VANTAGE MEDICARE ADVANTAGE

VHP VANTAGE HEALTH PLAN, INC.

EVIDENCE of COVERAGE 2010

Contact Member Services

Local
318-361-0900

Toll Free
888-823-1910

TTY Local
318-361-2131

TTY Toll Free
866-524-5144

MedicareRx
Prescription Drug Coverage

Call Monday - Friday
8:00 A.M. - 8:00 P.M. CST

An answering service will operate on weekends and holidays.

Nov 15, 2009 - March 1, 2010:
7 Days a Week
8:00 A.M. - 8:00 P.M. CST

Your Medical Health Benefits and Services as a Member of Vantage Health Plan, Inc.

VANTAGE MEDICARE ADVANTAGE

MEDICARE ADVANTAGE HMO-POS FOR LOUISIANA STATE RETIREES

January 1, 2010 - December 31, 2010

This booklet gives the details about your Medicare health coverage and explains how to get the care you need. This booklet is an important legal document. Please keep it in a safe place.

Your Medicare Health Benefits and Services and Prescription Drug Coverage as a Member of Vantage Medicare Advantage

This mailing gives you the details about your Medicare health and prescription drug coverage from January 1 – December 31, 2010, and explains how to get the health care and prescription drugs you need. This is an important legal document. Please keep it in a safe place.

Vantage Health Plan, Inc.'s Member Services:
For help or information, please call Member Services or go to our Plan website at *www.vhp-stategroup.com*.

318-361-0900
1-888-823-1910 (Calls to this number are free)
TTY users call: 318-361-2131 or toll free 866-524-5144

Hours of Operation:

November 15, 2009 – March 1, 2010, Member Services will operate (7) days a week from 8:00 a.m. – 8:00 p.m. CST. After March 1, 2010, Member Services will operate five (5) days a week, Monday – Friday, 8:00 a.m. – 8:00 p.m. CST. An answering service will operate on weekends and holidays. When leaving a message, please leave your name, number and the time you called, and a representative will return your call no later than one business day.

This Plan is offered by Vantage Health Plan, Inc., referred throughout the EOC as "we", "us" or "our." Vantage Medicare Advantage is referred to as "Plan" or "our Plan." Our organization contracts with the Federal government.

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

This is Your 2010 Evidence of Coverage (EOC)

Table of Contents

1. Introduction

Thank you for being a member of our Plan!

This is your Evidence of Coverage, which explains how to get your Medicare health care and drug coverage through our Plan, an HMO-POS (Health Maintenance Organization with Point of Service). "Point of Service" is an option that lets a member use non-network providers for an additional cost. You are still covered by Medicare, but you are getting your health care and Medicare prescription drug coverage through our Plan.

This Evidence of Coverage, together with your enrollment form, riders, formulary, and amendments that we send to you, is our contract with you. The Evidence of Coverage explains your rights, benefits, and responsibilities as a member of our Plan and is in effect from January 1, 2010 - December 31, 2010. Our plan's contract with the Centers for Medicare & Medicaid Services (CMS) is renewed annually, and availability of coverage beyond the end of the current contract year is not guaranteed.

This Evidence of Coverage will explain to you:

- What is covered by our Plan and what is not covered.
- How to get the care you need or your prescriptions filled, including some rules you must follow.
- What you will have to pay for your health care or prescriptions.
- What to do if you are unhappy about something related to getting your covered services or prescriptions filled.
- How to leave our Plan, and other Medicare options, including your options for continuing Medicare prescription drug coverage that are available through your employer group.

This Section of the EOC has important information about:

- Eligibility requirements
- The geographic service area of our Plan
- Keeping your membership record up-to-date
- Materials that you will receive from our Plan
- Paying your plan premiums
- Late enrollment penalty
- Extra help available from Medicare to help pay your plan costs

Eligibility Requirements

To be a member of our Plan, you must live in our service area, be entitled to Medicare Part A, and enrolled in Medicare Part B. If you currently pay a premium for Medicare Part A and/or Medicare Part B, you must continue paying your premium in order to keep your Medicare Part A and/or Medicare Part B and remain a member of this plan.

The geographic service area for our Plan

The geographic service area for our Plan is the entire state of Louisiana.

How do I keep my membership record up to date?

We have a membership record about you. Your membership record has information from your enrollment form, including your address and telephone number. It shows your specific Plan coverage, including the Primary Care Physician you chose and other information. Doctors, hospitals, pharmacists and others, and other network providers use your membership record to know what services or drugs are covered for you. Section 3 tells how we protect the privacy of your personal health information.

Please help keep your membership record up to date if there are changes to your name, address, phone number, work status, or if you go into a nursing home. You may send your changes directly to the Office of Group Benefits, ATTN: Eligibility, P.O. Box 66678, Baton Rouge, Louisiana 70896 or call the Office of Group Benefits Customer Service Department. Also, tell the Office of Group Benefits about any changes in other health insurance coverage you have, such as from your employer, your spouse's employer, workers' compensation, Medicaid, or liability claims such as claims from an automobile accident.

Materials that you will receive from our Plan

Plan membership card

While you are a member of our Plan, you must use our membership card for services covered by this plan and prescription drug coverage at network pharmacies. While you are a member of our Plan you must not use your red, white, and blue Medicare card to get covered services, items or drugs. Keep your red, white, and blue Medicare card in a safe place in case you need it later. If you get covered services using your red, white, and blue Medicare card instead of using our membership card while you are a plan member, the Medicare Program will not pay for these services and you may have to pay the full cost yourself.

Please carry your membership card that we gave you at all times and remember to show your card when you get covered services, items and drugs. If your membership card is damaged, lost, or stolen, call Member Services right away and we will send you a new card. There is a sample card in Section 9 to show you what it looks like.

The Provider Directory gives you a list of network providers

Every year that you are a member of our Plan, we will send you either a Provider Directory or an update to your Provider Directory, which lists our network providers. If you do not have the Provider Directory, you can get a copy from Member Services. You may ask Member Services for more information about our network providers, including their qualifications. Member

Services can give you the most up-to-date information about changes in our network providers. A complete list of network providers is available on our website (*www.vhp-stategroup.com*).

You may be required to use network providers for services to be covered by us at plan cost-sharing levels, except in emergencies, for urgently needed care out-of-area, or for out of the area dialysis services. See the benefits chart in Section 9 for more specific out-of-network coverage information.

Our Plan does offer a Point of Service (POS) option for certain services. All services obtained from non-plan providers require prior authorization (except emergency services, urgently needed care and dialysis outside the Plan's service area) and may be subject to an additional twenty percent (20%) coinsurance. The details of POS are addressed in Section 2.

The Pharmacy Directory gives you a list of Plan network pharmacies

As a member of our Plan, we will send you a complete Pharmacy Directory, which gives you a list of our network pharmacies at least every three years and an update of our Pharmacy Directory every year that we do not send you a complete Pharmacy Directory. You can use it to find the network pharmacy closest to you. If you do not have the Pharmacy Directory, you can get a copy from Member Services. They can also give you the most up-to-date information about changes in this Plan's pharmacy network, which can change during the year. You can also find this information on our website *(www.vhp-stategroup.com)*.

Part D Explanation of Benefits

What is the Explanation of Benefits?

The Explanation of Benefits (EOB) is a document you will get for each month you use your Part D prescription drug coverage. The EOB will tell you the total amount you have spent on your prescription drugs and the total amount we have paid for your prescription drugs. An Explanation of Benefits is also available upon request. To get a copy, please contact Member Services.

What information is included in the Explanation of Benefits?

Your Explanation of Benefits will contain the following information:

- A list of prescriptions you filled during the month, as well as the amount paid for each prescription;
- Information about how to request an exception and appeal our coverage decisions;
- A description of changes to the formulary that will occur at least 60 days in the future and affect the prescriptions you have gotten filled;
- A summary of your coverage this year, including information about:
    - **Amount Paid For Prescriptions-**The amounts paid that count towards your initial coverage limit.

- **Total Out-Of-Pocket Costs that count toward Catastrophic Coverage-**The total amount you and/or others have spent on prescription drugs that count towards you qualifying for catastrophic coverage. This total includes the amounts spent for your coinsurance or co-payments, and payments made on covered Part D drugs after you reach the initial coverage limit. (This amount does not include payments made by your current or former employer/union, another insurance plan or policy, a government-funded health program or other excluded parties.)

Your monthly plan premium

The monthly premium amount described in this section does not include any late enrollment penalty you may be responsible for paying (see "What is the Medicare Prescription Drug Plan late enrollment penalty?" later in this section for more information).

As a member of our Plan, you pay:

1) Your monthly Medicare Part B premium. Most people will pay the standard premium amount, which is $96.40 in 2010. (Your Part B premium is typically deducted from your Social Security payment.) (If you receive benefits from your state Medicaid program, all or part of your Part B premium may be paid for you.)

   Your monthly premium will be higher if your yearly income exceeds specified thresholds.

2) Your monthly Medicare Part A premium, if necessary (most people do not have to pay this premium).

3) Your monthly premium for our Plan.

If you have any questions about your Plan premiums or the payment programs, please call the Office of Group Benefits (OGB) at 225-925-6625 or toll free 1-800-272-8451.

As a member of our Plan, you pay a monthly plan premium. (If you qualify for extra help from Medicare, called the Low-Income Subsidy or LIS, you may not have to pay for all or part of the monthly premium.)

If you get benefits from your current or former employer, or from your spouse's current or former employer, call the employer's benefits administrator for information about your monthly plan premium.

Note: If you are getting extra help (LIS) with paying for your drug coverage, the premium amount that you pay as a member of this Plan is listed in your "Evidence of Coverage Rider for those who Receive Extra Help for their Prescription Drugs". Or, if you are a member of a State Pharmacy Assistance Program (SPAP), you may get help paying your premiums. Please contact

your SPAP at the phone number listed in Section 7 to determine what benefits are available to you.

Monthly Plan Premium Payment Options

Your employer will forward your monthly plan premiums to our Plan on your behalf. Please contact OGB at 225-925-6625 or toll free 1-800-272-8451 for more information about monthly plan premium payment options.

Can your monthly plan premiums change during the year?

The monthly plan premium associated with this plan cannot change during the year. However, the amount you pay could change, depending on whether you become eligible for, or lose, extra help for your prescription drug costs. If our monthly plan premium changes for next year, we will tell you in October and the change will take effect on January 1.

What is the Medicare Prescription Drug Plan late enrollment penalty?

If you do not join a Medicare drug plan when you are first eligible, and/or you go without creditable prescription drug coverage for a continuous period of 63 days or more, you may have to pay a late enrollment penalty when you enroll in a plan later. The Medicare drug plan will let you know what the amount is and it will be added to your monthly premium. This penalty amount changes every year, and you have to pay it as long as you have Medicare prescription drug coverage. However, if you qualify, you may not have to pay a penalty.

If you must pay a late enrollment penalty, your penalty is calculated when you first join a Medicare drug plan. To estimate your penalty, take 1% of the national base beneficiary premium for the year you join. In 2010, the national base beneficiary premium is $31.94. Multiply it by the number of full months you were eligible to join a Medicare drug plan but did not, and then round that amount to the nearest ten cents. This is your estimated penalty amount, which is added each month to your Medicare drug plan's premium for as long as you are in that plan.

If you disagree with your late enrollment penalty, you may be eligible to have it reconsidered (reviewed). Call Member Services to find out more about the late enrollment penalty reconsideration process and how to ask for such a review.

You will not have to pay a late enrollment penalty if:

- You had creditable coverage (coverage that expects to pay, on average, at least as much as Medicare's standard prescription drug coverage)
- You had prescription drug coverage but you were not adequately informed that the coverage was <u>not</u> creditable (as good as Medicare's drug coverage)
- Any period of time that you did not have creditable prescription drug coverage was less than 63 continuous days

- You lived in an area affected by Hurricane Katrina at the time of the hurricane (August 2005) AND you signed up for a Medicare prescription drug plan by December 31, 2006, AND you stay in a Medicare prescription drug plan
- You received or are receiving extra help

What extra help is available to help pay my plan costs?

Medicare provides "extra help" to pay prescription drug costs for people who have limited income and resources. Resources include your savings and stocks, but not your home or car. If you qualify, you will get help paying for any Medicare drug plan's monthly premium and prescription co-payments. If you qualify, this extra help will count toward your out-of-pocket costs.

How do costs change when you qualify for extra help?

If you qualify for extra help, we will send you by mail an "Evidence of Coverage Rider for People who Get Extra Help Paying for Prescription Drugs" that explains your costs as a member of our Plan. If the amount of your extra help changes during the year, we will also mail you an updated "Evidence of Coverage Rider for People who Get Extra Help Paying for Prescription Drugs".

What if you believe you have qualified for extra help and you believe that you are paying an incorrect co-payment amount?

If you believe you have qualified for extra help and you believe that you are paying an incorrect co-payment amount when you get your prescription at a pharmacy, our Plan has established a process that will allow you to either request assistance in obtaining evidence of your proper co-payment level, or, if you already have the evidence, to provide this evidence to us. Please provide written documentation from Medicaid (indicates your co-payment levels and effective date of coverage) within 60 days of the date the prescription was filled.

Any of the following forms of evidence is accepted to establish the subsidy status of a full benefit dual eligible beneficiary when provided by the beneficiary or the beneficiary's pharmacist, advocate, representative, family member or other individual acting on behalf of the beneficiary:

1. A copy of the beneficiary's Medicaid card that includes the beneficiary's name and an eligibility date during a month after June of the previous calendar year;
2. A copy of a state document that confirms active Medicaid status during a month after June of the previous calendar year;
3. A print out from the State electronic enrollment file showing Medicaid status during a month after June of the previous calendar year;
4. A screen print from the State's Medicaid systems showing Medicaid status during a month after June of the previous calendar year;
5. Other documentation provided by the State showing Medicaid status during a month after June of the previous calendar year; or,

6. For individuals who are not deemed eligible, but who apply and are found LIS eligible, a copy of the SSA award letter.

Any one of the following forms of evidence is accepted from beneficiaries or pharmacists to establish that a beneficiary is institutionalized and qualifies for zero cost-sharing:

1. A remittance from the facility showing Medicaid payment for a full calendar month for that individual during a month after June of the previous calendar year;
2. A copy of a state document that confirms Medicaid payment on behalf of the individual to the facility for a full calendar month after June of the previous calendar year; or
3. A screen print from the State's Medicaid systems showing that individual's institutional status based on at least a full calendar month stay for Medicaid payment purposes during a month after June of the previous calendar year.

When we receive the evidence showing your co-payment level, we will update our system or implement other procedures so that you can pay the correct co-payment when you get your next prescription at the pharmacy. Please be assured that if you overpay your co-payment, we will reimburse you. Either we will forward a check to you in the amount of your overpayment or we will offset future co-payments. Of course, if the pharmacy has not collected a co-payment from you and is carrying your co-payment as a debt owed by you, we may make the payment directly to the pharmacy. If a state paid on your behalf, we may make payment directly to the state. Please contact Member Services if you have questions.

Important Information

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

2. How You Get Care and Prescription Drugs

How You Get Care

What are "providers"?

"Providers" is the term we use for doctors, other health care professionals, hospitals, and other health care facilities that are licensed by the state and as appropriate eligible to receive payment from Medicare.

What are "network providers"?

A provider is a "network provider" when they participate in our Plan. When we say that network providers "participate in our Plan," this means that we have arranged with them (for example, by contracting with them) to coordinate or provide covered services to members in our Plan. Network providers may also be referred to as "Plan providers."

What are "covered services"?

"Covered services" is the term we use for all the medical care, health care services, supplies, and equipment that are covered by our Plan. Covered services are listed in the Benefits Chart in Section 9.

What do you pay for "covered services"?

The amount you pay for covered services is listed in Section 9.

Providers you can use to get services covered by our Plan

While you are a member of our Plan, you must normally use our network providers to get your covered services except in limited cases such as emergency care, urgently needed care when our network is not available, or out-of-network dialysis.

However, our Plan does offer a Point-of-Service (POS) option for certain services. All services obtained from non-network providers require prior authorization (except emergency services, urgently needed care and dialysis outside the Plan's service area) and are subject to an additional twenty percent (20%) coinsurance in addition to in-network cost sharing. In most cases, services obtained from non-network providers will be treated as in-plan if prior authorization has been obtained and will not be subject to the additional twenty percent (20%) coinsurance. Our Plan will notify you in writing if an authorized service from a non-network provider will not be

treated as in-plan. See the Benefits Chart in Section 9 for detailed benefits which are covered under the POS option.

Choosing Your Primary Care Physician (PCP)

What is a "PCP"?

When you become a member of our Plan, you must choose a plan provider to be your PCP. Your PCP is a Family Practitioner, General Practitioner, or Internal Medicine Physician who meets state requirements and is trained to give you basic medical care. As we explain below, you will get your routine or basic care from your PCP. Your PCP will also coordinate the rest of the covered services you get as a member of our Plan. For example, in order for you to see a specialist, you usually need to get your PCP's approval first (this is called getting a "referral" to a specialist). Your PCP will provide most of your care and will help you arrange or coordinate the rest of the covered services you get as a member of our Plan. This includes:

- x-rays
- laboratory tests
- therapies
- care from doctors who are specialists
- hospital admissions,
- home health, and
- follow-up care.

"Coordinating" your services includes checking or consulting with other plan providers about your care and how it is going. If you need certain types of covered services or supplies, you must get approval in advance from your PCP (such as giving you a referral to see a specialist). In some cases, your PCP will need to get prior authorization (prior approval) from us. See Section 9 for prior authorization requirements. Since your PCP will provide and coordinate your medical care, you should have all of your past medical records sent to your PCP's office. Section 3 tells you how we will protect the privacy of your medical records and personal health information.

How do you choose a PCP?

You can choose the PCP you want from the Plan's panel of doctors. Each member can select his/her own personal PCP who specializes in Family or General Practice, Pediatrics, or Internal Medicine. Your selection can be made from the Provider Directory, by contacting Member Services, or by visiting our website for a complete listing at ***www.vhp-stategroup.com***. Once your choice is made, you can call Member Services or fill out a member change form which is located on our website. Once we receive this information, the provider you selected will immediately be added to your record.

PCP selection is a very personal and private decision and Vantage Health Plan, Inc. would like you to be comfortable with your choice. You have the option of changing your selection at any time and you may change as often as you like.

How do you get care from your PCP?

You will usually see your PCP first for most of your routine health care needs. There are only a few types of covered services you may get on your own, without contacting your PCP first except as we explain below.

How do you get care from doctors, specialists and hospitals?

When your PCP thinks that you need specialized treatment, he/she will give you a referral (approval in advance) to see a plan specialist or certain other providers. A specialist is a doctor who provides health care services for a specific disease or part of the body. Specialists include but are not limited to such doctors as:

- oncologists (who care for patients with cancer),
- cardiologists (who care for patients with heart conditions),
- orthopedists (who care for patients with certain bone, joint, or muscle conditions).

For some types of referrals, your PCP may need to get approval in advance from our Plan (this is called getting "prior authorization").

