

Today's Options® PFFS

Medicare Advantage Health Plans



January 1 – December 31, 2012

Evidence of Coverage:

Your Medicare Health Benefits and Services as a Member of Today's Options Premier 400 (PFFS)

This booklet gives you the details about your Medicare health care coverage from January 1 – December 31, 2012. It explains how to get the health care you need covered. This is an important legal document. Please keep it in a safe place.

This plan, Today's Options Premier 400 (PFFS), is offered by American Progressive Life & Health Insurance Company of New York and The Pyramid Life Insurance Company. (When this Evidence of Coverage says “we,” “us,” or “our,” it means American Progressive Life & Health Insurance Company of New York and The Pyramid Life Insurance Company. When it says “plan” or “our plan,” it means Today's Options Premier 400 (PFFS).)

Today's Options® PFFS is offered by the following organizations that contract with the Federal government: American Progressive Life & Health Insurance Company of New York and The Pyramid Life Insurance Company, members of the Universal American family of companies.

Medicare-approved PFFS plan.

This information is available for free in other languages. Please contact our Member Services number at (866) 568-8921 for additional information. (TTY users should call (877) 907-2986. Hours are 8:00 a.m. to 8:00 p.m. in your local time zone, 7 days a week. Member Services also has free language interpreter services available for non-English speakers.

Esta información está disponible gratuitamente en otros idiomas. Por favor, póngase en contacto con nuestro número de servicios al miembro al (866) 568-8921 para obtener información adicional. (Los usuarios de TTY deben llamar (877) 907-2986. Horas son 8:00 a.m. a 8:00 p.m. en la zona horaria local, 7 días a la semana. Servicios para Miembros también dispone de intérprete de lengua servicios disponibles para quienes no hablan inglés.

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

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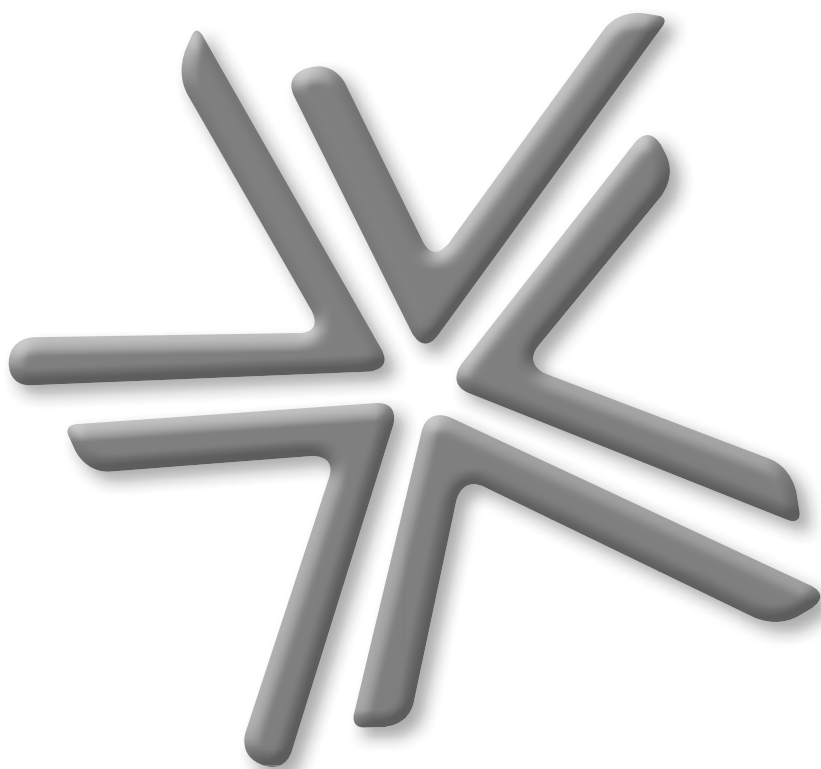
PFFS

Today's Options[®] PFFS

Medicare Advantage Health Plans

2012 Evidence of Coverage

January 1 -- December 31, 2012



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2012 Evidence of Coverage
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SECTION 1 Introduction

Section 1.1 You are enrolled in Today's Options Premier 400 (PFFS), which is a Medicare Private Fee-for-Service Plan
--

You are covered by Medicare, and you have chosen to get your Medicare health care through our plan, Today's Options Premier 400 (PFFS).

There are different types of Medicare health plans. Our plan is a Medicare Advantage Private Fee-for-Service (PFFS) Plan. Like all Medicare health plans, this Medicare PFFS plan is approved by Medicare and run by a private company.

Section 1.2 What is the <i>Evidence of Coverage</i> booklet about?
--

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

This plan, Today's Options Premier 400 (PFFS), is offered by American Progressive Life & Health Insurance Company of New York and The Pyramid Life Insurance Company. (When this *Evidence of Coverage* says “we,” “us,” or “our,” it means American Progressive Life & Health Insurance Company of New York and The Pyramid Life Insurance Company. When it says “plan” or “our plan,” it means Today's Options Premier 400 (PFFS).

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

Section 1.3 What does this Chapter tell you?
--

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

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

Section 1.4 What if you are new to our plan?
--

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

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

Section 1.5 Legal information about the *Evidence of Coverage*

It's part of our contract with you

This *Evidence of Coverage* is part of our contract with you about how our plan covers your care. Other parts of this contract include your enrollment form and any notices you receive from us about changes to your coverage or conditions that affect your coverage. These notices are sometimes called "riders" or "amendments."

The contract is in effect for months in which you are enrolled in our plan between January 1, 2012 and December 31, 2012.

Medicare must approve our plan each year

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

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

Section 2.1 Your eligibility requirements

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

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

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

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

- Medicare Part A generally covers services furnished by institutional providers such as hospitals, skilled nursing facilities, or home health agencies.

- Medicare Part B is for most other medical services (such as physician's services and other outpatient services) and certain items (such as durable medical equipment and supplies).

Section 2.3 Here is the plan service area for our plan

Although Medicare is a Federal program, our plan is available only to individuals who live in our plan service area. To remain a member of our plan, you *generally* must keep living in this service area. The service area is described in Appendix B of this *Evidence of Coverage*.

We offer coverage in several states. However, there may be cost or other differences between the plans we offer in each state. If you move out of the state where you live into a state that is still within our service area, you must call Member Services in order to update your information. If you move into a state outside of our service area, you cannot remain a member of our plan. Please call Member Services to find out if we have a plan in your new state.

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

SECTION 3 What other materials will you get from us?

Section 3.1 Your plan membership card – Use it to get all covered care

While you are a member of our plan, you must use your membership card for our plan whenever you get any services covered by this plan.

Here is a sample membership card to show you what yours will look like:

Today's Options® PFFS Plan Name (PFFS)

Medicare Advantage Private Fee-for-Service Plan
Issuer ID: XXXXX

John Q. Smith
Member ID: XXXXXXXXXXXX

Member Copays	Rx BIN	XXXXXX
PCP / Spec / ER / Urg Care	Rx PCN	XXX
\$XX \$XX \$XX \$XX	Rx GRP	XXXXXXXXX
		XXXXX XXX

Important Phone Numbers:
Member Services: 1-XXX-XXX-XXXX/TTYXXX-XXX-XXXX
24/7 Health Hotline: 1-XXX-XXX-XXXX/TTYXXX-XXX-XXXX
In emergency, call 911 or go to the nearest emergency room.

Information for Providers: www.TodaysOptions.com
Underwriter: XXXXXXXXXXXXXXXX
Provider Relations: 1-XXX-XXX-XXXX
Pharmacy Support: 1-XXX-XXX-XXXX

Providers may send claims to:
Medical: XXXXXXXXXXXXXXXXXXXX, P.O. Box XXXXXX,
City, ST XXXXX-XXXX
Pharmacy: XXXXXXXXXXXXXXXXXXXX, P.O. Box XXXXX
City, ST XXXXX-XXXX

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

Here's why this is so important: If you get covered services using your red, white, and blue Medicare card instead of using your Today's Options Premier 400 (PFFS) membership card while you are a plan member, you may have to pay the full cost yourself.

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

SECTION 4 Your monthly premium for our plan

Section 4.1 How much is your plan premium?
--

As a member of our plan, you pay a monthly plan premium. The monthly premium amount for our plan is listed in Appendix B of this *Evidence of Coverage*. In addition, you must continue to pay your Medicare Part B premium (unless your Part B premium is paid for you by Medicaid or another third party).

Many members are required to pay other Medicare premiums

As explained in Section 2 above, in order to be eligible for our plan, you must be entitled to Medicare Part A and enrolled in Medicare Part B. For that reason, some plan members will be paying a premium for Medicare Part A and most plan members will be paying a premium for Medicare Part B, in addition to paying the monthly plan premium. You must continue paying your Medicare Part B premium to remain a member of the plan.

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

Section 4.2 There are several ways you can pay your plan premium
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There are three (3) ways you can pay your plan premium. These choices are explained to you during the enrollment process and are found on your enrollment application. If you have any additional questions about how to pay your Plan premiums, or would like to change your payment options (as explained below), please contact Member Services. The contact information for Member Services can be found in Chapter 2.

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

Option 1: You can pay by check

If you elect Direct Bill option, your monthly premium will be mailed to you on or around the 10th of each month. Your premium payment will be due, via personal check, cashier's check or money order, by the 1st day of the following month. Please remit payments to:

Today's Options Premier 400 (PFFS)
P.O. Box 504734
St Louis, MO 63150-4734

Please include your payment along with the statement coupon and your Subscriber ID written on the check, cashier's check or money order.

Option 2: You can pay by automatic withdrawal from your checking or savings account

If you elect to pay via Automatic Bank Withdrawal from your checking or savings account, your monthly premium will be automatically deducted from your checking or savings account on or around the 5th day of each month.

You may contact Member Services and request a Change Notice Form, which will include specific instructions, to set up your Automatic Bank Withdrawal.

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

You can have the plan premium taken out of your monthly Social Security check. Contact Member Services for more information on how to pay your plan premium this way. We will be happy to help you set this up.

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

Your plan premium is due in our office by the 1st day of each month.

If you are having trouble paying your premium on time, please contact Member Services to see if we can direct you to programs that will help with your plan premium.

We have the right to pursue collection of these premiums.

Section 4.3	Can we change your monthly plan premium during the year?
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No. We are not allowed to change the amount we charge for the plan's monthly plan premium during the year. If the monthly plan premium changes for next year we will tell you in September and the change will take effect on January 1.

SECTION 5

Please keep your plan membership record up to date

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

We use information in your membership record to provide your coverage and to coordinate your benefits with any other insurance you have. Because of this, it is very important that you help us keep your information up to date.

Let us know about these changes:

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

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

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

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

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

SECTION 6 We protect the privacy of your personal health information

Section 6.1 We make sure that your health information is protected
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Federal and state laws protect the privacy of your medical records and personal health information. We protect your personal health information as required by these laws.

For more information about how we protect your personal health information, please go to Chapter 6, Section 1.4 of this booklet.

SECTION 7 How other insurance works with our plan

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

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

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

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

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

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

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

If you have other insurance, tell your doctor, hospital, and pharmacy. If you have questions about who pays first, or you need to update your other insurance information, call Member Services (phone numbers are on the back cover of this booklet.) You may need to give your plan member ID number to your other insurers (once you have confirmed their identity) so your bills are paid correctly and on time.

Chapter 2. Important phone numbers and resources

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SECTION 1 **Today's Options Premier 400 (PFFS) contacts** (how to contact us, including how to reach Member Services at the plan)

How to contact our plan's Member Services

For assistance with claims, billing or member card questions, please call or write to Today's Options Premier 400 (PFFS) Member Services. We will be happy to help you.

Member Services	
CALL	(866) 568-8921. Calls to this number are free. Hours are 8:00 a.m. to 8:00 p.m. in your local time zone, 7 days a week. Member Services also has free language interpreter services available for non-English speakers.
TTY	(877) 907-2986 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free. Hours are 8:00 a.m. to 8:00 p.m. in your local time zone, 7 days a week.
FAX	(877) 907-2982
WRITE	Today's Options PFFS P.O. Box 742528 Houston, TX 77274
WEBSITE	www.TodaysOptions.com

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

A coverage decision is a decision we make about your benefits and coverage or about the amount we will pay for your medical services. For more information on asking for coverage decisions about your medical care, see Chapter 7 (*What to do if you have a problem or complaint (coverage decisions, appeals, complaints)*).

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

Coverage Decisions for Medical Care	
CALL	(866) 568-8921. Calls to this number are free. Hours are 8:00 a.m. to 8:00 p.m. in your local time zone, 7 days a week.
TTY	(877) 907-2986 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free. Hours are 8:00 a.m. to 8:00 p.m. in your local time zone, 7 days a week.
FAX	(877) 907-2982
WRITE	Today's Options PFFS c/o Medical Management P.O. Box 740444 Houston, TX 77274-0444
WEBSITE	www.TodaysOptions.com

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

An appeal is a formal way of asking us to review and change a coverage decision we have made. For more information on making an appeal about your medical care, see Chapter 7 (*What to do if you have a problem or complaint (coverage decisions, appeals, complaints)*).

Appeals for Medical Care	
CALL	(866) 568-8921 Calls to this number are free. Hours are 8:00 a.m. to 8:00 p.m. in your local time zone, 7 days a week.
TTY	(877) 907-2986 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free. Hours are 8:00 a.m. to 8:00 p.m. in your local time zone, 7 days a week.
FAX	(800) 817-3516
WRITE	Today's Options PFFS c/o Appeals and Grievances P.O. Box 742608 Houston, TX 77274
WEBSITE	www.TodaysOptions.com

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

You can make a complaint about us or one of our providers, including a complaint about the quality of your care. This type of complaint does not involve coverage or payment disputes. (If your problem is about the plan's coverage or payment, you should look at the section above about making an appeal.) For more information on making a complaint about your medical care, see Chapter 7 (*What to do if you have a problem or complaint (coverage decisions, appeals, complaints)*).

Complaints about Medical Care	
CALL	(866) 568-8921 Calls to this number are free. Hours are 8:00 a.m. to 8:00 p.m. in your local time zone, 7 days a week.
TTY	(877) 907-2986 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free. Hours are 8:00 a.m. to 8:00 p.m. in your local time zone, 7 days a week.
FAX	(800) 817-3516
WRITE	Today's Options PFFS c/o Appeals and Grievances P.O. Box 742608 Houston, TX 77274

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

For more information on situations in which you may need to ask us for reimbursement or to pay a bill you have received from a provider, see Chapter 5 (*Asking us to pay our share of a bill you have received for covered medical services*).

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

Payment Requests	
CALL	(866) 568-8921 Calls to this number are free. Hours are 8:00 a.m. to 8:00 p.m. in your local time zone, 7 days a week.
TTY	(877) 907-2986 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free. Hours are 8:00 a.m. to 8:00 p.m. in your local time zone, 7 days a week.
FAX	(713) 972-0247
WRITE	Today's Options PFFS P.O. Box 742568 Houston, TX 77274
WEBSITE	www.TodaysOptions.com

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

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

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

Medicare	
CALL	1-800-MEDICARE, or 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 with hearing or speaking. Calls to this number are free.
WEBSITE	http://www.medicare.gov This is the official government website for Medicare. It gives you up-to-date information about Medicare and current Medicare issues. It also has information about hospitals, nursing homes, physicians, home health agencies, and dialysis facilities. It includes booklets you can print directly from your computer. You can also find Medicare contacts in your state by selecting "Help and Support" and then clicking on "Useful Phone Numbers and Websites." The Medicare website also has detailed information about your Medicare eligibility and enrollment options with the following tools: <ul style="list-style-type: none">• Medicare Eligibility Tool: Provides Medicare eligibility status information. Select "Find Out if You're Eligible."• Medicare Plan Finder: Provides personalized information about available Medicare prescription drug plans, Medicare health plans, and Medigap (Medicare Supplement Insurance) policies in your area. Select "Health & Drug Plans" and then "Compare Drug and Health Plans" or "Compare Medigap Policies." These tools provide an <i>estimate</i> of what your out-of-pocket costs might be in different Medicare plans. If you don't have a computer, your local library or senior center may be able to help you visit this website using its computer. Or, you can call Medicare at the number above and tell them what information you are looking for. They will find the information on the website, print it out, and send it to you.

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

The State Health Insurance Assistance Program (SHIP) is a government program with trained counselors in every state. For information about the SHIP in your state, see Appendix A of this *Evidence of Coverage*. SHIP is independent (not connected with any insurance company or health plan). It is a state program that gets money from the Federal government to give free local health insurance counseling to people with Medicare.

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

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

There is a Quality Improvement Organization for each state. For information about the Quality Improvement Organization in your state, see Appendix A of this *Evidence of Coverage*.

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

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

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

SECTION 5 **Social Security**

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

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

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

Medicaid is a joint Federal and state government program that helps with medical costs for certain people with limited incomes and resources. Some people with Medicare are also eligible for Medicaid. For information about the Medicaid office in your state, see Appendix A of this *Evidence of Coverage*.

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

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

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

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

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

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

SECTION 8 Do you have "group insurance" or other health insurance from an employer?

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

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

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

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

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

Section 1.1 What are “covered services”?

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

- **“Providers”** are doctors and other health care professionals licensed by the state to provide medical services and care. The term “providers” also includes hospitals and other health care facilities.
- **“Covered services”** include all the medical care, health care services, supplies, and equipment that are covered by our plan. Your covered services for medical care are listed in the Benefits Chart in Chapter 4.

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

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

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

- **The care you receive is included in the plan's Medical Benefits Chart** (this chart is in Chapter 4 of this booklet).
- **The care you receive is considered medically necessary.** “Medically necessary” means that the services, supplies or drugs are needed for the prevention, diagnosis or treatment of your medical condition and meet accepted standards of medical practice.
- **You receive your care from a provider in the United States who (1) agrees to accept our plan's terms and conditions** of payment prior to providing services to you and **(2) is eligible to provide services under Original Medicare.**
 - A Medicare Advantage Private Fee-for-Service plan works differently than a Medicare supplement plan. Your provider is not required to agree to accept the plan's terms and conditions of payment, and thus may choose not to treat you, with the exception of emergencies. If your provider does not agree to accept our terms and conditions of payment, they may choose not to provide health care services to you, except in emergencies. If this happens, you will need to find another provider that will accept our terms and conditions of payment. Providers can find the plan's terms and conditions of payment on our website at: www.TodaysOptions.com.

- A provider is considered to have agreed to accept the terms and conditions of payment if the provider was aware that you are a member of the PFFS plan before providing services to you (for example: if you showed them your PFFS plan card); the provider had reasonable access to our terms and conditions of payment; and the provider provided covered services to you. The provider doesn't have to actually read the terms and conditions of payment - If the provider had the opportunity to read them and treats you, the law deems this provider to have agreed to accept our plan's terms and conditions of payment for that specific visit.
 - You must show your plan membership card every time you visit a provider. A provider can decide at every visit whether to accept our plan's terms and conditions, and thus treat you. A provider cannot change his/her mind about accepting the terms and conditions of payment after providing services.
 - Not all providers accept our plan's terms and conditions of payment or agree to treat you. If a provider from whom you seek care decides not to accept our plan's terms and conditions of payment or refuses to treat you, then you will need to find another provider that will accept our plan's terms and conditions of payment. A provider that decides not to accept our plan's terms and conditions of payment should not provide services to you, except in emergencies. You may contact us at (866) 568-8921 for assistance locating another provider in your area who will accept our plan's terms and conditions of payment.
- If you need emergency care, it is covered whether a provider agrees to accept the plan's payment terms or not.
- **You are required to pay only the copayment or coinsurance amount allowed by our plan at the time of the visit.** You should ask the provider to bill the plan for your covered services. If provider asks you to pay the full amount of the services, and have you paid back by the plan, remind the provider that you are only responsible for the cost-sharing amount. If the provider wants further information on payment for covered services, please have the provider contact us at (866) 568-8921 or via written correspondence to: Today's Options PFFS, P.O. Box 742568, Houston, TX 77274.
- If you receive a service from a provider who accepts our plan's terms and conditions of payment, you and the provider have the right to request a written coverage decision from us before you get the service in order to confirm that the service is medically necessary and a covered service, and therefore, will be paid for by our plan. Chapter 7 has more information about what to do if you want a coverage decision from us or want to appeal a decision we have already made.
- Our plan does not require members or their providers to obtain prior authorization or a referral from the plan as a condition for covering medically necessary services that are covered by our plan. Under prior authorization, a plan requires members or providers to seek authorization from the plan prior to obtaining services. There is no such requirement for our members. Our plan also does not have any prior notification rules. Under prior notification, a plan charges members lower cost-sharing amounts for some services if members or their providers notify the plan before the member receives the service. If you have any questions about whether we will pay for any medical service or care that you are considering, you have the right to ask us whether we will cover it before you get it.

SECTION 2 How to get covered services when you have an emergency

Section 2.1 Getting care if you have a medical emergency
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What is a “medical emergency” and what should you do if you have one?

A “medical emergency” is when you believe that you have an injury or illness that requires immediate medical attention to prevent a disability or death. A medical emergency can include severe pain, a bad injury, a sudden illness, or a medical condition that is quickly getting much worse.

If you have a medical emergency:

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

What is covered if you have a medical emergency?

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

This plan covers emergency services outside the U.S. For more information, see the Medical Benefits Chart in Chapter 4 of this booklet.

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

After the emergency is over you are entitled to follow-up care to be sure your condition continues to be stable. If you decide to get follow-up care from the provider treating you, then you should advise them of your plan enrollment as soon as possible, by showing them your membership ID card. The plan will pay for all medically-necessary plan-covered services furnished by the provider and non-emergency care that you get from any provider in the United States who agrees to accept our plan's terms and conditions of payment and is eligible to provide services under Original Medicare.

What if it wasn't a medical emergency?

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

SECTION 3 What if you are billed directly for the full cost of your covered services?

Section 3.1 You can ask the plan to pay our share of the cost of your covered services
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If you have paid more than your share for covered services, or if you have received a bill for the full cost of covered medical services, go to Chapter 5 (*Asking us to pay our share of a bill you have received for covered medical services*) for information about what to do.

Section 3.2 If services are not covered by our plan, you must pay the full cost

Our plan covers all medical services that are medically necessary, are listed in the plan's Medical Benefits Chart (this chart is in Chapter 4 of this booklet), and are obtained consistent with plan rules. You are responsible for paying the full cost of services that aren't covered by our plan.

If you receive a service from a provider who accepts our plan's terms and conditions of payment, you and the provider have the right to request a written coverage decision from us before you get the service in order to confirm that the service is medically necessary and a covered service, and therefore, will be paid for by our plan.

If we say we will not cover your services, you have the right to appeal our decision not to cover your care. Chapter 7 (*What to do if you have a problem or complaint (coverage decisions, appeals, complaints)*) has more information about what to do if you want a coverage decision from us or want to appeal a decision we have already made. You may also call Member Services at the number on the back cover of this booklet to get more information about how to do this.

For covered services that have a benefit limitation, you pay the full cost of any services you get after you have used up your benefit for that type of covered service. For example, you may have to pay the full cost of any skilled nursing facility care you get after our Plan's payments reach the benefit limit of 100 days per benefit period of confinement. In this example, the cost of that care, beyond the benefit limit, does not count toward the yearly out-of-pocket maximum described in Chapter 4. You can call Member Services when you want to know how much of your benefit limit you have already used.

SECTION 4 How are your medical services covered when you are in a "clinical research study"?

Section 4.1 What is a "clinical research study"?
--

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

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

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

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

If you want to participate in a Medicare-approved clinical research study, you do *not* need to get approval from us.

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

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

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

Section 4.2 When you participate in a clinical research study, who pays for what?

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

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

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

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

In order for us to pay for our share of the costs, you will need to submit a request for payment. With your request, you will need to send us a copy of your Medicare Summary Notices or other documentation that shows what services you received as part of the study and how much you owe. Please see Chapter 5 for more information about submitting requests for payment.

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

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

Do you want to know more?

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

SECTION 5 Rules for getting care covered in a "religious non-medical health care institution"

Section 5.1 What is 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 care. If getting care in a hospital or a skilled nursing facility is against a member's religious beliefs, we will instead provide coverage for care in a religious non-medical health care institution. You may choose to pursue medical care at any time for any reason. This benefit is provided only for Part A inpatient services (non-medical health care services). Medicare will only pay for non-medical health care services provided by religious non-medical health care institutions.

Section 5.2 What care from a religious non-medical health care institution is covered by our plan?
--

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

- "Non-accepted" medical care or treatment is any medical care or treatment that is *voluntary* and *not required* by any federal, state, or local law.

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

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

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

Coverage for your stay in the religious non-medical health care institution would follow the coverage descriptions in the Benefit Chart in Chapter 4, Section 2.

SECTION 6 Rules for ownership of durable medical equipment

Section 6.1 Will you own your durable medical equipment after making a certain number of payments under our plan?

Durable medical equipment includes items such as oxygen equipment and supplies, wheelchairs, walkers, and hospital beds ordered by a provider for use in the home. Certain items, such as prosthetics, are always owned by the enrollee. In this section, we discuss other types of durable medical equipment that must be rented.

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

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

If you switch to Original Medicare after being a member of our plan: If you did not acquire ownership of the durable medical equipment item while in our plan, you will have to make 13 new consecutive payments

for the item while in Original Medicare in order to acquire ownership of the item. Your previous payments while in our plan do not count toward these new 13 consecutive payments.

