes will apply to all information we have about you. The new notice will be available on request, and we will mail a copy to you.

Section 1.4 We must give you information about our plan, our network of providers, and your covered services

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, call Customer Service at 888-863-3637 (TTY users call 711):

- **Information about our plan**. This includes, for example, information about our plan's financial condition.
- **Information about our network providers.** You have the right to get information about the qualifications of the providers 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.
- **Information about why something is not covered and what you can do about it.** Chapter 7 provides information on asking for a written explanation on why a medical service isn't covered or if your coverage is restricted. Chapter 7 also provides information on asking us to change a decision, also called an appeal.

Section 1.5 You have the right to know your treatment options and participate in decisions about your 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 your choices.** You have the right to be told about all treatment options recommended for your condition, no matter what they cost or whether they're covered by our plan.

- **To know about the risks.** You have the right to be told about any risks involved in your care. You must be told in advance if any proposed medical care or treatment is part of a research experiment. You always have the choice to refuse any experimental treatments.

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

You have the right to give instructions about what's to be done if you can't 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're in this situation. This means, *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.

Legal documents you can use to give directions in advance in these situations are called **advance directives**. Documents like a **living will** and **power of attorney for health care** are examples of advance directives.

How to set up an advance directive to give instructions:

- **Get a form.** You can get an advance directive form from your lawyer, a social worker, or some office supply stores. You can sometimes get advance directive forms from organizations that give people information about Medicare. You can also call Customer Service at 888-863-3637 (TTY users call 711) to ask for the forms.

- **Fill out the form and sign it.** No matter where you get this form, it's a legal document. Consider having a lawyer help you prepare it.

- **Give copies of the form to the right people.** 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're going to be hospitalized, and you signed an advance directive, **take a copy with you to the hospital**.

- The hospital will ask whether you signed an advance directive form and whether you have it with you.

- If you didn't sign an advance directive form, the hospital has forms available and will

ask if you want to sign one.

Filling out an advance directive is your choice (including whether you want to sign one if you're in the hospital). According to law, no one can deny you care or discriminate against you based on whether or not you signed an advance directive.

If your instructions aren't followed

If you sign an advance directive and you believe that a doctor or hospital didn't follow the instructions in it, you can file a complaint with:

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

Section 1.6 You have the right to make complaints and ask us to reconsider decisions we made

If you have any problems, concerns, or complaints and need to ask for coverage, or make an appeal, Chapter 7 of this document tells what you can do. Whatever you do — ask for a coverage decision, make an appeal, or make a complaint — **we're required to treat you fairly**.

Section 1.7 If you believe you're being treated unfairly, or your rights aren't being respected

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

If you believe you've been treated unfairly or your rights haven't been respected *and* it's *not* about discrimination, you can get help dealing with the problem you're having from these places:

- **Call Customer Service at 888-863-3637 (TTY users call 711)**
- **Call your local SHIP** at 800-722-4134
- **Call Medicare** at 1-800-MEDICARE (1-800-633-4227) (TTY users call 1-877-486-2048)

Section 1.8 How to get more information about your rights

Get more information about your rights from these places:

- **Call Customer Service at 888-863-3637 (TTY users call 711)**
- **Call your local SHIP** at 800-722-4134
- **Contact Medicare**
  - Visit Medicare.gov to read the publication *Medicare Rights & Protections*. (available at: medicare.gov/publications/11534-medicare-rights-and-protections.pdf)

- Call 1-800-MEDICARE (1-800-633-4227) (TTY users call 1-877-486-2048)

SECTION 2 Your responsibilities as a member of our plan

Things you need to do as a member of our plan are listed below. For questions, call Customer Service at 888-863-3637 (TTY users call 711).

- **Get familiar with your covered services and the rules you must follow to get these covered services.** Use this *Evidence of Coverage* document to learn what's covered and the rules you need to follow to get covered services.
  - Chapters 3 and 4 give details about medical services.
- **If you have any other health coverage in addition to our plan, or separate prescription drug coverage, you're required to tell us.** Chapter 1 tells you about coordinating these benefits.
- **Tell your doctor and other health care providers that you're enrolled in our plan.** Show our plan membership card whenever you get medical care.
- **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 you and your doctors agree on.
  - Make sure your doctors know all the drugs you're taking, including over-the-counter drugs, vitamins, and supplements.
  - If you have questions, be sure to ask and get an answer you can understand.
- **Be considerate.** We expect 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're responsible for these payments:
  - You must continue to pay your premium for your Medicare Part B to stay a member of our plan.
  - For some of your medical services covered by our plan, you must pay your share of the cost when you get the service.
- **If you move *within* our plan 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* our plan service area, you can't stay a member of our plan.**
- **If you move, tell Social Security (or the Railroad Retirement Board).**

CHAPTER 7:
If you have a problem or complaint (coverage decisions, appeals, complaints)

SECTION 1 What to do if you have a problem or concern

This chapter explains 2 types of processes for handling problems and concerns:

- 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).

Both processes have been approved by Medicare. Each process has a set of rules, procedures, and deadlines that must be followed by us and by you.

The information in this chapter will help you identify the right process to use and what to do.

Section 1.1 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. To make things easier, this chapter uses more familiar words in place of some legal terms.

However, it's sometimes important to know the correct legal terms. To help you know which terms to use to get the right help or information, we include these legal terms when we give details for handling specific situations.

SECTION 2 Where to get more information and personalized help

We're always available to help you. Even if you have a complaint about our treatment of you, we're obligated to honor your right to complain. You should always call Customer Service at 888-863-3637 (TTY users call 711) for help. In some situations, you may also want help or guidance from someone who isn't connected with us. Two organizations that can help you are:

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're having. They can also answer questions, give you more information, and offer guidance on what to do.