It is very important to get a referral (approval in advance) from your PCP before you see a plan specialist or certain other providers (there are a few exceptions, including routine women's health care that we explain later in this section). **If you do not have a referral (approval in advance) before you get services from a specialist, you may have to pay for these services yourself.**

A referral is good for two visits within a 90-day period. **If the specialist wants you to come back for more care,** your specialist can contact our Plan for approval of additional visits.

How can you switch to another PCP?

You may change your PCP for any reason, at any time. To change your PCP, call Member Services. They will check to be sure the PCP you want to switch to is accepting new patients. Member Services will change your membership record to show the name of your new PCP, and tell you when the change to your new PCP will take effect.

What services can you get on your own, without getting a referral (approval in advance) from your Primary Care Physician (PCP)?

You may get the following services on your own, without a referral (approval in advance) from your PCP. You still have to pay your share of the cost, as appropriate, for these services.

- Routine women's health care, which include breast exams, mammograms (x-rays of the breast), Pap tests, and pelvic exams from plan providers. This care is covered without a referral from a plan provider.
- Flu shots and pneumonia vaccinations, as long as you get them from a plan provider.
- Emergency services, whether you get these services from plan providers or non-plan providers.
- Urgently needed care that you get from non-plan providers when you are temporarily outside the Plan's service area. Also, urgently needed care that you get from non-plan providers when you are in the service area but, because of unusual or extraordinary circumstances, the Plan providers are temporarily unavailable or inaccessible.
- Dialysis (kidney) services that you get at a Medicare-certified dialysis facility when you are temporarily outside the Plan's service area. If possible, please let us know before you leave the service area where you are going to be so we can help arrange for you to have maintenance dialysis while outside the service area.
- Prostate screening exams, as long as you get them from a plan provider.
- Routine physical exams, as long as you get them from a plan provider.

What if your doctor or other provider leaves your plan?

Sometimes a network provider you are using might leave the Plan. We will send you written notification, along with a Provider Directory to assist you in selecting a new provider who is part of our Plan. Member Services can also assist you in finding and selecting another provider.

Getting care if you have a medical emergency or an urgent need for care

What is a "medical emergency"?

A "medical emergency" is when you believe that your health is in serious danger. A medical emergency includes 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 medical help as quickly as possible. Call 911 for help or go to the nearest emergency room, hospital, or urgent care center. You do not need to get approval or a referral first from your doctor or other network provider.
- As soon as possible, make sure that your PCP knows about your emergency, because your PCP needs to be involved in following up on your emergency care. You or someone else should call to tell your PCP about your emergency care, usually within 48 hours. If you need assistance, call Vantage Health Plan, Inc. at 318-361-0900 or toll free 1-888-823-1910 (TTY 318-361-2131 or toll free 1-866-524-5144).

Your PCP will talk with the doctors who are giving you emergency care to help manage and follow up on your care. When the doctors who are giving you emergency care say that your condition is stable and the medical emergency is over then you are still entitled to follow-up post stabilization care. Your follow-up post stabilization care will be covered according to Medicare guidelines. In general, if your emergency care is provided out of network, your PCP will try to arrange for network providers to take over your care as soon as your medical condition and the circumstances allow.

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. We discuss filling prescriptions when you cannot access a network pharmacy later in this section.
- Ambulance services are covered in situations where other means of transportation in the United States would endanger your health. (See the benefits chart in Section 9 for more detailed information.)
- For emergencies or ambulance services outside of the country, refer to Section 9 for more information.

What if it was not 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 was not a medical emergency after all. If this happens, you are still covered for the care you got to determine what was wrong, as long as you thought your health was in serious danger, as explained in "What is a 'medical emergency'?" above. If you get any extra care after the doctor says it was not a medical emergency, the Plan will pay its portion of the covered additional care if authorized by us**.** We will pay our portion of the covered additional care from an out-of-network provider as a POS benefit if authorized by us.

What is urgently needed care?

Urgently needed care refers to a non-emergency situation when you are:

- Inside the United States
- Temporarily absent from the Plan's authorized service area

- In need of medical attention right away for an unforeseen illness, injury, or condition, and
- It is not reasonable given the situation for you to obtain medical care through the Plan's participating provider network.

Under unusual and extraordinary circumstances, care may be considered urgently needed and paid for by our Plan when the member is in the service area, but the provider network of the Plan is temporarily unavailable or inaccessible.

What is the difference between a "medical emergency" and "urgently needed care"?
The two main differences between urgently needed care and a medical emergency are in the danger to your health and your location. A "medical emergency" occurs when you reasonably believe that your health is in serious danger, whether you are in or outside of the service area. "Urgently needed care" is when you need medical help for an unforeseen illness, injury, or condition, but your health is not in serious danger and you are generally outside of the service area.

How to get urgently needed care

If, while temporarily outside the Plan's service area, you require urgently needed care, then you may get this care from any provider.

Note: If you have a pressing, non-emergency medical need while in the service area, you generally must obtain services from the Plan according to its procedures and requirements as outlined earlier in this section.

How to submit a paper claim for emergency or urgently needed care

When you receive emergency or urgently needed health care services from a provider who is not part of our network, you are responsible for paying your plan cost sharing amount and you should tell the provider to bill our Plan for the balance of the payment they are due. However, if you have received a bill from the provider, please send that claim to Vantage Health Plan, Inc. 130 DeSiard St, Suite 300, Monroe, LA 71201 so we can pay the provider the amount they are owed. If you have any questions about what to pay a provider or where to send a paper claim, you may call Member Services.

What is your cost for services that are not covered by our Plan?

Our Plan covers all of the medically-necessary services that are covered under Medicare Part A and Part B. Our Plan uses Medicare's coverage rules to decide what services are medically necessary. You are responsible for paying the full cost of services that are not covered by our Plan. Other sections of this booklet describe the services that are covered under our Plan and the rules that apply to getting your care as a plan member. Our plan might not cover the costs of services that are not medically necessary under Medicare, even if the service is listed as covered by our Plan.

If you need a service that our Plan decides is not medically necessary based on Medicare's coverage rules, you may have to pay all of the costs of the service if you did not ask for an advance coverage determination. However, you have the right to appeal the decision.

If you have any questions about whether our Plan will pay for a service or item, including inpatient hospital services, you have the right to have an organization determination or a coverage determination made for the service. You may call Member Services and tell us you would like a decision on whether the service will be covered before you get the service.

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 Physical Therapy services you get after our Plan's payments reach the benefit limit. Paying for costs once the benefit limit has been reached will not count toward your out-of-pocket maximum. You can call Member Services when you want to know how much of your benefit limit you have already used.

How can you participate in a clinical trial?

A "clinical trial" is a way of testing new types of medical care, like how well a new cancer drug works. A clinical trial is one of the final stages of a research process that helps doctors and researchers see if a new approach works and if it is safe.

The Original Medicare Plan pays for routine costs if you take part in a clinical trial that meets Medicare requirements (meaning it's a "qualified" clinical trial and Medicare-approved). Routine costs include costs like room and board for a hospital stay that Medicare would pay for even if you were not in a trial, an operation to implant an item that is being tested, and items and services to treat side effects and complications arising from the new care. Generally, Medicare will not cover the costs of experimental care, such as the drugs or devices being tested in a clinical trial.

There are certain requirements for Medicare coverage of clinical trials. If you participate as a patient in a clinical trial that meets Medicare requirements, the Original Medicare Plan (and not our Plan) pays the clinical trial doctors and other providers for the covered services you get that are related to the clinical trial. When you are in a clinical trial, you may stay enrolled in our Plan and continue to get the rest of your care, like diagnostic services, follow-up care, and care that is unrelated to the clinical trial through our Plan. Our Plan is still responsible for coverage of certain investigational devices exemptions (IDE), called Category B IDE devices, needed by our members.

You will have to pay the same coinsurance amounts charged under Original Medicare for the services you receive when participating in a qualifying clinical trial, but you do not have to pay the Original Medicare Part A or Part B deductibles because you are enrolled in our Plan.

You do not need to get a referral (approval in advance) from a network provider to join a clinical trial, and the clinical trial providers do not need to be network providers. However, please be

sure to **tell us before you start participation in a clinical trial** so that we can keep track of your health care services. When you tell us about starting participation in a clinical trial, we can let you know whether the clinical trial is Medicare-approved, and what services you will get from clinical trial providers instead of from our plan.

You may view or download the publication "Medicare and Clinical Trials" at www.medicare.gov under "Search Tools" select "Find a Medicare Publication." Or, call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

How to access care in Religious Non-medical Health Care Institutions

Care in a Medicare-certified Religious Non-medical Health Care Institution (RNHCI) is covered by our Plan under certain conditions. Covered services in an RNHCI are limited to non-religious aspects of care. To be eligible for covered services in a RNHCI, you must have a medical condition that would allow you to receive inpatient hospital or skilled nursing facility care. You may get services furnished in the home, but only items and services ordinarily furnished by home health agencies that are not RNHCIs. In addition, you must sign a legal document that says you are conscientiously opposed to the acceptance of "non-excepted" medical treatment. ("Excepted" medical treatment is medical care or treatment that you receive involuntarily or that is required under federal, state or local law. "Non-excepted" medical treatment is any other medical care or treatment.) Your stay in the RNHCI is not covered by our Plan unless you obtain authorization (approval) in advance from our Plan. Our Plan's Inpatient hospital coverage limits also apply. Please refer to the Benefits Chart in Section 9.

How you get prescription drugs

What do you pay for covered drugs?

The amount you pay for covered drugs is listed in Section 9.

If you have Medicare and Medicaid

Medicare, not Medicaid, will pay for most of your prescription drugs. You will continue to get your health coverage under both Medicare and Medicaid as long as you qualify for Medicaid benefits.

If you are a member of a State Pharmacy Assistance Program (SPAP)

If you are currently enrolled in an SPAP, you may get help paying your premiums, and/or cost-sharing. Please contact your SPAP to determine what benefits are available to you. SPAPs have different names in different states. See Section 7 for the name and phone number for the SPAP in your area.

What drugs are covered by this Plan?

What is a formulary?

A formulary is a list of the drugs that we cover. We will generally cover the drugs listed in our formulary as long as the drug is medically necessary, the prescription is filled at a network pharmacy and other coverage rules are followed. For certain prescription drugs, we have additional requirements for coverage or limits on our coverage. These requirements and limits are described later in this section under "Utilization Management."

The drugs on the formulary are selected by our Plan with the help of a team of health care providers. Both brand-name drugs and generic drugs are included on the formulary. A generic drug is a prescription drug that is approved by the Food and Drug Administration (FDA) as having the same active ingredient(s) as the brand-name drug. Generally, generic drugs cost less than brand-name drugs.

Not all drugs are covered by our plan. In some cases, the law prohibits Medicare coverage of certain types of drugs. (See Section 9 for more information about the types of drugs that are not normally covered under a Medicare Prescription Drug Plan.) In other cases, we have decided not to include a particular drug on our formulary.

In certain situations, prescriptions filled at an out-of-network pharmacy may also be covered. See information later in this section about filling a prescription at an out-of-network pharmacy.

How do you find out what drugs are on the formulary?

Each year, we send you an updated formulary so you can find out what drugs are on our formulary. You can get updated information about the drugs our Plan covers by visiting our website (www.vhp-medicare.com). You may also call Member Services to find out if your drug is on the formulary or to request an updated copy of our formulary.

What are drug tiers?

Drugs on our formulary are organized into different drug tiers, or groups of different drug types. Your coinsurance or co-payment depends on which drug tier your drug is in.

You may ask us to make an exception (which is a type of coverage determination) to your drug's tier placement. See Section 4 to learn more about how to request an exception.

Can the formulary change?

We may make certain changes to our formulary during the year. Changes in the formulary may affect which drugs are covered and how much you will pay when filling your prescription. The kinds of formulary changes we may make include:

- Adding or removing drugs from the formulary

- Adding prior authorizations, quantity limits, and/or step-therapy restrictions on a drug
- Moving a drug to a higher or lower cost-sharing tier
- Replace a brand-name drug with a generic drug

If we remove drugs from the formulary, or add prior authorizations, quantity limits and/or step therapy restrictions on a drug, or move a drug to a higher cost-sharing tier and you are taking the drug affected by the change, you will be permitted to continue taking that drug for the remainder of the Plan year. However, if a brand name drug is replaced with a new generic drug, or our formulary is changed as a result of new information on a drug's safety or effectiveness, you may be affected by this change. We will notify you of the change at least 60 days before the date that the change becomes effective or provide you with a 60-day supply at the pharmacy. This will give you an opportunity to work with your physician to switch to a different drug that we cover or request an exception. (If a drug is removed from our formulary because the drug has been recalled from the pharmacies, we will not give 60 days notice before removing the drug from the formulary. Instead, we will remove the drug immediately and notify members taking the drug about the change as soon as possible.)

What if your drug is not on the formulary?

If your prescription is not listed on your copy of our formulary, you should first check the formulary on our website which we update at least monthly (if there is a change). In addition, you may contact Member Services to be sure it is not covered. If Member Services confirms that we do not cover your drug, you have three options:

1. You may be able to get a temporary supply of the drug (only members in certain situations can get a temporary supply).

   Under certain circumstances, the plan can offer a temporary supply of a drug to you when your drug is not on the Drug List or when it is restricted in some way. Doing this gives you time to talk with your doctor about the change in coverage and figure out what to do.

   To be eligible for a temporary supply, you must meet the two requirements below:
   -The change to your drug coverage must be one of the following types of changes:

   - The drug you have been taking is **no longer on the plan's Drug List, or**
   - The drug you have been taking is **now restricted in some way**.

   -You must be in one of the situations described below:

   - **For those members who were in the plan last year and are not in a long-term care facility:**

     We will cover a temporary supply of your drug **one time only during the first *90 days* of the calendar year**. This temporary supply will be for a maximum of *a 31-day supply*, or less if your prescription is written for fewer days. The prescription must be filled at a network pharmacy.

- **For those members who are new to the plan and are not in a long-term care facility:**

  We will cover a temporary supply of your drug **one time only during the first *90 days* of your membership** in the plan. This temporary supply will be for a maximum of *a 31-day supply*, or less if your prescription is written for fewer days.

- **For those who are new members and are residents in a long-term care facility:**

  We will cover a temporary supply of your drug **during the first *90 days* of your membership** in the plan. The first supply will be for a maximum of *a 31-day supply*, or less if your prescription is written for fewer days. If needed, we will cover additional refills during your first *90 days* in the plan.

- **For those who have been a member of the plan for more than *90 days*, and are a resident of a long-term care facility and need a supply right away:**

  We will cover one *31-day supply*, or less if your prescription is written for fewer days. This is in addition to the above long-term care transition supply.

- Our plan will cover a temporary 31-day supply of non-formulary drugs (unless the prescription is written for fewer days) for current members with level of care changes.

2. You may ask your doctor if you can switch to another drug that is covered by us. If you would like to give your doctor a list of covered drugs that are used to treat similar medical conditions, please contact Member Services or go to our formulary on our website.
3. You or your doctor may ask us to make an exception (a type of coverage determination) to cover your drug. If you pay out-of-pocket for the drug and request an exception that we approve, the Plan will reimburse you. If the exception is not approved, you may appeal the Plan's denial. See Section 4 for more information on how to request an exception or appeal.

To ask for a temporary supply, call Member Services (phone numbers are on the front cover).

During the time when you are getting a temporary supply of a drug, you should talk with your doctor to decide what to do when your temporary supply runs out. Perhaps there is a different drug covered by the plan that might work just as well for you. Or you and your doctor can ask the plan to make an exception for you and cover the drug in the way you would like it to be covered.

In some cases, we will contact you if you are taking a drug that is not on our formulary. We can give you the names of covered drugs that also are used to treat your condition so you can ask your doctor if any of these drugs are an option for your treatment.

If you recently joined this Plan, you may be able to get a temporary supply of a drug you were taking when you joined our Plan if it is not on our formulary.

Drug Management Programs

Utilization management

For certain prescription drugs, we have additional requirements for coverage or limits on our coverage. These requirements and limits ensure that our members use these drugs in the most effective way and also help us control drug plan costs. A team of doctors and/or pharmacists developed these requirements and limits for our Plan to help us provide quality coverage to our members. Please consult your copy of our formulary or the formulary on our website for more information about these requirements and limits.

The requirements for coverage or limits on certain drugs are listed as follows:

Prior Authorization: We require you to get prior authorization (prior approval) for certain drugs. This means that your provider will need to contact us before you fill your prescription. If we do not get the necessary information to satisfy the prior authorization, we may not cover the drug.

Quantity Limits: For certain drugs, we limit the amount of the drug that we will cover per prescription or for a defined period of time.

Step Therapy: In some cases, we require you to first try one drug to treat your medical condition before we will cover another drug for that condition. For example, if Drug A and Drug B both treat your medical condition, we may require your doctor to prescribe Drug A first. If Drug A does not work for you, then we will cover Drug B.

Generic Substitution: When there is a generic version of a brand-name drug available, our network pharmacies may recommend and/or provide you the generic version, unless your doctor has told us that you must take the brand-name drug and we have approved this request.

You can find out if the drug you take is subject to these additional requirements or limits by looking in the formulary or on our website, or by calling Member Services. If your drug is subject to one of these additional restrictions or limits and your physician determines that you are not able to meet the additional restriction or limit for medical necessity reasons, you or your physician may request an exception (which is a type of coverage determination). See Section 4 for more information about how to request an exception.

Drug utilization review

We conduct drug utilization reviews for all of our members to make sure that they are getting safe and appropriate care. These reviews are especially important for members who have more than one doctor who prescribes their medications. We conduct drug utilization reviews each time you fill a prescription and on a regular basis by reviewing our records. During these reviews, we look for medication problems such as:

- Possible medication errors
- Duplicate drugs that are unnecessary because you are taking another drug to treat the same medical condition
- Drugs that are inappropriate because of your age or gender
- Possible harmful interactions between drugs you are taking
- Drug allergies
- Drug dosage errors

If we identify a medication problem during our drug utilization review, we will work with your doctor to correct the problem.

Medication therapy management programs

We offer medication therapy management programs at no additional cost to members who have multiple medical conditions, who are taking many prescription drugs, and who have high drug costs. These programs were developed for us by a team of pharmacists and doctors. We use these medication therapy management programs to help us provide better coverage for our members. For example, these programs help us make sure that our members are using appropriate drugs to treat their medical conditions and help us identify possible medication errors.
We may contact members who qualify for these programs. If we contact you, we hope you will join so that we can help you manage your medications. Remember, you do not need to pay anything extra to participate.

If you are selected to join a medication therapy management program we will send you information about the specific program, including information about how to access the program.

How does your enrollment in this Plan affect coverage for the drugs covered under Medicare Part A or Part B?

We cover drugs under both Parts A and B of Medicare, as well as Part D. The Part D coverage we offer does not affect Medicare coverage for drugs that would normally be covered under Medicare Part A or Part B. Depending on where you may receive your drugs, for example in the doctor's office versus from a network pharmacy, there may be a difference in your cost-sharing for those drugs. You may contact our Plan about different costs associated with drugs available in different settings and situations.

If you are a member of an employer or retiree group

If you currently have other prescription drug coverage through your (or your spouse's) employer or retiree group, please contact your benefits administrator to determine how your current prescription drug coverage will work with this Plan. In general, if you are currently employed, the prescription drug coverage you get from us will be secondary to your employer or retiree group coverage.