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

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

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

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

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

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

- The **“deductible”** is the amount you must pay for medical services before our plan begins to pay its share. (Section 1.2 tells you more about your service deductible for Worldwide coverage for Emergency Care.)
- A **“copayment”** is the fixed amount you pay each time you receive certain medical services. You pay a copayment at the time you get the medical service. (The Medical Benefits Chart in Section 2 tells you more about your copayments.)
- **“Coinsurance”** is the percentage you pay of the total cost of certain medical services. You pay a coinsurance at the time you get the medical service. (The Medical Benefits Chart in Section 2 tells you more about your coinsurance.)
- **“Balance billing”** is when providers, such as doctors or hospitals, charge and bill patients up to 15% more than the plan’s payment amount for services. The “balance billing” amount is collected in addition to the patient’s regular plan cost-sharing amount. Our plan does not allow providers who provide plan-covered services to balance bill members of our plan. (For more information, see Section 1.4 of this chapter.)

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

Section 1.2 Our plan has a separate deductible for certain types of services

The plan has a service deductible amount of \$250 for Worldwide coverage of Emergency Care. Until you have paid the deductible amount, you must pay the full cost for Worldwide coverage of Emergency Care that is not typically covered by Medicare. Once you have paid your deductible, we will pay our share of the costs for these services and you will pay your share (your coinsurance amount) for the rest of the calendar year.

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

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

As a member of our plan, the most you will have to pay out-of-pocket for covered Part A and Part B services in 2012 is \$6,700. The amounts you pay for copayments, and coinsurance for covered services count toward this maximum out-of-pocket amount. (The amount you pay for your plan premium does not count toward your maximum out-of-pocket amount. In addition, amounts you pay for some services do not count toward your maximum out-of-pocket amount. These services are described in the Medical Benefits Chart as “**not typically covered by Medicare**”.) If you reach the maximum out-of-pocket amount of \$6,700, you will not have to pay any out-of-pocket costs for the rest of the year for covered Part A and Part B services. However, you must continue to pay your plan premium and the Medicare Part B premium (unless your Part B premium is paid for you by Medicaid or another third party).

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

As a member of our plan, an important protection for you is that you only have to pay the plan’s cost-sharing amount described in our terms and conditions when you get services covered by our plan. The provider is allowed to collect only the plan cost-sharing amount from you and is not allowed to charge or bill you more for covered services.

In some cases, out-of-network providers can balance bill our plan. If you get covered services from an out-of-network provider and the plan’s cost sharing for the services is a coinsurance (a percentage of the provider’s bill), then the provider is allowed to bill us the Medicare rate. If the provider does not participate with Medicare, the provider may also be allowed to bill us an extra amount (up to 15% of the Medicare rate). However, you only pay your plan cost-sharing amount. You never pay a balance billing amount. Even if our plan and your provider has a dispute and we will not pay the balance billing amount, the provider is still not allowed to charge you more than your plan cost-sharing amount for covered services.

Section 1.5 How does “balance billing” affect your costs?

Our plan does not allow “balance billing.” This means a provider is allowed to collect only the plan cost-sharing amounts from you and is not allowed to charge or bill you more for services. Balance billing is prohibited by providers who provide plan-covered services to our plan members.

There is an additional type of balance billing that physicians who do not participate with Medicare and who are not in the plan’s network have a right to collect. However, you will never have to pay this type of balance billing. The provider will collect this balance billing amount from us and you will only pay your

cost-sharing amount. If you have any questions about how much you would have to pay a provider, please contact Member Services (phone numbers are on the back cover of this booklet).

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

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

The Medical Benefits Chart on the following pages lists the services 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 the following coverage requirements are met:

- Your Medicare covered services must be provided according to the coverage guidelines established by Medicare.
- Your services (including medical care, services, supplies, and equipment) *must* be medically necessary. “Medically necessary” means that the services, supplies, or drugs are needed for the prevention, diagnosis or treatment of your medical condition and meet accepted standards of medical practice.
- No prior authorization, prior notification, or referral is required as a condition of coverage when medically necessary, plan-covered services are provided to our members.
- For all preventive services that are covered at no cost under Original Medicare, we also cover the service at no cost to you. However, if you also are treated or monitored for an existing medical condition during the visit when you receive the preventive service, a copayment will apply for the care received for the existing medical condition.

Services that are covered for you	What you must pay when you get these services
Inpatient Care	
<p>Inpatient hospital care</p> <p>There is no limit to the number of days covered by the plan each admission. There is no limit to the number of days covered by the plan each Benefit Period.</p> <p>Covered services include:</p> <ul style="list-style-type: none">• Semi-private room (or a private room if medically necessary)• Meals including special diets• Regular nursing services• Costs of special care units (such as intensive care or coronary care units)• Drugs and medications• Lab tests• X-rays and other radiology services• Necessary surgical and medical supplies• Use of appliances, such as wheelchairs• Operating and recovery room costs• Physical, occupational, and speech language therapy• Inpatient substance abuse services	<p>For Medicare-covered hospital stays:</p> <p>Days 1-6: \$235 copay per day</p> <p>Days 7-90: \$0 copay per day</p>

Services that are covered for you	What you must pay when you get these services
<ul style="list-style-type: none">• Under certain conditions, the following types of transplants are covered: corneal, kidney, kidney-pancreatic, heart, liver, lung, heart/lung, bone marrow, stem cell, and intestinal/multivisceral. If you need a transplant, we will arrange to have your case reviewed by a Medicare-approved transplant center that will decide whether you are a candidate for a transplant. If you are sent outside of your community for a transplant, we will arrange or pay for appropriate lodging and transportation costs for you and a companion (or two companions if you are a minor). The lodging and transportation costs are limited to \$10,000.• Blood - including storage and administration. Coverage of whole blood and packed red cells and all other components of blood are covered beginning with the first pint used.• Physician services <p>Note: To be an inpatient, your provider must write an order to admit you to the hospital. Even if you stay in the hospital overnight, you might still be considered an “outpatient.” If you are not sure if you are an inpatient, you should ask the hospital staff.</p> <p>You can also find more information in a Medicare fact sheet called “Are You a Hospital Inpatient or Outpatient? If You Have Medicare – Ask!” This fact sheet is available on the Web at http://www.medicare.gov/Publications/Pubs/pdf/11435.pdf or by calling 1-800-MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048. You can call these numbers for free, 24 hours a day, 7 days a week.</p>	

Services that are covered for you	What you must pay when you get these services
<p>Inpatient mental health care</p> <ul style="list-style-type: none"> Covered services include mental health care services that require a hospital stay. You receive up to 190-days in a psychiatric hospital in a lifetime. The 190-day limit does not apply to Mental Health services provided in a psychiatric unit of a general hospital. 	<p>For Medicare-covered hospital stays: Days 1-6: \$235 copay per day Days 7-190: \$0 copay per day</p>
<p>Skilled nursing facility (SNF) care</p> <p>(For a definition of “skilled nursing facility care,” see Chapter 10 of this booklet. Skilled nursing facilities are sometimes called “SNFs.”)</p> <p>Up to 100 days per Benefit Period of confinement and skilled care services in SNF or alternate setting are Covered Services when such services meet the Plan’s and Medicare coverage guidelines. Medicare’s requirement that a patient spend at least three (3) consecutive days in a hospital for a related condition before transferring to a SNF is not required. The 100-day per Benefit Period includes SNF days received through the Plan, Original Medicare or any other Medicare Advantage Organization during the Benefit Period.</p> <p>Covered services include:</p> <ul style="list-style-type: none"> Semiprivate room (or a private room if medically necessary) Meals, including special diets Regular nursing services Physical therapy, occupational therapy, and speech therapy Drugs administered to you as part of your plan of care (This includes substances that are naturally present in the body, such as blood clotting factors.) 	<p>For each Benefit Period: Days 1-20: \$0 copay per day Days 21-100: \$135 copay per day</p> <p>A Benefit Period begins on the first day you go to a Medicare-covered skilled nursing facility. A Benefit Period ends when you haven’t been inpatient at any SNF for 60 days in a row. If you go to the SNF after one Benefit Period has ended, a new Benefit Period begins. There is no limit to the number of Benefit Periods you can have. You are an inpatient in a SNF only if your care in a SNF meets certain standards for skilled level of care. Specifically, in order to be an inpatient in a SNF, you must need daily skilled nursing or skilled rehabilitation care, or both.</p>

Services that are covered for you	What you must pay when you get these services
<ul style="list-style-type: none"> • Blood - including storage and administration. Coverage of whole blood and packed red cells and 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 services 	
<p>Inpatient services covered during a non-covered inpatient stay</p> <p>If you have exhausted your Skilled Nursing Facility (SNF) Care or if the inpatient stay is not reasonable and necessary, we will not cover your inpatient stay. However, in some cases, we will cover certain services you receive while you are in the hospital or the skilled nursing facility (SNF) stay. Covered services include:</p> <ul style="list-style-type: none"> • Physician services • Diagnostic tests (like lab tests) • X-ray, radium, and isotope therapy including technician materials and services • Surgical dressings • Splints, casts and other devices used to reduce fractures and dislocations • Prosthetics and orthotics devices (other than dental) that replace all or part of an internal body organ (including contiguous tissue), or all or part of the function of a permanently inoperative or malfunctioning internal body organ, including replacement or repairs of such devices 	<p>Your applicable outpatient services copayments and/or coinsurances apply to the Medicare-Covered Services and supplies you receive during a non-covered inpatient hospital, or SNF stay. Please see outpatient services section below for your costs.</p>

Services that are covered for you	What you must pay when you get these services
<ul style="list-style-type: none"> • Leg, arm, back, and neck braces; trusses, and artificial legs, arms, and eyes including adjustments, repairs, and replacements required because of breakage, wear, loss, or a change in the patient's physical condition • Physical therapy, speech therapy, and occupational therapy 	
<p>Home health agency care</p> <p>Covered services include:</p> <ul style="list-style-type: none"> • Part-time or intermittent skilled nursing and home health aide services (To be covered under the home health care benefit, your skilled nursing and home health aide services combined must total fewer than 8 hours per day and 35 hours per week) • Physical therapy, occupational therapy, and speech therapy • Medical and social services • Medical equipment and supplies 	<p>\$0 copay for Medicare-covered home health visits.</p> <p>There will also be a copayment and/or coinsurance for Medically Necessary Medicare-Covered Services for Durable Medical Equipment, prosthetic devices, certain medical supplies, and Medicare Part B prescription drugs, where applicable.</p>
<p>Hospice care</p> <p>You may receive care from any Medicare-certified hospice program.</p> <p>Original Medicare (rather than our plan) will pay for your hospice services and any Part A and Part B services related to your terminal condition. While you are in the hospice program, your hospice provider will bill Original Medicare for the services that Original Medicare pays for.</p> <p>Covered services include:</p> <ul style="list-style-type: none"> • Drugs for symptom control and pain relief • Short-term respite care • Home care 	<p>When you enroll in a Medicare-certified hospice program, your hospice services and your Part A and Part B services related to your terminal condition are paid for by Original Medicare, not our plan.</p> <p>The cost-share for hospice consultation services is the same as the cost-share you pay for physician services, including doctor office visits (see benefit category below).</p>

Services that are covered for you	What you must pay when you get these services
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You are still a member of our plan. If you need non-hospice care (care that is not related to your terminal condition), you have two options:

- You can obtain your non-hospice care from plan providers. In this case, you only pay plan allowed cost sharing
- --or-- You can get your care covered by Original Medicare. In this case, you must pay the cost-sharing amounts under Original Medicare, except for emergency or urgently needed care. However, after payment, you can ask us to pay you back for the difference between the cost sharing in our plan and the cost sharing under Original Medicare.

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

Our plan covers hospice consultation services (one time only) for a terminally ill person who hasn't elected the hospice benefit.

Outpatient Services

Physician services, including doctor's office visits

Covered services include:

- Medically-necessary medical or surgical services furnished in a physician's office, certified ambulatory surgical center, hospital outpatient department, or any other location
- Consultation, diagnosis, and treatment by a specialist
- Basic hearing and balance exams performed by your PCP or specialist, if your doctor orders it to see if you need medical treatment

\$25 copay for each Medicare-covered primary care doctor visit.

\$50 copay for each Medicare-covered specialist visit.

\$20 copay for each Medicare-covered basic hearing and balance exam performed by a specialist.

In addition to the cost-share above, there will be a copay and/or coinsurance for Medically Necessary Medicare-Covered Services for Durable Medical Equipment and supplies, prosthetic devices and supplies, outpatient diagnostic tests and therapeutic services, eyeglasses and contacts after cataract surgery, and Medicare Part B prescription drugs, as described in this Benefit Chart.

Services that are covered for you	What you must pay when you get these services
<ul style="list-style-type: none"> • Telehealth office visits including consultation, diagnosis and treatment by a specialist • Second opinion prior to surgery. • Non-routine dental care (covered services are limited to surgery of the jaw or related structures, setting fractures of the jaw or facial bones, extraction of teeth to prepare the jaw for radiation treatments of neoplastic cancer disease, or services that would be covered when provided by a physician) 	<p>For other physician services not listed here, please see the appropriate section of this Benefit Chart for details.</p>
<p>Outpatient hospital services</p> <p>We cover medically-necessary services you get in the outpatient department of a hospital for diagnosis or treatment of an illness or injury.</p> <p>Covered services include:</p> <ul style="list-style-type: none"> • Services in an emergency department or outpatient clinic, including same-day surgery • Laboratory tests billed by the hospital • Mental health care, including care in a partial-hospitalization program, if a doctor certifies that inpatient treatment would be required without it • X-rays and other radiology services billed by the hospital • Medical supplies such as splints and casts • Certain screenings and preventive services • Certain drugs and biologicals that you can't give yourself <p>Note: Unless the provider has written an order to admit you as an inpatient to the hospital, you are an outpatient and pay the cost-sharing amounts for outpatient hospital services. Even if you stay in the hospital overnight, you might still be considered an "outpatient." If you are not sure if you are an outpatient, you should ask the hospital staff.</p>	<p>The cost shares for these services are provided in the appropriate section of this Benefit Chart.</p>

Services that are covered for you	What you must pay when you get these services
<p>You can also find more information in a Medicare fact sheet called “Are You a Hospital Inpatient or Outpatient? If You Have Medicare – Ask!” This fact sheet is available on the Web at http://www.medicare.gov/Publications/Pubs/pdf/11435.pdf or by calling 1-800-MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048. You can call these numbers for free, 24 hours a day, 7 days a week.</p>	
<p>Chiropractic services</p> <p>Covered services include:</p> <ul style="list-style-type: none"> • We cover only manual manipulation of the spine to correct subluxation 	<p>50% of the cost for each Medicare-covered visit</p>
<p>Podiatry services</p> <p>Covered services include:</p> <ul style="list-style-type: none"> • Treatment of injuries and diseases of the feet (such as hammer toe or heel spurs). • Routine foot care for members with certain medical conditions affecting the lower limbs 	<p>\$50 copay for each Medicare-covered visit.</p>
<p>Outpatient mental health care</p> <p>Covered services include:</p> <p>Mental health services provided by a doctor, clinical psychologist, clinical social worker, clinical nurse specialist, nurse practitioner, physician assistant, or other Medicare-qualified mental health care professional as allowed under applicable state laws.</p>	<p>40% of the cost for each Medicare-covered individual therapy visit provided by a non-physician. 40% of the cost for each Medicare-covered group therapy visit provided by a non-physician. 40% of the cost for each Medicare-covered individual therapy visit with a psychiatrist. 40% of the cost for each Medicare-covered group therapy visit with a psychiatrist.</p>
<p>Partial hospitalization services</p> <p>“Partial hospitalization” is a structured program of active psychiatric treatment provided in a hospital outpatient setting or by a community mental health center, that is more intense than the care received in your doctor’s or therapist’s office and is an alternative to inpatient hospitalization.</p>	<p>\$265 copay for Medicare-covered partial hospitalization program services per day.</p>

Services that are covered for you	What you must pay when you get these services
<p>Outpatient substance abuse services</p>	<p>40% of the cost for each Medicare-covered individual therapy visit. 40% of the cost for each Medicare-covered group therapy visit.</p>
<p>Outpatient surgery, including services provided at hospital outpatient facilities and ambulatory surgical centers</p> <p>Note: If you are having surgery in a hospital, you should check with your provider about whether you will be an inpatient or outpatient. Unless the provider writes an order to admit you as an inpatient to the hospital, you are an outpatient and pay the cost-sharing amounts for outpatient surgery. Even if you stay in the hospital overnight, you might still be considered an “outpatient.”</p>	<p>\$150 copay for each Medicare-covered ambulatory surgical center visit. \$300 copay for each Medicare-covered outpatient hospital facility visit. Additional coinsurance applies for Medicare-covered Part B prescription drugs. If you are admitted to the inpatient acute level of care from outpatient surgery or ambulatory surgery the above cost shares are waived and the Inpatient Hospital care cost share applies.</p>
<p>Outpatient observation</p> <p>Observation care includes ongoing short term treatment, assessment, and reassessment before a decision can be made regarding whether patients will require further treatment as hospital inpatients or if they are able to be discharged from the hospital. Observation status is commonly assigned to patients who present to the emergency department and who then require a significant period of treatment or monitoring before a decision is made concerning their admission or discharge. Such services are covered only when provided by the order of a physician or another individual authorized by state licensure law and hospital staff by-laws to admit patients to the hospital or to order outpatient tests.</p>	<p>\$0 copay if you are admitted directly to Observation. Additional coinsurance will apply for Medicare Part B prescription drugs. If you are admitted to observation from outpatient surgery or an ambulatory surgery center, you pay the applicable copayment for outpatient surgery services or ambulatory surgical services and the coinsurance for Medicare Part B prescription drugs. If you are admitted to an inpatient acute level of care (as described in Inpatient hospital care) from outpatient surgery, ambulatory surgery or observation, this copayment and coinsurance is waived and the Inpatient hospital care copayment applies. If you are admitted to outpatient hospital observation from the emergency room (up to 48 hours in the emergency room), the emergency room copayment applies. If you are then admitted to the inpatient acute level of care (as described in inpatient hospital care) within 48 hours, the emergency room copayment is waived and the Inpatient hospital care copayment applies.</p>

Services that are covered for you	What you must pay when you get these services
<p>Ambulance services</p> <ul style="list-style-type: none"> Covered ambulance services include fixed wing, rotary wing, and ground ambulance services, to the nearest appropriate facility that can provide care only if they are furnished to a member whose medical condition is such that other means of transportation are contraindicated (could endanger the person's health) or if authorized by the plan. The member's condition must require both the ambulance transportation itself and the level of service provided in order for the billed service to be considered medically necessary. Non-emergency transportation by ambulance is appropriate if it is documented that the member's condition is such that other means of transportation are contraindicated (could endanger the person's health) and that transportation by ambulance is medically required. 	<p>\$150 copay for Medicare-covered ambulance services per one-way trip.</p> <p>This cost share is not waived if you are admitted for Inpatient hospital care.</p>
<p>Emergency care</p> <p>Emergency care is care that is needed to evaluate or stabilize an emergency medical condition.</p> <p>A medical emergency is when you, or any other prudent layperson with an average knowledge of health and medicine, believe that you have medical symptoms that require immediate medical attention to prevent loss of life, loss of a limb, or loss of function of a limb. The medical symptoms may be an illness, injury, severe pain, or a medical condition that is quickly getting worse.</p> <p>This plan offers Worldwide coverage for Emergency Care, not generally covered by Medicare. This benefit includes emergency care as described above until you are medically stabilized for transport or discharge up to a maximum of \$20,000 and 60 days per calendar year.</p>	<p><i>Inside the U.S.</i></p> <p>\$65 copay for each Medicare-covered emergency room visit.</p> <p>If you are admitted to the hospital for inpatient hospital care within 24 hours for the same condition, the copayment is waived for the emergency room visit.</p> <p><u>Outside the United States – Worldwide Emergency Coverage:</u></p> <p>\$250 Deductible with 20% coinsurance after the Deductible has been satisfied, for emergency services outside the U.S.</p> <p>If you are admitted to the hospital for inpatient hospital care within 24 hours for the same condition, the copayment is waived for the emergency room visit.</p>

Services that are covered for you	What you must pay when you get these services
<p>Outpatient rehabilitation service</p> <p>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).</p> <p>Medicare provides an annual limit on therapy services. The amount of the limit is set each year by Congress. The therapy limits for 2012 were not available at the time of printing. Please contact Member Services for the 2012 limit. For 2011 the limits were \$1,870 for physical and speech language therapy combined and \$1,870 for occupational therapy. The limit applies to outpatient therapy services from all settings except outpatient hospital and hospital emergency room.</p>	<p>\$45 copay for each Medicare-covered Occupational Therapy visit.</p> <p>\$45 copay for each Medicare-covered Physical and/or Speech and Language Therapy visit.</p> <p>If these services are provided in your home, then the home health cost-share applies instead of the above.</p>
<p>Cardiac rehabilitation services</p> <p>Comprehensive programs that include exercise, education, and counseling are covered for members who meet certain conditions with a doctor's order. The plan also covers intensive cardiac rehabilitation programs that are typically more rigorous or more intense than cardiac rehabilitation programs.</p>	<p>\$45 copay for Medicare-covered Cardiac Rehabilitation Services.</p> <p>\$45 copay for Medicare-covered Intensive Cardiac Rehabilitation Services.</p>
<p>Pulmonary rehabilitation services</p> <p>Comprehensive programs of pulmonary rehabilitation are covered for members who have moderate to very severe chronic obstructive pulmonary disease (COPD) and an order for pulmonary rehabilitation from the doctor treating their chronic respiratory disease.</p>	<p>\$45 copay for Medicare-covered Pulmonary Rehabilitation Services.</p>
<p>Durable medical equipment and related supplies</p> <p>(For a definition of "durable medical equipment," see Chapter 10 of this booklet.)</p>	<p>20% of the cost for Medicare-covered items.</p> <p>In addition, physician services and doctor office visit cost-share (primary care or specialty care as</p>

Services that are covered for you	What you must pay when you get these services
<p>Covered items include, but are not limited to: wheelchairs, crutches, hospital bed, IV infusion pump, oxygen equipment, nebulizer, and walker.</p>	<p>applicable), urgently needed care, or home health care cost-share also applies.</p>
<p>Prosthetic devices and related supplies</p> <p>Devices (other than dental) that replace a body part or function. These include, but are not limited to: colostomy bags and supplies directly related to colostomy care, pacemakers, braces, prosthetic shoes, artificial limbs, and breast prostheses (including a surgical brassiere after a mastectomy). Includes certain supplies related to prosthetic devices, and repair and/or replacement of prosthetic devices. Also includes some coverage following cataract removal or cataract surgery – see “Vision Care” later in this section for more detail.</p>	<p>20% of the cost for Medicare-covered items.</p> <p>In addition, physician services and doctor office visit cost-share (primary care or specialty care as applicable), urgently needed care, or home health care cost-share also applies.</p>
<p>Diabetes self-management training, diabetic services and supplies</p> <p>For all people who have diabetes (insulin and non-insulin users). Covered services include:</p> <ul style="list-style-type: none"> • Blood glucose monitor, blood glucose test strips, lancet devices and lancets, and glucose-control solutions for checking the accuracy of test strips and monitors. • For people with diabetes who have severe diabetic foot disease: One pair per calendar year of therapeutic custom-molded shoes (including inserts provided with such shoes) and two additional pairs of inserts, or one pair of depth shoes and three pairs of inserts (not including the non-customized removable inserts provided with such shoes). Coverage includes fitting. • Diabetes self-management training is covered under certain conditions • See “Diabetes Screening” in this Benefit Chart for information on fasting glucose tests. 	<p>\$0 copay for Medicare-covered Diabetes self-management training.</p> <p>0% of the cost for preferred-brand Medicare-covered Diabetic supplies.</p> <p>20% of the cost for non-preferred brand Medicare-covered Diabetic supplies.</p> <p>20% of the cost for Medicare-covered Therapeutic shoes or inserts.</p> <p>In addition, if other medical services are provided, for other medical conditions in the same visit, then the appropriate physician cost share applies for the additional services rendered during the office visit.</p>

Services that are covered for you	What you must pay when you get these services
<p>Outpatient diagnostic tests and therapeutic services and supplies</p> <p>Covered services include, but are not limited to:</p> <ul style="list-style-type: none"> • X-rays • Radiation (radium and isotope) therapy including technician materials and supplies • Chemotherapy services – see Medicare Part B prescription drugs in this Benefit Chart for the cost share for Medicare-covered Part B chemotherapy drugs • Surgical supplies, such as dressings • Splints, casts and other devices used to reduce fractures and dislocations • Laboratory tests • Blood. Coverage begins with the first pint of blood that you need. Coverage of storage and administration begins with the first pint of blood that you need. • Other Medicare covered outpatient diagnostic tests and diagnostic radiological services such as cardiac stress tests, MRIs, MRAs, CT scans and PET scans. 	<p>20% of the cost for Medicare-covered diagnostic procedures and tests.</p> <p>20% of the cost for Medicare-covered lab services.</p> <p>20% of the cost for Medicare-covered diagnostic radiology services (not including X-rays).</p> <p>20% of the cost for Medicare-covered therapeutic radiology services.</p> <p>20% of the cost for Medicare-covered X-rays.</p> <p>A separate facility charge could apply for the facility in which the service is received.</p> <p>In addition, physician services and doctors office visit cost-share also applies.</p>
<p>Vision care</p> <p>Covered services include:</p> <ul style="list-style-type: none"> • Outpatient physician services for the diagnosis and treatment of diseases and conditions of the eye. Original Medicare doesn't cover routine eye exams (eye refractions) for eyeglasses/contacts. • For people who are at high risk of glaucoma, such as people with a family history of glaucoma, people with diabetes, and African-Americans who are age 50 and older: glaucoma screening once per year. 	<p>\$20 copay for Medicare-covered exams to diagnose and treat diseases and conditions of the eye.</p> <p>\$0 copay for Medicare-covered Glaucoma screening.</p> <p>\$20 copay for routine eye exams.</p> <p>\$20 copay for one pair of eyeglasses or contact lenses after cataract surgery.</p> <p>A separate facility charge could apply for the facility in which the service is received.</p> <p>In addition, cost-share for physician services and doctors office visit and urgently needed care also applies.</p>