The services of SHIP counselors are free.

State	Agency	Phone
Oregon	Senior Health Insurance Benefits Assistance	800-722-4134

Medicare

You can also contact Medicare for help.

- Call 1-800-MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048
- Visit Medicare.gov

SECTION 3 Which process to use for your problem

Is your problem or concern about your benefits or coverage?

This includes problems about whether medical care (medical items, services and/or Part B drugs) are covered or not, the way they're covered, and problems related to payment for medical care.

Yes.

Go to **Section 4, A guide to coverage decisions and appeals.**

No.

Go to **Section 9, How to make a complaint about quality of care, waiting times, customer service or other concerns.**

Coverage decisions and appeals

SECTION 4 A guide to coverage decisions and appeals

Coverage decisions and appeals deal with problems about your benefits and coverage for your medical care (services, items, and Part B drugs, including payment). To keep things simple, we generally refer to medical items, services, and Medicare Part B drugs as **medical care**. You may use the coverage decision and appeals process for issues such as whether something is covered or not and the way in which something is covered.

Asking for coverage decisions before you get services

If you want to know if we'll cover medical care before you get it, you can ask us to make a coverage decision for you. A coverage decision is a decision we make about your benefits and coverage or about the amount we'll pay for your medical care. For example, if our plan network doctor refers you to a medical specialist not inside the network, this referral is considered a favorable coverage decision unless either you or your network doctor can show that you got a standard denial notice for this medical specialist, or the *Evidence of Coverage* makes it clear that the referred service is never covered under any condition. You or your doctor can also contact us and ask for a coverage decision if your doctor is unsure whether we'll cover a particular medical service or refuses to provide medical care you think you need.

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'll send a notice explaining why the request was dismissed and how to ask for a review of the dismissal.

We make a coverage decision whenever we decide what's covered for you and how much we pay. In some cases, we might decide medical care isn't covered or is no longer covered 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 you get a benefit, and you aren't satisfied, you can **appeal** the decision. An appeal is a formal way of asking us to review and change a coverage decision we made. Under certain circumstances, you can ask for 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 properly followed the rules. When we complete 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'll send a notice explaining why the request was dismissed and how to ask for a review of the dismissal.

If we say no to all or part of your Level 1 appeal for medical care, your appeal will automatically go on to a Level 2 appeal conducted by an independent review organization not connected to us.

- You don't need to do anything to start a Level 2 appeal. Medicare rules require we automatically send your appeal for medical care to Level 2 if we don't fully agree with your Level 1 appeal.
- Go to **Section 5.4** for more information about Level 2 appeals for medical care.

If you aren't satisfied with the decision at the Level 2 appeal, you may be able to continue through additional levels of appeal (this chapter explains the Level 3, 4, and 5 appeals processes).

Section 4.1 Get help 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:

- **Call Customer Service at 888-863-3637 (TTY users call 711)**
- **Get free help** from your State Health Insurance Program.
- **Your doctor can make a request for you.** If your doctor helps with an appeal past

Level 2, they need to be appointed as your representative. Call Customer Service at 888-863-3637 (TTY users call 711) and ask for the *Appointment of Representative* form. (The form is also available at CMS.gov/Medicare/CMS-Forms/CMS-Forms/downloads/cms1696.pdf or on our website at www.Medicare.PacificSource.com.)

  - For medical care or Part B drugs, your doctor can ask for 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.

- **You can ask someone to act on your behalf.** 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 another person to be your representative, call Customer Service at 888-863-3637 (TTY users call 711) and ask for the *Appointment of Representative* form. (The form is also available at CMS.gov/Medicare/CMS-Forms/CMS-Forms/downloads/cms1696.pdf or on our website at www.Medicare.PacificSource.com.) This form gives that person permission to act on your behalf. It must be signed by you and by the person you want to act on your behalf. You must give us a copy of the signed form.

  - We can accept an appeal request from a representative without the form, but we can't complete our review until we get it. If we don't get the form before our deadline for making a decision on your appeal, your appeal request will be dismissed. If this happens, we'll send you a written notice explaining your right to ask the independent review organization to review our decision to dismiss your appeal.

- **You also have the right to hire a lawyer.** You can contact your own lawyer or get the name of a lawyer from your local bar association or other referral service. There are groups that will give you free legal services if you qualify. However, **you aren't required to hire a lawyer** to ask for any kind of coverage decision or appeal a decision.

Section 4.2 Rules and deadlines for different situations

There are 3 different situations that involve coverage decisions and appeals. Each situation has different rules and deadlines. We give the details for each of these situations:

- **Section 5**: Medical care: How to ask for a coverage decision or make an appeal

- **Section 6**: How to ask us to cover a longer inpatient hospital stay if you think the doctor is discharging you too soon

- **Section 7**: How to ask us to keep covering certain medical services if you think your coverage is ending too soon (*Applies to only these services*: home health care, skilled nursing facility care, and Comprehensive Outpatient Rehabilitation Facility (CORF) services)

If you're not sure information applies to you, call Customer Service at 888-863-3637 (TTY users call 711). You can also get help or information from your SHIP.

SECTION 5 Medical care: How to ask for a coverage decision or make an appeal

Section 5.1 What to do if you have problems getting coverage for medical care or want us to pay you back for our share of the cost of your care

Your benefits for medical care are described in Chapter 4 in the Medical Benefits Chart. In some cases, different rules apply to a request for a Part B drug. In those cases, we'll explain how the rules for Part B drugs are different from the rules for medical items and services.