Each year (prior to November 15), your employer or retiree group should provide a disclosure notice to you that indicates if your prescription drug coverage is creditable (meaning it expects to pay, on average, at least as much as Medicare's standard prescription drug coverage) and the options available to you. You should keep the disclosure notices that you get each year in your personal records to present to a Part D plan when you enroll to show that you have maintained creditable coverage. If you did not get this disclosure notice, you may get a copy from the employer's or retiree group's benefits administrator or employer/union.

Using network pharmacies to get your prescription drugs

With few exceptions, which are noted later in this section under "How do you fill prescriptions outside the network?", **you must use network pharmacies to get your prescription drugs covered.** A network pharmacy is a pharmacy that has a contract with us to provide your covered prescription drugs. The term "covered drugs" means all of the Part D prescription drugs that are covered by our Plan. Covered drugs are listed in our formulary.

In most cases, your prescriptions are covered only if they are filled at one of our network pharmacies. You are not required to always go to the same pharmacy to fill your prescription; you may go to any of our network pharmacies. However, if you switch to a different network pharmacy than the one you have previously used, you must either have a new prescription written by a doctor or have the previous pharmacy transfer the existing prescription to the new pharmacy if any refills remain. To find a network pharmacy in your area, please review your Pharmacy Directory. You can also visit our website or call Member Services.

What if a pharmacy is no longer a network pharmacy?

Sometimes a pharmacy might leave the Plan's network. If this happens, you will have to get your prescriptions filled at another Plan network pharmacy. Please refer to your Pharmacy Directory or call Member Services to find another network pharmacy in your area.

How do you fill a prescription at a network pharmacy?

To fill your prescription, you must show your Plan membership card at one of our network pharmacies. If you do not have your membership card with you when you fill your prescription, you may have the pharmacy call Member Services to obtain the necessary information. If the pharmacy is unable to obtain the necessary information, you may have to pay the full cost of the prescription. If you pay the full cost of the prescription (rather than paying just your coinsurance or co-payment) you may ask us to reimburse you for our share of the cost by submitting a claim

to us. To learn how to submit a paper claim, please refer to the paper claims process described in the subsection below called "How do you submit a paper claim?"

How do you fill a prescription through our Plan's network mail-order-pharmacy service?

You can use our network mail-order service to fill prescriptions for maintenance drugs. These are drugs that you take on a regular basis, for a chronic or long-term medical condition.

When you order prescription drugs through our network mail-order-pharmacy service, you may order no more than a 90-day supply of the drug.

Generally, it takes the mail-order pharmacy 5 days to process your order and ship it to you. However, sometimes your mail-order may be delayed. Should your mail order be delayed, you may call Vantage Health Plan, Inc. at 318-361-0900 or toll free 888-823-1910 (TTY 318-361-2131 or toll free 866-524-5144) to request authorization to obtain a supply of medication from a retail network pharmacy until your mail order is received.

You are not required to use mail-order prescription drug services to obtain an extended supply of mail-order medications. Instead, you have the option of using another network retail pharmacy in our network to obtain a supply of mail-order medications. Some of these retail pharmacies may agree to accept the mail-order cost-sharing amount for an extended supply of mail-order medications, which may result in no out-of-pocket payment difference to you. Other retail pharmacies may not agree to accept the mail-order cost-sharing amounts for an extended supply of mail-order medications. In this case, you will be responsible for the difference in price. You can also call Member Services for more information.

To get order forms and information about filling your prescriptions by mail, call our Member Services department at 318-361-0900, or 1-888-823-1910, Monday – Friday, 8:00 a.m. – 8:00 p.m. CST. TTY users should call 1-866-524-5144. Please note that you must use the Vantage Medicare Advantage network mail-order service. Prescription drugs that you get through any other mail-order services are not covered.

How do you fill prescriptions outside the network?

We have network pharmacies outside of the service area where you can get your drugs covered as a member of our Plan. Generally, we only cover drugs filled at an out-of-network pharmacy in limited, non-routine circumstances when a network pharmacy is not available. Below are some circumstances when we would cover prescriptions filled at an out-of-network pharmacy. Before you fill your prescription in these situations, call Member Services to see if there is a network pharmacy in your area where you can fill your prescription. If you do go to an out-of-network pharmacy for the reasons listed below, you may have to pay the full cost (rather than paying just coinsurance OR co-payment) when you fill your prescription. You may ask us to reimburse you for our share of the cost by submitting a paper claim. You should submit a claim to us if you fill a prescription at an out-of-network pharmacy, as any amount you pay for a covered Part D drug will help you qualify for catastrophic coverage. To learn how to submit a

paper claim, please refer to the paper claims process described in the subsection below called "How do you submit a paper claim?". If we do pay for the drugs you get at an out-of-network pharmacy, you may still pay more for your drugs than what you would have paid if you had gone to an in-network pharmacy. Our Plan will cover your prescriptions at an out-of-network pharmacy if at least one of the following applies:

- The prescriptions are related to care for a medical emergency or urgently needed care.
- You are unable to get a covered drug in a timely manner within our service area because there are no network pharmacies within a reasonable driving distance that provide 24-hour service.
- You are trying to fill a covered prescription drug that is not regularly stocked at an eligible network retail or mail-order pharmacy (these drugs include orphan drugs or other specialty pharmaceuticals).
- Limited circumstances.
- The prescription is limited to no more than a 31-day supply, or less if written for fewer days, and requires authorization.

How do you submit a paper claim?

You may submit a paper claim for reimbursement of your drug expenses in the situations described below:

- **Drugs purchased out-of-network.** When you go to a network pharmacy and use our membership card, your claim is automatically submitted to us by the pharmacy. However, if you go to an out-of-network pharmacy and attempt to use our membership card for one of the reasons listed in the section above ("How do you fill prescriptions outside the network?), the pharmacy may not be able to submit the claim directly to us. When that happens, you will have to pay the full cost of your prescription and submit a paper claim to us. This type of reimbursement request is considered a request for a coverage determination and is subject to the rules contained in Section 4.

- **Drugs paid for in full when you do not have your membership card.** If you pay the full cost of the prescription (rather than paying just your coinsurance or co-payment) because you do not have your membership card with you when you fill your prescription, you may ask us to reimburse you for our share of the cost by submitting a paper claim to us. This type of reimbursement request is considered a request for a coverage determination and is subject to the rules contained in Section 4.

- **Drugs paid for in full in other situations.** If you pay the full cost of the prescription (rather than paying just your coinsurance or co-payment) because it is not covered for some reason (for example, the drug is not on the formulary or is subject to coverage requirements or limits) and you need the prescription immediately, you may ask us to reimburse you for our share of the cost by submitting a paper claim to us. In these situations, your doctor may need to submit additional documentation supporting your request. This type of reimbursement request is considered a request for a coverage determination and is subject to the rules contained in Section 4.

- **Drugs purchased at a better cash price**. In rare circumstances when you are in a coverage gap or deductible period and have bought a covered Part D drug at a network pharmacy under a special price or discount card that is outside the Plan's benefit, you may submit a paper claim to have your out-of-pocket expense count towards qualifying you for catastrophic coverage.

- **Co-payments for drugs provided under a drug manufacturer patient assistance program**. If you get help from, and pay co-payments under, a drug manufacturer patient assistance program outside our Plan's benefit, you may submit a paper claim to have your out-of-pocket expense count towards qualifying you for catastrophic coverage.

You may ask us to reimburse you for our share of the cost of the prescription by sending a written request to us. Although not required, you may use our reimbursement claim form to submit your written request. You can get a copy of our reimbursement claim form on our website or by calling Member Services**. Please include your bill and documentation of any payment you have made.**

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

130 Desiard Street, Suite 300, Monroe, LA 71201

How does your prescription drug coverage work if you go to a hospital or skilled nursing facility?

If you are admitted to a hospital for a Medicare-covered stay, our Plan's medical (Part C) benefit should generally cover the cost of your prescription drugs while you are in the hospital. Once you are released from the hospital, our plan's Part D benefit will cover your prescription drugs as long as the drugs meet all of our coverage requirements (such as that the drugs are on our formulary, filled at a network pharmacy, and they are not covered by our medical benefit (Part C)). We will also cover your prescription drugs if they are approved under the Part D coverage determination, exceptions, or appeals process.

If you are admitted to a skilled nursing facility for a Medicare-covered stay: After our plan's medical benefit (Part C) stops paying for your prescription drug costs as part of a Medicare-covered skilled nursing facility stay, our plan's Part D benefit will cover your prescription drugs as long as the drug meets all of our coverage requirements (such as that the drugs are on our formulary, the skilled nursing facility pharmacy is in our pharmacy network, and the drugs are not otherwise covered by our plan's medical benefit (Part C)).

Please Note: When you enter, live in, or leave a skilled nursing facility, you are entitled to a special enrollment period, during which time you will be able to leave this Plan and join a new Medicare Advantage Plan, Prescription Drug Plan, or the Original Medicare Plan. See Section 5 for more information about leaving this Plan and joining a new Medicare Plan.

Long-term care (LTC) pharmacies

Generally, residents of a long-term-care facility (like a nursing home) may get their prescription drugs through the facility's LTC pharmacy or another network LTC pharmacy. Please refer to your Pharmacy Directory to find out if your LTC pharmacy is part of our network. If it is not, or for more information, contact Member Services.

Home infusion pharmacies

Please refer to your Pharmacy Directory to find a home infusion pharmacy provider in your area. For more information, contact Member Services.

Some vaccines and drugs may be administered in your doctor's office

We may cover vaccines that are preventive in nature and are not already covered by our Plan's medical benefit (Part C). This coverage includes the cost of vaccine administration. See Section 9 for more information about your costs for covered vaccinations.

3. Your Rights and Responsibilities as a Member of our Plan

Introduction to your rights and protections

Since you have Medicare, you have certain rights to help protect you. In this section, we explain your Medicare rights and protections as a member of our Plan and we explain what you can do if you think you are being treated unfairly or your rights are not being respected.

Your right to be treated with dignity, respect and fairness

You have the right to be treated with dignity, respect, and fairness at all times. Our Plan must obey laws that protect you from discrimination or unfair treatment. We do not discriminate based on a person's race, disability, religion, sex, sexual orientation, health, ethnicity, creed, age, or national origin. If you need help with communication, such as help from a language interpreter, please call Member Services. Member Services can also help if you need to file a complaint about access (such as wheel chair access). You may also call the Office for Civil Rights at 1-800-368-1019 or TTY 1-800-537-7697, or your local Office for Civil Rights.

Your right to the privacy of your medical records and personal health information

There are federal and state laws that protect the privacy of your medical records and personal health information. We protect your personal health information under these laws. Any personal information that you give us when you enroll in this plan is protected. We will make sure that unauthorized people do not see or change your records. Generally, we must get written permission from you (or from someone you have given legal power to make decisions for you) before we can give your health information to anyone who is not providing your care or paying for your care. There are exceptions allowed or required by law, such as release of health information to government agencies that are checking on quality of care. The Plan will release your information, including your prescription drug event data, to Medicare, which may release it for research and other purposes that follow all applicable Federal statutes and regulations.

The laws that protect your privacy give you rights related to getting information and controlling how your health information is used. We are required to provide you with a notice that tells about these rights and explains how we protect the privacy of your health information. You have the right to look at medical records held at the Plan, and to get a copy of your records (there may be a fee charged 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 review your request and figure out whether the changes are appropriate). You have the right to know how your health information has been given out and used for non-routine purposes. If you have questions or

concerns about privacy of your personal information and medical records, please call Member Services.

Your right to see network providers, get covered services, and get your prescriptions filled within a reasonable period of time

As explained in this booklet, you will get most or all of your care from network providers, that is, from doctors and other health providers who are part of our Plan. You have the right to choose a network provider (we will tell you which doctors are accepting new patients). You have the right to go to a women's health specialist in our Plan (such as a gynecologist) without a referral You have the right to timely access to your providers and to see specialists when care from a specialist is needed. "Timely access" means that you can get appointments and services within a reasonable amount of time. You have the right to timely access to your prescriptions at any network pharmacy.

Your right to know your treatment options and participate in decisions about your health care

You have the right to get full information from your providers when you go for medical care, and the right to participate fully in decisions about your health care. Your providers must explain things in a way that you can understand. Your rights include knowing 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. This includes the right to know about the different Medication Therapy Management Programs we offer and in which you may participate. 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, and be given the choice of refusing experimental treatments.

You have the right to receive a detailed explanation from us if you believe that a provider has denied care that you believe you were entitled to receive or care you believe you should continue to receive. In these cases, you must request an initial decision called an organization determination or a coverage determination. Organization determinations and coverage determinations are discussed in Section 4.

You have the right to refuse treatment. This includes the right to leave a hospital or other medical facility, even if your doctor advises you not to leave. This includes the right to stop taking your medication. If you refuse treatment, you accept responsibility for what happens as a result of your refusing treatment.

Your right to use advance directives (such as a living will or a power of attorney)

You have the right to ask someone such as a family member or friend to help you with decisions about your health care. Sometimes, people become unable to make health care decisions for themselves due to accidents or serious illness. If you want to, you can use a special form to give

someone the legal authority to make decisions for you if you ever become unable to make decisions for yourself. You also have the right to 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 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 or you can call Member Services. 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. It is important to sign this form and keep a copy at home. 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 not. You may want to give copies to close friends or family members as well.

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. If you have signed an advance directive, and you believe that a doctor or hospital has not followed the instructions in it, you may file a complaint with Louisiana Department of Health & Hospitals, 628 N. 4th Street, P.O. Box 629 (Zip 70821-0629), Baton Rouge, LA 70802, Phone: 225-342-9500, Fax: 225-342-5568.

Your right to get information about our Plan

You have the right to get information from us about our Plan. This includes information about our financial condition, and how our Plan compares to other health plans. To get any of this information, call Member Services.

Your right to get information in other formats

You have the right to get your questions answered. Our plan must have individuals and/or translation services available to answer questions from non-English speaking beneficiaries, and must provide information about our benefits that is accessible and appropriate for persons eligible for Medicare because of disability. If you have difficulty obtaining information from your plan based on language or a disability, call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

Your right to get information about our network pharmacies and/or providers

You have the right to get information from us about our network pharmacies, providers and their qualifications and how we pay our doctors. To get this information, call Member Services.

Your right to get information about your prescription drugs, Part C medical care or services, and costs

You have the right to an explanation from us about any prescription drugs or Part C medical care or service not covered by our Plan. We must tell you in writing why we will not pay for or approve a prescription drug or Part C medical care or service, and how you can file an appeal to ask us to change this decision. See Section 4 for more information about filing an appeal. You also have the right to this explanation even if you obtain the prescription drug, or Part C medical care or service from a pharmacy and/or provider not affiliated with our organization. You also have the right to receive an explanation from us about any utilization-management requirements, such as step therapy or prior authorization, which may apply to your plan. Please review our formulary website or call Member Services for more information.

Your right to make complaints

You have the right to make a complaint if you have concerns or problems related to your coverage or care. See Section 4 for more information about complaints. If you make a complaint, we must treat you fairly (i.e., not retaliate against you) because you made a complaint. You have the right to get a summary of information about the appeals and grievances that members have filed against our Plan in the past. To get this information, call Member Services.

NOTICE OF PRIVACY PRACTICE

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

At Vantage Health Plan, Inc., we respect the confidentiality of your health information and will protect it in a responsible and professional manner. We consider this information private and confidential and have policies and procedures in place to protect the information against unlawful use and disclosure.

This notice describes what types of information we collect, explains when and to whom we may disclose it, and provides you with additional important information. We are allowed by law to use and disclose your health information to carry out the operations of our business. We are required by law to maintain the privacy of your health information, to provide you with this notice and abide by the notice in effect. It also informs you of your rights with respect to your health information and how you can exercise those rights.

What is Protected Health Information or PHI?

When we talk about "information" or "health information" in this notice we mean Protected Health Information or PHI. PHI is information that identifies an individual enrolled in a our Plan. It relates to the person's participation in the plan, the person's physical or mental health or condition, the provision of health care to that person, or payment for the provision of health care to that person. It does not include publicly available information, or information that is available or reported in a summarized fashion that does not identify any individual person.

What types of personal information do we collect?

Like all health benefits companies, we collect the following types of information about you:

- Information we receive directly or indirectly from you or your employer through applications, surveys, or other forms, in writing, in person, by telephone, or electronically, including our web site (e.g., name, address, social security number, date of birth, marital status, dependent information, employment information, medical history).
- Information about your relationship and transactions with us, our affiliates, our providers, our agents, and others (e.g., health care claims and encounters, medical history, eligibility information, payment information, service request, and appeal and grievance information).
- Information we receive from the Centers for Medicare and Medicare Services (CMS).

How do we protect this information?

We have policies that limit internal and external sharing of PHI to only persons who have a need for it to provide benefit services to you and your dependents. We maintain physical, electronic and procedural safeguards to protect PHI against unauthorized access and use. For example, access to our facilities is limited to authorized personnel and we protect information electronically through a variety of technical tools. We also have established a Privacy Committee, which has overall responsibility for the development, implementation, training, oversight and enforcement of policies and procedures to safeguard PHI against inappropriate access, use and disclosure, consistent with applicable law.

How may we use or share your information?

To effectively operate your health benefit plan, we may use and share PHI about you to:

- Perform certain duties, which may involve claims review and payment or denial; coordination of benefits; utilization review; medical necessity review; coordination of care; response to member inquiries or requests for services; conduct of grievance, appeals, and external review programs; benefits and program analysis and reporting; risk management; detection and investigation of fraud and other unlawful conduct; auditing; underwriting; administration and coordination of reinsurance contracts.

- Operate preventive health programs, disease early detection programs, disease management programs and case management programs in which we or our affiliates or contractors send educational materials and screening reminders to eligible members and providers; perform health risk assessments; identify and contact members who may benefit from participation in disease or case management programs; and send relevant information to those members who enroll in the programs, and their providers.
- Conduct quality improvement activities, such as the credentialing of participating network providers; and accreditation by the National Committee for Quality Assurance (NCQA), Centers for Medicare & Medicaid Services (CMS), and/or other independent organizations, where applicable.
- Conduct performance measurement and outcomes assessment; health claims analysis and reporting.
- Provide data to outside contractors who help us conduct our business operations. **We will not share your PHI with these outside contractors unless they agree in writing to keep it protected.**
- Manage data and information systems.
- Perform mandatory licensing, regulatory compliance/reporting, and public health activities; responding to requests for information from regulatory authorities, responding to government agency or court subpoenas as required by law, reporting suspected or actual fraud or other criminal activity; conducting litigation, arbitration, or similar dispute resolution proceedings; and performing third-party liability and subrogation activities.
- Change policies or contracts from and to other insurers, HMOs, or third party administrators.
- Provide data to the employer that sponsors the benefit plan through which you receive health benefits. **We will not share your PHI with your benefit plan sponsor except for deidentified summary health information, enrollment and disenrollment information, specific information authorized by you and any information necessary to administer the plan.**

We consider the activities described above as essential for the operation of our Plan. For example, we may feature:

- Cancer screening reminder programs that promote early detection of breast, ovarian, and colorectal cancer, when these illnesses are most treatable.
- Disease management programs that help members work with their physicians to effectively manage chronic conditions like asthma, diabetes, and heart disease to improve quality of life and avoid preventable emergencies and hospitalizations.
- Quality assessment programs that help us review and improve the services we provide.
- A variety of outreach programs that help us educate members about the programs and services that are available to them, and let members know how they can make the most of their health benefits.