Services that are covered for you	What you must pay when you get these services
<ul style="list-style-type: none"> • One pair of eyeglasses or contact lenses after each cataract surgery that includes insertion of an intraocular lens. (If you have two separate cataract operations, you cannot reserve the benefit after the first surgery and purchase two eyeglasses after the second surgery.) Corrective lenses/frames (and replacements) needed after a cataract removal without a lens implant. • One (1) annual routine vision exam not generally covered by Medicare; includes refraction and prescription and fitting of contact lenses. 	
Preventive Services	
<p>For all preventive services that are covered at no cost under Original Medicare, we also cover the service at no cost to you. However, if you are treated or monitored for an existing medical condition during the visit when you receive the preventive service, a copayment will apply for the care received for the existing medical condition.</p>	
<p>Abdominal aortic aneurysm screening</p> <p>A one-time screening ultrasound for people at risk. The plan only covers this screening if you get a referral for it as a result of your “Welcome to Medicare” physical exam.</p>	<p>\$0 copay for Medicare-covered abdominal aortic aneurysm preventive screenings.</p> <p>If your physician performs additional diagnostic or surgical procedures or if other medical services are provided, for other medical conditions, in the same visit, then the appropriate cost-share applies for those services rendered during that visit.</p>
<p>Bone mass measurement</p> <p>For qualified individuals (generally, this means people at risk of losing bone mass or at risk of osteoporosis), the following services are covered every 24 months or more frequently if medically necessary: procedures to identify bone mass, detect bone loss, or determine bone quality, including a physician’s interpretation of the results.</p>	<p>\$0 copay for Medicare-covered bone mass measurement.</p> <p>If your physician performs additional diagnostic or surgical procedures or if other medical services are provided, for other medical conditions, in the same visit, then the appropriate cost-share applies for those services rendered during that visit.</p>

Services that are covered for you	What you must pay when you get these services
<p>Colorectal cancer screening</p> <p>For people 50 and older, the following are covered:</p> <ul style="list-style-type: none"> • Flexible sigmoidoscopy (or screening barium enema as an alternative) every 48 months • Fecal occult blood test, every 12 months <p>For people at high risk of colorectal cancer, we cover:</p> <ul style="list-style-type: none"> • Screening colonoscopy (or screening barium enema as an alternative) every 24 months <p>For people not at high risk of colorectal cancer, we cover:</p> <ul style="list-style-type: none"> • Screening colonoscopy every 10 years (120 months), but not within 48 months of a screening sigmoidoscopy 	<p>\$0 copay for Medicare-covered colorectal screenings.</p> <p>If your physician performs additional diagnostic or surgical procedures or if other medical services are provided, for other medical conditions, in the same visit, then the appropriate cost-share applies for those services rendered during that visit.</p>
<p>HIV screening</p> <p>For people who ask for an HIV screening test or who are at increased risk for HIV infection, we cover:</p> <ul style="list-style-type: none"> • One screening exam every 12 months <p>For women who are pregnant, we cover:</p> <ul style="list-style-type: none"> • Up to three screening exams during a pregnancy 	<p>\$0 copay for Medicare-covered HIV testing.</p> <p>If other medical services are provided, for other medical conditions, in the same visit, then the appropriate physician cost-share applies for services rendered during that office visit.</p>
<p>Immunizations</p> <p>Covered Medicare Part B services include:</p> <ul style="list-style-type: none"> • Pneumonia vaccine • Flu shots, once a year in the fall or winter • Hepatitis B vaccine if you are at high or intermediate risk of getting Hepatitis B • Other vaccines if you are at risk and they meet Medicare Part B coverage rules 	<p>\$0 copay for Hepatitis B vaccine, Flu and Pneumonia vaccines and other Medicare-covered vaccines.</p> <p>If your physician performs additional diagnostic or surgical procedures or if other medical services are provided, for other medical conditions, in the same visit, then the appropriate cost-share applies for those services rendered during that visit.</p>
<p>Breast cancer screening (mammograms)</p> <p>Covered services include:</p>	<p>\$0 copay for Medicare-covered mammography screening.</p> <p>\$0 copay for Medicare-covered breast exams.</p>

Services that are covered for you	What you must pay when you get these services
<ul style="list-style-type: none"> • One baseline mammogram between the ages of 35 and 39 • One screening mammogram every 12 months for women age 40 and older • Clinical breast exams once every 24 months 	<p>If your physician performs additional diagnostic or surgical procedures or if other medical services are provided, for other medical conditions, in the same visit, then the appropriate cost-share applies for those services rendered during that visit.</p>
<p>Cervical and vaginal cancer screening</p> <p>Covered services include:</p> <ul style="list-style-type: none"> • For all women: Pap tests and pelvic exams are covered once every 24 months • If you are at high risk of cervical cancer or have had an abnormal Pap test and are of childbearing age: one Pap test every 12 months 	<p>\$0 copay for Medicare-covered pap smears and pelvic exams.</p> <p>If your physician performs additional diagnostic or surgical procedures or if other medical services are provided, for other medical conditions, in the same visit, then the appropriate cost-share applies for those services rendered during that visit.</p>
<p>Prostate cancer screening exams</p> <p>For men age 50 and older, covered services include the following - once every 12 months:</p> <ul style="list-style-type: none"> • Digital rectal exam • Prostate Specific Antigen (PSA) test 	<p>\$0 copay for Medicare-covered prostate screenings.</p> <p>If your physician performs additional diagnostic or surgical procedures or if other medical services are provided, for other medical conditions, in the same visit, then the appropriate cost-share applies for those services rendered during that visit.</p>
<p>Cardiovascular disease testing</p> <p>Blood tests for the detection of cardiovascular disease (or abnormalities associated with an elevated risk of cardiovascular disease) once every 5 years (60 months). The Medicare-covered blood tests include: total cholesterol test, cholesterol test for high-density, and triglycerides test.</p>	<p>\$0 copay for Medicare-covered cardiovascular disease testing.</p> <p>If your physician performs additional diagnostic or surgical procedures or if other medical services are provided, for other medical conditions, in the same visit, then the appropriate cost-share applies for those services rendered during that visit.</p>
<p>"Welcome to Medicare" physical exam</p> <p>The plan covers a one-time "Welcome to Medicare" physical exam, which includes a review of your health, as well as education and counseling about the preventive services you need (including certain screenings and shots), and referrals for other care if needed.</p> <p>Important: You must have the physical exam within the first 12 months you have Medicare Part B. When</p>	<p>There is no coinsurance, copayment, or deductible for the Welcome to Medicare exam.</p> <p>If your physician performs additional diagnostic or surgical procedures or if other medical services are provided, for other medical conditions, in the same visit, then the appropriate cost-share applies for those services rendered during that visit.</p>

Services that are covered for you	What you must pay when you get these services
<p>you make your appointment, let your doctor's office know you would like to schedule your "Welcome to Medicare" physical exam.</p>	
<p>Annual wellness visit</p> <p>If you've had Part B for longer than 12 months, you can get an annual wellness visit to develop or update a personalized prevention plan based on your current health and risk factors. This is covered once every 12 months.</p> <p>Note: Your first annual wellness visit can't take place within 12 months of your "Welcome to Medicare" exam. However, you don't need to have had a "Welcome to Medicare" exam to be covered for annual wellness visits after you've had Part B for 12 months.</p>	<p>There is no coinsurance, copayment, or deductible for the annual wellness visit.</p> <p>If your physician performs additional diagnostic or surgical procedures or if other medical services are provided, for other medical conditions, in the same visit, then the appropriate cost-share applies for those services rendered during that visit.</p>
<p>Diabetes screening</p> <p>We cover this screening (includes fasting glucose tests) if you have any of the following risk factors: high blood pressure (hypertension), history of abnormal cholesterol and triglyceride levels (dyslipidemia), obesity, or a history of high blood sugar (glucose). Tests may also be covered if you meet other requirements, like being overweight and having a family history of diabetes.</p> <p>Based on the results of these tests, you may be eligible for up to two diabetes screenings every 12 months.</p>	<p>\$0 copay for Medicare-covered Diabetes screening.</p> <p>If your physician performs additional diagnostic or surgical procedures or if other medical services are provided, for other medical conditions, in the same visit, then the appropriate cost-share applies for those services rendered during that visit.</p>
<p>Medical nutrition therapy</p> <p>This benefit is for people with diabetes, renal (kidney) disease (but not on dialysis), or after a transplant when ordered by your doctor.</p> <p>We cover 3 hours of one-on-one counseling services during your first year that you receive medical nutrition therapy services under Medicare (this includes our plan, any other Medicare Advantage plan, or Original Medicare), and 2 hours each year</p>	<p>\$0 copay for Medicare-covered medical nutritional therapy.</p> <p>If your physician performs additional diagnostic or surgical procedures or if other medical services are provided, for other medical conditions, in the same visit, then the appropriate cost-share applies for those services rendered during that visit.</p>

Services that are covered for you	What you must pay when you get these services
<p>after that. If your condition, treatment, or diagnosis changes, you may be able to receive more hours of treatment with a physician's order. A physician must prescribe these services and renew their order yearly if your treatment is needed into another calendar year.</p>	
<p>Smoking and tobacco use cessation (counseling to stop smoking)</p> <p>If you use tobacco, but do not have signs or symptoms of tobacco-related disease: we cover two counseling quit attempts within a 12-month period. Each counseling attempt includes up to four face-to-face visits.</p> <p>If you use tobacco and have been diagnosed with a tobacco-related disease or are taking medicine that may be affected by tobacco: we cover cessation counseling services. We cover two counseling quit attempts within a 12-month period. Each counseling attempt includes up to four face-to-face visits, however, you will pay the applicable inpatient or outpatient cost sharing.</p>	<p>If you haven't been diagnosed with an illness caused or complicated by tobacco use:</p> <p>\$0 copay for Medicare-covered smoking cessation therapy visits.</p> <p>If you have been diagnosed with an illness caused or complicated by tobacco use, or you take a medicine that is affected by tobacco:</p> <p>\$0 copay for Medicare-covered smoking cessation therapy visits.</p> <p>If your physician performs additional diagnostic or surgical procedures or if other medical services are provided, for other medical conditions, in the same visit, then the appropriate cost-share applies for those services rendered during that visit.</p>
<p>Other Services</p>	
<p>Services to treat kidney disease and conditions</p> <p>Covered services include:</p> <ul style="list-style-type: none"> • Kidney disease education services to teach kidney care and help members make informed decisions about their care. For members with stage IV chronic kidney disease when referred by their doctor, we cover up to six sessions of kidney disease education services per lifetime. • Outpatient dialysis treatments (including dialysis treatments when temporarily out of the service area, as explained in Chapter 3) • Inpatient dialysis treatments (if you are admitted as an inpatient to a hospital for special care) 	<p>\$0 copay for Medicare-covered kidney disease education services.</p> <p>\$30 copay for Medicare-covered outpatient renal dialysis treatments.</p> <p>If other medical services are provided, for other medical conditions, in the same visit, then the appropriate physician cost-share applies for services rendered during that office visit.</p>

Services that are covered for you	What you must pay when you get these services
<ul style="list-style-type: none"> • Self-dialysis training (includes training for you and anyone helping you with your home dialysis treatments) • Home dialysis equipment and supplies • Certain home support services (such as, when necessary, visits by trained dialysis workers to check on your home dialysis, to help in emergencies, and check your dialysis equipment and water supply) <p>Certain drugs for dialysis are covered under your Medicare Part B drug benefit. For information about coverage for Part B Drugs, please go to the section below, “Medicare Part B prescription drugs.”</p>	
<p>Medicare Part B prescription drugs</p> <p>These drugs are covered under Part B of Original Medicare. Members of our plan receive coverage for these drugs through our plan. Covered drugs include:</p> <ul style="list-style-type: none"> • Drugs that usually aren’t self-administered by the patient and are injected or infused while you are getting physician, hospital outpatient, or ambulatory surgical center services • Drugs you take using durable medical equipment (such as nebulizers) that was authorized by the plan • Clotting factors you give yourself by injection if you have hemophilia • Immunosuppressive Drugs, if you were enrolled in Medicare Part A at the time of the organ transplant • Injectable osteoporosis drugs, if you are homebound, have a bone fracture that a doctor certifies was related to post-menopausal osteoporosis, and cannot self-administer the drug • Antigens and Allergy shots 	<p>20% of the cost for Part B-covered chemotherapy drugs.</p> <p>20% of the cost for Part B-covered Drugs covered under Medicare Part B (Original Medicare).</p> <p>Coinsurance for Medicare-covered Part B drugs applies in addition to the cost-share for home health, outpatient services, preventive care and additional benefits as described in this Benefit Chart.</p> <p>For Medicare Part B prescription drugs obtained at a Network Pharmacy the coinsurance is applied to the health plan’s actual cost, which reflects the Pharmacy Benefit Manager’s pricing and dispensing fee. Both the pricing and dispensing fee vary by drug and by brand vs. generic. It can also vary by the type of dispensing pharmacy (e.g. long term care vs. retail).</p> <p>For Medicare Part B prescription drugs obtained from a physician, the coinsurance is applied to the Medicare fee schedule.</p>

Services that are covered for you	What you must pay when you get these services
<ul style="list-style-type: none"> • Certain oral anti-cancer drugs and anti-nausea drugs • Certain drugs for home dialysis, including heparin, the antidote for heparin when medically necessary, topical anesthetics, and erythropoiesis-stimulating agents (such as Epogen[®], Procrit[®], Epoetin Alfa, Aranesp[®], or Darbepoetin Alfa) • Intravenous Immune Globulin for the home treatment of primary immune deficiency diseases 	
Additional Benefits	
<p>Hearing services</p> <p>Basic hearing evaluations performed by your provider are covered as outpatient care when furnished by a physician, audiologist, or other qualified provider. In addition, our plan includes the additional benefit of one (1) annual hearing screening not generally covered by Medicare. Hearing aids are not covered.</p>	<p>\$25 copay for each Medicare-covered basic hearing and balance exam performed by a primary care doctor.</p> <p>\$20 copay for each Medicare- covered basic hearing and balance exam performed by a specialist, audiologist or other provider that is not a primary care doctor.</p> <p>\$20 copay for each annual hearing screening.</p>
<p>Health and wellness education programs</p> <p>These are care management programs that include assistance for such health conditions as high blood pressure, cholesterol, respiratory illness, diabetes and others. The benefit includes:</p> <ul style="list-style-type: none"> • Nursing Hotline • And Written Health Educational Materials 	<p>\$0 copay for education/wellness programs.</p>

SECTION 3 What benefits are not covered by the plan?

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

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

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

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

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

- Services considered not reasonable and necessary, according to the standards of Original Medicare, unless these services are listed by our plan as covered services.
- Experimental medical and surgical procedures, equipment and medications, unless covered by Original Medicare or under a Medicare-approved clinical research study. (See Chapter 3, Section 5 for more information on clinical research studies). Experimental procedures and items are those items and procedures determined by our plan and Original Medicare to not be generally accepted by the medical community.
- Surgical treatment for morbid obesity, except when it is considered medically necessary and covered under Original Medicare.
- Private room in a hospital, except when it is considered medically necessary.
- Private duty nurses.
- Personal items in your room at a hospital or a skilled nursing facility, such as a telephone or a television.
- Full-time nursing care in your home.
- Custodial care, unless it is provided with covered skilled nursing care and/or skilled rehabilitation services. Custodial care, or non-skilled care, is care that helps you with activities of daily living, such as bathing or dressing.
- Homemaker services include basic household assistance, including light housekeeping or light meal preparation.
- Fees charged by your immediate relatives or members of your household.
- Meals delivered to your home.
- Elective or voluntary enhancement procedures or services (including weight loss, hair growth, sexual performance, athletic performance, cosmetic purposes, anti-aging and mental performance), except when medically necessary.
- Cosmetic surgery or procedures, unless because of an accidental injury or to improve a malformed part of the body. However, all stages of reconstruction are covered for a breast after a mastectomy, as well as for the unaffected breast to produce a symmetrical appearance.
- Routine dental care, such as cleanings, fillings or dentures. However, non-routine dental care required to treat illness or injury may be covered as inpatient or outpatient care.

- Chiropractic care, other than manual manipulation of the spine consistent with Medicare coverage guidelines.
- Routine foot care, except for the limited coverage provided according to Medicare guidelines.
- Orthopedic shoes, unless the shoes are part of a leg brace and are included in the cost of the brace or the shoes are for a person with diabetic foot disease.
- Supportive devices for the feet, except for orthopedic or therapeutic shoes for people with diabetic foot disease.
- Hearing aids, or exams to fit hearing aids.
- Eyeglasses, routine eye examinations (except as noted in the Benefit Chart above), radial keratotomy, LASIK surgery, vision therapy and other low vision aids. However, eyeglasses are covered for people after cataract surgery.
- Part D Outpatient prescription drugs.
- Reversal of sterilization procedures, sex change operations, and non-prescription contraceptive supplies.
- Acupuncture.
- Naturopath services (uses natural or alternative treatments).
- Services provided to veterans in Veterans Affairs (VA) facilities. However, when emergency services are received at VA hospital and the VA cost sharing is more than the cost sharing under our plan, we will reimburse veterans for the difference. Members are still responsible for our cost-sharing amounts.
- Routine transportation.

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

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

SECTION 1 Situations in which you should ask us to pay our share of the cost of your covered services 57

Section 1.1 If you pay our plan’s share of the cost of your covered services, or if you receive a bill, you can ask us for payment 57

SECTION 2 How to ask us to pay you back or to pay a bill you have received 59

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

Section 1.1 If you pay our plan's share of the cost of your covered services, or if you receive a bill, you can ask us for payment
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Sometimes when you get medical care or, you may need to pay the full cost right away. Other times, you may find that you have paid more than you expected under the coverage rules of the plan. In either case, you can ask our plan to pay you back (paying you back is often called “reimbursing” you). It is your right to be paid back by our plan whenever you’ve paid more than your share of the cost for medical services that are covered by our plan.

There may also be times when you get a bill from a provider for the full cost of medical care you have received. In many cases, you should send this bill to us instead of paying it. We will look at the bill and decide whether the services should be covered. If we decide they should be covered, we will pay the provider directly.

Here are examples of situations in which you may need to ask our plan to pay you back or to pay a bill you have received.

1. When you've received emergency care

When you receive emergency care, you are only responsible for paying your share of the cost, not for the entire cost. You should ask the provider to bill the plan for our share of the cost.

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

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

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

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

3. If you are retroactively enrolled in our plan

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

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

- Please call Member Services for additional information about how to ask us to pay you back and deadlines for making your request.

All of the examples above are types of coverage decisions. This means that if we deny your request for payment, you can appeal our decision. Chapter 7 of this booklet (*What to do if you have a problem or complaint (coverage decisions, appeals, complaints)*) has information about how to make an appeal.

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

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

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

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

- You don't have to use the form, but it will help us process the information faster.
- Either download a copy of the form from our website (www.TodaysOptions.com) or call Member Services and ask for the form. The phone numbers for Member Services are on the back cover of this booklet.

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

For Medical Care:

Today's Options PFFS
P.O. Box 742568
Houston, TX 77274

You may also call our plan to request payment. For details, go to Chapter 2, Section 1 and look for the section called, *Where to send a request that asks us to pay for our share of the cost for medical care you have received.*

Please be sure to contact Member Services if you have any questions. If you don't know what you should have paid, or you receive bills and you don't know what to do about those bills, we can help. You can also call if you want to give us more information about a request for payment you have already sent to us.

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

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

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

- If we decide that the medical care is covered and you followed all the rules for getting the care, we will pay for our share of the cost. If you have already paid for the service, we will mail your reimbursement of our share of the cost to you. If you have not paid for the service yet, we will mail the payment directly to the provider. (Chapter 3 explains the rules you need to follow for getting your medical services covered.)

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

Section 3.2	If we tell you that we will not pay for all or part of the medical care, you can make an appeal
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If you think we have made a mistake in turning down your request for payment or you don't agree with the amount we are paying, you can make an appeal. If you make an appeal, it means you are asking us to change the decision we made when we turned down your request for payment.

For the details on how to make this appeal, go to Chapter 7 of this booklet (*What to do if you have a problem or complaint (coverage decisions, appeals, complaints)*). The appeals process is a formal process with detailed procedures and important deadlines. If making an appeal is new to you, you will find it helpful to start by reading Section 4 of Chapter 7. Section 4 is an introductory section that explains the process for coverage decisions and appeals and gives definitions of terms such as "appeal." Then after you have read Section 4, you can go to the section in Chapter 7 that tells what to do for your situation:

- If you want to make an appeal about getting paid back for a medical service, go to Section 5.3 in Chapter 7.

Chapter 6. Your rights and responsibilities

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

Section 1.1	We must provide information in a way that works for you (in languages other than English, in Braille, in large print, or other alternate formats, etc.)
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To get information from us in a way that works for you, please call Member Services (phone numbers are on the back cover of this booklet).

Our plan has people and free language interpreter services available to answer questions from non-English speaking members. We can also give you information in Braille, in large print, or other alternate formats if you need it. If you are eligible for Medicare because of a disability, we are required to give you information about the plan's benefits that is accessible and appropriate for you.

If you have any trouble getting information from our plan because of problems related to language or a disability, please call Medicare at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week, and tell them that you want to file a complaint. TTY users call 1-877-486-2048.

Para obtener información de nosotros de una manera que funciona para usted, por favor llame a servicios para miembros (teléfono números están en la contraportada de este folleto).

Nuestro plan tiene personas y servicios de intérprete de lengua libre disponibles para responder preguntas de los miembros que no hablan inglés. Podemos también darle información en Braille, en letra grande, o en otros formatos alternativos si es necesario. Si usted es elegible para Medicare debido a una discapacidad, estamos obligados a dar información acerca de los beneficios del plan que es accesible y conveniente para usted.

Si tiene problemas obteniendo información de nuestro plan debido a problemas relacionados con la lengua o una discapacidad, por favor llame a Medicare al 1-800-MEDICARE (1-800-633-4227), 24 horas al día, 7 días a la semana y decirles que desea presentar una queja. Los usuarios de TTY llaman 1-877-486-2048.

Section 1.2	We must treat you with fairness and respect at all times
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Our plan must obey laws that protect you from discrimination or unfair treatment. **We do not discriminate** based on a person's race, ethnicity, national origin, religion, gender, age, mental or physical disability, health status, claims experience, medical history, genetic information, evidence of insurability, or geographic location within the service area.

If you want more information or have concerns about discrimination or unfair treatment, please call the Department of Health and Human Services' **Office for Civil Rights** 1-800-368-1019 (TTY 1-800-537-7697) or your local Office for Civil Rights.

If you have a disability and need help with access to care, please call us at Member Services (phone numbers are on the back cover of this booklet). If you have a complaint, such as a problem with wheelchair access, Member Services can help.

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

You may seek care from any provider in the United States, if the provider agrees to accept our plan's terms and conditions of payment prior to providing services to you and is eligible to provide services under Original Medicare, as described in Chapter 3, Section 1.2. You should always (except possibly in emergencies) show the provider your PFFS plan membership card. As a plan member, you have the right to get appointments and covered services from providers *within a reasonable amount of time*.

A provider can decide whether to accept our plan's terms and conditions of payment each time you see the provider.

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

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

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

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

How do we protect the privacy of your health information?

- We make sure that unauthorized people don't see or change your records.
- In most situations, if we give your health information to anyone who isn't providing your care or paying for your care, *we are required to get written permission from you first*. Written permission can be given by you or by someone you have given legal power to make decisions for you.
- There are certain exceptions that do not require us to get your written permission first. These exceptions are allowed or required by law.
 - For example, we are required to release health information to government agencies that are checking on quality of care.
 - Because you are a member of our plan through Medicare, we are required to give Medicare your health information. If Medicare releases your information for research or other uses, this will be done according to Federal statutes and regulations.

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

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

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

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

Section 1.5 We must give you information about the plan and your covered services

As a member of our plan, you have the right to get several kinds of information from us. (As explained above in Section 1.1, you have the right to get information from us in a way that works for you. This includes getting the information in languages other than English and in large print or other alternate formats.)

If you want any of the following kinds of information, please call Member Services (phone numbers are on the back cover of this booklet):

- **Information about our plan.** This includes, for example, information about the plan's financial condition. It also includes information about the number of appeals made by members and the plan's performance ratings, including how it has been rated by plan members and how it compares to other Medicare health plans.
- **Information about your coverage and rules you must follow in using your coverage.**
 - In Chapters 3 and 4 of this booklet, we explain what medical services are covered for you, any restrictions to your coverage, and what rules you must follow to get your covered medical services.
 - If you have questions about the rules or restrictions, please call Member Services (phone numbers are on the back cover of this booklet).
- **Information about why something is not covered and what you can do about it.**
 - If a medical service is not covered for you, or if your coverage is restricted in some way, you can ask us for a written explanation.
 - If you are not happy, or if you disagree with a decision we make about what medical care is covered for you, you have the right to ask us to change the decision. You can ask us to change the decision by making an appeal. For details on what to do if something is not covered for you in the way you think it should be covered, see Chapter 7 of this booklet. It gives you the details about how to make an appeal if you want us to change our decision. (Chapter 7 also tells about how to make a complaint about quality of care, waiting times, and other concerns.)
 - If you want to ask our plan to pay our share of a bill you have received for medical care, see Chapter 5 of this booklet.