This section tells what you can do if you're in any of the 5 following situations:

1. You aren't getting certain medical care you want, and you believe this is covered by our plan. **Ask for a coverage decision. Section 5.2.**

2. Our plan won't approve the medical care your doctor or other medical provider wants to give you, and you believe this care is covered by our plan. **Ask for a coverage decision. Section 5.2.**

3. You got medical care that you believe should be covered by our plan, but we said we won't pay for this care. **Make an Appeal. Section 5.3.**

4. You got and paid for medical care that you believe should be covered by our plan, and you want to ask our plan to reimburse you for this care. **Send us the bill. Section 5.5**

5. You're being told that coverage for certain medical care you've 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 5.3**

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, go to Sections 6 and 7 of this chapter. Special rules apply to these types of care.

Section 5.2 How to ask for a coverage decision

Legal Terms:

A coverage decision that involves your medical care is called an **organization determination.**

A fast coverage decision is called an **expedited determination.**

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

A standard coverage decision is usually made within 7 calendar days when the medical item or service is subject to our prior authorization rules, 14 calendar days for all other medical items and services, 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. To get a fast coverage decision, you must meet 2 requirements:

- You may *only ask* for coverage for medical care items and/or services (not requests

for payment for items and/or services you already got).

- 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 regain function.

If your doctor tells us that your health requires a fast coverage decision, we'll 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'll decide whether your health requires that we give you a fast coverage decision. If we don't approve a fast coverage decision, we'll send you a letter that:

- Explains that we'll use the standard deadlines.
- Explains if your doctor asks for the fast coverage decision, we'll 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 asked for.

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'll give you an answer within 7 calendar days after we get your request for a medical item or service that is subject to our prior authorization rules. If your requested medical item or service is not subject to our prior authorization rules, we'll give you an answer within 14 calendar days after we get your request. If your request is for a Part B drug, we'll give you an answer within 72 hours after we get 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 calendar days** if your request is for a medical item or service. If we take extra days, we'll tell you in writing. We can't take extra time to make a decision if your request is for a Part B drug.

- If you believe we *shouldn't* take extra days, you can file a *fast complaint*. We'll 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. Go to Section 9 for information on complaints.)

For fast Coverage decisions, we use an expedited timeframe.

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

- **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 we take extra days, we'll tell you in writing. We can't take extra time to make a decision if your request is for a Part B drug.
- If you believe we *shouldn't* take extra days, you can file a *fast complaint*. (Go to Section 9 of this chapter for information on complaints.) We'll call you as soon as we make the decision.
- If our answer is no to part or all of what you asked for, we'll 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're going on to Level 1 of the appeals process.

Section 5.3 How to make a Level 1 appeal

Legal Terms:

An appeal to our plan about a medical care coverage decision is called a plan **reconsideration**.

A fast appeal is also called an **expedited reconsideration.**

Step 1: Decide if you need a standard appeal or a fast appeal.

A standard appeal is usually made within 30 calendar days or 7 calendar days for Part B drugs. A fast appeal is generally made within 72 hours.

- If you're appealing a decision we made about coverage for care, you and/or your doctor need to decide if you need a fast appeal. If your doctor tells us that your health requires a fast appeal, we'll give you a fast appeal.
- The requirements for getting a *fast appeal* are the same as those for getting a fast coverage decision in Section 5.2 of this chapter.

Step 2: Ask our plan for an Appeal or a Fast Appeal

- **If you're 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're 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 65 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 asking for an appeal.
- **You can ask for a copy of the information regarding your medical decision. 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 our plan is reviewing your appeal, we take a careful look at all the information. We check to see if we were following all the rules when we said no to your request.
- We'll gather more information if needed and may contact you or your doctor.

Deadlines for a fast appeal

- For fast appeals, we must give you our answer **within 72 hours after we get your appeal**. We'll give you our answer sooner if your health requires us to.
    - 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'll tell you in writing. We can't take extra time if your request is for a Part B drug.
    - If we don't give you an answer within 72 hours (or by the end of the extended time period if we took extra days), we're required to automatically send your request to Level 2 of the appeals process, where it will be reviewed by an independent review organization. The independent review organization will notify you in writing when it gets your appeal. Section 5.4 explains the Level 2 appeal process.
- **If our answer is yes to part or all of what you asked for,** we must authorize or provide the coverage we agreed to within 72 hours after we get your appeal.
- **If our answer is no to part or all of what you asked for,** we'll 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 gets your appeal.

Deadlines for a standard appeal

- For standard appeals, we must give you our answer **within 30 calendar days** after we get your appeal. If your request is for a Part B drug you didn't get yet, we'll give you our answer **within 7 calendar days** after we get your appeal. We'll 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'll tell you in writing. We can't take extra time to make a decision if your request is for a Part B drug.
- If you believe we shouldn't take extra days, you can file a *fast complaint*. When you file a fast complaint, we'll give you an answer to your complaint within 24 hours. (Go to Section 9 for information on complaints.)
- If we don't give you an answer by the deadline (or by the end of the extended time period), we'll send your request to a Level 2 appeal, where an independent review organization will review the appeal. The independent review organization will notify you in writing when it gets your appeal. Section 5.4 explains the Level 2 appeal process.

- **If our answer is yes to part or all of what you asked for,** we must authorize or provide the coverage within **30 calendar days** if your request is for a medical item or service, or **within 7 calendar days** if your request is for a Part B drug.
- **If our plan says no to part or all of your appeal**, we'll automatically send your appeal to the independent review organization for a Level 2 appeal. The independent review organization will notify you in writing when it gets your appeal.