There are also state and federal laws that may require us to release your health information to others. We may be required to provide information as follows:

- To state and federal agencies that regulate us such as the US Department of Health and Human Services and the Louisiana Department of Insurance.
- For public health activities. For example, we may report information to the Food and Drug Administration for investigating or tracking of prescription drug and medical device problems.
- To public health agencies if we believe there is a serious health or safety threat.
- With a health oversight agency for certain oversight activities (for example, audits, inspections, licensure, and disciplinary actions.)
- To a court or administrative agency (for example, pursuant to a court order, search warrant or subpoena).
- For law enforcement purposes. For example, we may give information to a law enforcement official for purposes of identifying or locating a suspect, fugitive, material witness or missing person.
- To a government authority regarding child abuse, neglect or domestic violence.
- To a coroner or medical examiner to identify a deceased person, determine a cause of death, or as authorized by law. We may also share information with funeral directors as necessary to carry out their duties.
- For procurement, banking or transplantation of organs, eyes or tissue.
- To specialized government functions, such as military and veteran activities, national security and intelligence activities, and the protective services for the President and others.
- For on-the-job-related injuries because of requirements of state workers' compensation laws.

We do not share PHI for any purpose other than those listed above. If one of the above reasons does not apply, **we must get your written authorization to use or disclose your health information**. In the event that you are unable to provider the authorization (for example, if you are medically unable to give consent), we accept authorization from any person legally authorized to give consent on your behalf, such as a parent or guardian. If you give us written authorization and change your mind, you may revoke your written authorization at any time.

What are your rights?

The following are your rights with respect to your PHI. If you would like to exercise any of these rights, please contact us at the address or phone numbers listed at the end of this notice. We will require that you make your request in writing and will provide you with the appropriate forms.

> ***You have the right to inspect and/or obtain a copy or summary of information*** that we maintain about you in your designated record set. A "designated record set" is a group of records maintained by or for us that are your enrollment, payment, claims determination, and case or medical management records or a group of records, used in whole or in part, by us to make decisions about you, such as appeals and grievance records. We may charge you a reasonable administrative fee for copying, postage or summary preparation depending on your specific request.

However, you do not have the right to inspect certain types of information and we can not provide you with copies of the following information:

- contained in psychotherapy notes;
- compiled in reasonable anticipation of, or for use in a civil criminal or administrative action or proceeding; or
- subject to certain federal laws governing biological products and clinical laboratories.

We will respond to your request no later than 30 days after we receive it or if the information requested is not accessible or maintained on site, no later than 60 days after we receive it.

Additionally, in certain other situations, we may deny your request to inspect or obtain a copy of your information. If we deny your request, we will notify you in writing and may provide you with a right to have the denial reviewed.

You have the right to ask us to amend information we maintain about you in your designated record set. We will require that your request be in writing and that you provide a reason for your request. We will respond to your request no later than 60 days after we receive it. If we are unable to act within 60 days, we may extend that time by no more than an additional 30 days. If we need to extend this time, we will notify you of the delay and the date by which we will complete action on your request.

If we make the amendment, we will notify you that it was made. In addition, we will provide the amendment to any person that we know has received your health information. We will also provide the amendment to other persons identified by you.

If we deny your request to amend, we will notify you in writing of the reason for the denial. The denial will explain your right to file a written statement of disagreement. We have a right to dispute your statement. However, you have the right to request that your written request, our written denial and your statement of disagreement be included with your information for any future disclosures.

NOTE: If you want to access or amend information about yourself, you should first go to your provider (e.g., doctor, pharmacy, hospital or other caregiver) that generated the original records, which are more complete than any we maintain.

You have the right to receive an accounting of certain disclosures of your information made by us during the six years prior to your request. Please note that we are not required to provide you with an accounting of the following information:

- Any information collected prior to April 14, 2003.
- Information disclosed or used for treatment, payment, and health care operations purposes.
- Information disclosed to you or pursuant to your authorization;

- Information that is incident to a use or disclosure otherwise permitted.
- Information disclosed for a facility's directory or to persons involved in your care or other notification purposes;
- Information disclosed for national security or intelligence purposes;
- Information disclosed to correctional institutions, law enforcement officials or health oversight agencies;
- Information that was disclosed or used as part of a limited data set for research, public health, or health care operations purposes.

We will act on your request for an accounting within 60 days. We may need additional time to act on your request, and therefore may take up to an additional 30 days. Your first accounting will be free, and we will continue to provide to you one free accounting upon request every 12 months. However, if you request an additional accounting within 12 months of receiving your free accounting, we may charge you a fee. We will inform you in advance of the fee and provide you with an opportunity to withdraw or modify your request.

You have the right to ask us to restrict how we use or disclose your information for treatment, payment, or health care operations. You also have the right to ask us to restrict information that we have been asked to give to family members or to others who are involved in your health care or payment for your health care.

You have the right to ask to receive confidential communications of information, if you believe that you would be harmed if we send your information to your current mailing address. For example, in situations involving domestic disputes or violence, you can ask us to send the information by alternative means (for example by fax) or to an alternative address. We will try to accommodate a reasonable request made by you.

What do we do with member PHI when the member is no longer enrolled in our Plan?

We do not destroy PHI when individuals terminate their coverage. The information is necessary and used for many purposes as described in this document, even after the individual leaves a plan. However, the policies and procedures that protect that information against inappropriate use and disclosure apply regardless of the status of any individual member. In many cases, PHI is subject to legal retention requirements, and after that requirement for record maintenance, PHI is destroyed in a confidential process.

Exercising your rights:

- **You have a right to receive a copy of this notice upon request at any time**. We provide this notice to our subscribers upon enrollment in a VHP group health plan. You can also view a copy of the notice on our web site at *www.vhp-stategroup.com*. Should any of our privacy practices change, **we reserve the right to change the**

terms of this notice and to make the new notice effective for all protected health information that we maintain. Once revised, we will provide the new notice to you and post it on our web site.

- If you have any questions about this notice or about how we use or share information, please write to the Privacy Officer at 130 DeSiard Street, Suite 300, Monroe, LA 71201 or email **Privacy.Officer@vhpla.com**. Or you can contact our Member Services Department at the phone numbers listed on the front cover.

If you are concerned that your privacy rights may have been violated, you may file a complaint with us. You also have the right to complain to the Secretary of the U.S. Department of Health and Human Services. If you have any questions about the complaint process, including the address of the Secretary of Health and Human Services, please write to our Privacy Officer at the address mentioned above or contact our Member Services Department (phone numbers are on the cover of this booklet).

VHP will not take any action against you for filing a complaint.

How to get more information about your rights

If you have questions or concerns about your rights and protections, you can

1. Call Member Services at the number on the cover of this booklet.
2. Get free help and information from your State Health Insurance Assistance Program (SHIP). Contact information for your SHIP is in Section 7 of this booklet.
3. Visit www.medicare.gov to view or download the publication "Your Medicare Rights & Protections."
4. Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

What can you do if you think you have been treated unfairly or your rights are not being respected?

If you think you have been treated unfairly or your rights have not been respected, you may call Member Services or:

- If you think you have been treated unfairly due to your race, color, national origin, disability, age, or religion, you can call the Office for Civil Rights at 1-800-368-1019 or TTY 1-800-537-7697, or call your local Office for Civil Rights.
- If you have any other kind of concern or problem related to your Medicare rights and protections described in this section, you can also get help from your SHIP (State Health Insurance Assistance Program). For details about this organization and how to contact it, go to Section 7.

Your responsibilities as a member of our Plan include:

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

  Sections 2 and 9 give the details about your medical services, including what is covered, what is not covered, rules to follow, and what you pay.

  Sections 2 and 9 give the details about your coverage for Part D prescription drugs.

- ***If you have any other health insurance coverage or prescription drug coverage besides 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 and drug benefits you get from our plan with any other health and drug benefits available to you. We will help you with it.

- ***Tell your doctor and other health care providers that you are enrolled in our plan***. Show your plan membership card whenever you get your medical care or Part D prescription drugs.

- ***Help your doctors and other providers help you by giving them information, asking questions, and following through on your care***.

  To help your doctors and other health providers give you the best care, learn as much as you are able to about your health problems and give them the information they need about you and your health. Follow the treatment plans and instructions that you and your doctors agree upon.

  If you have any questions, be sure to ask. Your doctors and other health care providers are supposed to explain things in a way you can understand. If you ask a question and you do not understand the answer you are given, ask again.

- ***Be considerate***. We expect all our members to respect the rights of other patients. We also expect you to act in a way that helps the smooth running of your doctor's office, hospitals, and other offices.

- ***Pay what you owe.*** As a plan member, you are responsible for these payments:

  You must pay your plan premiums to continue being a member of our plan.

  For some of your medical services or drugs covered by the plan, you must pay your share of the cost when you get the service or drug. This will be a copayment (a fixed amount) or coinsurance (a percentage of the total cost). Section 9 tells what you must pay for your medical services and your Part D prescription drugs.

If you get any medical services or drugs that are not covered by our plan or by other insurance you may have, you must pay the full cost.

- ***Tell us if you move***. If you are going to move, it is important to tell us right away. Contact the Office of Group Benefits' Customer Service Department at 225-925-6625 or toll free 1-800-272-8451.

  If you move outside of our plan service area, you cannot remain a member of our plan. (Section 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, the Office of Group Benefits still needs to know so we can keep your membership record up to date and know how to contact you.

- ***Call Member Services for help if you have questions or concerns***. We also welcome any suggestions you may have for improving our plan.

  Phone numbers and calling hours for Member Services are on the cover of this booklet.

  For more information on how to reach us, including our mailing address, please see Section 7.

4. What to Do if You Have a Problem or Complaint

BACKGROUND

A. Introduction

What to do if you have a problem or concern

Please call us first

Your health and satisfaction are important to us. When you have a problem or concern, we hope you will try an informal approach first: Please call Member Services (phone numbers are on the cover of this booklet). We will work with you to try to find a satisfactory solution to your problem.

You have rights as a member of our plan and as someone who is getting Medicare. We pledge to honor your rights, to take your problems and concerns seriously, and to treat you with respect.

Two formal processes for dealing with problems

Sometimes you might need a formal process for dealing with a problem you are having as a member of our plan.
This section explains two types of formal processes for handling problems:

- 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 will help you identify the right process to use.

What about the legal terms?

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

To keep things simple, this section explains the legal rules and procedures using simpler words in place of certain legal terms. For example, this section 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.

B. You can get help from government organizations that are not connected with us

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. Perhaps both are true for you.

Get help from an independent government organization

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

Their services are free. You will find phone numbers in Section 7 of this booklet.

You can also get help and information from Medicare

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

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

C. To deal with your problem, which process should you use?

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

If you have a problem or concern and you want to do something about it, you do not need to read this whole section. You just need to find and read the parts of this section that apply to your situation. The guide that follows will help.

To figure out which part of this chapter tells what to do for your problem or concern,
START HERE:

Is your problem or concern about your benefits and coverage?

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

Yes:
Go to Section 4 (D): "**A guide to the basics of coverage decisions and making appeals**."

No:
Skip ahead to Section 4 (J): "**How to make a complaint about quality of care, waiting times, customer service or other concerns**."

COVERAGE DECISIONS AND APPEALS

D. A guide to the basics of coverage decisions and appeals

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 and prescription drugs, 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 or drugs. We make a coverage decision for you whenever you go to a doctor for medical care. You can also contact the plan and ask for a coverage decision. For example, if you want to know if we will cover a medical service before you receive it, you can ask us to make a coverage decision for you.
We are making a coverage decision for you whenever we decide what is covered for you and how much we pay:

- Usually, there is no problem. We decide the service or drug is covered and pay our share of the cost.

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

Making an appeal

If we make a coverage decision 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 being fair and following all of the rules properly. When we have completed the review, we give you our decision.

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

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 cover).
- To **get free help from an independent organization** that is not connected with our plan, contact your State Health Insurance Assistance Program (see Section 7 of this chapter).
- **You should consider getting your doctor or other provider involved if possible, especially if you want a "fast" or "expedited" decision.** In most situations involving a coverage decision or appeal, your doctor or other provider must explain the medical reasons that support your request. Your doctor or other prescriber cannot request every appeal. He/she can request a coverage decision and a Level 1 Appeal with the plan. To request any appeal after Level 1, your doctor or other prescriber must be appointed as your "representative" (see below about "representatives").
- **You can ask someone to act on your behalf.** If you want to, you can name another person to act for you as your "representative" to ask for a coverage decision or make an appeal.
    - There may be someone who is already legally authorized to act as your representative under State law.
    - If you want a friend, relative, your doctor or other provider, or other person to be your representative, call Member Services and ask for the form to give that

person permission to act on your behalf. The form must be signed by you and by the person who you would like to act on your behalf. You must give our plan a copy of the signed form.

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

Which section gives the details for <u>your</u> situation?

There are four 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 4 (E)**: "Your medical care: How to ask for a coverage decision or make an appeal"
- **Section 4 (F)**: "Your Part D prescription drugs: How to ask for a coverage decision or make an appeal"
- **Section 4 (G)**: "How to ask us to cover a longer hospital stay if you think the doctor is discharging you too soon"
- **Section 4 (H)**: "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 are still not sure which section you should be using, please call Member Services (phone numbers are on the front cover). You can also get help or information from government organizations such as your State Health Insurance Assistance Program (Section 7, of this booklet has the phone numbers for this program).

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

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

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

This section is about your benefits for medical care and services. These are the benefits described in Section 9 of this booklet. To keep things simple, we generally refer to "medical care coverage" or "medical care" in the rest of this section, instead of repeating "medical care or treatment or services" every time.
This section tells what you can do if you are in any of the five following situations:

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

Which of these situations are you in?		
Do you want to find out whether our plan will cover the medical care or services you want? You need to ask our plan to make a coverage decision for you. See below.	Has our plan 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.) See page 53.	Do you want to ask our plan to pay you back for medical care or services you have already received and paid for? You can send us the bill. See page 57.

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 A coverage decision is often called an **"initial determination"** or "initial decision." When a coverage decision involves your medical care, the initial determination is called an **"organization determination."**

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

Legal Terms A "fast decision" is called an **"expedited decision."**

How to request coverage for the medical care you want

- Start by calling, writing, or faxing our plan to make your request for us to provide coverage for the medical care you want. You, or your doctor, or your representative can do this.
- For the details on how to contact us, go to Section 7 and look for the section called, *How to contact us when you are asking for a coverage decision about your medical care or Part D prescription drugs*.

Generally we use the standard deadlines for giving you our decision

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

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

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

- **A fast decision means we will answer within 72 hours.**
  - **However, we can take up to 14 more days** if we find that some information is missing that may benefit you, or if you need 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. We will call you as soon as we make the decision.
- **To get a fast decision, you must meet two requirements:**
  - You can get a fast decision only if you are asking for coverage for medical care *you have not yet received*. (You cannot get a fast decision if your request is about payment for medical care you have already received.)
  - You can get a fast decision *only* if using the standard deadlines could *cause serious harm to your health or hurt your ability to function.*
- **If your doctor tells us that your health requires a "fast decision," we will automatically agree to give you a fast decision.**
- If you ask for a fast decision on your own, without your doctor's support, our plan will decide whether your health requires that we give you a fast decision.
  - If we decide that your medical condition does not meet the requirements for a fast decision, we will send you a letter that says so (and we will use the standard deadlines instead).
  - This letter will tell you that if your doctor asks for the fast decision, we will automatically give a fast decision.
  - The letter will also tell how you can file a "fast complaint" about our decision to give you a standard decision instead of the fast decision you requested. (For more information about the process for making complaints, including fast complaints, see Section 4 (J).

<u>Step 2:</u> Our plan considers your request for medical care coverage and we give you our answer.

*Deadlines for a **"fast"** coverage decision*

- Generally, for a fast decision, we will give you our answer **within 72 hours**.
  - As explained above, we can take up to 14 more days under certain circumstances. If we take extra days, it is called "an extended time period."
  - If we do not give you our answer within 72 hours (or if there is an extended time period, by the end of that period), you have the right to appeal.
- **If our answer is yes to part or all of what you requested,** we must authorize or provide the medical care coverage we have agreed to provide within 72 hours after we received your request. If we extended the time needed to make our decision, we will provide the coverage by the end of that extended period.
- **If our answer is no to part or all of what you requested,** we will send you a written statement that explains why we said no.

*Deadlines for a **"standard"** coverage decision*

- Generally, for a standard decision, we will give you our answer **within 14 days of receiving your request.**
  - We can take up to 14 more days ("an extended time period") under certain circumstances.
  - If we 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.
- **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.

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

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

Step-by-step: How to make a Level 1 Appeal (how to ask for a review of a medical care coverage decision made by our plan)

Legal Terms	When you start the appeal process by making an appeal, it is called the "first level of appeal" or a "Level 1 Appeal." An appeal to the plan about a medical care coverage decision is called a plan **"reconsideration."**

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

What to do

- **To start an appeal you, your representative, or in some cases your doctor must contact our plan.** For details on how to reach us for any purpose related to your appeal, go to Section 7 (*How to contact us when you are making an appeal about your medical care or Part D prescription drugs*).
- **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 Section 7 (*How to contact us when you are making an appeal about your medical care or Part D prescription drugs*).
- **You must make your appeal request within 60 calendar days** from the date on the written notice we sent to tell you our answer to your request for a coverage decision. If you miss this deadline and have a good reason for missing it, we may give you more time to make your appeal.
- **You can ask for a copy of the information in your appeal and add more information if you like.**
  - You have the right to ask us for a copy of the information regarding your appeal. We are allowed to charge a fee for copying and sending this information to you.
  - If you wish, you and your doctor may give us additional information to support your appeal.

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

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

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

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

- When our plan is reviewing your appeal, we take another careful look at all of the information about your request for coverage of medical care. We check to see if we were being fair and 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 days.**
    - 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 send your request on to Level 2 of the appeals process, where it will be reviewed by an independent organization. Later in this section, we tell you about this organization and explain what happens at Level 2 of the appeals process.
- **If our answer is yes to part or all of what you requested,** we must authorize or provide the coverage we have agreed to provide within 72 hours.
- **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 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 days.**
    - If we do not give you an answer by the deadline above (or by the end of the extended time period if we took extra days), we are required to send your request on to Level 2 of the appeals process, where it will be reviewed by an independent outside organization. Later in this section, we tell about this review organization and explain what happens at Level 2 of the appeals process.
- **If our answer is yes to part or all of what you requested,** we must authorize or provide the coverage we have agreed to provide within 30 days after we receive your appeal.

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

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

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

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

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

Step 1: The Independent Review Organization reviews your appeal.

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

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

- If you had a fast appeal to our plan at Level 1, 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 days**.