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

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

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

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

- **To know about all of your choices.** This means that you have the right to be told about all of the treatment options that are recommended for your condition, no matter what they cost or whether they are covered by our plan.
- **To know about the risks.** You have the right to be told about any risks involved in your care. You must be told in advance if any proposed medical care or treatment is part of a research experiment. You always have the choice to refuse any experimental treatments.
- **The right to say "no."** You have the right to refuse any recommended treatment. This includes the right to leave a hospital or other medical facility, even if your doctor advises you not to leave. Of course, if you refuse treatment, you accept full responsibility for what happens to your body as a result.
- **To receive an explanation if you are denied coverage for care.** You have the right to receive an explanation from us if a provider has denied care that you believe you should receive. To receive this explanation, you will need to ask us for a coverage decision. Chapter 7 of this booklet tells how to ask the plan for a coverage decision.

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

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

- Fill out a written form to give **someone the legal authority to make medical decisions for you** if you ever become unable to make decisions for yourself.
- **Give your doctors written instructions** about how you want them to handle your medical care if you become unable to make decisions for yourself.

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

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

- **Get the form.** If you want to have an advance directive, you can get a form from your lawyer, from a social worker, or from some office supply stores. You can sometimes get advance directive forms from organizations that give people information about Medicare.
- **Fill it out and sign it.** Regardless of where you get this form, keep in mind that it is a legal document. You should consider having a lawyer help you prepare it.
- **Give copies to appropriate people.** You should give a copy of the form to your doctor and to the person you name on the form as the one to make decisions for you if you can't. You may want to give copies to close friends or family members as well. Be sure to keep a copy at home.

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

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

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

What if your instructions are not followed?

If you have signed an advance directive, and you believe that a doctor or hospital hasn't followed the instructions in it, you may file a complaint with your State Department of Health. Please refer to Appendix A at the end of the *Evidence of Coverage* for contact information.

Section 1.7	You have the right to make complaints and to ask us to reconsider decisions we have made
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If you have any problems or concerns about your covered services or care, Chapter 7 of this booklet tells what you can do. It gives the details about how to deal with all types of problems and complaints.

As explained in Chapter 7, what you need to do to follow up on a problem or concern depends on the situation. You might need to ask our plan to make a coverage decision for you, make an appeal to us to change a coverage decision, or make a complaint. Whatever you do – ask for a coverage decision, make an appeal, or make a complaint – **we are required to treat you fairly.**

You have the right to get a summary of information about the appeals and complaints that other members have filed against our plan in the past. To get this information, please call Member Services (phone numbers are on the back cover of this booklet).

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

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

Is it about something else?

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

- You can **call Member Services** (phone numbers are on the back cover of this booklet).
- You can **call the State Health Insurance Assistance Program**. For details about this organization and how to contact it, go to Chapter 2, Section 3.

- Or, you can call **Medicare** at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

Section 1.9 How to get more information about your rights

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

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

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

Section 2.1 What are your responsibilities?

Things you need to do as a member of the plan are listed below. If you have any questions, please call Member Services (phone numbers are on the back cover of this booklet). We're here to help.

- ***Get familiar with your covered services and the rules you must follow to get these covered services.*** Use this Evidence of Coverage booklet to learn what is covered for you and the rules you need to follow to get your covered services.
 - Chapters 3 and 4 give the details about your medical services, including what is covered, what is not covered, rules to follow, and what you pay.
- ***If you have any other health insurance coverage in addition to our plan, you are required to tell us.*** Please call Member Services to let us know.
 - We are required to follow rules set by Medicare to make sure that you are using all of your coverage in combination when you get your covered services from our plan. This is called "**coordination of benefits**" because it involves coordinating the health benefits you get from our plan with any other health benefits available to you. We'll help you with it. (For more information about coordination of benefits, go to Chapter 1, Section 7.)
- ***Tell your doctor and other health care providers that you are enrolled in our plan.*** Show your plan membership card whenever you get your medical care.
- ***Help your doctors and other providers help you by giving them information, asking questions, and following through on your care.***

- To help your doctors and other health providers give you the best care, learn as much as you are able to about your health problems and give them the information they need about you and your health. Follow the treatment plans and instructions that you and your doctors agree upon.
- Make sure your doctors know all of the drugs you are taking, including over-the-counter drugs, vitamins, and supplements.
- If you have any questions, be sure to ask. Your doctors and other health care providers are supposed to explain things in a way you can understand. If you ask a question and you don't understand the answer you are given, ask again.
- ***Be considerate.*** *We expect all our members to respect the rights of other patients. We also expect you to act in a way that helps the smooth running of your doctor's office, hospitals, and other offices.*
- ***Pay what you owe.*** *As a plan member, you are responsible for these payments:*
 - In order to be eligible for our plan, you must be entitled to Medicare Part A and enrolled in Medicare Part B. For that reason, some plan members must pay a premium for Medicare Part A and most plan members must pay a premium for Medicare Part B to remain a member of the plan.
 - For most of your medical services covered by the plan, you must pay your share of the cost when you get the service. This will be a copayment (a fixed amount) or coinsurance (a percentage of the total cost). Chapter 4 tells what you must pay for your medical services.
 - If you get any medical services that are not covered by our plan or by other insurance you may have, you must pay the full cost.
 - If you disagree with our decision to deny coverage for a service, you can make an appeal. Please see Chapter 7 of this booklet for information about how to make an appeal.
 - If you are required to pay a late enrollment penalty, you must pay the penalty to remain a member of the plan.
- ***Tell us if you move.*** *If you are going to move, it's important to tell us right away. Call Member Services (phone numbers are on the back cover of this booklet).*
 - **If you move *outside* of our plan service area, you cannot remain a member of our plan.** (Chapter 1 tells about our service area.) We can help you figure out whether you are moving outside our service area. If you are leaving our service area, we can let you know if we have a plan in your new area.
 - **If you move *within* our service area, we still need to know** so we can keep your membership record up to date and know how to contact you.
- ***Call Member Services for help if you have questions or concerns.*** *We also welcome any suggestions you may have for improving our plan.*
 - Phone numbers and calling hours for Member Services are on the back cover of this booklet.
 - For more information on how to reach us, including our mailing address, please see Chapter 2.

Chapter 7. What to do if you have a problem or complaint (coverage decisions, appeals, complaints)

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BACKGROUND

SECTION 1 Introduction

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

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

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

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

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

Section 1.2 What about the legal terms?

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

To keep things simple, this chapter explains the legal rules and procedures using simpler words in place of certain legal terms. For example, this chapter generally says "making a complaint" rather than "filing a grievance," "coverage decision" rather than "organization determination" or "coverage determination," and "Independent Review Organization" instead of "Independent Review Entity." It also uses abbreviations as little as possible.

However, it can be helpful – and sometimes quite important – for you to know the correct legal terms for the situation you are in. Knowing which terms to use will help you communicate more clearly and accurately when you are dealing with your problem and get the right help or information for your situation. To help you know which terms to use, we include legal terms when we give the details for handling specific types of situations.

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

Section 2.1 Where to get more information and personalized assistance

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

Get help from an independent government organization

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

The services of SHIP counselors are free. You will find phone numbers in Appendix A of this *Evidence of Coverage*.

You can also get help and information from Medicare

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

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

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

Section 3.1	Should you use the process for coverage decisions and appeals? Or should you use the process for making complaints?
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If you have a problem or concern, you only need to read the parts of this chapter that apply to your situation. The guide that follows will help.

<p>To figure out which part of this chapter will help with your specific problem or concern, START HERE</p>
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Is your problem or concern about your benefits or coverage?	
(This includes problems about whether particular medical care or prescription drugs are covered or not, the way in which they are covered, and problems related to payment for medical care.)	
Yes.	No.
My problem is about benefits or coverage. Go on to the next section of this chapter, Section 4, “A guide to the basics of coverage decisions and making appeals.”	My problem is <u>not</u> about benefits or coverage. Skip ahead to Section 9 at the end of this chapter: “How to make a complaint about quality of care, waiting times, customer service or other concerns.”

COVERAGE DECISIONS AND APPEALS

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

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

The process for coverage decisions and making appeals deals with problems related to your benefits and coverage for medical services, including problems related to payment. This is the process you use for issues such as whether something is covered or not and the way in which something is covered.

Asking for coverage decisions

A coverage decision is a decision we make about your benefits and coverage or about the amount we will pay for your medical services. You can also contact us and ask for a coverage decision if your doctor is unsure whether we will cover a particular medical service or refuses to provide medical care you think that you need. In other words, if you want to know if we will cover a medical service before you receive it, you can ask us to make a coverage decision for you.

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

Making an appeal

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

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

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

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

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

- **You can call us at Member Services** (phone numbers are on the back cover of this booklet).

- **To get free help from an independent organization** that is not connected with our plan, contact your State Health Insurance Assistance Program (see Section 2 of this chapter).
- **Your doctor or other provider can make a request for you.** Your doctor or other provider can request a coverage decision or a Level 1 Appeal on your behalf. To request any appeal after Level 1, your doctor or other provider must be appointed as your representative.
- **You can ask someone to act on your behalf.** If you want to, you can name another person to act for you as your "representative" to ask for a coverage decision or make an appeal.
 - There may be someone who is already legally authorized to act as your representative under State law.
 - If you want a friend, relative, your doctor or other provider, or other person to be your representative, call Member Services and ask for the "Appointment of Representative" form. (The form is also available on Medicare's website at <http://www.cms.hhs.gov/cmsforms/downloads/cms1696.pdf>.) The form gives that person permission to act on your behalf. It must be signed by you and by the person who you would like to act on your behalf. You must give us a copy of the signed form.
- **You also have the right to hire a lawyer to act for you.** You may contact your own lawyer, or get the name of a lawyer from your local bar association or other referral service. There are also groups that will give you free legal services if you qualify. However, **you are not required to hire a lawyer** to ask for any kind of coverage decision or appeal a decision.

Section 4.3 Which section of this chapter gives the details for <u>your</u> situation?
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There are three (3) different types of situations that involve coverage decisions and appeals. Since each situation has different rules and deadlines, we give the details for each one in a separate section:

- **Section 5** of this chapter: "Your medical care: How to ask for a coverage decision or make an appeal"
- **Section 6** of this chapter: "How to ask us to cover a longer inpatient hospital stay if you think the doctor is discharging you too soon"
- **Section 7** of this chapter: "How to ask us to keep covering certain medical services if you think your coverage is ending too soon" (*Applies to these services only*: home health care, skilled nursing facility care, and Comprehensive Outpatient Rehabilitation Facility (CORF) services)

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

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



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

Section 5.1	This section tells what to do if you have problems getting coverage for medical care or if you want us to pay you back for our share of the cost of your care
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This section is about your benefits for medical care and services. These benefits are described in Chapter 4 of this booklet: *Medical Benefits Chart (what is covered and what you pay)*. To keep things simple, we generally refer to “medical care coverage” or “medical care” in the rest of this section, instead of repeating “medical care or treatment or services” every time.

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

1. You are not getting certain medical care you want, and you believe that this care is covered by our plan.
2. Our plan will not approve the medical care your doctor or other medical provider wants to give you, and you believe that this care is covered by the plan.
3. You have received medical care or services that you believe should be covered by the plan, but we have said we will not pay for this care.
4. You have received and paid for medical care or services that you believe should be covered by the plan, and you want to ask our plan to reimburse you for this care.
5. You are being told that coverage for certain medical care you have been getting that we previously approved will be reduced or stopped, and you believe that reducing or stopping this care could harm your health.
 - **NOTE: If the coverage that will be stopped is for hospital care, home health care, skilled nursing facility care, or Comprehensive Outpatient Rehabilitation Facility (CORF) services,** you need to read a separate section of this chapter because special rules apply to these types of care. Here's what to read in those situations:
 - Chapter 7, Section 6: *How to ask us for a longer hospital stay if you think you are being asked to leave the hospital too soon.*
 - Chapter 7, Section 7: *How to ask us to keep covering certain medical services if you think your coverage is ending too soon.* This section is about three services only: home health care, skilled nursing facility care, and Comprehensive Outpatient Rehabilitation Facility (CORF) services.
 - For *all other* situations that involve being told that medical care you have been getting will be stopped, use this section (Section 5) as your guide for what to do.

Which of these situations are you in?	
If you are in this situation:	This is what you can do:
Do you want to find out whether we will cover the medical care or services you want?	You can ask us to make a coverage decision for you. Go to the next section of this chapter, Section 5.2 .
Have we already told you that we will not cover or pay for a medical service in the way that you want it to be covered or paid for?	You can make an appeal . (This means you are asking us to reconsider.) Skip ahead to Section 5.3 of this chapter.
Do you want to ask us to pay you back for medical care or services you have already received and paid for?	You can send us the bill. Skip ahead to Section 5.5 of this chapter.

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

Legal Terms	When a coverage decision involves your medical care, it is called an " organization determination ."
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Step 1: You ask our plan to make a coverage decision on the medical care you are requesting. If your health requires a quick response, you should ask us to make a "**fast decision**."

Legal Terms	A "fast decision" is called an " expedited determination ."
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How to request coverage for the medical care you want

- Start by calling, 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.
- For the details on how to contact us, go to Chapter 2, Section 1.2 and look for the section called, *How to contact us when you are asking for a coverage decision about your medical care*.

Generally we use the standard deadlines for giving you our decision

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

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

If your health requires it, ask us to give you a "fast decision"

- **A fast decision means we will answer within 72 hours.**
 - **However, we can take up to 14 more calendar days** if we find that some information that may benefit you is missing, or if you need time to get information to us for the review. If we decide to take extra days, we will tell you in writing.
 - If you believe we should *not* take extra days, you can file a "fast complaint" about our decision to take extra days. (For more information about the process for making complaints, including fast complaints, see Section 9 of this chapter.) We will call you as soon as we make the decision.
- **To get a fast decision, you must meet two requirements:**
 - You can get a fast decision *only* if you are asking for coverage for medical care *you have not yet received*. (You cannot get a fast decision if your request is about payment for medical care you have already received.)
 - You can get a fast decision *only* if using the standard deadlines could *cause serious harm to your health or hurt your ability to function*.
- **If your doctor tells us that your health requires a "fast decision," we will automatically agree to give you a fast decision.**
- If you ask for a fast decision on your own, without your doctor's support, we will decide whether your health requires that we give you a fast decision.
 - If we decide that your medical condition does not meet the requirements for a fast decision, we will send you a letter that says so (and we will use the standard deadlines instead).
 - This letter will tell you that if your doctor asks for the fast decision, we will automatically give a fast decision.
 - The letter will also tell how you can file a "fast complaint" about our decision to give you a standard decision instead of the fast decision you requested. (For more information about the process for making complaints, including fast complaints, see Section 9 of this chapter.)

Step 2: We consider your request for medical care coverage and give you our answer.

Deadlines for a "fast" coverage decision

- Generally, for a fast decision, we will give you our answer **within 72 hours**.
 - As explained above, we can take up to 14 more calendar days under certain circumstances. If we decide to take extra days to make the decision, we will tell you in writing.

- If you believe we should *not* take extra days, you can file a “fast complaint” about our decision to take extra days. When you file a fast complaint, we will give you an answer to your complaint within 24 hours. (For more information about the process for making complaints, including fast complaints, see Section 9 of this chapter).
- If we do not give you our answer within 72 hours (or if there is an extended time period, by the end of that period), you have the right to appeal. Section 5.3 below tells how to make an appeal.
- **If our answer is yes to part or all of what you requested**, we must authorize or provide the medical care coverage we have agreed to provide within 72 hours after we received your request. If we extended the time needed to make our decision, we will provide the coverage by the end of that extended period.
- **If our answer is no to part or all of what you requested**, we will send you a written statement that explains why we said no.

Deadlines for a "standard" coverage decision

- Generally, for a standard decision, we will give you our answer **within 14 days of receiving your request**.
 - We can take up to 14 more calendar days ("an extended time period") under certain circumstances. If we decide to take extra days to make the decision, we will tell you in writing.
 - If you believe we should *not* take extra days, you can file a “fast complaint” about our decision to take extra days. When you file a fast complaint, we will give you an answer to your complaint within 24 hours. (For more information about the process for making complaints, including fast complaints, see Section 9 of this chapter).
 - If we do not give you our answer within 14 days (or if there is an extended time period, by the end of that period), you have the right to appeal. Section 5.3 below tells how to make an appeal.
- **If our answer is yes to part or all of what you requested**, we must authorize or provide the coverage we have agreed to provide within 14 days after we received your request. If we extended the time needed to make our decision, we will provide the coverage by the end of that extended period.
- **If our answer is no to part or all of what you requested**, we will send you a written statement that explains why we said no.

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

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

Section 5.3	Step-by-step: How to make a Level 1 Appeal (how to ask for a review of a medical care coverage decision made by our plan)
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Legal Terms	An appeal to the plan about a medical care coverage decision is called a plan " reconsideration. "
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Step 1: You contact us and make your appeal. If your health requires a quick response, you must ask for a "fast appeal".

What to do

- **To start your appeal, you, your doctor, or your representative, must contact us.** For details on how to reach us for any purpose related to your appeal, go to Chapter 2, Section 1.2 look for section called, *How to contact us when you are making an appeal about your medical care.*
- **If you are asking for a standard appeal, make your standard appeal in writing by submitting a signed request.** You may also ask for an appeal by calling us at the phone number shown in Chapter 2, Section 1.2 (*How to contact us when you are making an appeal about your medical care*).
 - If you have someone appealing our decision for you other than your doctor, your appeal must include an Appointment of Representative form authorizing this person to represent you. (To get the form, call Member Services and ask for the "Appointment of Representative" form. It is also available on Medicare's website at <http://www.cms.hhs.gov/cmsforms/downloads/cms1696.pdf>.) While we can accept an appeal request without the form, we cannot complete our review until we receive it. If we do not receive the form within 44 days after receiving your appeal request (our deadline for making a decision on your appeal), your appeal request will be sent to the Independent Review Organization for dismissal.
- **If you are asking for a fast appeal, make your appeal in writing or call us** at the phone number shown in Chapter 2, Section 1 (*How to contact us when you are making an appeal about your medical care*).
- **You must make your appeal request within 60 calendar days** from the date on the written notice we sent to tell you our answer to your request for a coverage decision. If you miss this deadline and have a good reason for missing it, we may give you more time to make your appeal. Examples of good cause for missing the deadline may include if you had a serious illness that prevented you from contacting us or if we provided you with incorrect or incomplete information about the deadline for requesting an appeal.
- **You can ask for a copy of the information regarding your medical decision and add more information to support your appeal.**
 - You have the right to ask us for a copy of the information regarding your appeal. We are allowed to charge a fee for copying and sending this information to you.
 - If you wish, you and your doctor may give us additional information to support your appeal.

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

**Legal
Terms**A "fast appeal" is also called an "**expedited reconsideration.**"

- If you are appealing a decision we made about coverage for care you have not yet received, you and/or your doctor will need to decide if you need a "fast appeal."
- The requirements and procedures for getting a "fast appeal" are the same as those for getting a "fast decision." To ask for a fast appeal, follow the instructions for asking for a fast decision. (These instructions are given earlier in this Section.)
- If your doctor tells us that your health requires a "fast appeal," we will give you a fast appeal.

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

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

Deadlines for a "fast appeal"

- When we are using the fast deadlines, we must give you our answer **within 72 hours after we receive your appeal**. We will give you our answer sooner if your health requires us to do so.
 - However, if you ask for more time, or if we need to gather more information that may benefit you, we **can take up to 14 more calendar days**. If we decide to take extra days to make the decision, we will tell you in writing.
 - If we do not give you an answer within 72 hours (or by the end of the extended time period if we took extra days), we are required to automatically send your request on to Level 2 of the appeals process, where it will be reviewed by an independent organization. Later in this section, we tell about this organization and explain what happens at Level 2 of the appeals process.
- **If our answer is yes to part or all of what you requested**, we must authorize or provide the coverage we have agreed to provide within 72 hours after we receive your appeal.
- **If our answer is no to part or all of what you requested**, we will send you a written denial notice informing you that we have automatically sent your appeal to the Independent Review Organization for a Level 2 Appeal.

Deadlines for a "standard appeal"

- If we are using the standard deadlines, we must give you our answer **within 30 calendar days** after we receive your appeal if your appeal is about coverage for services you have not yet received. We will give you our decision sooner if your health condition requires us to.
 - However, if you ask for more time, or if we need to gather more information that may benefit you, **we can take up to 14 more calendar days**.

- If you believe we should *not* take extra days, you can file a “fast complaint” about our decision to take extra days. When you file a fast complaint, we will give you an answer to your complaint within 24 hours. (For more information about the process for making complaints, including fast complaints, see Section 9 of this chapter.)
- If we do not give you an answer by the deadline above (or by the end of the extended time period if we took extra days), we are required to send your request on to Level 2 of the appeals process, where it will be reviewed by an independent outside organization. Later in this section, we tell about this review organization and explain what happens at Level 2 of the appeals process.
- **If our answer is yes to part or all of what you requested**, we must authorize or provide the coverage we have agreed to provide within 30 days after we receive your appeal.
- **If our answer is no to part or all of what you requested**, we will send you a written denial notice informing you that we have automatically sent your appeal to the Independent Review Organization for a Level 2 Appeal.

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

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

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

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

Legal Terms	The formal name for the "Independent Review Organization" is the " Independent Review Entity ." It is sometimes called the " IRE ."
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Step 1: The Independent Review Organization reviews your appeal.

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

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

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

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

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

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

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

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

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

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

- There are three additional levels in the appeals process after Level 2 (for a total of five levels of appeal).
- If your Level 2 Appeal is turned down and you meet the requirements to continue with the appeals process, you must decide whether you want to go on to Level 3 and make a third appeal. The details on how to do this are in the written notice you got after your Level 2 Appeal.
- The Level 3 Appeal is handled by an administrative law judge. Section 8 in this chapter tells more about Levels 3, 4, and 5 of the appeals process.

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

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

Asking for reimbursement is asking for a coverage decision from us

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

We will say yes or no to your request

- If the medical care you paid for is covered and you followed all the rules, we will send you the payment for our share of the cost of your medical care within 60 calendar days after we receive your request. Or, if you haven't paid for the services, we will send the payment directly to the provider. When we send the payment, it's the same as saying *yes* to your request for a coverage decision.)
- If the medical care is *not* covered, or you did *not* follow all the rules, we will not send payment. Instead, we will send you a letter that says we will not pay for the services and the reasons why. (When we turn down your request for payment, it's the same as saying *no* to your request for a coverage decision.)

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

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

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

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

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

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

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

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

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

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

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

Legal Terms	<p>The written notice from Medicare tells you how you can "request an immediate review." Requesting an immediate review is a formal, legal way to ask for a delay in your discharge date so that we will cover your hospital care for a longer time. (Section 6.2 below tells you how you can request an immediate review.)</p>
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2. You must sign the written notice to show that you received it and understand your rights.

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

3. Keep your copy of the signed notice so you will have the information about making an appeal (or reporting a concern about quality of care) handy if you need it.

- If you sign the notice more than 2 days before the day you leave the hospital, you will get another copy before you are scheduled to be discharged.
- To look at a copy of this notice in advance, you can call Member Services or 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048. You can also see it online at http://www.cms.gov/BNI/12_HospitalDischargeAppealNotices.asp.

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

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

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

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

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

Legal Terms	A "fast review" is also called an " immediate review. "
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What is the Quality Improvement Organization?

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

How can you contact this organization?

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

Act quickly:

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

Ask for a "fast review":

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

**Legal
Terms**

A "**fast review**" is also called an "**immediate review**" or an "**expedited review**."

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

What happens during this review?

- Health professionals at the Quality Improvement Organization (we will call them "the reviewers" for short) will ask you (or your representative) why you believe coverage for the services should continue. You don't have to prepare anything in writing, but you may do so if you wish.
- The reviewers will also look at your medical information, talk with your doctor, and review information that the hospital and we have given to them.

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

**Legal
Terms**

This written explanation is called the "**Detailed Notice of Discharge.**" You can get a sample of this notice by calling Member Services or 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. (TTY users should call 1-877-486-2048.) Or you can get see a sample notice online at <http://www.cms.hhs.gov/BNI/>.

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

What happens if the answer is yes?

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

What happens if the answer is no?

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

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

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

Section 6.3

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

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

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

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

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

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

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

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

If the review organization says yes:

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

If the review organization says no:

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

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

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

Section 6.4	What if you miss the deadline for making your Level 1 Appeal?
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You can appeal to us instead

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

If you use this other way of making your appeal, *the first two levels of appeal are different.*

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

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

Legal Terms	A "fast review" (or "fast appeal") is also called an "expedited appeal".
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Step 1: Contact us and ask for a "fast review."

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

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

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

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

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

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

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

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

If we say no to your Level 1 Appeal, your case will *automatically* be sent on to the next level of the appeals process. During the Level 2 Appeal, the **Independent Review Organization** reviews the decision we made

when we said no to your "fast appeal." This organization decides whether the decision we made should be changed.