Section 5.4 The Level 2 appeal process

Legal Term:

The formal name for the independent review organization is the **Independent Review Entity.** It's sometimes called the **IRE.**

The **independent review organization is an independent organization hired by Medicare**. It isn't connected with us and isn't 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: The independent review organization reviews your appeal.

- We'll send the information about your appeal to this organization. This information is called your **case file**. **You have the right to ask us for a copy of your case file**.
- You have a right to give the independent review organization additional information to support your appeal.
- Reviewers at the independent review organization will take a careful look at all the information related to your appeal.

If you had a fast appeal at Level 1, you'll also have a fast appeal at Level 2.

- For the fast appeal, the independent review organization must give you an answer to your Level 2 appeal **within 72 hours** of when it gets 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**. If they take extra days, they will notify you in writing. The independent review organization can't take extra time to make a decision if your request is for a Part B drug.

If you had a standard appeal at Level 1, you'll also have a standard appeal at Level 2.

- For the standard appeal, if your request is for a medical item or service, the independent review organization must give you an answer to your Level 2 appeal **within 30 calendar days** of when it gets your appeal. If your request is for a Part B drug, the independent review organization must give you an answer to your Level 2 appeal **within 7 calendar days** of when it gets 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**. If they take extra days, they will notify you in writing. The independent review organization can't take extra time to make a decision if your request is for a Part B drug.

Step 2: The independent review organization gives you its 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 get the decision from the independent review organization for **standard requests**. For **expedited requests**, we have **72 hours** from the date we get the decision from the independent review organization.
- **If the independent review organization says yes to part or all of a request for a Part B drug**, we must authorize or provide the Part B drug within **72 hours** after we get the decision from the independent review organization for **standard requests.** For **expedited requests,** we have **24 hours** from the date we get the decision from the independent review organization.
- **If this organization says no to part or all of your appeal**, it means they agree with us that your request (or part of your request) for coverage for medical care shouldn't 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 that:
    - Explains the decision.

- Lets you know about your 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.
- Tells you how to file a Level 3 appeal.

Step 3: If your case meets the requirements, you choose whether you want to take your appeal further.

- There are 3 additional levels in the appeals process after Level 2 (for a total of 5 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.
- The Level 3 appeal is handled by an Administrative Law Judge or attorney adjudicator. Section 8 explains the Level 3, 4, and 5 appeals processes.

Section 5.5 If you're asking us to pay for our share of a bill you got for medical care

Chapter 5 describes when you may need to ask for reimbursement or to pay a bill you have got from a provider. It also tells how to send us the paperwork that asks us for payment.

Asking for reimbursement is asking for a coverage decision from us

If you send us the paperwork asking for reimbursement, you're asking for a coverage decision. To make this decision, we'll check to see if the medical care you paid for is covered. We'll also check to see if you followed 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 the rules, we'll send you the payment for our share of the cost typically within 30 calendar days, but no later than 60 calendar days after we get your request. If you haven't paid for the medical care, we'll send the payment directly to the provider.
- **If we say no to your request:** If the medical care is *not* covered, or you did *not* follow all the rules, we won't send payment. Instead, we'll send you a letter that says we won't pay for the medical care and the reasons why.

If you don't agree with our decision to turn you down, **you can make an appeal**. If you make an appeal, it means you're 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 in Section 5.3. For appeals concerning reimbursement, note:

- We must give you our answer within 60 calendar days after we get your appeal. If you're asking us to pay you back for medical care you already got and paid for, you aren't 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 payment you asked for to you or the provider within 60 calendar days.

SECTION 6 How to ask us to cover a longer inpatient hospital stay if you think you're being discharged too soon

When you're admitted to a hospital, you have the right to get all covered hospital services necessary to diagnose and treat your illness or injury.

During your covered hospital stay, your doctor and the hospital staff will work with you to prepare for the day you leave the hospital. They'll 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're being asked to leave the hospital too soon, you can ask for a longer hospital stay, and your request will be considered.

Section 6.1 During your inpatient hospital stay, you'll get a written notice from Medicare that tells you about your rights

Within 2 calendar days of being admitted to the hospital, you'll 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 don't 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 at 888-863-3637 (TTY users call 711) or 1-800-MEDICARE (1-800-633-4227) (TTY users call 1-877-486-2048).

1. **Read this notice carefully and ask questions if you don't understand it.** It tells you:
   - Your right to get 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 quality of your hospital care.
   - Your right to **request an immediate review** of the decision to discharge you if you think you're being discharged from the hospital too soon. This is a formal, legal way to ask for a delay in your discharge date, so we'll cover your hospital care for a longer time.

2. **You'll be asked to sign the written notice to show that you got 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 got the information about your rights. The notice doesn't give your discharge date. Signing the notice **doesn't mean** you're agreeing on a discharge date.

3. **Keep your copy** of the notice so you 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 2 calendar days before your discharge date, you'll get another copy before you're scheduled to be discharged.
   - To look at a copy of this notice in advance, call Customer Service at 888-863-3637 (TTY users call 711) or 1-800 MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048. You can also get the notice online at CMS.gov/Medicare/forms-notices/beneficiary-notices-initiative/ffs-ma-im.

Section 6.2 How to make a Level 1 appeal to change your hospital discharge date

To ask us to cover your inpatient hospital services for a longer time, 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, call Customer Service at 888-863-3637 (TTY users call 711). Or call your State Health Insurance Program (SHIP) for personalized help. In Oregon, the SHIP is Senior Health Insurance Benefits Assistance at 800-722-4134. SHIP contact information is available in Chapter 2, Section 3.