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

- If you made a standard appeal to our plan at Level 1, 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 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 days after we receive the decision from the review organization.
- **If this organization says no to your appeal**, it means they agree with our plan that your request for coverage for medical care should not be approved. (This is called "upholding the decision." It is also called "turning down your appeal.")
    - The notice you get from the Independent Review Organization will tell you in writing if your case meets the requirements for continuing with the appeals process. For example, to continue and make another appeal at Level 3, the dollar value of the medical care coverage you are requesting must meet a certain minimum. If the dollar value of the coverage you are requesting is too low, you cannot make another appeal, which means that the decision at Level 2 is final.

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

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

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

If you want to ask our plan for payment for medical care, start by reading Section 10 of this booklet: *Asking the plan to pay its share of a bill you have received for covered services or drugs*. Section 10 describes the situations in which you may need to ask for reimbursement or to pay a bill you have received from a provider. It also tells how to send us the paperwork that asks us for payment.

Asking for reimbursement is asking for a coverage decision from our plan

If you send us the paperwork that asks for reimbursement, you are asking us to make a coverage decision. To make this coverage decision, we will check to see if the medical care you paid for is a covered service (see Section 9). We will also check to see if you followed all the rules for using your coverage for medical care (these rules are given in Section 2 of this booklet).

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. Or, if you have not paid for the services, we will send the payment directly to the provider. When we send the payment, it is 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 is 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. 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.

F. Your Part D prescription drugs: How to ask for a coverage decision or make an appeal

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

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

Your benefits as a member of our plan include coverage for many outpatient prescription drugs. Medicare calls these outpatient prescription drugs "Part D drugs." You can get these drugs as long as they are included in our plan's *List of Covered Drugs (Formulary)* and they are medically necessary for you, as determined by your primary care doctor or other provider.

- **This is about your Part D drugs only.** To keep things simple, we generally say "drug", instead of repeating "covered outpatient prescription drug" or "Part D drug" every time.
- For details about what we mean by Part D drugs, the *List of Covered Drugs*, rules and restrictions on coverage, and cost information, see Section 2 and Section 9.

Part D coverage decisions and appeals

As discussed in earlier in this section, a coverage decision is a decision we make about your benefits and coverage or about the amount we will pay for your drugs.

Legal Terms	A coverage decision is often called an **"initial determination"** or "initial decision." When the coverage decision is about your Part D drugs, the initial determination is called a **"coverage determination."**

Here are examples of coverage decisions you ask us to make about your Part D drugs:

- You ask us to make an exception, including:
  - Asking us to cover a Part D drug that is not on the plan's *List of Covered Drugs*
  - Asking us to waive a restriction on the plan's coverage for a drug (such as limits on the amount of the drug you can get)
  - Asking to pay a lower cost-sharing amount for a covered non-preferred drug
- You ask us whether a drug is covered for you and whether you satisfy any applicable coverage rules. (For example, when your drug is on the plan's *List of Covered Drugs* but we require you to get approval from us before we will cover it for you.)
- You ask us to pay for a prescription drug you already bought. This is a request for a coverage decision about payment.

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

This section tells you both how to ask for coverage decisions and how to request an appeal. Use this guide to help you determine which part has information for your situation:

Which of these situations are you in?			
Request a Coverage Decision:			**Make an Appeal:**
Do you want to ask us to make an exception to the rules or restrictions on our plan's coverage of a drug?	Do you want to ask us to cover a drug for you? (For example, if we cover the drug but we require you to get an approval from us first.	Do you want to ask us to pay you back for a drug you have already received and paid for?	Has our plan already told you that we will not cover or pay for a drug in the way that you want it to be covered or paid for?
▼	▼	▼	▼
You can ask us to make an exception. (This is a type of coverage decision.) See below.	You can ask us for a coverage decision. Go to page 62.	You can ask us to pay you back. (This is a type of coverage decision.) See page 62.	You can make an appeal. (This means you are asking us to reconsider.) See page 64.

What is an exception?

If a drug is not covered in the way you would like it to be covered, you can ask the plan to make an "exception." An exception is a type of coverage decision. Similar to other types of coverage decisions, if we turn down your request for an exception, you can appeal our decision.
When you ask for an exception, your doctor or other prescriber will need to explain the medical reasons why you need the exception approved. We will then consider your request. Here are three examples of exceptions that you or your doctor or other prescriber can ask us to make:

1. **Covering a Part D drug for you that is not on our plan's *List of Covered Drugs (Formulary).*** (We call it the "Drug List" for short.)

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

   - If we agree to make an exception and cover a drug that is not on the Drug List, you will need to pay the cost-sharing amount that applies to drugs in Tier 3. You cannot ask for an exception to the copayment or co-insurance amount we require you to pay for the drug.
   - You cannot ask for coverage of any "excluded drugs" or other non-Part D drugs which Medicare does not cover. (For more information about excluded drugs, see Section 9.)

2. **Removing a restriction on the plan's coverage for a covered drug**. There are extra rules or restrictions that apply to certain drugs on the plan's *List of Covered Drugs*.

Legal Terms	Asking for removal of a restriction on coverage for a drug is sometimes called asking for a **"formulary exception."**

   - The extra rules and restrictions on coverage for certain drugs include:
     - *Being required to use the generic version* of a drug instead of the brand-name drug.
     - *Getting plan approval in advance* before we will agree to cover the drug for you. (This is sometimes called "prior authorization.")
     - *Being required to try a different drug first* before we will agree to cover the drug you are asking for. (This is sometimes called "step therapy.")
     - *Quantity limits*. For some drugs, there are restrictions on the amount of the drug you can have.
   - If our plan agrees to make an exception and waive a restriction for you, you can ask for an exception to the copayment or co-insurance amount we require you to pay for the drug.

3. **Changing coverage of a drug to a lower cost-sharing tier.** Every drug on the plan's Drug List is in one of four cost-sharing tiers. In general, the lower the cost-sharing tier number, the less you will pay as your share of the cost of the drug.

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

   - If your drug is in Tier 3 you can ask us to cover it at the cost-sharing amount that applies to drugs in Tier 2. This would lower your share of the cost for the drug.
   - You cannot ask us to change the cost-sharing tier for any drug in Tier 4.

Important things to know about asking for exceptions

Your doctor must tell us the medical reasons

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

Typically, our Drug List includes more than one drug for treating a particular condition. These different possibilities are called "alternative" drugs. If an alternative drug would be just as effective as the drug you are requesting and would not cause more side effects or other health problems, we will generally *not* approve your request for an exception.

Our plan can say yes or no to your request

- If we approve your request for an exception, our approval usually is valid until the end of the plan year. This is true as long as your doctor continues to prescribe the drug for you and that drug continues to be safe and effective for treating your condition.
- If we say no to your request for an exception, you can ask for a review of our decision by making an appeal.

The next section tells you how to ask for a coverage decision, including an exception.

Step-by-step: How to ask for a coverage decision, including an exception

Step 1: You ask our plan to make a coverage decision about the drug(s) or payment you need. If your health requires a quick response, you must ask us to make a **"fast decision." You cannot ask for a fast decision if you are asking us to pay you back for a drug you already bought.**

What to do

- **Request the type of coverage decision you want.** Start by calling, writing, or faxing our plan to make your request. You, your representative, or your doctor (or other prescriber) can do this. For the details, go to Section 7 and look for the section called, *How to contact us when you are asking for a coverage decision about your medical care or Part D prescription drugs*.
- **You or your doctor or someone else who is acting on your behalf** can ask for a coverage decision.
- **If you want to ask our plan to pay you back for a drug,** start by reading Section 2 of this booklet *("How do you submit a paper claim?").* It describes the situations in which you may need to ask for reimbursement. It also tells how to send us the paperwork that asks us to pay you back for our share of the cost of a drug you have paid for.
- **If you are requesting an exception, provide the "doctor's statement."** Your doctor or other prescriber must give us the medical reasons for the drug exception you are requesting. (We call this the "doctor's statement.") Your doctor or other prescriber can fax or mail the statement to our plan. Or your doctor or other prescriber can tell us on the phone and follow up by faxing or mailing the signed statement.

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

Legal Terms	A "fast decision" is called an **"expedited 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 72 hours after we receive your doctor's statement. A fast decision means we will answer within 24 hours.

- **To get a fast decision, you must meet two requirements:**
  - You can get a fast decision only if you are asking for a *drug you have not yet received*. (You cannot get a fast decision if you are asking us to pay you back for a drug you are already bought.)
  - 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 or other prescriber 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 or other prescriber's support), our plan will decide whether your health requires that we give you a fast decision.
  - If we decide that your medical condition does not meet the requirements for a fast decision, we will send you a letter that says so (and we will use the standard deadlines instead).
  - This letter will tell you that if your doctor or other prescriber asks for the fast decision, we will automatically give a fast decision.
  - The letter will also tell how you can file a complaint about our decision to give you a standard decision instead of the fast decision you requested. It tells how to file a "fast" complaint, which means you would get our answer to your complaint within 24 hours. (The process for making a complaint is different from the process for coverage decisions and appeals.

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

*Deadlines for a **"fast"** coverage decision*

- If we are using the fast deadlines, we must give you our answer **within 24 hours**.
  - Generally, this means within 24 hours after we receive your request. If you are requesting an exception, we will give you our answer within 24 hours after we receive your doctor's statement supporting your request. We will give you our answer sooner if your health requires us to.
  - If we do not meet this deadline, we are required to send your request on to Level 2 of the appeals process, where it will be reviewed by an independent outside organization. Later in this section, we tell about this review organization and explain what happens at Appeal Level 2.
- **If our answer is yes to part or all of what you requested,** we must provide the coverage we have agreed to provide within 24 hours after we receive your request or doctor's statement supporting your request.

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

*Deadlines for a **"standard"** coverage decision*

- If we are using the standard deadlines, we must give you our answer **within 72 hours.**
  - Generally, this means within 72 hours after we receive your request. If you are requesting an exception, we will give you our answer within 72 hours after we receive your doctor's statement supporting your request. We will give you our answer sooner if your health requires us to.
  - If we do not meet this deadline, we are required to send your request on to Level 2 of the appeals process, where it will be reviewed by an independent organization. Later in this section, we tell about this review organization and explain what happens at Appeal Level 2.
- **If our answer is yes to part or all of what you requested –**
  - If we approve your request for coverage, we must **provide the coverage** we have agreed to provide **within 72 hours** after we receive your request or doctor's statement supporting your request.
  - If we approve your request to pay you back for a drug you already bought, we are also required to **send payment to you within 30 calendar days** after we receive your request or doctor's statement supporting your request.
- **If our answer is no to part or all of what you requested**, we will send you a written statement that explains why we said no.

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

- If our plan says no, you have the right to request an appeal. Requesting an appeal means asking us to reconsider – and possibly change – the decision we made.

Step-by-step: How to make a Level 1 Appeal (how to ask for a review of a coverage decision made by our plan)

Legal Terms

When you start the appeals process by making an appeal, it is called the "first level of appeal" or a "Level 1 Appeal."

An appeal to the plan about a Part D drug coverage decision is called a plan **"redetermination."**

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

What to do

- **To start your appeal, you (or your representative or your doctor or other prescriber) must contact our plan.**
    - For details on how to reach us by phone, fax, mail, or in person for any purpose related to your appeal, go to Section 7, and look for the section called, *How to contact us when you are making an appeal about your medical services or Part D prescription drugs.*
- **Make your appeal in writing by submitting a signed request.** You may also ask for an appeal by calling us at the phone number shown in Section 7 (*How to contact us when you are making an appeal about your medical services or Part D prescription drugs*).
- **You must make your appeal request within 60 calendar days** from the date on the written notice we sent to tell you our answer to your request for a coverage decision. If you miss this deadline and have a good reason for missing it, we may give you more time to make your appeal.
- **You can ask for a copy of the information in your appeal and add more information.**
    - 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 or other prescriber may give us additional information to support your appeal.

If your health requires it, ask for a "fast appeal"

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

- If you are appealing a decision our plan made about a drug you have not yet received, you and your doctor or other prescriber will need to decide if you need a "fast appeal."
- The requirements for getting a "fast appeal" are the same as those for getting a "fast decision".

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

- When our plan is reviewing your appeal, we take another careful look at all of the information about your coverage request. We check to see if we were being fair and following all the rules when we said no to your request. We may contact you or your doctor or other prescriber to get more information.

*Deadlines for a **"fast" appeal***

- If 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 it.
    - If we do not give you an answer within 72 hours, we are required to send your request on to Level 2 of the appeals process, where it will be reviewed by an Independent Review Organization. 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 provide the coverage we have agreed to provide within 72 hours.
- **If our answer is no to part or all of what you requested,** we will send you a written statement that explains why we said no and how to appeal our decision.

*Deadlines for a **"standard" appeal***

- If we are using the standard deadlines, we must give you our answer **within 7 calendar days** after we receive your appeal. We will give you our decision sooner if you have not received the drug yet and your health condition requires us to do so.
    - If we do not give you a decision within 7 calendar days, we are required to send your request on to Level 2 of the appeals process, where it will be reviewed by an Independent Review Organization. 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 –**
    - If we approve a request for coverage, we must **provide the coverage** we have agreed to provide as quickly as your health requires, but **no later than 7 calendar days** after we receive your appeal.
    - If we approve a request to pay you back for a drug you already bought, we are required to **send payment to you within 30 calendar days** after we receive your appeal request.
- **If our answer is no to part or all of what you requested**, we will send you a written statement that explains why we said no and how to appeal our decision.

<u>Step 3:</u> If we say no to your appeal, you decide if you want to continue with the appeals process and make *another* appeal.

- If our plan says no to your appeal, you then choose whether to accept this decision or continue by making another appeal.
- If you decide to make another appeal, it means your appeal is going on to Level 2 of the appeals process (see below).

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

If our plan says no to your appeal, you then choose whether to accept this decision or continue by making another appeal. If you decide to go on to a Level 2 Appeal, the **Independent Review Organization** reviews the decision our plan made when we said no to your first appeal. This organization decides whether the decision we made should be changed.

Legal Terms	The formal name for the "Independent Review Organization" is the **"Independent Review Entity."** It is sometimes called the **"IRE."**

Step 1: To make a Level 2 Appeal, you must contact the Independent Review Organization and ask for a review of your case.

- If our plan says no to your Level 1 Appeal, the written notice we send you will include **instructions on how to make a Level 2 Appeal** with the Independent Review Organization. These instructions will tell who can make this Level 2 Appeal, what deadlines you must follow, and how to reach the review organization.
- When you make an appeal to the Independent Review Organization, we will send the information we have 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.

Step 2: The Independent Review Organization does a review of your appeal and gives you an answer.

- **The Independent Review Organization is an outside, independent organization that is hired by Medicare**. This organization is not connected with our plan and it is not a government agency. This organization is a company chosen by Medicare to review our decisions about your Part D benefits with our plan.
- Reviewers at the Independent Review Organization will take a careful look at all of the information related to your appeal. The organization will tell you its decision in writing and explain the reasons for it.

*Deadlines for **"fast" appeal** at Level 2*

- If your health requires it, ask the Independent Review Organization for a "fast appeal."
- If the review organization agrees to give you a "fast appeal," the review organization must give you an answer to your Level 2 Appeal **within 72 hours** after it receives your appeal request.
- **If the Independent Review Organization says yes to part or all of what you requested,** we must provide the drug coverage that was approved by the review

organization **within 24 hours** after we receive the decision from the review organization.

*Deadlines for **"standard" appeal** at Level 2*

- If you have a standard appeal at Level 2, the review organization must give you an answer to your Level 2 Appeal **within 7 calendar days** after it receives your appeal.
- **If the Independent Review Organization says yes to part or all of what you requested –**
  - If the Independent Review Organization approves a request for coverage, we must **provide the drug coverage** that was approved by the review organization **within 72 hours** after we receive the decision from the review organization.
  - If the Independent Review Organization approves a request to pay you back for a drug you already bought, we are required to s**end payment to you within 30 calendar days** after we receive the decision from the review organization.

What if the review organization says no to your appeal?

If this organization says no to your appeal, it means the organization agrees with our decision not to approve your request. (This is called "upholding the decision." It is also called "turning down your appeal.")

To continue and make another appeal at Level 3, the dollar value of the drug coverage you are requesting must meet a minimum amount. If the dollar value of the coverage you are requesting is too low, you cannot make another appeal and the decision at Level 2 is final. The notice you get from the Independent Review Organization will tell you if the dollar value of the coverage you are requesting is high enough to continue with the appeals process.

Step 3: If the dollar value of the coverage you are requesting meets the requirement, 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. If you decide to make a third appeal, the details on how to do this are in the written notice you got after your second appeal.
- The Level 3 Appeal is handled by an administrative law judge.

G. How to ask us to cover a longer 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 the plan's coverage for your hospital care, including any limitations on this coverage, see Section 9 of this booklet. 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.

During your 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 is supposed to give it to you within two days after you are admitted.

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

Legal Terms	The written notice from Medicare tells you how you can **"make an appeal."** Making an appeal is a formal, legal way to ask for a delay in your discharge date so that your hospital care will be covered for a longer time.

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.
   - 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 or TTY: 1-877-486-2048). You can also see it online at http://www.cms.hhs.gov

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 our plan for a longer time, you will need to use the appeals process to make this request. Before you start, understand what you need to do and what the deadlines are.

- **Follow the process.** Each step in the first two levels of the appeals process is explained below.
- **Meet the deadlines.** The deadlines are important. Be sure that you understand and follow the deadlines that apply to things you must do.
- **Ask for help if you need it**. If you have questions or need help at any time, please call Member Services (phone numbers are on the front cover of this booklet). Or call your State Health Insurance Assistance Program, a government organization that provides personalized assistance (see Section 7 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.

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

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"** or an **"expedited review."**

What is the Quality Improvement Organization?

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

How can you contact this organization?

- The written notice you received (*An Important Message from Medicare*) tells you how to reach this organization. (Or find the name, address, and phone number of the Quality Improvement Organization for your state in Section 7, 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.

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**."

<u>Step 2:</u> 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 do not have to prepare anything in writing, but you may do so if you wish.
- The reviewers will also look at your medical information, talk with your doctor, and review information that the hospital and our plan has given to them.
- During this review process, you will also get a written notice that gives your planned discharge date and explains the reasons why your doctor, the hospital, and our plan think it is right (medically appropriate) for you to be discharged on that date.

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

What happens if the answer is no?

- If the review organization says *no* to your appeal, they are saying that your planned discharge date is medically appropriate. (Saying *no* to your appeal is also called *turning down* your appeal.) If this happens, **our plan's coverage for your hospital services will end** at noon on the day *after* the Quality Improvement Organization gives you its answer to your appeal.
- If 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.

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.
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 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 days, the Quality Improvement Organization reviewers will decide on your appeal and tell you their decision.

If the review organization says yes:

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

If the review organization says no:

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

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

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

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

You can appeal to our plan instead

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

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

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

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

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

- For details on how to contact our plan, go to Section 7 and look for the section called, *How to contact us when you are making an appeal about your medical care or Part D prescription drugs*.
- **Be sure to ask for a "fast review**." This means you are asking us to give you an answer using the "fast" deadlines rather than the "standard" deadlines.