Legal Terms	The formal name for the "Independent Review Organization" is the " Independent Review Entity. " It is sometimes called the " IRE. "
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Step 1: We will automatically forward your case to the Independent Review Organization.

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

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

- **The Independent Review Organization is an independent organization that is hired by Medicare.** This organization is not connected with our plan and it is not a government agency. This organization is a company chosen by Medicare to handle the job of being the Independent Review Organization. Medicare oversees its work.
- Reviewers at the Independent Review Organization will take a careful look at all of the information related to your appeal of your hospital discharge.
- **If this organization says *yes* to your appeal,** then we must reimburse you (pay you back) for our share of the costs of hospital care you have received since the date of your planned discharge. We must also continue the plan's coverage of your hospital services for as long as it is medically necessary. You must continue to pay your share of the costs. If there are coverage limitations, these could limit how much we would reimburse or how long we would continue to cover your services.
- **If this organization says *no* to your appeal,** it means they agree with us that your planned hospital discharge date was medically appropriate.
 - The notice you get from the Independent Review Organization will tell you in writing what you can do if you wish to continue with the review process. It will give you the details about how to go on to a Level 3 Appeal, which is handled by a judge.

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

- There are three additional levels in the appeals process after Level 2 (for a total of five levels of appeal). If reviewers say no to your Level 2 Appeal, you decide whether to accept their decision or go on to Level 3 and make a third appeal.
- Section 8 in this chapter tells more about Levels 3, 4, and 5 of the appeals process.

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

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

- **Home health care services** you are getting.
- **Skilled nursing care** you are getting as a patient in a skilled nursing facility. (To learn about requirements for being considered a "skilled nursing facility," see Chapter 10, *Definitions of important words*.)
- **Rehabilitation care** you are getting as an outpatient at a Medicare-approved Comprehensive Outpatient Rehabilitation Facility (CORF). Usually, this means you are getting treatment for an illness or accident, or you are recovering from a major operation. (For more about this type of facility, see Chapter 10, *Definitions of important words*.)

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

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

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

Section 7.2	We will tell you in advance when your coverage will be ending
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1. **You receive a notice in writing.** At least two days before our plan is going to stop covering your care, the agency or facility that is providing your care will give you a letter or notice.
 - The written notice tells you the date when we will stop covering the care for you.
 - The written notice also tells what you can do if you want to ask our plan to change this decision about when to end your care, and keep covering it for a longer period of time.

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

The written notice is called the "**Notice of Medicare Non-Coverage**." To get a sample copy, call Member Services or 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. (TTY users should call 1-877-486-2048.). Or see a copy online at <http://www.cms.hhs.gov/BNI/>.

2. You must sign the written notice to show that you received it.

- You, or someone who is acting on your behalf, must sign the notice. (*Section 4 tells how you can give written permission to someone else to act as your representative.*)
- Signing the notice shows *only* that you have received the information about when your coverage will stop. **Signing it does not mean you agree** with the plan that it's time to stop getting the care.

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

If you want to ask us to cover your care for a longer period of time, you will need to use the appeals process to make this request. Before you start, understand what you need to do and what the deadlines are.

- **Follow the process.** Each step in the first two levels of the appeals process is explained below.
- **Meet the deadlines.** The deadlines are important. Be sure that you understand and follow the deadlines that apply to things you must do. There are also deadlines our plan must follow. (If you think we are not meeting our deadlines, you can file a complaint. Section 9 of this chapter tells you how to file a complaint.)
- **Ask for help if you need it.** If you have questions or need help at any time, please call Member Services (phone numbers are on the back cover of this booklet). Or call your State Health Insurance Assistance Program, a government organization that provides personalized assistance. (See Section 2 of this chapter).

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

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

What is the Quality Improvement Organization?

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

How can you contact this organization?

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

What should you ask for?

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

Your deadline for contacting this organization.

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

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

What happens during this review?

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

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

What happens if the reviewers say yes to your appeal?

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

What happens if the reviewers say no to your appeal?

- If the reviewers say *no* to your appeal, then **your coverage will end on the date we have told you.** We will stop paying its share of the costs of this care.

- If you decide to keep getting the home health care, or skilled nursing facility care, or Comprehensive Outpatient Rehabilitation Facility (CORF) services *after* this date when your coverage ends, then **you will have to pay the full cost** of this care yourself.

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

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

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

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

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

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

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

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

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

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

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

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

What happens if the review organization says no?

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

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

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

Section 7.5 What if you miss the deadline for making your Level 1 Appeal?**You can appeal to us instead**

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

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

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

Here are the steps for a Level 1 Alternate Appeal:

Legal Terms	A "fast" review (or "fast appeal") is also called an "expedited appeal".
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Step 1: Contact us and ask for a "fast review".

- For details on how to contact us, go to Chapter 2, Section 1.2 and look for the section called, *How to contact our plan when you are making an appeal about your medical care.*
- **Be sure to ask for a "fast review".** This means you are asking us to give you an answer using the "fast" deadlines rather than the "standard" deadlines.

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

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

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

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

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

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

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

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

Legal Terms	The formal name for the "Independent Review Organization" is the "Independent Review Entity." It is sometimes called the "IRE."
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Step 1: We will automatically forward your case to the Independent Review Organization.

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

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

- **The Independent Review Organization is an independent organization that is hired by Medicare.** This organization is not connected with our plan and it is not a government agency. This organization is a company chosen by Medicare to handle the job of being the Independent Review Organization. Medicare oversees its work.
- Reviewers at the Independent Review Organization will take a careful look at all of the information related to your appeal.

- **If this organization says *yes* to your appeal**, then we must reimburse you (pay you back) for our share of the costs of care you have received since the date when we said your coverage would end. We must also continue to cover the care for as long as it is medically necessary. You must continue to pay your share of the costs. If there are coverage limitations, these could limit how much we would reimburse or how long we would continue to cover your services.
- **If this organization says *no* to your appeal**, it means they agree with the decision our plan made to your first appeal and will not change it.
 - The notice you get from the Independent Review Organization will tell you in writing what you can do if you wish to continue with the review process. It will give you the details about how to go on to a Level 3 Appeal.

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

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

SECTION 8 Taking your appeal to Level 3 and beyond

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

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

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

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

Level 3 Appeal	A judge who works for the Federal government will review your appeal and give you an answer. This judge is called an "Administrative Law Judge."
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- **If the Administrative Law Judge says *yes* to your appeal, the appeals process *may* or *may not* be over** – We will decide whether to appeal this decision to Level 4. Unlike a decision at Level 2 (Independent Review Organization), we have the right to appeal a Level 3 decision that is favorable to you.

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

Level 4 Appeal	The Medicare Appeals Council will review your appeal and give you an answer. The Medicare Appeals Council works for the Federal government.
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- **If the answer is yes, or if the Medicare Appeals Council denies our request to review a favorable Level 3 Appeal decision, the appeals process *may* or *may not* be over** – We will decide whether to appeal this decision to Level 5. Unlike a decision at Level 2 (Independent Review Organization), we have the right to appeal a Level 4 decision that is favorable to you.
 - If we decide *not* to appeal the decision, we must authorize or provide you with the service within 60 days after receiving the Medicare Appeals Council's decision.
 - If we decide to appeal the decision, we will let you know in writing.
- **If the answer is no or if the Medicare Appeals Council denies the review request, the appeals process *may* or *may not* be over.**
 - If you decide to accept this decision that turns down your appeal, the appeals process is over.
 - If you do not want to accept the decision, you might be able to continue to the next level of the review process. If the Medicare Appeals Council says no to your appeal, the notice you get will tell you whether the rules allow you to go on to a Level 5 Appeal. If the rules allow you to go on, the written notice will also tell you who to contact and what to do next if you choose to continue with your appeal.

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

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



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

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

This section explains how to use the process for making complaints. The complaint process is used for certain types of problems *only*. This includes problems related to quality of care, waiting times, and the customer service you receive. Here are examples of the kinds of problems handled by the complaint process.

**If you have any of these kinds of problems, you can
“make a complaint”****Quality of your medical care**

- Are you unhappy with the quality of the care you have received (including care in the hospital)?

Respecting your privacy

- Do you believe that someone did not respect your right to privacy or shared information about you that you feel should be confidential?

Disrespect, poor customer service, or other negative behaviors

- Has someone been rude or disrespectful to you?
- Are you unhappy with how our Member Services has treated you?
- Do you feel you are being encouraged to leave the plan?

Waiting times

- Are you having trouble getting an appointment, or waiting too long to get it?
- Have you been kept waiting too long by doctors or other health professionals? Or by our Member Services or other staff at the plan?
 - Examples include waiting too long on the phone, in the waiting room, when getting a prescription or in the exam room.

Cleanliness

- Are you unhappy with the cleanliness or condition of a clinic, hospital, or doctor’s office?

Information you get from us

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

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

Possible complaints
(continued)

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

The process of asking for a coverage decision and making appeals is explained in sections 4-8 of this chapter. If you are asking for a decision or making an appeal, you use that process, not the complaint process.

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

- If you have asked us to give you a “fast response” for a coverage decision or appeal, and we have said we will not, you can make a complaint.
- If you believe we are not meeting the deadlines for giving you a coverage decision or an answer to an appeal you have made, you can make a complaint.
- When a coverage decision we made is reviewed and we are told that we must cover or reimburse you for certain medical services, there are deadlines that apply. If you think we are not meeting these deadlines, you can make a complaint.
- When we do not give you a decision on time, we are required to forward your case to the Independent Review Organization. If we do not do that within the required deadline, you can make a complaint.

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

**Legal
Terms**

- What this section calls a "**complaint**" is also called a "**grievance.**"
- Another term for "**making a complaint**" is "**filing a grievance.**"
- Another way to say "**using the process for complaints**" is "**using the process for filing a grievance.**"

Section 9.3 Step-by-step: Making a complaint

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

- **Usually, calling Member Services is the first step.** If there is anything else you need to do, Member Services will let you know. You can reach Member Services at (866) 568-8921. Hours are 8:00 a.m. to 8:00 p.m. in your local time zone, 7 days a week. TTY users should call (877) 907-2986 (TTY). Hours are 8:00 a.m. to 8:00 p.m. in your local time zone, 7 days a week.
- **If you do not wish to call (or you called and were not satisfied), you can put your complaint in writing and send it to us.** If you put your complaint in writing, we will respond to your complaint in writing.

- **Standard Grievances**

To use our formal procedures for answering Grievances, you may call Member Services to submit a verbal grievance or you may forward your Grievance in written form to our address noted in Chapter 2, Section 1.

We will send you a letter notifying you of receipt of your grievance. Once we receive your grievance, we will research your complaint. We may contact you also to ask for additional information.

Once we reach a conclusion, we will notify you verbally or by written correspondence if your request is received in writing, if you request a written response, or if your complaint involves quality of care concerns. Our conclusion should reach you within thirty (30) calendar days of receipt of your grievance. However, some cases require additional time. In those cases, we will notify you of our need for an additional fourteen (14) calendar days to reach a conclusion.

- **Expedited Grievances**

You may file an expedited grievance orally or in writing should you disagree with our decision not to conduct an expedited organization/Coverage Determination or an expedited reconsideration/redetermination. You may also file an expedited grievance if you disagree with the plan's decision to request a fourteen (14) calendar day extension to make a decision on an organization determination, coverage determination or reconsideration. You may request an expedited grievance by contacting Member Services at (866) 568-8921. When an expedited grievance is requested, we are required to provide a response within 24 hours.

- **Whether you call or write, you should contact Member Services right away.** The complaint must be made within 60 calendar days after you had the problem you want to complain about.
- **If you are making a complaint because we denied your request for a "fast response" to a coverage decision or appeal, we will automatically give you a "fast" complaint.** If you have a "fast" complaint, it means we will give you an answer within 24 hours.

Legal Terms	What this section calls a " fast complaint " is also called an " expedited grievance. "
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Step 2: We look into your complaint and give you our answer.

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

- **Most complaints are answered in 30 calendar days.** If we need more information and the delay is in your best interest or if you ask for more time, we can take up to 14 more calendar days (44 calendar days total) to answer your complaint.
- **If we do not agree** with some or all of your complaint or don't take responsibility for the problem you are complaining about, we will let you know. Our response will include our reasons for this answer. We must respond whether we agree with the complaint or not.

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

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

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

Chapter 8. Ending your membership in the plan

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SECTION 1 Introduction

Section 1.1 This chapter focuses on 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 have decided that you *want* to leave.
 - There are only certain times during the year, or certain situations, when you may voluntarily end your membership in the plan. Section 2 tells you *when* you can end your membership in the plan.
 - The process for voluntarily ending your membership varies depending on what type of new coverage you are choosing. Section 3 tells you *how* to end your membership in each situation.
- There are also limited situations where you do not choose to leave, but we are required to end your membership. Section 5 tells you about situations when we must end your membership.

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

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

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

Section 2.1 You can end your membership during the Annual Enrollment Period
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You can end your membership during the **Annual Enrollment Period** (also known as the "Annual Coordinated Election Period"). This is the time when you should review your health coverage and make a decision about your coverage for the upcoming year.

- **When is the Annual Enrollment Period?** This happens from October 15 to December 7 in 2011.
- **What type of plan can you switch to during the Annual Enrollment Period?** During this time, you can review your health coverage. You can choose to keep your current coverage or make changes to your coverage for the upcoming year. If you decide to change to a new plan, you can choose any of the following types of plans:
 - Another Medicare health plan. (You can choose a plan that covers prescription drugs or one that does not cover prescription drugs.)
 - Original Medicare *with* a separate Medicare prescription drug plan.
 - – *or* – Original Medicare *without* a separate Medicare prescription drug plan.
- **What do you need to do to switch plans?**

- If you want to switch to Original Medicare: You must ask to disenroll from our plan. For more information on how to request disenrollment contact Member Services. You may also call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week, to request disenrollment from our plan. TTY users should call 1-877-486-2048.
- If you are currently enrolled in a Medicare prescription drug plan:
 - Leaving our plan will not affect your enrollment in your drug plan.
 - If you want to join a new drug plan, you must request enrollment in the new drug plan of your choice. Switching your Medicare prescription drug plan will *not* automatically disenroll you from our plan.
- If you do not have Medicare prescription drug coverage with another plan, you can join another Medicare health plan that does not offer drug coverage or you can switch to Original Medicare.
- **When will your membership end?** Your membership will end when your new plan's coverage begins on January 1.

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

- **When is the annual Medicare Advantage Disenrollment Period?** This happens every year from January 1 to February 14.
- **What type of plan can you switch to during the annual Medicare Advantage Disenrollment Period?** During this time, you can cancel your Medicare Advantage Plan enrollment and switch to Original Medicare. If you are enrolled in a separate Medicare prescription drug plan, you may not cancel that coverage when you switch to Original Medicare.
- **When will your membership end?** Your membership will end on the first day of the month after we get your request to switch to Original Medicare.

Section 2.3	In certain situations, you can end your membership during a Special Enrollment Period
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In certain situations, members of our plan may be eligible to end their membership at other times of the year. This is known as a **Special Enrollment Period**.

- **Who is eligible for a Special Enrollment Period?** If any of the following situations apply to you, you are eligible to end your membership during a Special Enrollment Period. These are just examples, for the full list you can contact the plan, call Medicare, or visit the Medicare website (<http://www.medicare.gov>):
 - Usually, when you have moved.
 - If you have Medicaid.

- If we violate our contract with you.
- If you are getting care in an institution, such as a nursing home or long-term care hospital.
- If you enroll in the Program of All-inclusive Care for the Elderly (PACE).
- **When are Special Enrollment Periods?** The enrollment periods vary depending on your situation.
- **What can you do?** To find out if you are eligible for a Special Enrollment Period, please call Medicare at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users call 1-877-486-2048. If you are eligible to end your membership because of a special situation, you can choose to change both your Medicare health coverage and prescription drug coverage. This means you can choose any of the following types of plans:
 - Another Medicare health plan. (You can choose a plan that covers prescription drugs or one that does not cover prescription drugs.)
 - Original Medicare *with* a separate Medicare prescription drug plan.
 - – *or* – Original Medicare *without* a separate Medicare prescription drug plan.
- **When will your membership end?** Your membership will usually end on the first day of the month after we receive your request to change your plan.

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

- You can **call Member Services** (phone numbers are on the back cover of this booklet).
- You can find the information in the *Medicare & You* 2012 Handbook.
 - Everyone with Medicare receives a copy of *Medicare & You* each fall. Those new to Medicare receive it within a month after first signing up.
 - You can also download a copy from the Medicare website (<http://www.medicare.gov>). Or, you can order a printed copy by calling Medicare at the number below.
- You can contact **Medicare** at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

SECTION 3	How do you end your membership in our plan?
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Section 3.1	Usually, you end your membership by enrolling in another plan
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Usually, to end your membership in our plan, you simply enroll in another Medicare plan during one of the enrollment periods (see Section 2 for information about the enrollment periods). However, if you want to switch from our plan to Original Medicare, you must ask to be disenrolled from our plan. There are two ways you can ask to be disenrolled:

- You can make a request in writing to us. (Contact Member Services if you need more information on how to do this.)
- --or-- You can contact Medicare at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

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

If you would like to switch from our plan to:	This is what you should do:
<ul style="list-style-type: none"> • Another Medicare Advantage health plan 	<ul style="list-style-type: none"> • Enroll in the new Medicare health plan. You will automatically be disenrolled from our plan when your new plan's coverage begins.
<ul style="list-style-type: none"> • Original Medicare <i>with</i> a separate Medicare prescription drug plan. 	<ul style="list-style-type: none"> • Send us a written request to disenroll. Contact Member Services if you need more information on how to do this (phone numbers are on the back cover of this booklet). • You can also contact Medicare, at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week, and ask to be disenrolled. TTY users should call 1-877-486-2048. • You will be disenrolled from our plan when your coverage in Original Medicare begins.
<ul style="list-style-type: none"> • Original Medicare <i>without</i> a separate Medicare prescription drug plan. <ul style="list-style-type: none"> ◦ Note: If you disenroll from a Medicare prescription drug plan and go without creditable prescription drug coverage, you may need to pay a late enrollment penalty if you join a Medicare drug plan later. See Chapter 6, Section 10 for more information about the late enrollment penalty. 	<ul style="list-style-type: none"> • Contact Member Services and ask to be disenrolled from the plan (phone numbers are on the back cover of this booklet). • You can also contact Medicare, at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week, and ask to be disenrolled. TTY users should call 1-877-486-2048. • You will be disenrolled from our plan when your coverage in Original Medicare begins.

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

Section 4.1 Until your membership ends, you are still a member of our plan
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If you leave our plan, it may take time before your membership ends and your new Medicare coverage goes into effect. (See Section 2 for information on when your new coverage begins.) During this time, you must continue to get your medical care through our plan.

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

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

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

Our plan must end your membership in the plan if any of the following happen:

- If you do not stay continuously enrolled in Medicare Part A and Part B.
 - If you move out of our service area for more than six months.
 - If you move or take a long trip, you need to call Member Services to find out if the place you are moving or traveling to is in our plan's area
- If you become incarcerated (go to prison).
- If you lie about or withhold information about other insurance you have that provides prescription drug coverage.
- If you intentionally give us incorrect information when you are enrolling in our plan and that information affects your eligibility for our plan.
- If you continuously behave in a way that is disruptive and makes it difficult for us to provide medical care for you and other members of our plan.
 - We cannot make you leave our plan for this reason unless we get permission from Medicare first.
- If you let someone else use your membership card to get medical care.
 - If we end your membership because of this reason, Medicare may have your case investigated by the Inspector General.

Where can you get more information?

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

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

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

What should you do if this happens?

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

Section 5.3 You have the right to make a complaint if we end your membership in our plan

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

Chapter 9. Legal notices

SECTION 1 Notice about governing law 112

SECTION 2 Notice about nondiscrimination 112

SECTION 1 **Notice about governing law**

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

SECTION 2 **Notice about nondiscrimination**

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

Chapter 10. Definitions of important words

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

Annual Enrollment Period – A set time each fall when members can change their health or drugs plans or switch to Original Medicare. The Annual Enrollment Period is from October 15 until December 7, 2011.

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

Balance Billing – A situation in when a provider, such as a doctor or hospital, bills patients up to 15% more than the plan's payment amount for services. The "balance billing" amount is collected in addition to the patient's regular plan cost-sharing amount. Our plan does not allow providers who provide plan-covered services to balance bill members of our plan. See Chapter 4, Section 1.6 for more information about balance billing.

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

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

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

Comprehensive Outpatient Rehabilitation Facility (CORF) – A facility that mainly provides rehabilitation services after an illness or injury, and provides a variety of services including physical therapy, social or psychological services, respiratory therapy, occupational therapy and speech-language pathology services, and home environment evaluation services.

Copayment – An amount you may be required to pay as your share of the cost for a medical service or supply, like a doctor's visit, hospital outpatient visit, or a prescription drug. A copayment is usually a set amount, rather than a percentage. For example, you might pay \$10 or \$20 for a doctor's visit or prescription drug.

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

“coinsurance” amount, a percentage of the total amount paid for a service, that a plan requires when a specific service is received.

Coverage Determination – A decision about whether a drug prescribed for you is covered by the plan and the amount, if any, you are required to pay for the prescription. In general, if you bring your prescription to a pharmacy and the pharmacy tells you the prescription isn’t covered under your plan, that isn’t a coverage determination. You need to call or write to your plan to ask for a formal decision about the coverage. Coverage determinations are called “coverage decisions” in this booklet. Chapter 9 explains how to ask us for a coverage decision.

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

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

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

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

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

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

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

Emergency Care – Covered services that are: 1) rendered by a provider qualified to furnish emergency services; and 2) needed to evaluate or stabilize an emergency medical condition.

Evidence of Coverage (EOC) and Disclosure Information – This document, along with your enrollment form and any other attachments, riders, or other optional coverage selected, which explains your coverage, what we must do, your rights, and what you have to do as a member of our Plan.

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

Grievance – A type of complaint you make about us or providers including a complaint concerning the quality of your care. This type of complaint does not involve coverage or payment disputes.

Home Health Aide – A home health aide provides services that don’t need the skills of a licensed nurse or therapist, such as help with personal care (e.g., bathing, using the toilet, dressing, or carrying out the prescribed exercises). Home health aides do not have a nursing license or provide therapy.

Initial Coverage Limit – The maximum limit of coverage under the Initial Coverage Stage.

Initial Enrollment Period – When you are first eligible for Medicare, the period of time when you can sign up for Medicare Part B. For example, if you're eligible for Part B when you turn 65, your Initial Enrollment Period is the 7-month period that begins 3 months before the month you turn 65, includes the month you turn 65, and ends 3 months after the month you turn 65.

Late Enrollment Penalty – An amount added to your monthly premium for Medicare drug coverage if you go without creditable coverage (coverage that is expected to pay, on average, at least as much as standard Medicare prescription drug coverage) for a continuous period of 63 days or more. You pay this higher amount as long as you have a Medicare drug plan. There are some exceptions. For example, if you receive Extra Help from Medicare to pay your prescription drug plan costs, the late enrollment penalty rules do not apply to you. If you receive Extra Help, you do not pay a penalty, even if you go without "creditable" prescription drug coverage.

Low Income Subsidy – See "Extra Help."

Maximum Out-of-Pocket Amount – The most that you pay out-of-pocket during the calendar year for covered services. Amounts you pay for your plan premiums, Medicare Part A and Part B premiums do not count toward the maximum out-of-pocket amount. See Chapter 4, Section 1.3 for information about your maximum out-of-pocket amount.

Medicaid (or Medical Assistance) – A joint Federal and state program that helps with medical costs for some people with low incomes and limited resources. Medicaid programs vary from state to state, but most health care costs are covered if you qualify for both Medicare and Medicaid. See Chapter 2, Section 6 for information about how to contact Medicaid in your state.

Medically Accepted Indication – A use of a drug that is either approved by the Food and Drug Administration or supported by certain reference books. See Chapter 5, Section 4 for more information about a medically accepted indication.

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

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

Medicare Advantage Disenrollment Period – A set time each year when members in a Medicare Advantage plan can cancel their plan enrollment and switch to Original Medicare. The Medicare Advantage Disenrollment Period is from January 1 until February 14, 2011.

Medicare Advantage (MA) Plan – Sometimes called Medicare Part C. A plan offered by a private company that contracts with Medicare to provide you with all your Medicare Part A and Part B benefits. A Medicare Advantage Plan can be an HMO, PPO, a Private Fee-for-Service (PFFS) plan, or a Medicare Medical Savings Account (MSA) plan. When you are enrolled in a Medicare Advantage Plan, Medicare services are covered through the plan, and are not paid for under Original Medicare. In most cases, Medicare Advantage Plans also offer Medicare Part D (prescription drug coverage). These plans are called **Medicare Advantage Plans with Prescription Drug Coverage**. Everyone who has Medicare Part A and Part B is

eligible to join any Medicare health plan that is offered in their area, except people with End-Stage Renal Disease (unless certain exceptions apply).

Medicare Cost Plan – A Medicare Cost Plan is a plan operated by a Health Maintenance Organization (HMO) or Competitive Medical Plan (CMP) in accordance with a cost-reimbursed contract under section 1876(h) of the Act.

Medicare Coverage Gap Discount Program – A program that provides discounts on most covered Part D brand name drugs to Part D enrollees who have reached the Coverage Gap stage and who are not already receiving “Extra Help.” Discounts are based on agreements between the Federal government and certain drug manufacturers. For this reason, most, but not all, brand name drugs are discounted.