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 who are 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 aren't part of our plan.

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 got (*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 can 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 don't meet this deadline, contact us.** If you decide to stay in the hospital after your planned discharge date, *you may have to pay all the costs* for hospital care you get after your planned discharge date.

- Once you ask for an immediate review of your hospital discharge the Quality Improvement Organization will contact us. By noon of the day after we're contacted, we'll 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's 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 at 888-863-3637 (TTY users call 711) or 1-800-MEDICARE (1-800-633-4227) (TTY users call 1-877-486-2048.) Or you can get a sample notice online at CMS.gov/Medicare/forms-notices/beneficiary-notices-initiative/ffs-ma-im.

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 can if you want.
- The reviewers will also look at your medical information, talk with your doctor, and review information that we and the hospital gave them.
- By noon of the day after the reviewers told us of your appeal, you'll 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's 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 independent review organization says *yes*, **we must keep providing your covered inpatient hospital services for as long as these services are medically necessary.**
- You'll 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 independent review organization says *no*, they're 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 independent review organization says *no* to your appeal and you decide to stay in the hospital, **you may have to pay the full cost** of hospital care you get 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 said no to your appeal, *and* you stay in the hospital after your planned discharge date, you can make another appeal. Making another appeal means you're going to *Level 2* of the appeals process.

Section 6.3 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 its 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 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 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 independent review organization says yes:

- **We must reimburse you** for our share of the costs of hospital care you got 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's medically necessary.**
- You must continue to pay your share of the costs and coverage limitations may apply.

If the independent review organization says no:

- It means they agree with the decision they made on your Level 1 appeal. This is called upholding the decision.
- The notice you get will tell you in writing what you can do if you want to continue with the review process.

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

- There are 3 additional levels in the appeals process after Level 2 (for a total of 5 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 8 in this chapter tells more about Levels 3, 4, and 5 of the appeals process.

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

When you're getting covered **home health services, skilled nursing care, or rehabilitation care (Comprehensive Outpatient Rehabilitation Facility)**, you have the right to keep getting your services for that type of care for as long as the care is needed to diagnose and treat your illness or injury.

When we decide it's time to stop covering any of these 3 types of care for you, we're required to tell you in advance. When your coverage for that care ends, *we'll stop paying our share of the cost for your care.*

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

Section 7.1 We'll tell you in advance when your coverage will be ending

Legal Term:

Notice of Medicare Non-Coverage. It tells you how you can ask for a **fast-track appeal.** Asking for a fast-track appeal is a formal, legal way to ask for a change to our coverage decision about when to stop your care.

1. **You get a notice in writing** at least 2 calendar days before our plan is going to stop covering your care. The notice tells you:
   - The date when we'll stop covering the care for you.
   - How to request a fast track appeal to ask 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 got it.** Signing the notice shows *only* that you got the information about when your coverage will stop. **Signing it doesn't mean you agree** with our plan's decision to stop care.

Section 7.2 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'll 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, call Customer Service at 888-863-3637 (TTY users call 711). Or call your State Health Insurance Program (SHIP) for personalized help. In Oregon, the SHIP is Senior Health Insurance Benefits Assistance at 800-722-4134. SHIP contact information is available in Chapter 2, Section 3.

During a Level 1 appeal, the Quality Improvement Organization reviews your appeal. It decides if the end date for your care is medically appropriate. The **Quality Improvement Organization** is a group of doctors and other health care experts who are 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 aren't 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 got (*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*.
- If you miss the deadline, and you want to file an appeal, you still have appeal rights. Contact the Quality Improvement Organization using the contact information on the Notice of Medicare Non-coverage. The name, address, and phone number of the Quality Improvement Organization for your state may also be found in Chapter 2.

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

Legal Term:

Detailed Explanation of Non-Coverage. Notice that gives 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 can if you want.

- The independent review organization will also look at your medical information, talk with your doctor, and review information our plan gives them.
- By the end of the day the reviewers tell us of your appeal, you'll get the *Detailed Explanation of Non-Coverage,* from us that explains in detail our reasons for ending our coverage for your services.

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's medically necessary.**
- You'll 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 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, **you'll 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 – <u>and</u> you choose to continue getting care after your coverage for the care has ended – then you can make a Level 2 appeal.

Section 7.3 How to make a Level 2 appeal to have our plan cover your care for a longer time

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 calendar days** after the day when the Quality Improvement Organization said *no* to your Level 1 appeal. You can ask for this review only if you continued getting care after the date 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 the information related to your appeal.

Step 3: Within 14 calendar days of receipt of your appeal request, reviewers will decide on your appeal and tell you their decision.

What happens if the independent review organization says yes?

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

What happens if the independent 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 want to continue with the review process. It will give you details about how to go 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 need to decide whether you want to take your appeal further.

- There are 3 additional levels of appeal after Level 2, (for a total of 5 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 8 in this chapter tells more about Levels 3, 4, and 5 of the appeals process.

SECTION 8 Taking your appeal to Levels 3, 4 and 5

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

This section may be right for you if you made a Level 1 appeal and a Level 2 appeal, and both of your appeals were turned down.

If the dollar value of the item or medical service you 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 can't appeal any further. The written response you get to your Level 2 appeal will explain how to make a Level 3 appeal.

For most situations that involve appeals, the last 3 levels of appeal work in much the same way as the first two levels. Here's 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's 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 medical care within 60 calendar days after we get the Administrative Law Judge's or attorney adjudicator's decision.
    - If we decide to appeal the decision, we'll 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 medical care in dispute.
- **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 the decision that turns down your appeal, the appeals process is over.
    - If you don't 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'll 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 medical care within 60 calendar days after getting the Council's decision.
    - If we decide to appeal the decision, we'll 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 don't 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 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 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.