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

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

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

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

- **If our plan says no to your fast appeal,** we are saying that your planned discharge date was medically appropriate. Our coverage for your hospital services ends as of the day we said coverage would end.
- If you stayed in the hospital *after* your planned discharge date, then **you may have to pay the full cost** of hospital care you received after the planned discharge date.

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

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

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

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

Legal Terms	The formal name for the "Independent Review Organization" is the **"Independent Review Entity."** It is sometimes called the **"IRE."**

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

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

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

- **The Independent Review Organization is an outside, independent organization that is hired by Medicare**. This organization is not connected with our plan and it is not a government agency. This organization is a company chosen by Medicare to handle the job of being the Independent Review Organization. Medicare oversees its work.
- Reviewers at the Independent Review Organization will take a careful look at all of the information related to your appeal of your hospital discharge.
- **If this organization says *yes* to your appeal,** then our plan must reimburse you (pay you back) for our share of the costs of hospital care you have received since the date of

your planned discharge. We must also continue the plan's coverage of your hospital services for as long as it is medically necessary. You must continue to pay your share of the costs. If there are coverage limitations, these could limit how much we would reimburse or how long we would continue to cover your services.

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

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

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

H. 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**

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 Section 6, *Definitions of important words*.)
- **Rehabilitation care** you are getting as an outpatient at a Medicare-approved Comprehensive Outpatient Rehabilitation Facility (CORF). Usually, this means you are getting treatment for an illness or accident, or you are recovering from a major operation. (For more information about this type of facility, see Section 6 *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 Section 9.

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

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

We will tell you in advance when your coverage will be ending

1. **You receive a notice in writing.** At least two days before our plan is going to stop covering your care, the agency or facility that is providing your care will give you a notice.
   - The written notice tells you the date when our plan will stop covering the care for you.

Legal Terms	In this written notice, we are telling you about a **"coverage decision"** we have made about when to stop covering your care.

   - 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 what you can do, the written notice is telling how you can **"make an appeal."** Making an appeal is a formal, legal way to ask our plan to change the coverage decision we have made about when to stop your care.

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.
   - Signing the notice shows *only* that you have received the information about when your coverage will stop. **Signing it does <u>not</u> mean you agree** with the plan that it is time to stop getting the care.

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

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

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

<u>Step 1:</u> 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 Section 7, of this booklet.)

What should you ask for?

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

Your deadline for contacting this organization.

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

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 do not 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.
- During this review process, you will also get a written notice from the plan that gives our reasons for wanting to end the plan's coverage for your services.

Legal Terms	This notice explanation is called the "**Detailed Explanation of Non-Coverage."**

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

What happens if the reviewers say yes to your appeal?

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

What happens if the reviewers say no to your appeal?

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

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

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

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

If the Quality Improvement Organization has turned down your appeal and you choose to continue getting care after your coverage for the care has ended, then you can make a Level 2 Appeal. During a Level 2 Appeal, you ask the Quality Improvement Organization to take another look at the decision they made on your first appeal.
Here are the steps for Level 2 of the appeal process:

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

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

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

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

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

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

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

What happens if the review organization says no?

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

- The notice you get will tell you in writing what you can do if you wish to continue with the review process. It will give you the details about how to go on to the next level of appeal, which is handled by a judge.

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

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

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

You can appeal to our plan instead

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

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

If you miss the deadline for contacting the Quality Improvement Organization, you can make an appeal to our plan, asking for a "fast review." A fast review is an appeal that uses the fast deadlines instead of the standard deadlines.
Here are the steps for a Level 1 Alternate Appeal:

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

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

- For details on how to contact our plan, go to Section 7 and look for the section called, *How to contact us when you are making an appeal about your medical care or Part D prescription drugs*.
- **Be sure to ask for a "fast review**." This means you are asking us to give you an answer using the "fast" deadlines rather than the "standard" deadlines.

Step 2: Our plan does a "fast" review of the decision we made about when to stop coverage for your services.

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

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

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

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

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

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

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

Legal Terms	The formal name for the "Independent Review Organization" is the **"Independent Review Entity."** It is sometimes called the **"IRE."**

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

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

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

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

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

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

I. Taking your appeal to Level 3 and beyond

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

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

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

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

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

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

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

- **If the answer is yes, or if the Medicare Appeals Council denies our request to review a favorable Level 3 Appeal decision, the appeals process *may* or *may not* be over** - We will decide whether to appeal this decision to Level 5. Unlike a decision at Level 2

(Independent Review Organization), we have the right to appeal a Level 4 decision that is favorable to you.

- If we decide *not* to appeal the decision, we must authorize or provide you with the service within 60 days after receiving the Medicare Appeals Council's decision.
- If we decide to appeal the decision, we will let you know in writing.

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

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

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

Levels of Appeal 3, 4, and 5 for Part D Drug 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 drug you have appealed meets certain minimum levels, you may be able to go on to additional levels of appeal. If the dollar value is less than the minimum level, you cannot appeal any further. If the dollar value is high enough, the written response you receive to your Level 2 Appeal will explain who to contact and what to do to ask for a Level 3 Appeal.

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

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

- **If the answer is yes, the appeals process is over**. What you asked for in the appeal has been approved.
- **If the answer is no, the appeals process *may* or *may not* be over**.

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

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

- **If the answer is yes, the appeals process is over**. What you asked for in the appeal has been approved.
- **If the answer is no, the appeals process *may* or *may not* be over**.
  - If you decide to accept this decision that turns down your appeal, the appeals process is over.
  - If you do not want to accept the decision, you might be able to continue to the next level of the review process. It depends on your situation. Whenever the reviewer says no to your appeal, the notice you get will tell you whether the rules allow you to go on to another level of appeal. If the rules allow you to go on, the written notice will also tell you who to contact and what to do next if you choose to continue with your appeal.

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

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

MAKING COMPLAINTS

J. 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 (D).

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 dealt with you?
- Do you feel you are being encouraged to leave our plan?

Waiting times

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

Cleanliness

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

Information you get from our plan

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

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

Possible Complaints – continued

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

The process of asking for a coverage decision and making appeals is explained in Section 4 (D-I). If you are asking for a decision or making an appeal, you use the process of asking for a coverage decision or making appeals, not the complaint process.

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

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

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."**

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.

Local (318) 361-0900 (**Toll Free (**888) 823-1910)
TTY Local (318) 361-2131 (**TTY Toll Free (**866) 524-5144)

Call Monday – Friday 8:00 A.M. - 8:00 P.M. CST

- **If you do not wish to call (or you called and were not satisfied), you can put your complaint in writing and send it to us.** If you do this, it means that we will use our *formal procedure* for answering grievances. Here is how it works:
    - A grievance may be filed by submitting the completed details in writing to Vantage Health Plan, Inc. at the following location: ATTN: Medical Director, 130 DeSiard Street, Suite 300, Monroe, LA 71201. The grievance must be submitted within 60 days of the event or incident. For grievances submitted in writing, a letter will be sent to you acknowledging receipt of the grievance. We must address your grievance as quickly as your case requires based on your health status, but no later than 30 days after receiving your complaint. You have the right to file an expedited grievance whenever we deny your request for an expedited decision about your request for a service, or, whenever we deny your request for an expedited decision about your appeal for a service. You also have the right to file an expedited grievance if you do not agree with our decision to extend the time needed to decide on your request for a service, or to consider your appeal for a service. We must decide within 24 hours if our decision to deny or delay making an expedited decision puts your life or health at risk. We may extend the time frame by up to 14 days if you ask for the extension, or if we justify a need for additional information and the delay is in your best interest. If we deny your grievance in whole or in part, our written decision will explain why we denied it, and will tell you about any dispute resolution options you may have.
- **Whether you call or write, you should contact Member Services right away.** The complaint must be made within 60 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 a **"fast grievance."**

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

- **If possible, we will answer you right away.** If you call us with a complaint, we may be able to give you an answer on the same phone call. If your health condition requires us to answer quickly, we will do that.
- **Most complaints are answered in 30 days, but we may take up to 44 days.** If we need more information and the delay is in your best interest or if you ask for more time, we can take up to 14 more days (44 days total) to answer your complaint.

- **If we do not agree** with some or all of your complaint or do not 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.

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

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

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

- **You can make your complaint to the Quality Improvement Organization**. If you prefer, you can make your complaint about the quality of care you received directly to this organization (*without* making the complaint to our plan). To find the name, address, and phone number of the Quality Improvement Organization in your state, look in Section 7, of this booklet. If you make a complaint to this organization, we will work together with them to resolve your complaint.

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

5. Ending your Membership

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 also limited situations where you do not choose to leave but we are required to end your membership. For example, if you move permanently out of our geographic service area.

Voluntarily ending your membership

There are only certain times during the year when you may voluntarily end your membership in our Plan. The key time to make changes is the Medicare Advantage Fall Enrollment Period, which occurs every year from November 15 through December 31. This is the time to review your health care and drug coverage for the following year and choose to keep your current coverage or make changes to your Medicare health or prescription drug coverage for the upcoming year. Any changes you make during this time will be effective January 1. Certain individuals, such as those with Medicaid, those who get extra help, or who move, can make changes at other times. The enrollment period table below summarizes the enrollment periods.

Enrollment Period	When?	Effective Date
Medicare Advantage Fall Open Enrollment Time to review health and drug coverage and make changes.	Every year from November 15 to December 31	January 1
Special Enrollment Periods for limited special exceptions, such as: • You have a change in residence • You have Medicaid • You are eligible for extra help with Medicare prescriptions • You live in an institution (such as a nursing home)	Determined by exception.	Generally, first day of next month after plan receives your enrollment request

For more information about the plan options available to you during these enrollment periods and how to change plans without losing your OGB benefits, contact the agency you retired from or call OGB's Customer Service Department at 225-925-6625 or toll free 1-800-272-8451.

Until your membership ends, you must keep getting your Medicare services and/or prescription drug coverage through our Plan

If you leave our Plan, it may take some time for your membership to end and your new way of getting Medicare to take effect (we discuss when the change takes effect earlier in this section). While you are waiting for your membership to end, you are still a member and must continue to get your care and/or prescription drugs as usual through our Plan. If you happen to be hospitalized on the day your membership ends, generally you will be covered by our Plan until you are discharged. Call Member Services for more information and to help us coordinate with your new plan.

Until your prescription drug coverage with our Plan ends, use our network pharmacies to fill your prescriptions. While you are waiting for your membership to end, you are still a member and must continue to get your prescription drugs as usual through our Plan's network pharmacies. In most cases, your prescriptions are covered only if they are filled at a network pharmacy, including our mail-order-pharmacy service, or are listed on our formulary, and you follow other coverage rules.

We cannot ask you to leave the Plan because of your health

We cannot ask you to leave your health plan for any health-related reasons. If you ever feel that you are being encouraged or asked to leave our Plan because of your health, you should call 1-800-MEDICARE (1-800-633-4227), which is the national Medicare help line. TTY users should call 1-877-486-2048. You may call 24 hours a day, 7 days a week.

Involuntarily ending your membership

If any of the following situations occur, we must end your membership in our Plan.

- If you do not stay continuously enrolled in Medicare A and B.
- If you move out of the service area or are away from the service area for more than 6 months you cannot remain a member of our Plan. And we must end your membership ("disenroll" you). If you plan to move or take a long trip, please call Member Services to find out if the place you are moving to or traveling to is in our Plan's service area.
- If you knowingly falsify or withhold information about other parties that provide reimbursement for your prescription drug coverage.
- If you intentionally give us incorrect information on your enrollment request that would affect your eligibility to enroll in our Plan.
- If you behave in a way that is disruptive, to the extent that you continued enrollment seriously impairs our ability to arrange or provide medical care for you or for others who are members of our Plan. We cannot make you leave our Plan for this reason unless we get permission first from Medicare.
- If you let someone else use your plan membership card to get medical care. If you are disenrolled for this reason, CMS may refer your case to the Inspector General for additional investigation.

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 and explain how you may file a complaint about our decision to end your membership. See Section 4 about how to make a complaint.

6. Definitions of Important Words Used in the EOC

Allowed Amount – The amount the Plan would pay before applicable deductibles, co-payments, or coinsurance to a provider for rendering a covered service/drug.

Appeal – An appeal is a special kind of complaint you make if you disagree with a decision to deny a request for health care services and/or prescription drugs or payment for services and/or prescription drugs you already received. You may also make a complaint if you disagree with a decision to stop services that you are receiving. For example, you may ask for an appeal if our Plan does not pay for a drug/item/service you think you should be able to receive. Section 6 explains appeals, including the process involved in making an appeal.

Balance Billing – Charging or collecting from a member an amount in excess of the Medicare reimbursement rate for Medicare-covered services, supplies or drugs provided to a member.

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

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

Brand-Name Drug – A prescription drug that is manufactured and sold by the pharmaceutical company that originally researched and developed the drug. Brand name drugs have the same active-ingredient formula as the generic version of the drug. However, generic drugs are manufactured and sold by other drug manufacturers and are generally not available until after the patent on the brand name drug has expired.

Catastrophic Coverage - The phase in the Part D Drug Benefit where you pay a low co-payment or coinsurance for your drugs after you or other qualified parties on your behalf have spent $4,550 in covered drugs during the covered year.

Centers for Medicare & Medicaid Services (CMS) – The Federal agency that runs the Medicare program. Section 7 explains how to contact CMS.

Coinsurance – The percentage (like 20%) of the total allowed amount that is owed by the member for covered services/drugs. See Section 9 for more details.

Co-payment – Fixed amount you pay each time you receive certain medical services. You pay a co-payment at the time you get the medical service.

Cost-sharing - Cost-sharing refers to amounts that a member has to pay when drugs/services are received. It includes any combination of the following three types of payments: (1) any deductible amount a plan may impose before drugs/services are covered; (2) any fixed "co-payment" amounts that a plan may require be paid when specific drugs/services are received; or (3) any "coinsurance" amount that must be paid as a percentage of the total amount paid for a drug/service.

Cost-sharing Tier – Every drug on the list of covered drugs is in one of four cost-sharing tiers. In general, the higher the cost-sharing tier, the higher your cost for the drug.

Coverage Determination –A decision from your Medicare drug plan 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 is not covered under your plan, that is not a coverage determination. You need to call or write to your plan to ask for a formal decision about the coverage if you disagree.

Covered Drugs – The term we use to mean all of the prescription drugs covered by our Plan.

Covered Services – 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 Section 9.

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

Custodial care - Care for personal needs rather than medically necessary needs. Custodial care is care that can be provided by people who do not have professional skills or training. This care includes help with walking, dressing, bathing, eating, preparation of special diets, and taking medication. Medicare does not cover custodial care unless it is provided as other care you are getting in addition to daily skilled nursing care and/or skilled rehabilitation services.

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). Section 5 discusses disenrollment.

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

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

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

Exception – A type of coverage determination that, if approved, allows you to get a drug that is not on your plan sponsor's formulary (a formulary exception), or get a non-preferred drug at the preferred cost-sharing level (a tiering exception). You may also request an exception if your plan sponsor requires you to try another drug before receiving the drug you are requesting, or the Plan limits the quantity or dosage of the drug you are requesting (a formulary exception).

Formulary – A list of covered drugs provided by the Plan. See "List of Covered Drugs."

Generic Drug – A prescription drug that is approved by the Food and Drug Administration (FDA) as having the same active ingredient(s) as the brand-name drug. Generally, generic drugs cost less than brand-name drugs.

Grievance - A type of complaint you make about us or one of our network providers/pharmacies, including a complaint concerning the quality of your care. This type of complaint does not involve coverage or payment disputes. See Section 4 for more information about grievances.

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

Home health care - Skilled nursing care and certain other health care services that you get in your home for the treatment of an illness or injury. Covered services are listed in the Benefits Chart in Section 9 under the heading "Home health care." If you need home health care services, our Plan will cover these services for you provided the Medicare coverage requirements are met. Home health care can include services from a **home health aide** if the services are part of the home health plan of care for your illness or injury. They are not covered unless you are also getting a covered skilled service. Home health services do not include the services of housekeepers, food service arrangements, or full-time nursing care at home.

Hospice care - A special way of caring for people who are terminally ill and providing counseling for their families. Hospice care is physical care and counseling that is given by a team of people who are part of a Medicare-certified public agency or private company. Depending on the situation, this care may be given in the home, a hospice facility, a hospital, or a nursing home. Care from a hospice is meant to help patients in the last months of life by giving comfort and relief from pain. The focus is on care, not cure. For more information on hospice care visit www.medicare.gov and under "Search Tools" choose "Find a Medicare Publication" to view or download the publication "Medicare Hospice Benefits." Or, call 1-800-MEDICARE (1-800-633-4227. TTY users should call 1-877-486-2048)

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

Initial Coverage Period – This is the period before your total drug expenses, have reached $2,830, including amounts you have paid and what our Plan has paid on your behalf.

Inpatient Care – Health care that you get when you are admitted to a hospital.

Late Enrollment Penalty – An amount added to your monthly premium for Medicare drug coverage if you go without creditable coverage (coverage that expects 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.

Lifetime Reserve Days – In the Original Medicare Plan and our Plan, a total of 60 extra days that Medicare will pay for when you are in a hospital more than 90 days during a benefit period. Once these 60 reserve days are used, you do not get any extra days during your lifetime.

List of Covered Drugs (Formulary or "Drug List") – A list of covered drugs provided by the plan. The drugs on this list are selected by the plan with the help of doctors and pharmacists. The list includes both brand-name and generic drugs.

Low Income Subsidy/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.

Maximum charge – The highest amount allowed, based on Medicare-approved amount, that can be billed by a provider.

Medical Emergency – You believe that your health is in serious danger – including severe pain, a bad injury, a sudden illness, or a medical condition that is quickly getting worse. (See "Emergency Care.")

Medically necessary – Services or supplies that are proper and needed for the diagnosis or treatment of your medical condition; are used for the diagnosis, direct care, and treatment of your medical condition; meet the standards of good medical practice in the local community; and are not mainly for your convenience or that of your doctor.

Medicare – The Federal health insurance program for people 65 years of age or older, some people under age 65 with certain disabilities, and people with End-Stage Renal Disease (generally those with permanent kidney failure who need dialysis or a kidney transplant).

Medicare Advantage (MA) Plan– Sometimes called Medicare Part C. A plan offered by a private company that contracts with Medicare to provide you with all your Medicare Part A (Hospital) and Part B (Medical) benefits. A MA plan offers a specific set of health benefits at the same premium and level of cost-sharing to all people with Medicare who live in the service area covered by the Plan. Medicare Advantage Organizations can offer one or more Medicare

Advantage plan in the same service area. A Medicare Advantage Plan can be an HMO, PPO, a Private Fee-for-Service (PFFS) Plan, or a Medicare Medical Savings Account (MSA) plan. In most cases, Medicare Advantage Plans also offer Medicare Part D (prescription drug coverage). These plans are called **Medicare Advantage Plans with Prescription Drug Coverage**. Everyone who has Medicare Part A and Part B is eligible to join any Medicare Health Plan that is offered in their area, except people with End-Stage Renal Disease (unless certain exceptions apply).