Medicare Health Plan – A Medicare health plan is offered by a private company that contracts with Medicare to provide Part A and Part B benefits to people with Medicare who enroll in the plan. This term includes all Medicare Advantage Plans, Medicare Cost Plans, Demonstration/Pilot Programs, and Programs of All-inclusive Care for the Elderly (PACE).

Medicare Prescription Drug Coverage (Medicare Part D) – Insurance to help pay for outpatient prescription drugs, vaccines, biologicals, and some supplies not covered by Medicare Part A or Part B.

"Medigap" (Medicare Supplement Insurance) Policy – Medicare supplement insurance sold by private insurance companies to fill "gaps" in Original Medicare. Medigap policies only work with Original Medicare. (A Medicare Advantage Plan is not a Medigap policy.)

Member (Member of our Plan, or "Plan Member") – A person with Medicare who is eligible to get covered services, who has enrolled in our plan and whose enrollment has been confirmed by the Centers for Medicare & Medicaid Services (CMS).

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

Organization Determination – The Medicare Advantage organization has made an organization determination when it, or one of its providers, makes a decision about whether services are covered or how much you have to pay for covered services. Organization determinations are called “coverage decisions” in this booklet. Chapter 7 explains how to ask us for a coverage decision.

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

Out-of-Pocket Costs – See the definition for “cost sharing” above. A member’s cost-sharing requirement to pay for a portion of services received is also referred to as the member’s “out-of-pocket” cost requirement.

PACE plan – A PACE (Program of All-Inclusive Care for the Elderly) plan combines medical, social, and long-term care services for frail people to help people stay independent and living in their community (instead of moving to a nursing home) as long as possible, while getting the high-quality care they need. People enrolled in PACE plans receive both their Medicare and Medicaid benefits through the plan.

Part C – see "Medicare Advantage (MA) Plan."

Preferred Provider Organization (PPO) Plan – A Preferred Provider Organization plan is a Medicare Advantage Plan that has a network of contracted providers that have agreed to treat plan members for a specified payment amount. A PPO plan must cover all plan benefits whether they are received from network or out-of-network providers. Member cost sharing will generally be higher when plan benefits are received from out-of-network providers. PPO plans have an annual limit on your out-of-pocket costs for services received from network (preferred) providers and a higher limit on your total combined out-of-pocket costs for services from both in-network (preferred) and out-of-network (non-preferred) providers.

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

Prior Authorization – Approval in advance to get services. In a PFFS plan, you do not need prior authorization to obtain services. However, you may want to check with your plan before obtaining services to confirm that the service is covered by your plan and what your cost-sharing responsibility is.

Quality Improvement Organization (QIO) – A group of practicing doctors and other health care experts paid by the Federal government to check and improve the care given to Medicare patients. See Chapter 2, Section 4 for information about how to contact the QIO for your state.

Rehabilitation Services – These services include physical therapy, speech and language therapy, and occupational therapy.

Service Area – A geographic area where a health plan accepts members if it limits membership based on where people live. For plans that limit which doctors and hospitals you may use, it's also generally the area where you can get routine (non-emergency) services. The plan may disenroll you if you move out of the plan's service area.

Skilled Nursing Facility (SNF) Care – Skilled nursing care and rehabilitation services provided on a continuous, daily basis, in a skilled nursing facility. Examples of skilled nursing facility care include physical therapy or intravenous injections that can only be given by a registered nurse or doctor.

Special Enrollment Period – A set time when members can change their health or drugs plans or return to Original Medicare. Situations in which you may be eligible for a Special Enrollment Period include: if you move outside the service area, if you are getting "Extra Help" with your prescription drug costs, if you move into a nursing home, or if we violate our contract with you.

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

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

Appendix A - CONTACT TABLES

SHIP - State Health Insurance Assistance Program

SHIP - State Health Insurance Assistance Program			
State	Agency Name	Contact Information	Web Site
Alabama	Alabama Department of Senior Services	Alabama Department of Senior Services 770 Washington Avenue RSA Plaza Suite 570 Montgomery, Alabama 36130 (334) 242-5743 1-(877)-425-2243 1-800-AGELINE (1-800-243-5463) Fax (334) 242-5594	http://www.alabamaageline.gov/
Arkansas	Arkansas Senior Health Insurance Information Program	1200 West Third Street Little Rock, AR 72201 (501) 371-2600 (800) 282-9134 (501) 371-2618 fax	http://insurance.arkansas.gov/seniors/homepage.htm
Arizona	Arizona Department of Economic Security - Division of Aging and Adult Services	(800) 432-4040	https://www.azdes.gov/common.aspx?menu=36&menuc=28&id=190
California	California Department of Aging	Legal Services of Northern California 3950 Industrial Blvd., Suite 500 West Sacramento, CA 95691 1-800-434-0222 TTY (800) 735-2929	http://www.aging.ca.gov/information_on/hicap.asp
Colorado	Division of Insurance	1560 Broadway, Suite 850, Denver, CO 80202 888-696-7213 En Espanol 866-665-9668	http://www.dora.state.co.us/insurance/senior/senior.htm

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State	Agency Name	Contact Information	Web Site
Connecticut	Aging Services Division	Department of Social Services Aging Services Division 25 Sigourney Street, 10th Floor Hartford, CT 06106 Phone (860) 424-5274 Toll Free (in State) 1-866-218-6631 Fax (860) 424-5301	http://www.ct.gov/agingservices/cwp/view.asp?a=2513&q=313032
Delaware	ELDERinfo	841 Silver Lake Blvd. Dover, DE 19904 (302) 674-7300	http://www.delawareinsurance.gov/departments/elder/eldindex.shtml
Florida	Serving Health Insurance Needs of Elders (SHINE)	Department of Elder Affairs 4040 Esplanade Way, Suite 270 Tallahassee, FL 32399-7000 800-963-5337 TDD 1-800-955-8770 TTY 1-800-955-8771	http://www.floridashine.org/
Georgia	GeorgiaCares	DHS Division of Aging Services Two Peachtree Street, NW Suite 9-385 Atlanta, Georgia 30303-3142 Phone: 404.657.5258 Fax: 404.657.5285 Toll Free: 1-866-55-AGING or 1-866-552-4464	http://aging.dhr.georgia.gov/portal/site
Iowa	Senior Health Insurance Information Program of Iowa (SHIP)	330 Maple St. Des Moines, IA 50319-0065 1-800-351-4664 TDD: 1-800-735-2942	http://www.shiip.state.ia.us/

SHIP - State Health Insurance Assistance Program			
State	Agency Name	Contact Information	Web Site
Idaho	SHIBA Health	Department of Insurance 700 West State Street P.O. Box 83720 Boise, ID 83720-0043 208-334-4250	http://www.doi.idaho.gov/shiba/shwelcome.aspx
Illinois	Senior Health Insurance Program	320 W. Washington Street Springfield, IL 62767 800-548-9043 TDD: 217-524-4872	http://insurance.illinois.gov/ship/
Indiana	State Health Insurance Information Program (SHIIP)	714 West 53rd Street Anderson, Indiana, 46013 1-800-452-4800 TDD: 1-866-846-0139	http://www.in.gov/idoi/2495.htm
Kansas	Senior Health Insurance Counseling For Kansas	1-800-860-5260	http://www.agingkansas.org/SHICK/shick_index.html
Kentucky	State Health Insurance Assistance Program	1-877-293-7447 National: 502-564-6930 TDD: 1-888-642-1137	http://www.chfs.ky.gov/dail/ship.htm
Louisiana	Senior Health Insurance Information Program	1702 N. Third Street P.O. Box 94214 Baton Rouge, LA 70802 1-800-259-5300	http://www.lda.la.gov/Health/SHIIP/index.html
Massachusetts	Serving Health Information Needs of Elders (SHINE)	Executive Office of Elder Affairs One Ashburton Place, Fifth floor Boston, Massachusetts 02108 617-727-7750 800-243-4636 (nationwide) 800-872-0166 (TTY) 617-727-9368 (FAX)	http://www.mass.gov/?pageID=eldershomepage&L=1&L0=Home&sid=Eelders

SHIP - State Health Insurance Assistance Program			
State	Agency Name	Contact Information	Web Site
Maryland	Department of Aging	301 West Preston Street Suite 1007 Baltimore, MD 21201 Phone: (410) 767-1100 Toll free, Maryland: 1-800-243-3425 Fax: (410) 333-7943 Maryland relay service: 1-800-201-7165	http://www.aging.maryland.gov/senior.html
Maine	State Health Insurance Assistance Program	Office of Elder Services Maine Department of Health and Human Services 11 State House Station 32 Blossom Lane Augusta, ME 04333 (207) 287-9200 (800) 262-2232 Fax: (207)287-9229 TTY: (800)606-0215	http://www.maine.gov/dhhs/oes/hiap/index.shtml
Michigan	Michigan Medicare Medicaid Assistance Program	6105 West St. Joseph, Suite 204 Lansing, MI. 48917-4850 (800) 803-7174	http://www.mmapinc.org/
Missouri	CLAIM	800-390-3330	http://www.missouricclaim.org/
Mississippi	Division of Aging & Adult Services	750 North State St., Jackson, MS 39202 (601)359-4500 (800) 345-6347	http://www.mdhs.state.ms.us/aas_info.html#MICAP
Montana	State Health and Insurance Assistance Program SHIP	800-332-2272	http://www.dphhs.mt.gov/sltc/services/aging/SHIP/ship.shtml
North Carolina	North Carolina Department of Insurance	Seniors' Health Insurance Information Program 11 South Boylan Avenue Raleigh, NC 27603 800-443-9354 919-807-6900 Fax: 919-807-6901 Email: ncship@ncdoi.gov	http://www.ncdoi.com/SHIP/Default.aspx

SHIP - State Health Insurance Assistance Program			
State	Agency Name	Contact Information	Web Site
North Dakota	State Health Insurance Counseling Program (SHIC)	North Dakota Insurance Department State Capitol, fifth floor 600 E. Boulevard Ave. Bismarck, ND 58505-0320 701.328.2440 701.328.4880 fax 888.575.6611 toll free 800.366.6888 TTY line	http://www.nd.gov/ndins/consumer/shic/
Nebraska	Nebraska Senior Health Insurance Information Program (SHIIP)	Nebraska Department of Insurance Terminal Building 941 O Street, Suite 400 Lincoln, NE 68508-3690 (402) 471-2201 (800) 234-7119 TDD (800) 833-7352 VOICE (800) 833-0920 (Nebraska Relay Service Voice option)	http://www.doi.ne.gov/shiip/
New Hampshire	ServiceLink	2 Industrial Park Drive, P.O. Box 1016 Concord, NH 03302-1016 866-634-9412	http://www.nh.gov/service-link/
New Jersey	State Health Insurance Assistance Program (SHIP)	P. O. Box 360 Trenton, NJ 08625-0360 800-792-8820	http://www.state.nj.us/health/senior/ship.shtml
New Mexico	Aging and Long-Term Services	Parks Building 1015 Tijeras NW, Suite 200 Albuquerque, New Mexico 87102 505-222-4500 866-842-9230	http://www.nmaging.state.nm.us/
Nevada	State Health Insurance Assistance Program	3416 Goni Road Suite D-132 Carson City, NV 89706 800-307-4444 En Espanol: (702) 759-0874	http://www.nvaging.net/ship/ship_main.htm

SHIP - State Health Insurance Assistance Program			
State	Agency Name	Contact Information	Web Site
New York	New York State Office for the Aging	New York State Office for the Aging 2 Empire State Plaza Albany, New York 12223-1251 (800) 342-9871	http://www.aging.ny.gov/
Ohio	Ohio Department of Insurance	50 W. Town Street, Third Floor - Suite 300 Columbus, Ohio 43215 800-686-1526	http://www.insurance.ohio.gov/Pages/default.aspx
Oklahoma	SHIP Senior Health Insurance Counseling Program	Five Corporate Plaza 3625 NW 56th, Suite 100 Oklahoma City, OK 73112-4511 800.763.2828	http://www.ok.gov/oid/Consumers/Information_for_Seniors/Senior_Health_Insurance_Counseling_Program_(SHIP)/index.html
Oregon	Senior Health Insurance Benefits Assistance Program	350 Winter Street NE, Suite 330, P.O. Box 14480 Salem, OR 97309-0405 Phone: 503-947-7979 Toll-free: 800-722-4134 Fax: 503-947-7092 TTY: 800-735-2900	http://www.oregon.gov/DCBS/SHIBA/
Pennsylvania	Apprise Health Insurance Counseling Program	Centre County Office of Aging Willowbank Office Building 420 Holmes Street Bellefonte, PA 16823-1488 800-783-7067	http://www.portal.state.pa.us/portal/server.pt?open=514&objID=616587&mode=2
Rhode Island	Division of Elderly Affairs	74 West Road Hazard Bldg , 2nd Floor Cranston RI 02920 401-462-3000 401-462-0740	http://www.dea.ri.gov/insurance/

SHIP - State Health Insurance Assistance Program			
State	Agency Name	Contact Information	Web Site
South Carolina	Office on Aging	1301 Gervais Street Suite 350 Columbia, SC 29201 Phone: (803) 734-9900 Toll Free: (800) 868-9095 Fax: (803) 734-9886 and (803) 734-9887	http://aging.sc.gov/Pages/default.aspx
South Dakota	SHIINE	Eastern South Dakota: Phone: 1-800-536-8197 or 605-333-3314 Central South Dakota: Phone: 1-877-331-4834 or 605-224-3212 Western South Dakota: Local: 1-877-286-9072 or 605-342-8635	http://www.shiine.net/
Tennessee	Tennessee's State Health Insurance Assistance Program (SHIP)	Andrew Jackson Building 500 Deaderick Street, Suite 825 Nashville, TN 37243-0860 877-801-0044 (615) 741-2056	http://www.state.tn.us/comaging/ship.html
Texas	Health Information Counseling and Advocacy Program (HICAP)	701 W. 51st St. Austin, Texas 78751 800-458-9858 800-252-9240	http://www.dads.state.tx.us/
Utah	Aging and Adult Services	195 North 1950 West Salt Lake City, UT 84116 Phone: (801) 538-3910 Toll free: 1-877-4aging0 or 1-877-424-4640 Fax: (801) 538-4395 Email: DAAS@utah.gov	http://www.hsdaas.utah.gov/insurance_programs.htm

SHIP - State Health Insurance Assistance Program			
State	Agency Name	Contact Information	Web Site
Virginia	Virginia Department for the Aging	Virginia Department for the Aging 1610 Forest Avenue, Suite 100 Richmond, VA 23229 1-800-552-3402 (Nationwide Voice/TTY) VA TTY Relay: 711	http://www.vda.virginia.gov/
Vermont	Vermont SHIP	Northeastern Vermont Area Agency on Aging 481 Summer Street, Suite 101 St. Johnsbury, Vermont 05819 1-802-748-5182 1-800-552-3402 (Nationwide Voice/TTY)	http://www.medicarehelpt.net/
Washington	SHIBA Health	SHIBA HelpLine Office of Insurance Commissioner PO Box 40256 Olympia, WA 98504-0256 800-562-6900 TDD: 360-586-0241	http://www.insurance.wa.gov/shiba/index.shtml
West Virginia	WV SHIP	1900 Kanawha Blvd. East Charleston, WV 25305 (304) 558-3317 (877) 987-4463 Fax: (304) 558-0004	http://www.wvship.org/
Wisconsin	State Health Insurance Assistance Program (SHIP)	1 West Wilson Street Madison, WI 53703 866-456-8211 888-758-6047 TTY/Textnet	http://www.dhs.wisconsin.gov/aging/EBS/ship.htm
Wyoming	WyomingSeniorCitizens, Inc.	P.O. Box BD Riverton, WY 82501 (307) 856-6880 (877) 634-1005 Fax: (307) 856-4466	http://www.wyomingseniors.com/WSHIIP.htm

QIO - Quality Improvement Organization (formerly PRO - Peer Review Organization)

QIO-Quality Improvement Organization (formerly PRO - Peer Review Organization)			
State	Agency Name	Contact Information	Web Site
Alabama	Alabama Quality Assurance Foundation	Two Perimeter Park South Suite 200 West Birmingham, AL 35243-23374 (205) 970-1600 Fax: (205) 970-1616	http://www.aqaf.com/
Arkansas	Arkansas Foundation for Medical Care	1020 West 4th Street, Suite 300 Little Rock, AR 72201 Phone: (501) 212-8600 Toll Free: 1-888-987-1200	http://www.afmc.org/HTML/index/index.aspx
Arizona	Health Services Advisory Group	1600 East Northern Avenue Suite 100 Phoenix, AZ 85020 (602) 264-6382 Fax: (602) 241-0757	http://www.hsag.com/home.aspx
California	Health Services Advisory Group	700 N. Brand Blvd. Suite 410 Glendale, CA 91203 (818) 409-9229	http://www.hsag.com/home.aspx
Colorado	Colorado Foundation for Medical Care	23 Inverness Way East Suite 100 Englewood, CO 80112-5708 (303) 695-3300 Fax: (303) 695-3350	http://www.cfmc.org/
Connecticut	Qualidigm	1111 Cromwell Avenue, Suite 201 Rocky Hill, CT 06067 (860) 632-6398 Fax: (860) 632-6326	http://www.qualidigm.org/
Delaware	Quality Insights of Delaware	Baynard Building, Suite 100 3411 Silverside Road Wilmington, DE 19810 (302) 478-3600 Fax: (302) 478-3873	http://www.qide.org/Home.aspx

QIO-Quality Improvement Organization (formerly PRO - Peer Review Organization)			
State	Agency Name	Contact Information	Web Site
Florida	FMQAI	5201 W. Kennedy Boulevard, Suite 900 Tampa, FL 33609-1812 (813) 354-9111 Fax: (813) 354-0737	http://www.fmqai.com/
Georgia	Alliant GMCF	1455 Lincoln Parkway Suite 800 Atlanta, GA 30346 (404) 982-0411 Fax: (404) 982-7584	http://www.gmcf.org/AlliantWeb/Default.aspx
Iowa	Telligen	6000 Westown Parkway Suite 350 E West Des Moines, IA 50266-7771 (515) 223-2900 Fax: (515) 222-2407	http://www.telligen.org/
Idaho	Qualis Health	720 Park Blvd. Suite 120 Boise, ID 83712-7756 (208) 343-4617 Fax: (208) 343-4705	http://www.qualishealth.org/
Illinois	Illinois Foundation for Quality Health Care	2625 Butterfield Road Suite 102E Oak Brook, IL 60523-1234 (800) 386-6431 Fax: (630) 571-5611	http://www.ifmc-il.org/
Indiana	Health Care Excel	2629 Waterfront Parkway East Drive Suite 200 Indianapolis, IN 46214 Phone: (317) 347-4500 Fax: (317) 347-4567	http://www.hce.org/
Kansas	Kansas Foundation for Medical Care	2947 S.W. Wanamaker Drive Topeka, KS 66614-4193 (785) 273-2552 Fax: (785) 273-0737	http://www.kfmc.org/

QIO-Quality Improvement Organization (formerly PRO - Peer Review Organization)			
State	Agency Name	Contact Information	Web Site
Kentucky	Health Care Excel	1951 Bishop Lane, Suite 300 Louisville, KY 40218 Phone: (502) 454-5112 Fax: (502) 454-5113	http://www.hce.org/
Louisiana	eQHealth Solutions	8591 United Plaza Blvd. Suite 270 Baton Rouge, LA 70809 (225) 926-6353 Fax: (225) 923-0957	http://www.lhcr.org/
Massachusetts	MassPRO	245 Winter Street Waltham, MA 02145 (781) 890-0011 Fax: (781) 487-0083	http://www.masspro.org/
Maryland	Delmarva Foundation	9240 Centreville Road Easton, MD 21601 (410) 822-0697 Fax: (410) 822-7291	http://www.mdqio.org/
Maine	Northeast Health Care Quality Foundation	15 Old Rollinsford Rd. Suite 302 Dover, NH 03820-2830 (603) 749-1641 Fax: (603) 749-1195	http://www.nhcqf.org/
Michigan	MPRO	22670 Haggerty Road, Suite 100 Farmington Hills, MI 48170-4495 (248) 465-7300 Fax: (248) 465-7428	http://www.mpro.org/
Minnesota	Stratis Health	2901 Metro Drive Suite 400 Bloomington, MN 55425 (952) 854-3306 Fax: (952) 853-8503	http://www.stratishealth.org/index.html
Missouri	Primaris	200 N. Keene St. Columbia, MO 65201 (573)-817-8300 Fax: (573) 817-8330	http://www.primaris.org/

QIO-Quality Improvement Organization (formerly PRO - Peer Review Organization)			
State	Agency Name	Contact Information	Web Site
Mississippi	Information & Quality Health Care	Renaissance Place, Suite 504 385B Highland Colony Parkway Ridgeland, MS 39157-6035 (601) 957-1575 Fax: (601) 956-1713	http://www.iqh.org/
Montana	Mountain-Pacific Quality Health Foundation	3404 Cooney Drive Helena, MT 59602 (406) 443-4020 Fax: (406) 443-4585	http://www.mpqhf.org/
North Carolina	The Carolinas Center for Medical Excellence	100 Regency Forest Drive Suite 100 Cary, NC 27511-8598 (919) 380-9860 Fax: (919) 380-7637	http://www.thecarolinascenter.org/
North Dakota	North Dakota Health Care Review, Inc.	800 31st Avenue, SW Minot, ND 58701 (701) 852-4231 Fax: (701) 838-6009	http://www.ndhcri.org/
Nebraska	CIMRO of Nebraska	1230 O Street, Suite 120 Lincoln, NE 68508 (402) 476-1399 Fax: (402) 476-1335	http://www.cimronebraska.org/default.aspx
New Hampshire	Northeast Health Care Quality Foundation	15 Old Rollinsford Rd. Suite 302 Dover, NH 03820-2830 (603) 749-1641 Fax: (603) 749-1195	http://www.nhcqf.org/
New Jersey	Healthcare Quality Strategies, Inc.	557 Cransbury Road Suite 21 East Brunswick, NJ 08816-4026 (732) 238-5570 Fax: (732) 238-7766	http://www.pronj.org/index.html

QIO-Quality Improvement Organization (formerly PRO - Peer Review Organization)			
State	Agency Name	Contact Information	Web Site
New Mexico	New Mexico Medical Review Association	Seagull Office Plaza 5801 Osuna Road NE, Suite 200 Albuquerque, NM 87109 (505) 998-9898 Fax: (505) 998-9899	http://www.nmmra.org/
Nevada	HealthInsight	6830 W. Oquendo Road, Suite 102 Las Vegas, Nevada 89118 (702) 385-9933 Fax: (702) 385-4586	http://www.healthinsight.org/
New York	IPRO	1979 Marcus Avenue First Floor Lake Success, NY 11042 (516) 326-7767 Fax: (516) 326-7791	http://www.ipro.org/
Ohio	Ohio KePRO	Rock Run Center Suite 100 5700 Lombardo Center Drive Seven Hills, OH 44131 (216) 447-9604 Fax: (216) 447-7925	http://www.ohiokepro.com/
Oklahoma	Oklahoma Foundation for Medical Quality	14000 Quail Springs Parkway, Ste. 400 Oklahoma City, OK 73134-2600 (405) 840-2891 Fax: (405) 840-1343	http://www.ofmq.com/
Oregon	Acumentra Health	2020 SW 4th Avenue Suite 520 Portland, OR 97201-4960 (503) 279-0100 Fax: (503) 279-0190	http://www.acumentra.org/
Pennsylvania	Quality Insights of Pennsylvania	Commerce Court 2601 Market Place Street Harrisburg, PA 17111 717-671-5425	http://www.qipa.org/Home.aspx

QIO-Quality Improvement Organization (formerly PRO - Peer Review Organization)			
State	Agency Name	Contact Information	Web Site
Rhode Island	Quality Partners of Rhode Island	235 Promenade Street Suite 500, Box 18 Providence, RI 08908 (401) 528-3200 Fax: (401) 528-3210	http://www.healthcentricadvisors.org/home.html
South Carolina	The Carolinas Center for Medical Excellence	246 Stoneridge Drive, Suite 200 Columbia, SC 29210 (803) 251-2215 Fax: (803) 255-0897	http://www.thecarolinascenter.org/
South Dakota	South Dakota Foundation for Medical Care	1323 South Minnesota Avenue Sioux Falls, SD 57105-0691 (605) 336-3505 Fax: (605) 336-0270	http://www.sdfmc.org/
Tennessee	Qsource	3175 Lenox Park Blvd. Suite 309 Memphis, TN 38115 (901) 682-0381 Fax: (901) 761-3786	http://www.qsource.org/
Texas	TMF Health Quality Institute	Bridgepoint I, Suite 300 5918 W Courtyard Dr. Austin, TX 78730-5036 512-329-6610 fax: 512-327-7159	http://www.tmf.org/
Utah	HealthInsight	348 East 4500 South Suite 300, Salt Lake City, Utah 84107 (801) 892-0155 Fax: (801) 892-0160	http://www.healthinsight.org/
Virginia	Virginia Health Quality Center	4510 Cox Road Suite 400 Glen Allen, VA 23060 (804) 289-5320 Fax: (804) 289-5324	http://www.vhqc.org/