Making complaints

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

Section 9.1 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 customer service. Here are examples of the kinds of problems handled by the complaint process.

Complaint	Example
Quality of your medical care	• Are you unhappy with the quality of the care you got (including care in the hospital)?
Respecting your privacy	• Did someone not respect your right to privacy or share confidential information?
Disrespect, poor customer service, or other negative behaviors	• Has someone been rude or disrespectful to you? • Are you unhappy with our Customer Service? • Do you feel you're being encouraged to leave our plan?
Waiting times	• Are you having trouble getting an appointment, or waiting too long to get it? • Have you been kept waiting too long by doctors, pharmacists, or other health professionals? Or by our Customer Service or other staff at our plan? ○ Examples include waiting too long on the phone, in the waiting or exam room, or getting a prescription.
Cleanliness	• Are you unhappy with the cleanliness or condition of a clinic, hospital, or doctor's office?
Information you get from us	• Did we fail to give you a required notice? • Is our written information hard to understand?

Complaint	Example
Timeliness (These types of complaints are all about the *timeliness* of our actions related to coverage decisions and appeals)	If you asked for a coverage decision or made an appeal, and you think we aren't responding quickly enough, you can make a complaint about our slowness. Here are examples: • You asked us for a *fast coverage decision* or a *fast appeal*, and we said no; you can make a complaint. • You believe we aren't meeting the deadlines for coverage decisions or appeals; you can make a complaint. • You believe we aren't meeting deadlines for covering or reimbursing you for certain medical items or services or drugs that were approved; you can make a complaint. • You believe we failed to meet required deadlines for forwarding your case to the independent review organization; you can make a complaint.

Section 9.2 How to make a complaint

Legal Terms:

A **complaint** is also called a **grievance**.

Making a complaint is called **filing a grievance**.

Using the process for complaints is called **using the process for filing a grievance**.

A **fast complaint** is called an **expedited grievance**.

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

- **Calling Customer Service at 888-863-3637 (TTY users call 711) is usually the first step.** If there's anything else you need to do, Customer Service will let you know.
- **If you don't want to call (or you called and weren't satisfied), you can put your complaint in writing and send it to us.** If you put your complaint in writing, we'll respond to your complaint in writing.
- **If you do this, it means that we will use our formal procedure for answering grievances**. Here's how it works:
    - You or your legal representative may file the grievance. Your representative may be a friend, lawyer, advocate, doctor, or anyone else you formally name as your representative. If your representative is not someone who is already authorized by a Court or under State law to act for you, then you and that person must sign and date a statement that gives the person legal permission to be your representative. To learn how to name your representative, you may contact Customer Service at the numbers listed above.

  - If you file your grievance in writing, please send it to the address listed 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 (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.

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

- **If possible, we'll 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'll tell you in writing.
- **If you're making a complaint because we denied your request for a fast coverage decision or a fast appeal, we'll automatically give you a fast complaint.** If you have a fast complaint, it means we'll give you **an answer within 24 hours**.
- **If we don't agree** with some or all of your complaint or don't take responsibility for the problem you're complaining about, we'll include our reasons in our response to you.

Section 9.3 You can also make complaints about quality of care to the Quality Improvement Organization

When your complaint is about *quality of care*, you have 2 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.**

Section 9.4 You can also tell Medicare about your complaint

You can submit a complaint about our plan directly to Medicare. To submit a complaint to Medicare, go to Medicare.gov/my/medicare-complaint. You can also call 1-800-MEDICARE (1-800-633-4227). TTY/TDD users call 1-877-486-2048.

CHAPTER 8:

Ending membership in our plan

SECTION 1 Ending your membership in our plan

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 decide you *want* to leave. Sections 2 and 3 give information on ending your membership voluntarily.
- There are also limited situations where we're required to end your membership. Section 5 tells you about situations when we must end your membership.

If you're leaving our plan, our plan must continue to provide your medical care, and you'll continue to pay your cost share until your membership ends.

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

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

You can end your membership in our plan during the **Open Enrollment Period** each year. During this time, review your health and drug coverage and decide about coverage for the upcoming year.

- The **Open 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 coverage:
    - Another Medicare health plan, with or without drug coverage,
    - Original Medicare *with* a separate Medicare drug plan,
    - Original Medicare *without* a separate Medicare drug plan.
- **Your membership will end in our plan** when your new plan's coverage starts on January 1.

Section 2.2 You can end your membership during the Medicare Advantage Open Enrollment Period

You can make *one* change to your health coverage during the **Medicare Advantage Open Enrollment Period** each year.

- **The Medicare Advantage Open Enrollment Period** is from January 1 to March 31 and, for new Medicare enrollees in an MA plan, from the month of entitlement to Part A and Part B until the last day of the 3rd month of entitlement.
- **During the Medicare Advantage Open Enrollment Period**, you can:
  - Switch to another Medicare Advantage Plan with or without drug coverage.
  - Disenroll from our plan and get coverage through Original Medicare. If you switch to Original Medicare during this period, you can also join a separate Medicare drug plan at the same 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 drug plan, your membership in the drug plan will start the first day of the month after the drug plan gets your enrollment request.

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

In certain situations, members of our plan may be eligible to end their membership at other times of the year. This is known as a **Special Enrollment Period**.

You may be eligible to end your membership during a Special Enrollment Period if any of the following situations apply**.** These are just examples. For the full list you can contact our plan, call Medicare, or visit Medicare.gov.