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 the Original Medicare Plan coverage. Medigap policies only work with the Original Medicare Plan. (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 Section 7 for information about how to contact Member Services.

Network pharmacy – A network pharmacy is a pharmacy where members of our Plan can get their prescription drug benefits. We call them "network pharmacies" because they contract with our Plan. In most cases, your prescriptions are covered only if they are filled at one of our network pharmacies.

Network provider – "Provider" is the general term we use for doctors, other health care professionals, hospitals, and other health care facilities that are licensed or certified by Medicare and by the State to provide health care services. We call them "**network providers**" when they have an agreement with our Plan to accept our payment as payment in full, and in some cases to coordinate as well as provide covered services to members of our Plan. Our Plan pays network providers based on the agreements it has with the providers or if the providers agree to provide you with plan-covered services. Network providers may also be referred to as "plan providers."

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

Original Medicare Plan – ("Traditional Medicare" or "Fee-for-service" Medicare) Original Medicare is offered by the government, and not a private health plan like Medicare Advantage plans and prescription drug plans. Under Original Medicare, Medicare services are covered by paying doctors, hospitals and other health care providers payment amounts established by

Congress. You can see any doctor, hospital, or other health care provider that accepts Medicare. You must pay the deductible. Medicare pays its share of the Medicare-approved amount, and you pay your share. Original Medicare has two parts: Part A (Hospital Insurance) and Part B (Medical Insurance) and is available everywhere in the United States.

Out-of-network provider or out-of-network facility – (Non-plan Provider or Non-plan Facility) – A provider or facility with which we have not arranged to coordinate or provide covered services to members of our plan. Out-of-network providers are providers that are not employed, owned, or operated by our plan or are not under contract to deliver covered services to you. "Out-of-network" may also be referred to as "non-plan providers." Using out-of-network providers or facilities is explained in this EOC in Section 2.

Out-of-network pharmacy – A pharmacy that does not have a contract with our Plan to coordinate or provide covered drugs to members of our Plan. As explained in this Evidence of Coverage, most drugs you get from out-of-network pharmacies are not covered by our Plan unless certain conditions apply.

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

Part D – The voluntary Medicare Prescription Drug Benefit Program. (For ease of reference, we will refer to the prescription drug benefit program as Part D.)

Part D Drugs – Drugs that can be covered under Part D. We may or may not offer all Part D drugs. (See your formulary for a specific list of covered drugs.) Certain categories of drugs were specifically excluded by Congress from being covered as Part D drugs.

Point of Service – An HMO option that lets a member use non-plan providers for an additional costs. See Sections 1 and 9 for more details.

Prescription Drug Benefit Manager – An entity that provides pharmacy benefit management services, including contracting with a network of pharmacies; establishing payment levels for network pharmacies; negotiating rebate arrangements; developing and managing formularies, preferred drug lists, and prior authorization programs; maintaining patient compliance programs; performing drug utilization review; and operating disease management programs. Many also operate mail-order pharmacies or have arrangements to include prescription availability through mail-order pharmacies.

Primary Care Physician (PCP) – A health care professional you select to coordinate your health care. Your PCP is responsible for providing or authorizing covered services while you are a plan member. Section 2 tells more about PCPs.

Prior authorization – Approval in advance to get services or certain drugs that may or may not be on our formulary. Some in-network medical services are covered only if your doctor or other network provider gets "prior authorization" from our plan. Covered services that need prior authorization are marked in the Benefits Chart in Section 9. Some drugs are covered only if your

doctor or other network provider gets "prior authorization" from us. Covered drugs that need prior authorization are marked in the formulary.

Providers – Doctors and other health care professionals that the state licenses to provide medical services and care. It also includes hospitals and other health care facilities.

Quality Improvement Organization (QIO) – Groups of practicing doctors and other health care experts that are paid by the Federal government to check and improve the care given to Medicare patients. They must review your complaints about the quality of care given by Medicare Providers.

Quantity Limits - A management tool that is designed to limit the use of selected drugs for quality, safety, or utilization reasons. Limits may be on the amount of the drug that we cover per prescription or for a defined period of time.

Referral – The recommendation of a medical professional. In HMO's, a referral is usually necessary to see any practitioner or specialist other than your primary care physician (PCP). The referral is obtained from your PCP.

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

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

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

Step Therapy - A utilization tool that requires you to first try another drug to treat your medical condition before we will cover the drug your physician may have initially prescribed.

Subrogation – Subrogation means our plan shall have the right to recover the cost of benefits we have paid to or for a member from any party who was responsible for the member's medical condition.

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

Urgently needed care – Urgently needed care is a non-emergency situation when you need medical care right away because of an illness, injury, or condition that you did not expect or anticipate, but your health is not in serious danger. Because of the situation, it is not reasonable for you to obtain medical care from a network provider.

7. Helpful Phone Numbers and Resources

Contact Information for our Plan Member Services

If you have any questions or concerns, please call or write to our Plan Member Services. We will be happy to help you.

CALL	318-361-0900 or toll free 1-888-823-1910 Member Services will operate seven (7) days a week from 8:00 a.m. – 8:00 p.m. CST from November 15, 2009 – March 1, 2010. After March 1, 2010, Member Services will operate five (5) days a week, Monday – Friday, 8:00 a.m. – 8:00 p.m. CST. An answering service will operate on weekends and holidays. When leaving a message, please leave your name, number and the time you called, and a representative will return your call no later than one business day.
TTY	318-361-2131 or toll free 1-866-524-5144 **This number requires special telephone equipment.**
FAX	318-361-2159
WRITE	130 DeSiard Street, Suite 300, Monroe, LA 71201
VISIT	130 DeSiard Street, Suite 300, Monroe, LA 71201
WEBSITE	*www.vhp-stategroup.com* or *www.vhp-medicare.com*

How to Contact Us When You Are Asking for a Coverage Decision about Your Medical Care or Part D Prescription Drugs

CALL	318-361-0900 or toll free 1-888-823-1910
TTY	318-361-2131 or toll free 1-866-524-5144 **This number requires special telephone equipment.**
FAX	318-361-2159
WRITE	130 DeSiard Street, Suite 300, Monroe, LA 71201

How to Contact Us When You Are Making an Appeal about Your Medical Care or Part D Prescription Drugs

CALL 318-361-0900 or toll free 1-888-823-1910

TTY 318-361-2131 or toll free 1-866-524-5144
This number requires special telephone equipment.

FAX 318-361-2159

WRITE 130 DeSiard Street, Suite 300, Monroe, LA 71201

How to Contact Us When You Are Making a Complaint about Your Medical Care or Part D Prescription Drugs

CALL 318-361-0900 or toll free 1-888-823-1910

TTY 318-361-2131 or toll free 1-866-524-5144
This number requires special telephone equipment.

FAX 318-361-2159

WRITE 130 DeSiard Street, Suite 300, Monroe, LA 71201

Where to Send a Request that Asks Us to Pay for Our Share of the Cost for Medical Care or a Drug You Have Received

CALL 318-361-0900 or toll free 1-888-823-1910

TTY 318-361-2131 or toll free 1-866-524-5144
This number requires special telephone equipment.

FAX 318-361-2159

WRITE 130 DeSiard Street, Suite 300, Monroe, LA 71201

Other important contacts

Below is a list of other important contacts. For the most up-to-date contact information, check your *Medicare & You* Handbook, visit www.medicare.gov and choose "Find Helpful Phone Numbers and Resources," or call 1-800-Medicare (1-800-633-4227). TTY users should call 1-877-486-2048.

Louisiana Senior Health Insurance Information Program

Louisiana Senior Health Insurance Information Program is a state program that gets money from the Federal government to give free local health insurance counseling to people with Medicare. Louisiana Senior Health Insurance Information Program can explain your Medicare rights and protections, help you make complaints about care or treatment, and help straighten out problems with Medicare bills. Louisiana Senior Health Insurance Information Program has information about Medicare Advantage Plans, Medicare Prescription Drug Plans, and about Medigap (Medicare supplement insurance) policies. This includes information about whether to drop your Medigap policy while enrolled in a Medicare Advantage Plan and special Medigap rights for people who have tried a Medicare Advantage Plan for the first time.

You may contact Louisiana Senior Health Insurance Information Program at P.O. Box 94214, 1702 N. Third Street, Baton Rouge, LA 70804-9214, toll free 800-259-5301. You may also find the website for Louisiana Senior Health Insurance Information Program at www.medicare.gov under "Search Tools" by selecting "Helpful Phone Numbers and Websites."

Louisiana Health Care Review, Inc.

"QIO" stands for Quality Improvement Organization. The QIO is a group of doctors and health professionals in your state that reviews medical care and handles certain types of complaints from patients with Medicare, and is paid by the federal government to check on and help improve the care given to Medicare patients. There is a QIO in each state. QIOs have different names, depending on which state they are in. The doctors and other health experts in the QIO review certain types of complaints made by Medicare patients. These include complaints about quality of care and appeals filed by Medicare patients who think the coverage for their hospital, skilled nursing facility, home health agency, or comprehensive outpatient rehabilitation stay is ending too soon. See Section 4 for more information about complaints, appeals and grievances.

You may contact Louisiana Health Care Review, Inc. at 8591 United Plaza Boulevard, Suite 270, Baton Rouge, LA 70809, Phone: 800-433-4958 or visit www.lhcr.org.

How to contact the Medicare program

Medicare is the Federal health insurance program for people 65 years of age or older, some people under age 65 with certain disabilities, and people with End-Stage Renal Disease

(generally those with permanent kidney failure who need dialysis or a kidney transplant). Our organization contracts with the federal government.

- Call 1-800-MEDICARE (1-800-633-4227) to ask questions or get free information booklets from Medicare 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048. Customer service representatives are available 24 hours a day, including weekends.
- Visit www.medicare.gov for information. This is the official government website for Medicare**.** This website gives you up-to-date information about Medicare and nursing homes and other current Medicare issues. It includes booklets you can print directly from your computer. It has tools to help you compare Medicare Advantage Plans and Medicare Prescription Drug Plans in your area. You can also search under "Search Tools" for Medicare contacts in your state. Select "Helpful Phone Numbers and Websites." If you do not have a computer, your local library or senior center may be able to help you visit this website using its computer.

Medicaid

Medicaid is a state government program that helps with medical costs for some people with limited incomes and resources. Some people with Medicare are also eligible for Medicaid. Medicaid has programs that can help pay for your Medicare premiums and other costs, if you qualify. To find out more about Medicaid and its programs, contact Louisiana Department of Health & Hospitals, 628 N. 4th Street, P.O. Box 629 (Zip 70821-0629), Baton Rouge, LA 70802, Phone: 888-324-6207 or TTY 225-216-7387. Or, visit www.dhh.louisiana.gov.

Social Security

Social Security programs include retirement benefits, disability benefits, family benefits, survivors' benefits, and benefits for the aged and blind. You may call Social Security at 1-800-772-1213. TTY users should call 1-800-325-0778. You may also visit **www.ssa.gov** on the Web.

Louisiana SenioRx (State Pharmacy Assistance Program - SPAP)

Louisiana SenioRx is a state organization that provides limited-income and medically needy senior citizens and individuals with disabilities financial help for prescription drugs. You may contact Louisiana SenioRx at 412 North 4th Street, 3rd Floor, (P.O. Box 61, 70821-0061)Baton Rouge, LA 70802, Toll free: 877-340-9100, Fax: 225-342-7133. The website for Louisiana SenioRx is *www.louisianaseniorx.org*.

Railroad Retirement Board

If you get benefits from the Railroad Retirement Board, you may call your local Railroad Retirement Board office or 1-877-772-5772. TTY users should call 312-751-4701. You may also visit www.rrb.gov on the Web.

Employer (or "Group") Coverage

If you get, or your spouse gets, benefits from your current or former employer, or from your spouse's current or former employer, call the agency you retired from or Vantage's Member Services Department if you have any questions about your employer benefits, plan premiums, and/or the open enrollment season. Contact the OGB if you have questions about your plan options. Important Note: Your (or your spouse's) employer benefits may change, or you (or your spouse) may lose the benefits, if you enroll in a plan not sponsored by the OGB.

8. Legal Notices

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.

Notice about nondiscrimination

We do not discriminate based on a person's race, disability, religion, sex, sexual orientation, 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.

9. How Much You Pay for Your Part C Medical Benefits and/or Part D Prescription Drugs

Your Monthly Premium for Our Plan

If you get your benefits from your current or former employer, or from your spouse's current or former employer, call the employer's benefits administrator for information about your Plan premium.

If you are getting extra help with paying for your drug coverage, the Part D premium amount that you pay as a member of this Plan is listed in your "Evidence of Coverage Rider for People who Get Extra Help for Prescription Drugs." You can also get that information by calling Member Services. If you are a member of a State Pharmacy Assistance Program (SPAP), you may get help paying your monthly plan premiums. Please contact your SPAP to determine what benefits are available to you. Note that there is not an SPAP in every state, and in some states the SPAP has another name. See Section 7.

You can find more information about paying your plan premium in Section 1.

How Much You Pay for Part C Medical Benefits

This section has a Benefits Chart that gives a list of your covered services and tells what you must pay for each covered service. These are the benefits and coverage you get as a member of our Plan. Later in this section under "General Exclusions" you can find information about services that are not covered. It also tells about limitations on certain services. Information about how much you pay for your Part D Prescription Drug Benefits is later in this section.

What do you pay for covered services?

"Co-payments" and "coinsurance" are the amounts you pay for covered services.

- A **"co-payment"** is a payment you make for your share of the cost of certain covered services you get. A co-payment is a set amount per service. You pay it when you get the service.
- **"Coinsurance"** is a payment you make for your share of the cost of certain covered services you receive. Coinsurance is a percentage of the cost of the service. Cost is based on the allowed amount. You pay your coinsurance when you get the service.
- Depending on your Medicaid benefit, you may not have to pay out-of-pocket costs for premiums, co-payments and coinsurance. These costs may be covered by Medicaid, as long as you qualify for Medicaid benefits and the provider accepts Medicaid.

What is the maximum amount you will pay for covered medical services?

There is a limit to how much you have to pay out-of-pocket for covered health care services each year. Once the total costs of co-payments and coinsurance related to covered health care services reaches $3,250, you will not have to continue paying for these covered services for the remainder of the year.

Benefits Chart

The benefits chart on the following pages lists the services our Plan covers and what you pay for each service. The covered services listed in the Benefits Chart in this section are covered only when all requirements listed below are met:

- Services must be provided according to the Medicare coverage guidelines established by the Medicare Program.
- The medical care, services, supplies, and equipment that are listed as covered services must be medically necessary. Certain preventive care and screening tests are also covered.
- Some of the covered services listed in the Benefits Chart are covered only if your doctor or other network provider gets "prior authorization" (approval in advance) from our Plan. Covered services that need prior authorization are marked in the Benefits Chart by an asterisk (*). Covered services that need a referral from your PCP are marked with a double asterisk (**). ***NOTE: PCP office visits do not need referrals/authorizations.***
- All in-network benefits will be applied to the out-of-pocket limit.

See Section 2 for information on requirements for using network providers.

Benefits chart – your covered services	**What you must pay** when you get these covered services
Inpatient Services	
Inpatient hospital care* Covered services include: • 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 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 • 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 is in our network that will decide whether you are a candidate for a transplant. • Blood - including storage and administration. All components of blood are covered beginning with the first pint used. • Physician Services	For Medicare-covered hospital stays: Days 1-5: $25 co-payment per day Days 6-90: $0 co-payment per day Plan covers 90 days each benefit period. A "benefit period" starts the day you go into a hospital or skilled nursing facility. It ends when you go for 60 days in a row without hospital or skilled nursing care. If you go into the hospital after one benefit period has ended, a new benefit period begins. There is no limit to the number of benefit periods you can have. Note: You are entitled to an extra 60 days of inpatient coverage when you are in a hospital more than 90 days. These 60 "Lifetime Reserve" days can be used only once during your lifetime. There is a $0 co-payment for the 60 lifetime reserve days. You will not be charged cost sharing for professional services. If you get inpatient care at a non-plan hospital after your emergency condition is stabilized, your cost is the cost-sharing you would pay at a plan hospital plus an additional 20% coinsurance. Except in an emergency, your doctor must tell the plan that you are going to be admitted to the hospital.
*Covered services that require prior authorization	

Benefits chart – your covered services	**What you must pay** when you get these covered services
Inpatient mental health care* Covered services include mental health care services that require a hospital stay. The 190-day limit does not apply to Mental Health services provided in a psychiatric unit of a general hospital.	For Medicare-covered hospital stays: Days 1-5: $25 co-payment per day Days 6-90: $0 co-payment per day Plan covers 90 days each benefit period. A "benefit period" starts the day you go into a hospital or skilled nursing facility. It ends when you go for 60 days in a row without hospital or skilled nursing care. If you go into the hospital after one benefit period has ended, a new benefit period begins. There is no limit to the number of benefit periods you can have. Note: You are entitled to an extra 60 days of inpatient coverage when you are in a hospital more than 90 days. These 60 "Lifetime Reserve" days can be used only once during your lifetime. There is a $0 co-payment for the 60 lifetime reserve days. Except in an emergency, your doctor must tell the plan that you are going to be admitted to the hospital. You will not be charged cost sharing for professional services. 190-day lifetime limit
Skilled nursing facility (SNF) care* Covered services include: • Semiprivate room (or a private room if medically necessary) • Meals, including special diets • Regular nursing services • Physical therapy, occupational therapy, and speech therapy	For Medicare-covered SNF stays: Days 1-20: $0 co-payment per day Days 21-100: $100 co-payment per day 3-day prior hospital stay is required. Plan covers up to 100 days each benefit period. A "benefit period"

Benefits chart – your covered services	**What you must pay** when you get these covered services
• Drugs administered to you as part of your plan of care (This includes substances that are naturally present in the body, such as blood clotting factors) • Blood - including storage and administration. All 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 Generally, you will get your SNF care from plan facilities. However, under certain conditions listed below, you may be able to pay in-network cost-sharing for a facility that is not a plan provider, if the facility accepts our Plan's amounts for payment. • A nursing home or continuing care retirement community where you were living right before you went to the hospital (as long as it provides skilled nursing facility care). • A SNF where your spouse is living at the time you leave the hospital.	starts the day you go into a hospital or SNF. It ends when you go for 60 days in a row without hospital or skilled nursing care. If you go into the hospital after one benefit period has ended, a new benefit period begins. There is no limit to the number of benefit periods you can have. Authorization rules may apply.
Inpatient services covered when the hospital or SNF days are not, or are no longer, covered* Covered services include: • Physician services • Tests (like X-ray or 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	Physician services are covered 100%. $0 co-payment for Medicare-covered lab services. 20% coinsurance up to $100 per day for Medicare-covered X-rays. 20% coinsurance up to $100 per day for Medicare-covered diagnostic procedures and tests. 0% coinsurance for Medicare-covered therapeutic radiology services.