QIO-Quality Improvement Organization (formerly PRO - Peer Review Organization)			
State	Agency Name	Contact Information	Web Site
Vermont	Northeast Health Care Quality Foundation	15 Old Rollinsford Rd. Suite 302 Dover, NH 03820-2830 (603) 749-1641 Fax: (603) 749-1195	http://www.nhcqf.org/
Washington	Qualis Health	10700 Meridan Avenue, North Suite 100 Seattle, WA 98133-9075 (206) 364-9700 Fax: (206) 368-2419	http://www.qualishealth.org/
West Virginia	West Virginia Medical Institute	3001 Chesterfield Place Charleston, WV 25304 (304) 346-9864 Fax: (304) 346-9863	http://www.wvmi.org/Home.aspx
Wisconsin	MetaStar, Inc.	2909 Landmark Place Madison, WI 53713 (608) 274-1940 Fax: (608) 274-5008	http://www.metastar.com/web/
Wyoming	Mountain-Pacific Quality Health Foundation	2206 Dell Range Blvd., Suite G Cheyenne, WY 82009 307-637-8162 Fax: 307-436-7176	http://www.mpqhf.org/

State Medical Assistance Office (Medicaid)

State Medical Assistance Office (Medicaid)			
State	Agency Name	Contact Information	Web Site
Alabama	Alabama Medicaid Agency	501 Dexter Avenue Montgomery, AL 36104 334-242-5000 800-362-1504	http://medicaid.alabama.gov/
Arkansas	Arkansas Medicaid	(800) 457-4454 (501) 374-6609 x 500 Voice Response System (VRS) (800) 806-6181	https://www.medicaid.state.ar.us/
Arizona	AHCCCS	801 E. Jefferson Street, MD 4100 Phoenix, AZ 85034 Ph: 602-417-4000 FAX: 602-252-6536 800-654-8713	http://www.azahcccs.gov/
California	Medi-Cal	800-541-5555 916-445-4171	http://www.medi-cal.ca.gov/
Colorado	Department of Health Care Policy and Financing	1570 Grant Street Denver, Colorado 80203 303-866-3513 1-800-221-3943 TDD 1-800-659-2656	http://www.colorado.gov/cs/Satellite/HCPF/HCPF/1197364086675
Connecticut	Connecticut Department of Social Services	25 Sigourney Street Hartford, CT 06106 1-800-842-1508 TTY: 1-800-842-4524	http://www.ct.gov/dss/cwp/view.asp?a=2353&q=305218
Delaware	Medicaid	1901 N. Du Pont Highway, Lewis Bldg. New Castle, DE 19720 (302) 255-9500 FAX: (302) 255-4454	http://www.dhss.delaware.gov/dss/medicaid.html
Florida	Florida Medicaid	2727 Mahan Drive Tallahassee, FL 32308 (888) 419-3456	http://www.fdhc.state.fl.us/Medicaid/index.shtml

State Medical Assistance Office (Medicaid)			
State	Agency Name	Contact Information	Web Site
Georgia	Georgia Department of Community Health (DCH)	2 Peachtree Street, NW Atlanta, GA 30303 (404) 656-4507 1.800.georgia	http://dch.georgia.gov/02/dch/home/0,2467,31446711,00.html;jsessionid=C453CE0C0F3B88EF349740CB01B15ED6
Iowa	Iowa Department of Human Services	Polk County DHS - Administrative Offices River Place 2309 Euclid Ave Des Moines, IA 50310 877-937-3663	http://www.dhs.iowa.gov/Consumers/Health/Medical_Insurance/WhatsAvailable.html
Idaho	Department of Health and Welfare	Idaho Department of Health and Welfare PO Box 83720 Boise, ID 83720-0036 208-334-6700	http://healthandwelfare.idaho.gov/
Illinois	Illinois Department of Healthcare and Family Services (HFS)	1-866-468-7543 1-217-785-8036 TTY: 1-877-204-1012	http://www.hfs.illinois.gov/programs/
Indiana	Indiana Medicaid	(317) 713-9627 (800) 457-4584	http://member.indianamedicaid.com/
Kansas	Kansas Medical Assistance Program	(888) 547-2878	https://www.kmap-state-ks.us/
Kentucky	Department for Medicaid Services	275 E. Main St. Frankfort, KY 40621 1-800-372-2973 TTY: 1-800-627-4702	http://chfs.ky.gov/dms/
Louisiana	Louisiana Medicaid	P. O. Box 629 Baton Rouge, LA 70821-0629 1.888.342.6207 225.342.9500 FAX: 225.342.5568	http://new.dhh.louisiana.gov/index.cfm/subhome/1
Massachusetts	MassHealth	1-888-665-9993 TTY: 1-888-665-9997	http://www.mass.gov/?pageID=eohhs2agencylanding&L=4&L0=Home&L1=Government&L2=Departments+and+Divisions&L3=MassHealth&sid=Eeohhs2

State Medical Assistance Office (Medicaid)			
State	Agency Name	Contact Information	Web Site
Maryland	Medicaid	(410) 767-1787 (800) 492-5231	http://www.dhmh.state.md.us/mma/Eligibility/MAelig-2009Q&A.html
Maine	MaineCare Services	Office of MaineCare Services 11 State House Station, Augusta, Maine 04333-0011 1-800-977-6740 TTY:1-800-977-6741	http://www.maine.gov/dhhs/oms/
Michigan	Department of Community Health	Capitol View Building 201 Townsend Street Lansing, Michigan 48913 517-373-3740 TTY: 711 or 800-649-3777	http://www.michigan.gov/mdch/0,1607,7-132-2943_4860---,00.html
Minnesota	Minnesota Department of Human Services	MinnesotaCare PO Box 64838 St. Paul, MN 55164-0838 (651) 297-3862 in the Twin Cities metro area (800) 657-3672 toll free from outside the Twin Cities TTY: (800) 627-3529 or 711	http://www.dhs.state.mn.us/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION&RevisionSelectionMethod=LatestReleased&Redirected=true&dDocName=id_006254
Missouri	MO HealthNet	615 Howerton Court P.O. Box 6500 Jefferson City, MO 65102-6500 (573) 751-3425	http://www.dss.mo.gov/fsd/msmed.htm
Mississippi	Division of Medicaid	Sillers Building, 550 High Street Suite 1000 Jackson, MS 39201-1399 601-359-6050 1-800-421-2408	http://www.medicaid.ms.gov/
Montana	Montana Medicaid	(800) 362-8312	http://www.dphhs.mt.gov/programsservices/medicaid.shtml

State Medical Assistance Office (Medicaid)			
State	Agency Name	Contact Information	Web Site
North Carolina	Division of Medical Assistance	2501 Mail Service Center Raleigh, NC 27699-2501 800-662-7030	http://www.ncdhhs.gov/dma/
North Dakota	North Dakota Medicaid	North Dakota Department of Human Services 600 E Boulevard Ave, Dept 325 Bismarck, ND 58505-0250 (701) 328-2321 Toll-free: 1-800-755-2604 Fax: (701) 328-1544	http://www.nd.gov/dhs/services/medicalserv/medicaid/
Nebraska	Nebraska Medicaid Program	301 Centennial Mall South Lincoln, Nebraska 68509 (402) 471-3121	http://www.hhs.state.ne.us/med/medindex.htm
New Hampshire	Medicaid	40 Terrill Park Drive Concord, NH 03301 (603) 271-4344 (800) 322-9191 TDD Access Relay: (800) 735-2964	http://www.dhhs.nh.gov/ombp/medicaid/
New Jersey	NJ Medicaid & Managed Care	P. O. Box 360, Trenton, NJ 08625-0360 Phone: (609) 292-7837 Toll-free in NJ: 800-367-6543	http://www.state.nj.us/humanservices/dmahs/info/resources/care/
New Mexico	Medical Assistance Division	2009 S. Pacheco, Pollon Plaza Santa Fe, NM 87504 (888) 997-2583	http://www.hsd.state.nm.us/mad/
Nevada	Division of Health Care Financing and Policy	Carson City 1100 East William Street Suite 101 Carson City, NV 89701 (775) 684-3676	https://dhcfnv.gov/index.htm
New York	Medicaid	1-800-541-2831	http://www.health.ny.gov/health_care/medicaid/

State Medical Assistance Office (Medicaid)			
State	Agency Name	Contact Information	Web Site
Ohio	Ohio Medicaid	The Ohio Department of Job and Family Services 30 E. Broad Street, 32nd Floor Columbus, Ohio 43215 (800) 324-8680 TTY/TDD (800) 292-3572	http://jfs.ohio.gov/ohp/
Oklahoma	Oklahoma Health Care Authority	2401 N.W. 23rd St., Suite 1A Oklahoma City, OK 73107 (800) 987-7767 (800) 757-5979 (TDD)	http://www.okhca.org/
Oregon	Oregon's Medicaid State Plan	Division of Medical Assistance Programs Administrative Office 500 Summer Street NE Salem, OR 97301-1079 Phone: 503-945-5772 Phone: 800-527-5772 TTY: 800-375-2863	http://www.oregon.gov/OH/A/healthplan/tools_policy/stateplan.shtml
Pennsylvania	Medical Assistance	1-800-692-7462	http://www.dpw.state.pa.us/foradults/healthcaremedicaidassistance/index.htm
Rhode Island	RI Medical Assistance	206 Elmwood Avenue Providence, RI 02907 (401) 462-5300	http://www.dhs.ri.gov/Adults/HealthMedicalServices/tabid/807/Default.aspx
South Carolina	South Carolina Healthy Connections (Medicaid) Program	Post Office Box 100101 Columbia, South Carolina 29202-3101 888-549-0820	http://www.dhhs.state.sc.us/dhhsnew/InsideDHHS/Bureaus/EligibilityPolicyAndOversight/Partners%20for%20Health%20(Medicaid)%20Program.asp
South Dakota	Division of Medical Services	Phone: 605-773-4678 Fax: 605-773-7183	http://dss.sd.gov/medicalse rvices/
Tennessee	TennCare	310 Great Circle Rd. Nashville, TN 37243 1-800-342-3145	http://www.state.tn.us/tenncare/

State Medical Assistance Office (Medicaid)			
State	Agency Name	Contact Information	Web Site
Texas	Texas Medicaid Program	P.O. Box 14200 Midland, TX 79711-4200 1-800-252-8263	http://www.hhsc.state.tx.us/medicaid/
Utah	Utah Medicaid Program	Utah Department of Health Division of Medicaid and Health Financing P.O. Box 143106 Salt Lake City, UT 84114-3106 801-538-6155 1-800-662-9651	http://health.utah.gov/medicaid/
Virginia	Virginia Medicaid	800-552-8627 804-786-6273	https://www.virginiamedicaid.dmas.virginia.gov/wps/portal
Vermont	Green Mountain Care	1-800-250-8427 TDD: 1-888-834-7898	http://www.greenmountaincare.org/
Washington	Health Care Authority	800-562-3022	http://maa.dshs.wa.gov/
West Virginia	Bureau for Medical Services	(304) 558-1700	http://www.dhhr.wv.gov/bms/Pages/default.aspx
Wisconsin	ForwardHealth: Wisconsin Medicaid	1-800-362-3002	http://www.dhs.wisconsin.gov/medicaid/
Wyoming	EqualityCare	6101 Yellowstone Rd., Ste 210 Cheyenne, WY 82002 (307) 777-7531	http://wyequalitycare.acs-inc.com/

State Health Departments

State Health Departments		
State	Agency Name	Contact Information
Alabama	Alabama Department of Public Health	1-800-ALA-1818
Arkansas	Arkansas Department of Health	1-501-661-2000 1-800-462-0599
Arizona	Arizona Department of Health Services	(602) 542-1025
California	Department of Health Care Services (DHCS)	916-445-4171
Colorado	Colorado Department of Public Health and Environment	303- 692-2000 1-800-886-7689
Connecticut	Department of Public Health	860-509-8000
Delaware	Delaware Health and Social Services	(302) 744-4700
Florida	Florida Department of Health	850/245-4444
Georgia	Georgia Department of Public Health (DPH)	(404) 657-2700
Iowa	Iowa Department of Public Health	866-227-9878
Idaho	Idaho Department of Health and Welfare	(208) 334-6996
Illinois	Illinois Department of Public Health	217-782-4977 TTY 800-547-0466
Indiana	Indiana State Department of Health	(317) 233-1325
Kansas	Kansas Department of Health and Environment	785-296-1500
Kentucky	Department for Public Health	800-372-2973
Louisiana	Office of Public Health	(225) 342-9500
Massachusetts	Department of Public Health	617-573-1600
Maryland	Department of Health and Mental Hygiene	1-877-463-3464
Maine	Department of Health and Human Services	207-287-3707 TTY: 800-606-0215
Michigan	Michigan Department of Community Health	517-373-3740
Minnesota	Minnesota Department of Health	888-345-0823 TTY: 651-201-5797
Missouri	Missouri Department of Health and Senior Services	573-751-6400

State Health Departments		
State	Agency Name	Contact Information
Mississippi	Mississippi State Department of Health	601-576-7400
Montana	Department of Public Health & Human Services	(406) 444-0936
North Carolina	Division of Public Health	919-707-5000
North Dakota	North Dakota Department of Health	701.328.2372
Nebraska	Department of Health and Human Services	402-471-3121
New Hampshire	Department of Health and Human Services	(603) 271-4501
New Jersey	Department of Health and Senior Services	1-800-328-3838
New Mexico	Department of Health	(505) 827-2613
Nevada	Nevada State Health Division	(775) 684-4200
New York	Department of Health	1-866-881-2809
Ohio	Ohio Department of Health	(800) 755-4769
Oklahoma	State Department Of Health	800-522-0203 405-271-5600
Oregon	Public Health Division	971-673-1222
Pennsylvania	Department Of Health	877-PA-HEALTH
Rhode Island	Department of Health	401-222-5960
South Carolina	Department of Health and Human Services	(888) 549-0820
South Dakota	Department of Health	800-738-3361
Tennessee	Department of Health	(615) 741-3111
Texas	Texas Department of State Health Services	1-888-963-7111 TDD: 1-800-735-2989
Utah	Department of Health	801-538-6003
Virginia	Department of Health	(804) 864-7660
Vermont	Department of Health	800-464-4343
Washington	Department of Health	(800) 525-0127
West Virginia	Department of Health and Human Resources	(304) 558-0684
Wisconsin	Department of Health Services	608-266-1865
Wyoming	Department of Health	(866) 571-0944

Appendix B - Service Area and Premium Table

Today's Options Premier 400 (PFFS)

Today's Options Premier 400 (PFFS)		
State	County	Premium
Arizona	Apache	\$60
Arizona	Coconino	\$60
Arizona	Gila	\$75
Arizona	Greenlee	\$25
Arizona	La Paz	\$75
Arizona	Navajo	\$60
Arizona	Yuma	\$75
Arkansas	Bradley	\$25
Arkansas	Chicot	\$75
Arkansas	Columbia	\$75
Arkansas	Drew	\$90
Arkansas	Hempstead	\$75
Arkansas	Lafayette	\$90
Arkansas	Lawrence	\$75
Arkansas	Little River	\$90
Arkansas	Nevada	\$75
Arkansas	Sevier	\$75
Arkansas	Van Buren	\$60
California	Butte	\$60
California	Calaveras	\$60
California	Colusa	\$60
California	Del Norte	\$25
California	Glenn	\$75
California	Humboldt	\$60
California	Imperial	\$60
California	Inyo	\$90
California	Lake	\$60
California	Lassen	\$90
California	Mendocino	\$60
California	Merced	\$60
California	Modoc	\$35
California	Mono	\$60

Today's Options Premier 400 (PFFS)		
State	County	Premium
California	Monterey	\$75
California	Napa	\$25
California	Plumas	\$75
California	San Benito	\$60
California	Sierra	\$60
California	Siskiyou	\$60
California	Tehama	\$75
California	Trinity	\$75
California	Tuolumne	\$75
Colorado	Baca	\$75
Florida	Bay	\$90
Florida	Dixie	\$90
Florida	Gilchrist	\$75
Florida	Gulf	\$75
Florida	Hamilton	\$90
Florida	Hardee	\$90
Florida	Hendry	\$90
Florida	Highlands	\$90
Florida	Holmes	\$75
Florida	Jackson	\$75
Florida	Lafayette	\$75
Florida	Levy	\$90
Florida	Monroe	\$90
Florida	Taylor	\$60
Florida	Walton	\$90
Florida	Washington	\$60
Georgia	Appling	\$75
Georgia	Atkinson	\$75
Georgia	Bacon	\$90
Georgia	Baker	\$90
Georgia	Baldwin	\$35
Georgia	Banks	\$60
Georgia	Barrow	\$60
Georgia	Bartow	\$60
Georgia	Ben Hill	\$60

Today's Options Premier 400 (PFFS)		
State	County	Premium
Georgia	Berrien	\$25
Georgia	Bibb	\$60
Georgia	Bleckley	\$90
Georgia	Brantley	\$75
Georgia	Brooks	\$75
Georgia	Bulloch	\$75
Georgia	Burke	\$60
Georgia	Butts	\$60
Georgia	Calhoun	\$75
Georgia	Candler	\$60
Georgia	Carroll	\$60
Georgia	Charlton	\$75
Georgia	Chattooga	\$60
Georgia	Clinch	\$75
Georgia	Coffee	\$90
Georgia	Colquitt	\$60
Georgia	Cook	\$90
Georgia	Crawford	\$60
Georgia	Crisp	\$60
Georgia	Dawson	\$35
Georgia	Decatur	\$35
Georgia	Dodge	\$90
Georgia	Dooly	\$60
Georgia	Dougherty	\$90
Georgia	Early	\$35
Georgia	Echols	\$75
Georgia	Elbert	\$25
Georgia	Emanuel	\$60
Georgia	Fannin	\$60
Georgia	Floyd	\$75
Georgia	Franklin	\$60
Georgia	Gilmer	\$60
Georgia	Glascok	\$75
Georgia	Gordon	\$90
Georgia	Grady	\$35

Today's Options Premier 400 (PFFS)		
State	County	Premium
Georgia	Habersham	\$60
Georgia	Hall	\$60
Georgia	Hancock	\$25
Georgia	Haralson	\$35
Georgia	Hart	\$60
Georgia	Heard	\$35
Georgia	Houston	\$60
Georgia	Irwin	\$35
Georgia	Jackson	\$60
Georgia	Jasper	\$60
Georgia	Jeff Davis	\$90
Georgia	Jefferson	\$75
Georgia	Jenkins	\$60
Georgia	Johnson	\$75
Georgia	Lamar	\$25
Georgia	Lanier	\$35
Georgia	Laurens	\$60
Georgia	Lee	\$90
Georgia	Lincoln	\$60
Georgia	Long	\$90
Georgia	Lowndes	\$75
Georgia	Lumpkin	\$60
Georgia	Macon	\$25
Georgia	Mc Duffie	\$60
Georgia	Miller	\$75
Georgia	Mitchell	\$75
Georgia	Monroe	\$75
Georgia	Montgomery	\$75
Georgia	Murray	\$60
Georgia	Peach	\$60
Georgia	Pickens	\$60
Georgia	Pierce	\$90
Georgia	Pike	\$25
Georgia	Polk	\$90
Georgia	Pulaski	\$75

Today's Options Premier 400 (PFFS)		
State	County	Premium
Georgia	Quitman	\$60
Georgia	Rabun	\$75
Georgia	Randolph	\$60
Georgia	Schley	\$90
Georgia	Seminole	\$75
Georgia	Spalding	\$60
Georgia	Stephens	\$60
Georgia	Sumter	\$60
Georgia	Taliaferro	\$25
Georgia	Tattnall	\$60
Georgia	Taylor	\$75
Georgia	Telfair	\$90
Georgia	Terrell	\$90
Georgia	Thomas	\$60
Georgia	Tift	\$60
Georgia	Toombs	\$75
Georgia	Towns	\$60
Georgia	Treutlen	\$60
Georgia	Troup	\$60
Georgia	Turner	\$60
Georgia	Twiggs	\$25
Georgia	Union	\$60
Georgia	Upson	\$60
Georgia	Walton	\$60
Georgia	Ware	\$90
Georgia	Warren	\$60
Georgia	Washington	\$25
Georgia	Wayne	\$60
Georgia	Wheeler	\$90
Georgia	White	\$60
Georgia	Whitfield	\$60
Georgia	Wilcox	\$60
Georgia	Wilkes	\$60
Georgia	Wilkinson	\$60
Georgia	Worth	\$75

Today's Options Premier 400 (PFFS)		
State	County	Premium
Idaho	Adams	\$60
Idaho	Bear Lake	\$60
Idaho	Blaine	\$60
Idaho	Butte	\$75
Idaho	Camas	\$75
Idaho	Clearwater	\$90
Idaho	Custer	\$35
Idaho	Idaho	\$90
Idaho	Jerome	\$25
Idaho	Lemhi	\$60
Idaho	Lewis	\$90
Idaho	Lincoln	\$60
Idaho	Valley	\$90
Illinois	Alexander	\$75
Illinois	Bond	\$75
Illinois	Clay	\$90
Illinois	Clinton	\$60
Illinois	De Kalb	\$60
Illinois	Edwards	\$60
Illinois	Fayette	\$90
Illinois	Franklin	\$75
Illinois	Gallatin	\$90
Illinois	Greene	\$75
Illinois	Grundy	\$90
Illinois	Hamilton	\$90
Illinois	Hardin	\$75
Illinois	Jackson	\$75
Illinois	Jefferson	\$75
Illinois	Johnson	\$60
Illinois	Kankakee	\$75
Illinois	Lawrence	\$75
Illinois	Macon	\$60
Illinois	Marion	\$75
Illinois	Massac	\$60
Illinois	Mc Henry	\$75

Today's Options Premier 400 (PFFS)		
State	County	Premium
Illinois	Perry	\$90
Illinois	Pope	\$60
Illinois	Pulaski	\$90
Illinois	Richland	\$60
Illinois	Saline	\$60
Illinois	Shelby	\$75
Illinois	Union	\$60
Illinois	Wabash	\$75
Illinois	Washington	\$60
Illinois	Wayne	\$75
Illinois	White	\$75
Illinois	Williamson	\$60
Indiana	Bartholomew	\$60
Indiana	Benton	\$75
Indiana	Cass	\$60
Indiana	Clay	\$75
Indiana	Clinton	\$75
Indiana	Crawford	\$75
Indiana	Daviess	\$75
Indiana	Decatur	\$60
Indiana	Dubois	\$60
Indiana	Elkhart	\$35
Indiana	Fayette	\$60
Indiana	Fountain	\$60
Indiana	Grant	\$60
Indiana	Greene	\$90
Indiana	Henry	\$60
Indiana	Jackson	\$25
Indiana	Jasper	\$60
Indiana	Jay	\$60
Indiana	Jefferson	\$60
Indiana	Jennings	\$75
Indiana	La Porte	\$75
Indiana	Lagrange	\$25
Indiana	Marshall	\$60

Today's Options Premier 400 (PFFS)		
State	County	Premium
Indiana	Martin	\$60
Indiana	Miami	\$75
Indiana	Montgomery	\$60
Indiana	Newton	\$60
Indiana	Ohio	\$60
Indiana	Orange	\$35
Indiana	Owen	\$60
Indiana	Parke	\$60
Indiana	Pulaski	\$60
Indiana	Randolph	\$60
Indiana	Ripley	\$60
Indiana	Rush	\$75
Indiana	Scott	\$60
Indiana	Starke	\$90
Indiana	Steuben	\$60
Indiana	Sullivan	\$90
Indiana	Switzerland	\$75
Indiana	Union	\$60
Indiana	Vermillion	\$75
Indiana	Wabash	\$25
Indiana	Warren	\$75
Indiana	Washington	\$25
Indiana	Wayne	\$60
Indiana	White	\$90
Iowa	Adair	\$60
Iowa	Adams	\$75
Iowa	Audubon	\$60
Iowa	Buena Vista	\$25
Iowa	Calhoun	\$60
Iowa	Cherokee	\$25
Iowa	Dickinson	\$60
Iowa	Emmet	\$60
Iowa	Humboldt	\$60
Iowa	Ida	\$60
Iowa	Lyon	\$60

Today's Options Premier 400 (PFFS)		
State	County	Premium
Iowa	O'Brien	\$60
Iowa	Pocahontas	\$75
Iowa	Ringgold	\$35
Iowa	Sac	\$75
Iowa	Sioux	\$60
Iowa	Taylor	\$60
Iowa	Webster	\$60
Kansas	Allen	\$75
Kansas	Anderson	\$60
Kansas	Atchison	\$60
Kansas	Barber	\$90
Kansas	Barton	\$90
Kansas	Brown	\$90
Kansas	Chase	\$90
Kansas	Chautauqua	\$90
Kansas	Cheyenne	\$75
Kansas	Clark	\$90
Kansas	Clay	\$60
Kansas	Cloud	\$60
Kansas	Coffey	\$60
Kansas	Comanche	\$75
Kansas	Cowley	\$25
Kansas	Crawford	\$90
Kansas	Decatur	\$35
Kansas	Dickinson	\$60
Kansas	Doniphan	\$90
Kansas	Edwards	\$90
Kansas	Elk	\$60
Kansas	Ellis	\$60
Kansas	Ellsworth	\$75
Kansas	Finney	\$90
Kansas	Ford	\$75
Kansas	Franklin	\$35
Kansas	Geary	\$60
Kansas	Gove	\$60