- Usually, when you move
- If you have Medicaid
- If we violate our contract with you
- If you're 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)

Enrollment time periods vary depending on your situation.

To find out if you're eligible for a Special Enrollment Period, call Medicare at 1-800 MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048. If you're 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 drug coverage.
- Original Medicare *with* a separate Medicare drug plan.
- Original Medicare *without* a separate Medicare drug plan.

Your membership will usually end on the first day of the month after we get your request to change your plan.

Section 2.4 Get more information about when you can end your membership

If you have questions about ending your membership, you can:

- **Call Customer Service at** 888-863-3637 (TTY users call 711)
- Find the information in the ***Medicare & You 2027*** handbook
- Contact **Medicare** at 1-800-MEDICARE (1-800-633-4227) TTY users call 1-877-486-2048

SECTION 3 How to end your membership in our plan

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

To switch from our plan to:	Here's what to do:
Another Medicare health plan	• Enroll in the new Medicare health plan. • You'll automatically be disenrolled from our plan when your new plan's coverage starts.
Original Medicare *with* a separate Medicare drug plan	• Enroll in the new Medicare drug plan. • You'll automatically be disenrolled from our plan when your new plan's coverage starts.
Original Medicare *without* a separate Medicare drug plan	• **Send us a written request to disenroll.** Contact Customer Service at 888-863-3637 (TTY users call 711) if you need more information on how to do this. • You can also contact **Medicare** at 1-800-MEDICARE (1-800-633-4227) and ask to be disenrolled. TTY users call 1-877-486-2048. • You'll be disenrolled from our plan when your coverage in Original Medicare starts.

Note: If you also have creditable prescription drug coverage (e.g., a separate Medicare drug plan) and disenroll from that coverage, you may have to pay a Part D late enrollment penalty if you join a Medicare drug plan later after going without creditable prescription drug coverage for 63 days or more in a row.

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

Until your membership ends, and your new Medicare coverage starts, you must continue to get your medical items, services care through our plan.

- **Continue to use our network providers to get medical care.**
- **If you're hospitalized on the day your membership ends, your hospital stay will be covered by our plan until you're discharged** (even if you're discharged after your new health coverage starts).

SECTION 5 Our plan must end your plan membership in certain situations

Our plan mu**st end your membership in our plan if any of the following happen:**

- If you no longer have Medicare Part A and Part B
- If you move out of our service area
- If you're away from our service area for more than 6 months
  - If you move or take a long trip, call Customer Service at 888-863-3637 (TTY users call 711) to find out if the place you're moving or traveling to is in our plan's area
- If you become incarcerated (go to prison)
- If you're no longer a United States citizen or national, or eligible noncitizen
- If you intentionally give us incorrect information when you're enrolling in our plan, and that information affects your eligibility for our plan (We can't make you leave our plan for this reason unless we get permission from Medicare first)
- If you continuously behave in a way that's disruptive and makes it difficult for us to provide medical care for you and other members of our plan (We can't 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 can't 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 don't pay your plan premiums for two calendar months.
  - We must notify you in writing that you have two calendar months to pay your plan premium before we end your membership

If you have questions or want more information on when we can end your membership, call Customer Service at 888-863-3637 (TTY users call 711).

Section 5.1 We can't ask you to leave our plan for any health-related reason

Our plan isn't allowed to ask you to leave our plan for any health-related reason.

What should you do if this happens?

If you feel you're being asked to leave our plan because of a health-related reason, call Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048.

Section 5.2 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 9:

Legal notices

SECTION 1 Notice about governing law

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, (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 aren't included or explained in this document.

SECTION 2 Notice about nondiscrimination

We don't discriminate based on race, ethnicity, national origin, color, religion, sex, age, 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, 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 HHS.gov/ocr/index.html.

If you have a disability and need help with access to care, call Customer Service at 888-863-3637 (TTY users call 711). If you have a complaint, such as a problem with wheelchair access, Customer Service can help.

SECTION 3 Notice about Medicare Secondary Payer subrogation rights

We have the right and responsibility to collect for covered Medicare services for which Medicare is not the primary payer. According to CMS regulations at 42 CFR sections 422.108 and 423.462, 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 10:

Definitions

Allowed Amount – The dollar amount considered payment-in-full by the plan. It includes any amount paid by the plan as well as any member cost sharing (such as copays and coinsurances). The Allowed Amount is typically a discounted rate rather than the actual charges billed by the provider.

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 doesn't 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 payment for services you already got. You may also make an appeal if you disagree with our decision to stop services that you're getting.

Balance Billing – When a provider (such as a doctor or hospital) bills a patient more than our plan's allowed cost-sharing amount. As a member of our plan, you only have to pay our plan's cost-sharing amounts when you get services covered by our plan. We don't allow providers to **balance bill** or otherwise charge you more than the amount of cost sharing our plan says you must pay.

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

Centers for Medicare & Medicaid Services (CMS) – The federal agency that administers Medicare.

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

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 about quality of care, waiting times, and the customer service you get. It also includes complaints if our plan doesn't 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 percentage.

Cost Sharing – Cost sharing refers to amounts that a member has to pay when services are gotten. Cost sharing includes any combination of the following 3 types of payments: 1) any deductible amount a plan may impose before services are covered; 2) any fixed copayment amount that a plan requires when a specific service is gotten; or 3) any coinsurance amount, a percentage of the total amount paid for a service, that a plan requires when a specific service is gotten.

Covered Services – The term we use to mean all 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 don't need skilled medical care or skilled nursing care. Custodial care, provided by people who don't 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.

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

Disenroll or **Disenrollment** – The process of ending your membership in our plan.

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're 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.

Extra Help – A Medicare program to help people with limited income and resources pay Medicare prescription drug program costs, such as premiums, deductibles, and coinsurance.

Grievance - A type of complaint you make about our plan or providers, including a complaint concerning the quality of your care. This doesn't involve coverage or payment disputes.

Health Maintenance Organization (HMO) – A Health Maintenance 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 HMO plan will cover all plan benefits only when they are received from in-network providers, unless noted otherwise.

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

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. Our plan must provide you with a list of hospices in your geographic area. If you elect hospice and continue to pay premiums, you're still a member of our plan. You can still get all medically necessary services as well as the supplemental benefits we offer.

Hospital Inpatient Stay – A hospital stay when you've been formally admitted to the hospital for skilled medical services. Even if you stay in the hospital overnight, you might still be considered an outpatient.

Initial Enrollment Period – When you're 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 Maximum Out-of-Pocket Amount – The most that you pay out-of-pocket during the calendar year for in-network covered Part A and Part B services. Amounts you pay for your Medicare Part A and Part B premiums don't count toward the maximum out-of-pocket amount.

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**.

Low Income Subsidy (LIS) – Go to Extra Help.

Maximum Allowable Charge – The most a provider can charge for a service.

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 Medicaid programs vary, but most health care costs are covered if you qualify for both Medicare and Medicaid.

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).

Medicare Advantage Open Enrollment Period – The time period from January 1 to March 31 when members in a Medicare Advantage plan can cancel their plan enrollment and switch to another Medicare Advantage plan or get 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 a person 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 i) an HMO, ii) a PPO, iii) a Private Fee-for-Service (PFFS) plan, or iv) a 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-Covered Services – Services covered by Medicare Part A and Part B. All Medicare health plans must cover all the services that are covered by Medicare Part A and B. The term Medicare-Covered Services doesn't 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 our 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 & Medicaid Services (CMS).

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.

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 2 parts: Part A (Hospital Insurance) and Part B (Medical Insurance) and is available everywhere in the United States.

Out-of-Network Provider or Out-of-Network Facility – A provider or facility that doesn't have a contract with our plan to coordinate or provide covered services to members of our plan. Out-of-network providers are providers that aren't employed, owned, or operated by our plan.

Out-of-Pocket Costs – Go to the definition for cost sharing above. A member's cost-sharing requirement to pay for a portion of services gotten 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 services and supports (LTSS) 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 get both their Medicare and Medicaid benefits through our plan.

Part C – Go to Medicare Advantage (MA) Plan.

Part D – The voluntary Medicare Prescription Drug Benefit Program.

Pharmacy Benefit Manager (PBM) – Typically a third party administrator who is responsible for processing and paying prescription drug claims on behalf of a health plan.

Point-of-Service (POS) – A type of managed care health insurance plan with characteristics of both an HMO and a PPO. This type of health insurance plan gives the Member the flexibility to receive some services from out-of-network providers.

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're received from network or out-of-network providers. Member cost sharing will generally be higher when plan benefits are gotten from out-of-network providers. PPO plans have an annual limit on your out-of-pocket costs for services received from network (preferred) providers and a higher limit on your total combined out-of-pocket costs for services from both in-network (preferred) and out-of-network (non-preferred) providers.

Premium – The periodic payment to Medicare, an insurance company, or a health care plan for health or prescription drug coverage.

Preventive services – Health care services that help you stay healthy, detect health problems early, determine the most effective treatments, and prevent certain diseases. Preventive services include exams, shots, lab tests, and screenings. They also include programs for health monitoring, and counseling and education to help you take care of your own health.

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 based on specific criteria. Covered services that need prior authorization are marked in the Medical Benefits Chart in Chapter 4.

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.

Rehabilitation Services – These services include inpatient rehabilitation care, physical therapy (outpatient), 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. Our plan must disenroll you if you permanently move out of our 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 Enrollment Period – A set time when members can change their health or drug plans or return to Original Medicare. Situations in which you may be eligible for a Special Enrollment Period include: if you move outside the service area, if you move into a nursing home, or if we violate our contract with you.

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 aren't the same as Social Security benefits.

Urgently Needed Services – A plan-covered service requiring immediate medical attention that's not an emergency is an urgently needed service if either you're temporarily outside our plan's service area, or it's unreasonable given your time, place, and circumstances to get this service from network providers. Examples of urgently needed services are unforeseen medical illnesses and injuries, or unexpected flare-ups of existing conditions. Medically necessary routine provider visits (like annual checkups) aren't considered urgently needed even if you're outside our plan's service area or our plan network is temporarily unavailable.

Our Plan Customer Service

Customer Service – Contact Information	
Call	888-863-3637 Calls to this number are free. Hours are: **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. • During this time of the year, please leave a message on weekends, holidays, and after hours. We will return your call the next business day. Customer Service 888-863-3637 (TTY users call 711) also has free language interpreter services for non-English speakers.
TTY	711. We accept all relay calls. This number requires special telephone equipment and is only for people who have difficulties hearing or speaking. Calls to this number are free. Hours are: **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.
Fax	541-322-6423
Write	PacificSource Medicare Customer Service Department PO Box 7469 Bend, Oregon 97708 MedicareCS@PacificSource.com
Website	Medicare.PacificSource.com

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.

Senior Health Insurance Benefits Assistance (Oregon SHIP) – Contact Information	
Call	800-722-4134
TTY	711 This number requires special telephone equipment and is only for people who have difficulties hearing or speaking.
Write	Senior Health Insurance Benefits Assistance 500 Summer St. NE, E-12 Salem, OR 97301
Website	shiba.oregon.gov

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