Today's Options Premier 400 (PFFS)		
State	County	Premium
Kansas	Graham	\$60
Kansas	Grant	\$90
Kansas	Gray	\$75
Kansas	Greeley	\$90
Kansas	Greenwood	\$90
Kansas	Hamilton	\$75
Kansas	Harper	\$90
Kansas	Haskell	\$90
Kansas	Hodgeman	\$90
Kansas	Jackson	\$90
Kansas	Jefferson	\$60
Kansas	Jewell	\$90
Kansas	Kingman	\$90
Kansas	Kiowa	\$60
Kansas	Lane	\$60
Kansas	Lincoln	\$75
Kansas	Logan	\$90
Kansas	Lyon	\$90
Kansas	Marion	\$75
Kansas	Marshall	\$90
Kansas	Mc Pherson	\$60
Kansas	Meade	\$90
Kansas	Mitchell	\$60
Kansas	Montgomery	\$60
Kansas	Morris	\$60
Kansas	Morton	\$75
Kansas	Nemaha	\$60
Kansas	Neosho	\$60
Kansas	Ness	\$90
Kansas	Norton	\$60
Kansas	Osage	\$75
Kansas	Osborne	\$60
Kansas	Ottawa	\$60
Kansas	Pawnee	\$90
Kansas	Phillips	\$75

Today's Options Premier 400 (PFFS)		
State	County	Premium
Kansas	Pottawatomie	\$75
Kansas	Pratt	\$35
Kansas	Rawlins	\$75
Kansas	Reno	\$90
Kansas	Republic	\$60
Kansas	Rice	\$90
Kansas	Riley	\$60
Kansas	Rooks	\$75
Kansas	Rush	\$75
Kansas	Russell	\$75
Kansas	Saline	\$25
Kansas	Scott	\$90
Kansas	Seward	\$75
Kansas	Sheridan	\$60
Kansas	Sherman	\$90
Kansas	Smith	\$60
Kansas	Stafford	\$90
Kansas	Stanton	\$90
Kansas	Stevens	\$90
Kansas	Sumner	\$60
Kansas	Thomas	\$75
Kansas	Trego	\$90
Kansas	Wabaunsee	\$60
Kansas	Wallace	\$90
Kansas	Washington	\$60
Kansas	Wichita	\$90
Kansas	Wilson	\$75
Kansas	Woodson	\$75
Kentucky	Adair	\$90
Kentucky	Allen	\$75
Kentucky	Ballard	\$75
Kentucky	Barren	\$60
Kentucky	Bell	\$90
Kentucky	Boyd	\$75
Kentucky	Boyle	\$75

Today's Options Premier 400 (PFFS)		
State	County	Premium
Kentucky	Bracken	\$75
Kentucky	Breathitt	\$90
Kentucky	Breckinridge	\$75
Kentucky	Butler	\$60
Kentucky	Caldwell	\$75
Kentucky	Calloway	\$75
Kentucky	Carlisle	\$75
Kentucky	Carroll	\$90
Kentucky	Carter	\$25
Kentucky	Casey	\$90
Kentucky	Christian	\$60
Kentucky	Clay	\$90
Kentucky	Clinton	\$90
Kentucky	Crittenden	\$90
Kentucky	Cumberland	\$60
Kentucky	Daviess	\$60
Kentucky	Edmonson	\$60
Kentucky	Elliott	\$60
Kentucky	Estill	\$60
Kentucky	Fleming	\$75
Kentucky	Floyd	\$90
Kentucky	Fulton	\$90
Kentucky	Gallatin	\$60
Kentucky	Garrard	\$60
Kentucky	Grant	\$60
Kentucky	Graves	\$90
Kentucky	Grayson	\$75
Kentucky	Green	\$75
Kentucky	Greenup	\$90
Kentucky	Hancock	\$75
Kentucky	Hardin	\$75
Kentucky	Harlan	\$75
Kentucky	Harrison	\$60
Kentucky	Hart	\$75
Kentucky	Henderson	\$60

Today's Options Premier 400 (PFFS)		
State	County	Premium
Kentucky	Hickman	\$75
Kentucky	Hopkins	\$60
Kentucky	Jackson	\$60
Kentucky	Johnson	\$75
Kentucky	Knott	\$90
Kentucky	Knox	\$75
Kentucky	Larue	\$60
Kentucky	Laurel	\$75
Kentucky	Lawrence	\$90
Kentucky	Lee	\$60
Kentucky	Leslie	\$90
Kentucky	Letcher	\$90
Kentucky	Lewis	\$75
Kentucky	Lincoln	\$60
Kentucky	Livingston	\$60
Kentucky	Logan	\$60
Kentucky	Lyon	\$75
Kentucky	Magoffin	\$75
Kentucky	Marion	\$35
Kentucky	Marshall	\$75
Kentucky	Martin	\$75
Kentucky	Mason	\$75
Kentucky	Mc Creary	\$60
Kentucky	Mc Lean	\$60
Kentucky	Meade	\$60
Kentucky	Mercer	\$60
Kentucky	Metcalf	\$60
Kentucky	Monroe	\$75
Kentucky	Morgan	\$60
Kentucky	Muhlenberg	\$90
Kentucky	Nelson	\$60
Kentucky	Nicholas	\$75
Kentucky	Ohio	\$60
Kentucky	Owen	\$90
Kentucky	Owsley	\$75

Today's Options Premier 400 (PFFS)		
State	County	Premium
Kentucky	Pendleton	\$35
Kentucky	Perry	\$90
Kentucky	Pike	\$90
Kentucky	Pulaski	\$75
Kentucky	Robertson	\$60
Kentucky	Rockcastle	\$60
Kentucky	Rowan	\$60
Kentucky	Russell	\$75
Kentucky	Simpson	\$75
Kentucky	Taylor	\$75
Kentucky	Todd	\$90
Kentucky	Trigg	\$60
Kentucky	Trimble	\$60
Kentucky	Union	\$75
Kentucky	Washington	\$60
Kentucky	Wayne	\$60
Kentucky	Webster	\$60
Kentucky	Whitley	\$75
Kentucky	Wolfe	\$90
Louisiana	Avoyelles	\$60
Louisiana	Evangeline	\$90
Louisiana	Lafourche	\$25
Louisiana	St Helena	\$75
Louisiana	Vernon	\$60
Maine	Washington	\$14
Maryland	Allegany	\$28
Maryland	Caroline	\$28
Maryland	Dorchester	\$28
Maryland	Garrett	\$28
Maryland	Kent	\$28
Maryland	Queen Annes	\$28
Maryland	Somerset	\$28
Maryland	St Marys	\$28
Maryland	Talbot	\$28
Maryland	Washington	\$14

Today's Options Premier 400 (PFFS)		
State	County	Premium
Maryland	Wicomico	\$28
Maryland	Worcester	\$28
Massachusetts	Berkshire	\$28
Massachusetts	Dukes	\$14
Massachusetts	Nantucket	\$28
Michigan	Alcona	\$75
Michigan	Alger	\$75
Michigan	Alpena	\$75
Michigan	Baraga	\$90
Michigan	Branch	\$90
Michigan	Charlevoix	\$75
Michigan	Cheboygan	\$75
Michigan	Chippewa	\$75
Michigan	Clare	\$90
Michigan	Delta	\$75
Michigan	Gladwin	\$75
Michigan	Gogebic	\$60
Michigan	Houghton	\$75
Michigan	Huron	\$90
Michigan	Iosco	\$90
Michigan	Iron	\$75
Michigan	Isabella	\$75
Michigan	Keweenaw	\$90
Michigan	Lake	\$75
Michigan	Luce	\$90
Michigan	Mackinac	\$75
Michigan	Mason	\$60
Michigan	Montmorency	\$60
Michigan	Ogemaw	\$90
Michigan	Ontonagon	\$75
Michigan	Oscoda	\$90
Michigan	Otsego	\$60
Michigan	Presque Isle	\$90
Michigan	Sanilac	\$75
Michigan	Schoolcraft	\$75

Today's Options Premier 400 (PFFS)		
State	County	Premium
Mississippi	Alcorn	\$90
Mississippi	Amite	\$90
Mississippi	Bolivar	\$90
Mississippi	Calhoun	\$60
Mississippi	Chickasaw	\$60
Mississippi	Choctaw	\$35
Mississippi	Clay	\$60
Mississippi	Franklin	\$60
Mississippi	Greene	\$75
Mississippi	Holmes	\$60
Mississippi	Humphreys	\$90
Mississippi	Itawamba	\$75
Mississippi	Jasper	\$75
Mississippi	Jefferson	\$90
Mississippi	Jefferson Davis	\$90
Mississippi	Lee	\$75
Mississippi	Leflore	\$60
Mississippi	Monroe	\$60
Mississippi	Montgomery	\$60
Mississippi	Neshoba	\$60
Mississippi	Noxubee	\$60
Mississippi	Oktibbeha	\$25
Mississippi	Perry	\$60
Mississippi	Pontotoc	\$60
Mississippi	Quitman	\$35
Mississippi	Sharkey	\$75
Mississippi	Tallahatchie	\$75
Mississippi	Tishomingo	\$75
Mississippi	Wayne	\$75
Mississippi	Webster	\$75
Mississippi	Wilkinson	\$25
Missouri	Adair	\$60
Missouri	Andrew	\$90
Missouri	Atchison	\$90
Missouri	Audrain	\$60

Today's Options Premier 400 (PFFS)		
State	County	Premium
Missouri	Bates	\$75
Missouri	Bollinger	\$60
Missouri	Buchanan	\$90
Missouri	Butler	\$60
Missouri	Caldwell	\$60
Missouri	Camden	\$75
Missouri	Cape Girardeau	\$60
Missouri	Carter	\$60
Missouri	Chariton	\$75
Missouri	Clark	\$60
Missouri	Cooper	\$60
Missouri	Daviess	\$90
Missouri	De Kalb	\$90
Missouri	Dent	\$90
Missouri	Dunklin	\$75
Missouri	Gentry	\$90
Missouri	Grundy	\$75
Missouri	Harrison	\$60
Missouri	Holt	\$75
Missouri	Howard	\$75
Missouri	Howell	\$25
Missouri	Iron	\$60
Missouri	Knox	\$60
Missouri	Lewis	\$75
Missouri	Linn	\$90
Missouri	Macon	\$75
Missouri	Madison	\$60
Missouri	Maries	\$75
Missouri	Marion	\$60
Missouri	Mercer	\$75
Missouri	Mississippi	\$75
Missouri	Monroe	\$60
Missouri	Morgan	\$75
Missouri	New Madrid	\$75
Missouri	Nodaway	\$90

Today's Options Premier 400 (PFFS)		
State	County	Premium
Missouri	Pemiscot	\$60
Missouri	Perry	\$90
Missouri	Pettis	\$60
Missouri	Pike	\$75
Missouri	Putnam	\$60
Missouri	Ralls	\$60
Missouri	Randolph	\$35
Missouri	Reynolds	\$90
Missouri	Ripley	\$90
Missouri	Scotland	\$60
Missouri	Scott	\$60
Missouri	Shannon	\$60
Missouri	Shelby	\$75
Missouri	St Francois	\$60
Missouri	Ste Genevieve	\$90
Missouri	Stoddard	\$60
Missouri	Sullivan	\$60
Missouri	Texas	\$60
Missouri	Vernon	\$60
Missouri	Wayne	\$60
Missouri	Worth	\$75
Montana	Blaine	\$60
Montana	Chouteau	\$60
Montana	Custer	\$25
Montana	Daniels	\$60
Montana	Dawson	\$25
Montana	Deer Lodge	\$75
Montana	Fallon	\$25
Montana	Glacier	\$90
Montana	Golden Valley	\$35
Montana	Hill	\$60
Montana	Judith Basin	\$25
Montana	Liberty	\$75
Montana	Lincoln	\$25
Montana	Madison	\$75

Today's Options Premier 400 (PFFS)		
State	County	Premium
Montana	Meagher	\$60
Montana	Musselshell	\$90
Montana	Phillips	\$60
Montana	Pondera	\$60
Montana	Prairie	\$35
Montana	Richland	\$25
Montana	Roosevelt	\$60
Montana	Rosebud	\$60
Montana	Sheridan	\$35
Montana	Silver Bow	\$60
Montana	Teton	\$75
Montana	Toole	\$60
Montana	Treasure	\$60
Montana	Valley	\$75
Montana	Wheatland	\$60
Nebraska	Adams	\$90
Nebraska	Antelope	\$90
Nebraska	Arthur	\$75
Nebraska	Blaine	\$60
Nebraska	Boone	\$25
Nebraska	Box Butte	\$25
Nebraska	Boyd	\$60
Nebraska	Brown	\$60
Nebraska	Buffalo	\$35
Nebraska	Cedar	\$60
Nebraska	Chase	\$75
Nebraska	Cherry	\$75
Nebraska	Cheyenne	\$25
Nebraska	Clay	\$75
Nebraska	Custer	\$90
Nebraska	Dakota	\$60
Nebraska	Dawson	\$60
Nebraska	Deuel	\$35
Nebraska	Dixon	\$25
Nebraska	Dundy	\$60

Today's Options Premier 400 (PFFS)		
State	County	Premium
Nebraska	Fillmore	\$75
Nebraska	Franklin	\$75
Nebraska	Frontier	\$75
Nebraska	Furnas	\$60
Nebraska	Garden	\$75
Nebraska	Garfield	\$60
Nebraska	Grant	\$60
Nebraska	Greeley	\$60
Nebraska	Hall	\$60
Nebraska	Hamilton	\$60
Nebraska	Harlan	\$75
Nebraska	Hayes	\$25
Nebraska	Hitchcock	\$75
Nebraska	Holt	\$60
Nebraska	Hooker	\$25
Nebraska	Howard	\$75
Nebraska	Johnson	\$75
Nebraska	Kearney	\$25
Nebraska	Keith	\$60
Nebraska	Keya Paha	\$25
Nebraska	Kimball	\$75
Nebraska	Knox	\$60
Nebraska	Lincoln	\$90
Nebraska	Logan	\$35
Nebraska	Loup	\$25
Nebraska	Madison	\$25
Nebraska	Merrick	\$60
Nebraska	Morrill	\$35
Nebraska	Nance	\$90
Nebraska	Nemaha	\$75
Nebraska	Nuckolls	\$90
Nebraska	Pawnee	\$75
Nebraska	Perkins	\$60
Nebraska	Phelps	\$60
Nebraska	Pierce	\$75

Today's Options Premier 400 (PFFS)		
State	County	Premium
Nebraska	Platte	\$60
Nebraska	Polk	\$75
Nebraska	Redwillow	\$75
Nebraska	Richardson	\$90
Nebraska	Rock	\$60
Nebraska	Saline	\$75
Nebraska	Scotts Bluff	\$25
Nebraska	Sherman	\$75
Nebraska	Stanton	\$25
Nebraska	Thayer	\$75
Nebraska	Thomas	\$60
Nebraska	Thurston	\$90
Nebraska	Valley	\$75
Nebraska	Webster	\$90
Nebraska	York	\$90
Nevada	Carson City	\$90
Nevada	Douglas	\$90
Nevada	Elko	\$75
Nevada	Humboldt	\$75
Nevada	Lander	\$60
Nevada	Lincoln	\$75
Nevada	Pershing	\$90
Nevada	Storey	\$75
Nevada	White Pine	\$90
New Hampshire	Belknap	\$28
New Hampshire	Cheshire	\$28
New Hampshire	Coos	\$28
New Hampshire	Grafton	\$28
New Hampshire	Merrimack	\$28
New Hampshire	Strafford	\$14
New Hampshire	Sullivan	\$14
North Carolina	Anson	\$60
North Carolina	Buncombe	\$25
North Carolina	Burke	\$25
North Carolina	Camden	\$60

Today's Options Premier 400 (PFFS)		
State	County	Premium
North Carolina	Cherokee	\$60
North Carolina	Clay	\$25
North Carolina	Cleveland	\$60
North Carolina	Currituck	\$25
North Carolina	Dare	\$75
North Carolina	Graham	\$25
North Carolina	Jackson	\$35
North Carolina	Jones	\$60
North Carolina	Lenoir	\$90
North Carolina	Mc Dowell	\$25
North Carolina	Mitchell	\$25
North Carolina	Montgomery	\$60
North Carolina	Moore	\$60
North Carolina	Pamlico	\$60
North Carolina	Pasquotank	\$60
North Carolina	Rutherford	\$60
North Carolina	Scotland	\$60
North Carolina	Swain	\$75
North Carolina	Transylvania	\$60
North Carolina	Union	\$35
North Carolina	Vance	\$25
North Carolina	Wilson	\$75
North Carolina	Yancey	\$25
North Dakota	Benson	\$60
North Dakota	Bottineau	\$25
North Dakota	Bowman	\$75
North Dakota	Divide	\$25
North Dakota	Dunn	\$35
North Dakota	Hettinger	\$25
North Dakota	Nelson	\$75
North Dakota	Pierce	\$75
North Dakota	Rolette	\$35
North Dakota	Sheridan	\$35
Oklahoma	Adair	\$90
Oklahoma	Alfalfa	\$90

Today's Options Premier 400 (PFFS)		
State	County	Premium
Oklahoma	Atoka	\$90
Oklahoma	Beaver	\$60
Oklahoma	Beckham	\$90
Oklahoma	Blaine	\$90
Oklahoma	Bryan	\$90
Oklahoma	Caddo	\$90
Oklahoma	Carter	\$60
Oklahoma	Cherokee	\$75
Oklahoma	Choctaw	\$90
Oklahoma	Cimarron	\$90
Oklahoma	Coal	\$90
Oklahoma	Comanche	\$60
Oklahoma	Cotton	\$90
Oklahoma	Craig	\$60
Oklahoma	Custer	\$75
Oklahoma	Dewey	\$60
Oklahoma	Ellis	\$60
Oklahoma	Garfield	\$75
Oklahoma	Garvin	\$60
Oklahoma	Grant	\$75
Oklahoma	Harmon	\$90
Oklahoma	Harper	\$75
Oklahoma	Haskell	\$75
Oklahoma	Hughes	\$35
Oklahoma	Jackson	\$90
Oklahoma	Jefferson	\$60
Oklahoma	Johnston	\$90
Oklahoma	Kay	\$60
Oklahoma	Kingfisher	\$60
Oklahoma	Kiowa	\$75
Oklahoma	Latimer	\$75
Oklahoma	Love	\$75
Oklahoma	Major	\$75
Oklahoma	Marshall	\$90
Oklahoma	Mc Curtain	\$60

Today's Options Premier 400 (PFFS)		
State	County	Premium
Oklahoma	Mc Intosh	\$90
Oklahoma	Murray	\$75
Oklahoma	Noble	\$90
Oklahoma	Nowata	\$60
Oklahoma	Okfuskee	\$60
Oklahoma	Pittsburg	\$90
Oklahoma	Pontotoc	\$60
Oklahoma	Pushmataha	\$60
Oklahoma	Roger Mills	\$90
Oklahoma	Stephens	\$60
Oklahoma	Texas	\$60
Oklahoma	Tillman	\$60
Oklahoma	Washita	\$90
Oklahoma	Woods	\$90
Oklahoma	Woodward	\$75
Tennessee	Clay	\$90
Tennessee	Cumberland	\$60
Tennessee	Fentress	\$75
Tennessee	Lincoln	\$60
Tennessee	Perry	\$60
Tennessee	Putnam	\$60
Texas	Andrews	\$75
Texas	Archer	\$90
Texas	Bailey	\$90
Texas	Baylor	\$90
Texas	Blanco	\$90
Texas	Borden	\$90
Texas	Brewster	\$60
Texas	Briscoe	\$90
Texas	Brown	\$60
Texas	Calhoun	\$60
Texas	Callahan	\$60
Texas	Castro	\$90
Texas	Childress	\$60
Texas	Clay	\$60

Today's Options Premier 400 (PFFS)		
State	County	Premium
Texas	Cochran	\$75
Texas	Colorado	\$90
Texas	Comanche	\$75
Texas	Cooke	\$90
Texas	Cottle	\$75
Texas	Dallam	\$75
Texas	Dawson	\$75
Texas	De Witt	\$90
Texas	Delta	\$60
Texas	Dickens	\$60
Texas	Donley	\$90
Texas	Eastland	\$60
Texas	Ector	\$75
Texas	Erath	\$75
Texas	Fannin	\$75
Texas	Fisher	\$90
Texas	Foard	\$75
Texas	Gaines	\$75
Texas	Gillespie	\$60
Texas	Goliad	\$75
Texas	Gonzales	\$90
Texas	Hall	\$60
Texas	Hardeman	\$90
Texas	Haskell	\$35
Texas	Howard	\$25
Texas	Jackson	\$75
Texas	Jeff Davis	\$60
Texas	Jim Hogg	\$60
Texas	Karnes	\$75
Texas	Kent	\$60
Texas	Kerr	\$90
Texas	King	\$75
Texas	Knox	\$35
Texas	Lamar	\$60
Texas	Lavaca	\$75

Today's Options Premier 400 (PFFS)		
State	County	Premium
Texas	Limestone	\$60
Texas	Lipscomb	\$25
Texas	Live Oak	\$35
Texas	Martin	\$35
Texas	Matagorda	\$75
Texas	Maverick	\$25
Texas	Mc Mullen	\$60
Texas	Mitchell	\$90
Texas	Montague	\$60
Texas	Moore	\$75
Texas	Motley	\$75
Texas	Nolan	\$60
Texas	Ochiltree	\$60
Texas	Palo Pinto	\$90
Texas	Parmer	\$60
Texas	Pecos	\$75
Texas	Presidio	\$35
Texas	Rains	\$25
Texas	Real	\$75
Texas	Reeves	\$60
Texas	Refugio	\$75
Texas	Roberts	\$25
Texas	Scurry	\$75
Texas	Sherman	\$90
Texas	Somervell	\$75
Texas	Starr	\$90
Texas	Stephens	\$90
Texas	Stonewall	\$75
Texas	Swisher	\$75
Texas	Terrell	\$60
Texas	Upton	\$60
Texas	Uvalde	\$60
Texas	Victoria	\$75
Texas	Ward	\$60
Texas	Webb	\$60

Today's Options Premier 400 (PFFS)		
State	County	Premium
Texas	Wharton	\$75
Texas	Wheeler	\$60
Texas	Wichita	\$90
Texas	Wilbarger	\$60
Texas	Winkler	\$60
Texas	Wise	\$60
Texas	Yoakum	\$60
Texas	Young	\$75
Texas	Zapata	\$60
Vermont	Addison	\$28
Vermont	Bennington	\$28
Vermont	Caledonia	\$14
Vermont	Chittenden	\$28
Vermont	Essex	\$28
Vermont	Franklin	\$28
Vermont	Grand Isle	\$28
Vermont	Lamoille	\$28
Vermont	Orange	\$28
Vermont	Orleans	\$14
Vermont	Rutland	\$28
Vermont	Washington	\$28
Vermont	Windham	\$28
Vermont	Windsor	\$28
Virginia	Alleghany	\$90
Virginia	Amherst	\$60
Virginia	Appomattox	\$35
Virginia	Augusta	\$60
Virginia	Bath	\$75
Virginia	Brunswick	\$35
Virginia	Buena Vista City	\$25
Virginia	Campbell	\$25
Virginia	Carroll	\$35
Virginia	Covington City	\$60
Virginia	Culpeper	\$35
Virginia	Danville City	\$25

Today's Options Premier 400 (PFFS)		
State	County	Premium
Virginia	Fauquier	\$60
Virginia	Fredericksburg City	\$60
Virginia	Galax City	\$35
Virginia	Halifax	\$25
Virginia	Harrisonburg City	\$25
Virginia	Henry	\$25
Virginia	Highland	\$60
Virginia	King George	\$60
Virginia	Lynchburg City	\$35
Virginia	Martinsville City	\$25
Virginia	Mecklenburg	\$25
Virginia	Patrick	\$60
Virginia	Pulaski	\$60
Virginia	Rockbridge	\$25
Virginia	Rockingham	\$25
Virginia	Spotsylvania	\$60
Virginia	Stafford	\$60
Virginia	Staunton City	\$35
Virginia	Waynesboro City	\$60
Virginia	Westmoreland	\$75
Washington	Garfield	\$90
Washington	Pacific	\$90
Wisconsin	Door	\$60
Wisconsin	Florence	\$60
Wisconsin	Green	\$25
Wisconsin	Marinette	\$25
Wisconsin	Menominee	\$25
Wisconsin	Walworth	\$75

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Today's Options® PFFS

Medicare Advantage Health Plans

Member Services

CALL	(866) 568-8921 Calls to this number are free. Hours are 8:00 a.m. to 8:00 p.m. in your local time zone, 7 days a week. Member Services also has free language interpreter services available for non-English speakers.
TTY	(877) 907-2986 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free. Hours are 8:00 a.m. to 8:00 p.m. in your local time zone, 7 days a week.
FAX	(877) 907-2982
WRITE	Today's Options PFFS P.O. Box 742528 Houston, TX 77274
WEBSITE	www.TodaysOptions.com

State Health Insurance Assistance Program

The State Health Insurance Assistance Program (SHIP) is a state program that gets money from the Federal government to give free local health insurance counseling to people with Medicare.

Please see the listing provided in Appendix A at the end of the *Evidence of Coverage* for contact information.

Today's Options® PFFS is offered by the following organizations that contract with the Federal government: American Progressive Life & Health Insurance Company of New York and The Pyramid Life Insurance Company, members of the Universal American family of companies.

Medicare-approved PFFS plan.

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

Esta información está disponible en diferentes formatos, incluyendo el español. Por favor llame a Servicios al Cliente al número indicado arriba si necesita información del plan en otro formato u idioma.

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