Benefits chart – your covered services	**What you must pay** when you get these covered services
malfunctioning internal body organ, including replacement or repairs of such devices • Leg, arm, back, and neck braces; trusses, and artificial legs, arms, and eyes including adjustments, repairs, and replacements required because of breakage, wear, loss, or a change in the patient's physical condition • Physical therapy, speech therapy, and occupational therapy	20% coinsurance up to $100 per day for Medicare-covered diagnostic radiology services. 20% of the cost for Medicare-covered prosthetic and orthotic devices, leg, arm, back, and neck braces. 20% of the cost for Medicare-covered physical therapy, speech therapy, and occupation therapy. Authorization rules may apply.
Home health agency care* Covered services include: • 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 less than eight hours per day and 35 or fewer hours per week) • Physical therapy, occupational therapy, and speech therapy • Medical social services • Medical equipment and supplies	$0 co-payment for Medicare-covered home health visits Authorization rules may apply.
Hospice care You may receive care from any Medicare-certified hospice program. The Original Medicare Plan (rather than our Plan) will pay the hospice provider for the services you receive. Your hospice doctor can be a network provider or an out-of-network provider. You will still be a plan member and will continue to get the rest of your care that is unrelated to your terminal condition through our Plan. Covered services include: • Drugs for symptom control and pain relief, short-term respite care, and other services not otherwise covered by the Original Medicare Plan • Home care	When you enroll in a Medicare-certified Hospice program, your hospice services are paid for by the Original Medicare Plan, not your Medicare Advantage plan.

Benefits chart – your covered services	**What you must pay** when you get these covered services
Outpatient Services	
Physician services, including doctor office visits Covered services include: • Office visits, including medical and surgical care in a physician's office or certified ambulatory surgical center** • Consultation, diagnosis, and treatment by a specialist* • Hearing and balance exams, if your doctor orders it to see if you need medical treatment.* • Telehealth office visits including consultation, diagnosis and treatment by a specialist* • Second opinion by another network provider prior to surgery* • Outpatient hospital services* • 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 doctor)*	See "Physical Exams" for more information. $5 co-payment for each primary care doctor visit for Medicare-covered benefits. $20 co-payment for each specialist visit for Medicare-covered benefits.** 20% coinsurance up to $100 per day for major diagnostic tests.* 20% coinsurance for durable medical equipment.* 20% coinsurance applies for professional pain management and allergy services.* Cholesterol screening is covered at 100% when performed by a PCP. Referrals are required from your PCP to see a specialist.
Chiropractic services** Covered services include: • Manual manipulation of the spine to correct subluxation	$20 co-payment for Medicare-covered benefits. Medicare-covered chiropractic visits are for manual manipulation of the spine to correct a displacement or misalignment of a joint of body part. Authorization rules may apply.
**Covered services that require a referral from your PCP	

Benefits chart – your covered services	**What you must pay** when you get these covered services
Podiatry services** Covered services include: • Treatment of injuries and diseases of the feet (such as hammer toe or heel spurs). • Routine foot care for members with certain medical conditions affecting the lower limbs.	$20 co-payment for Medicare-covered benefits. Medicare-covered podiatry benefits are form medically-necessary foot care. Most routine foot care is not covered. Authorization rules may apply.
Outpatient mental health care* Covered services include: • 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.	$20 co-payment for each Medicare-covered individual or group therapy visit. Additional facility charges may apply.
Partial Hospitalization* "Partial hospitalization" is a structured program of active treatment that is more intense than the care received in your doctor's or therapist's office and is an alternative to inpatient hospitalization.	$20 co-payment for each Medicare-covered individual or group therapy visit. Additional facility charges may apply.
Outpatient substance abuse services*	$20 co-payment for each Medicare-covered individual or group therapy visit. Additional facility charges may apply.

Benefits chart – your covered services	**What you must pay** when you get these covered services
Outpatient services/surgery (including services provided at ambulatory surgical centers)*	$100 co-payment for each Medicare-covered ambulatory surgical center visit. $100 co-payment for each Medicare-covered outpatient hospital facility visit. Physician services related to ambulatory/outpatient surgery will be covered at 100%, excluding pain management and allergy services. 20% coinsurance applies to professional pain management and allergy services. There is no cost share for blood; the Original Medicare three (3) pint blood deductible is waived. Authorization rules may apply.
Ambulance services Covered ambulance services include fixed wing, rotary wing, and ground ambulance services, to the nearest appropriate facility that can provide care only if they are furnished to a member whose medical condition is such that other means of transportation are contraindicated (could endanger the person's health). The member's condition must require both the ambulance transportation itself and the level of service provided in order for the billed service to be considered medically necessary. 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.	$100 co-payment per day for Medicare-covered ambulance benefits. Authorization rules may apply.

Benefits chart – your covered services	**What you must pay** when you get these covered services
Emergency care Coverage is worldwide.	$50 co-payment for Medicare-covered emergency room visits. If you need inpatient care at a non-plan hospital after your emergency condition is stabilized, you may return to a plan contracting hospital in order for your care to continue to be covered OR you may have your inpatient care at the non-plan hospital authorized by the plan and your cost is the cost-sharing you would pay at an in-plan hospital plus 20% coinsurance. If you are admitted to the hospital within 72-hours for the same condition, you pay $0 for the emergency room visit.
Urgently needed care Coverage is within the U.S.	$10 co-payment for Medicare-covered urgently needed care visits.
Outpatient rehabilitation services* Covered services include: physical therapy, occupational therapy, speech language therapy, and cardiac rehabilitative therapy	$5 co-payment per day for Medicare-covered Occupational therapy visits. Limited to the annual therapy cap as determined by CMS. $5 co-payment per day for Medicare-covered Physical and/or Speech/Language therapy visits. Limited to the annual therapy cap as determined by CMS.
Durable medical equipment and related supplies* Covered items include: wheelchairs, crutches, hospital bed, IV infusion pump, oxygen equipment, nebulizer, and walker. (See definition of "durable medical equipment" in Section 6.)	Authorization rules may apply. 20% of the cost for Medicare-covered items. Certain rental limitations apply as determined by CMS.

Benefits chart – your covered services	**What you must pay** when you get these covered services
Prosthetic devices and related supplies* (other than dental) that replace a body part or function. These include 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.	Authorization rules may apply. 20% of the cost for Medicare-covered items.
Diabetes self-monitoring, training, and supplies* – for all people who have diabetes (insulin and non-insulin users). Covered services include: • Blood glucose monitor, blood glucose test strips, lancet devices and lancets, and glucose-control solutions for checking the accuracy of test strips and monitors • One pair per calendar year of therapeutic shoes for people with diabetes who have severe diabetic foot disease, including fitting of shoes or inserts • Self-management training is covered under certain conditions • For persons at risk of diabetes: Fasting plasma glucose tests. Unlimited testing	Authorization rules may apply. 20% of the cost for Diabetes self-monitoring training. 20% of the cost for Nutrition therapy for diabetes and renal disease. Limitations apply as determined by CMS. 20% of the cost for Diabetes supplies.
Medical nutrition therapy* – for people with diabetes, renal (kidney) disease (but not on dialysis), and after a transplant when referred by your doctor.	Authorization rules may apply. 20% of the cost for nutrition therapy. Limitations apply as determined by CMS.

Benefits chart – your covered services	**What you must pay** when you get these covered services
Outpatient diagnostic tests and therapeutic services and supplies Covered services include: • X-rays • Radiation therapy* • Surgical supplies, such as dressings • Supplies, such as splints and casts • 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 outpatient diagnostic tests* include major diagnostic radiology services. Major diagnostic radiology services include, but are not limited to: Bone scan, Cardiac stress test, CT scan, Echocardiogram, EEG, EMG, Event monitor, HIDA scan, Holter monitor, MRI, Nerve conduction study, Nuclear cardiac stress test, PET scan, Pulmonary function test, and Sleep study	Authorization rules may apply. 20% coinsurance up to $100 per day for Medicare-covered X-rays. $0 co-payment for Medicare-covered therapeutic radiology services. $0 co-payment for Medicare-covered lab services. 20% coinsurance up to $100 per day for Medicare-covered diagnostic procedures and tests. 20% coinsurance up to $100 per day Medicare-covered diagnostic radiology services. Authorizations apply to major diagnostic tests and radiation therapy only. Labs do not require an authorization/referral.
Vision care Covered services include: • Outpatient physician services for eye care. • 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 • One pair of eyeglasses or contact lenses after each cataract surgery that includes insertion of an intraocular lens. Corrective lenses/frames (and replacements) needed after a cataract removal without a lens implant.	20% of the cost for one pair of eyeglasses or contact lenses after each cataract surgery. $20 co-payment for exams to diagnose and treat diseases and conditions of the eye. Glaucoma screening is covered at 100%.

Benefits chart – your covered services	**What you must pay** when you get these covered services
Preventive Care and Screening Tests	
Abdominal Aortic Aneurysm Screening** A one-time screening ultrasound for people at risk. Our Plan only covers this screening if you get a referral for it as a result of your Routine Physical Exam.	20% of the cost for Medicare-covered abdominal aortic aneurysm screening
Bone-mass measurements For qualified individuals (generally, this means people at risk of losing bone mass or at risk of osteoporosis), the following services are covered every 2 years or more frequently if medically necessary: procedures to identify bone mass, detect bone loss, or determine bone quality, including a physician's interpretation of the results.	$0 co-payment for Medicare-covered bone-mass measurements Authorization rules may apply. There are no authorization requirements for initial exam and bi-annual services. Office visit co-payment may apply.
Colorectal screening For people 50 and older, the following are covered: • Flexible sigmoidoscopy* (or screening barium enema as an alternative) every 48 months • Fecal occult blood test, every 12 months For people at high risk of colorectal cancer, we cover: • Screening colonoscopy* (or screening barium enema as an alternative) every 24 months For people not at high risk of colorectal cancer, we cover: • Screening colonoscopy* every 10 years, but not within 48 months of a screening sigmoidoscopy	$0 co-payment for Medicare-covered colorectal screenings. There is a $100 outpatient facility co-payment for sigmoidoscopies and colonoscopies. Authorization rules may apply. There is no co-payment for lab services.
Immunizations Covered services include: • 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 We also cover some vaccines under our outpatient prescription drug benefit**.**	$0 co-payment for flu and pneumonia vaccines. $0 co-payment for Hepatitis B vaccine. No referral needed for flu, pneumonia, and Hepatitis B vaccines.

Benefits chart – your covered services	**What you must pay** when you get these covered services
Mammography screening Covered services include: • One baseline exam between the ages of 35 and 39 • One screening every 12 months for women age 40 and older	$0 co-payment for Medicare-covered screening and mammograms.
Pap tests, pelvic exams, and clinical breast exam Covered services include: • For all women, Pap tests, pelvic exams, and clinical breast 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	$0 co-payment for Medicare-covered pap smears and pelvic exams. Office visit co-payment may apply.
Prostate cancer screening exams For men age 50 and older, covered services include the following - once every 12 months: • Digital rectal exam • Prostate Specific Antigen (PSA) test	$0 co-payment for Medicare-covered prostate cancer screening. Office visit co-payment may apply.
Cardiovascular disease testing Blood tests for the detection of cardiovascular disease (or abnormalities associated with an elevated risk of cardiovascular disease). Annual screening	$0 co-payment for Medicare-covered cardiovascular disease testing.
Physical exams As a member of Vantage Medicare Advantage, you are entitled to an annual physical exam by your PCP or OBGYN.	$0 co-payment for routine exams. Limited to 1 exam every year.

Benefits chart – your covered services	**What you must pay** when you get these covered services
Other Services	
Dialysis (Kidney)* Covered services include: • Outpatient dialysis treatments (including dialysis treatments when temporarily out of the service area, as explained in Section 2) • Inpatient dialysis treatments (if you are admitted to a hospital for special care) • Self-dialysis training (includes training for you and anyone helping you with your home dialysis treatments) • Home dialysis equipment and supplies • Certain home support services (such as, when necessary, visits by trained dialysis workers to check on your home dialysis, to help in emergencies, and check your dialysis equipment and water supply)	Authorization rules may apply. Out-of-area renal dialysis services do not require authorization. 20% of the cost for in and out-of-area dialysis. 20% of the cost for Nutrition therapy for renal disease. Limitations apply as determined by CMS.
Medicare Part B Prescription Drugs These drugs are covered under Part B of the Original Medicare Plan. Members of our plan receive coverage for these drugs through our plan. Covered drugs include: • Drugs that usually are not self-administered by the patient and are injected while you are getting physician services • Drugs you take using durable medical equipment (such as nebulizers) that was authorized by the plan • Clotting factors you give yourself by injection if you have hemophilia • Immunosuppressive Drugs, if you were enrolled in Medicare Part A at the time of the organ transplant • Injectable osteoporosis drugs, if you are homebound, have a bone fracture that a doctor certifies was related to post-menopausal osteoporosis, and cannot self-administer the drug • Antigens • Certain oral anti-cancer drugs and anti-nausea drugs • Certain drugs for home dialysis, including heparin, the antidote for heparin when medically necessary, topical anesthetics, and erythropoisis-stimulating agents (such as Epogen®, Procrit®, Epoetin Alfa,	20% of the cost for Part B covered drugs, **except**: ▪ Most Part B drugs given in the office are covered 100%. ▪ Injectable chemotherapy drugs given in any setting during the course of cancer/radiation treatment are covered 100%. Authorization rules may apply.

Benefits chart – your covered services	**What you must pay** when you get these covered services
Aranesp®, or Darbepoetin Alfa) • Intravenous Immune Globulin for the home treatment of primary immune deficiency diseases Section 2 explains the Part D prescription drug benefit, including rules you must follow to have prescriptions covered. What you pay for your Part D prescription drugs through our plan is listed later in this section.	
Additional Benefits	
Dental Services* Services by a dentist or oral surgeon 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 disease, or services that would be covered when provided by a doctor.	Authorization rules may apply. In general, preventive dental benefits (such as cleaning) are not covered. 20% of the cost for Medicare-covered dental benefits.
Hearing Services* Diagnostic hearing exams	Authorization rules may apply. In general, routine hearing exams and hearing aids are not covered. 20% of the cost for Medicare-covered diagnostic hearing exams.
Health and wellness education programs Covered if ordered by your doctor. Includes two counseling attempts within a 12-month period if you are diagnosed with a smoking-related illness or are taking medicine that may be affected by tobacco. Each counseling attempt includes up to four face-to-face visits.	This plan does not cover health/wellness education benefits. 20% of the cost for each Medicare-covered smoking cessation counseling session.

Benefits chart – your covered services	**What you must pay** when you get these covered services
Point of Services (POS)* Point of Service plans allow members to receive medical care outside of the network; however, use of facilities and physicians within the network is encouraged. $5,000 limit every year for POS benefits. **The POS benefits include a 20% coinsurance in addition to the in-network cost sharing.**	Authorization rules may apply. Point of Service is available for the following benefits: - Inpatient Hospital Care - Doctor Office Visits - Outpatient Services/Surgery - Ambulance Services - Diagnostic Tests, X-Rays, Lab Services and Radiology Services - Colorectal Screening Exam - Immunizations - Mammograms (Annual Screenings) - Pap Smears and Pelvic Exams - Prostate Cancer Screening Exams - Diagnostic Radiological Services - Therapeutic Radiological Services - Outpatient X-Rays - Cardiac Rehabilitation Services 20% of the cost per hospital stay ***PLUS*** Days 1-5: $25 co-payment per day Days 6-90: $0 co-payment per day

How Much You Pay for Part D Prescription Drugs

This section has a chart that tells you what you must pay for covered drugs. These are the benefits you get as a member of our Plan. (Covered Part B drugs were described earlier in this section, and later in this section under "General Exclusions" you can find information about drugs that are not covered.) For more detailed information about your benefits, please refer to our Summary of Benefits. If you do not have a current copy of the Summary of Benefits, you can view it on our website or contact Member Services to request one.

How much do you pay for drugs covered by this Plan?

When you fill a prescription for a covered drug, you may pay part of the costs for your drug. The amount you pay for your drug depends on what coverage level you are in (i.e., initial coverage period, the period after you reach your initial coverage limit, and catastrophic level), the type of drug it is, and whether you are filling your prescription at an in-network or out-of-network pharmacy. Each phase of the benefit is described below. Refer to your plan formulary to see what drugs we cover and what tier they are on. (More information on the formulary is included later in this section.)

If you qualify for extra help with your drug costs, your costs for your drugs may be different from those described below. For more information, see the "Evidence of Coverage Rider for People who Get Extra Help Paying for Prescription Drugs." If you do not already qualify for extra help, see "Do you qualify for extra help?" in Section 1 for more information.

Initial Coverage Period

During the **initial coverage period**, we will pay part of the costs for your covered drugs and you will pay the other part. The amount you pay when you fill a covered prescription is called the coinsurance or co-payment. Your coinsurance or copayment will vary depending on the drug and where the prescription is filled.

You will pay the following for your covered prescription drugs:

Drug Tier	Network Retail Cost-Sharing (31-day supply)	Network Retail Cost-Sharing (90-day supply)	Network Long-Term Care Cost-Sharing (31-day supply)	Network Mail-Order Cost-Sharing (90-day supply)	Out-of-Network Cost-Sharing (31-day supply) See Section 2
Tier 1	$0.00	$0.00	$0.00	$0.00	$0.00 plus cost differential (1)
Tier 2	$20.00	$60.00	$20.00	$60.00	$20.00 plus cost differential (1)
Tier 3	$40.00	$120.00	$40.00	$120.00	$40.00 plus cost differential (1)
Tier 4	25% coinsurance	25% coinsurance	25% coinsurance	25% coinsurance	25% coinsurance plus cost differential (1)

(1) Cost differential – difference between billed amount and contracted rate.

Once your total drug costs reach $2,830, you will reach your **initial coverage limit**. Your initial coverage limit is calculated by adding payments made by this Plan and you. If other individuals, organizations, current or former employer/union, and another insurance plan or policy help pay for your drugs under this Plan, the amount they spend may count towards your initial coverage limit.

Coverage Gap

After your total drug costs reach $2,830 you, or others on your behalf, will continue to pay the co-payments/coinsurance listed in the table above until your total out-of-pocket costs reach $4,550, and you qualify for catastrophic coverage.

Catastrophic Coverage

All Medicare Prescription Drug Plans include catastrophic coverage for people with high drug costs. In order to qualify for catastrophic coverage, you must spend $4,550 out-of-pocket for the year. When the total amount you have paid toward coinsurance or co-payments and the cost for covered Part D drugs after you reach the initial coverage limit reaches $4,550, you will qualify for catastrophic coverage. During catastrophic coverage you will pay the greater of a) 5% coinsurance or b) $2.50 for generics or drugs that are treated like generics and $6.30 for all other drugs. We will pay the rest.

Vaccine Coverage (including administration)

Our Plan provides coverage for a number of vaccines. There are two parts to our coverage of vaccinations:

- The first part of coverage is the cost of **the vaccine medication itself**. The vaccine is a prescription medication.
- The second part of coverage is for the cost of **giving you the vaccination shot**. (This is sometimes called the "administration" of the vaccine.)

What do you pay for a vaccination?

Some vaccines are considered medical benefits. You can find out about your coverage of these vaccines by going to the *Benefits Chart.*

Other vaccines are considered Part D drugs. You can find these vaccines listed in the plan's *List of Covered Drugs.*

- You will have to pay your Part D copayment for the vaccine itself.
- Our Plan will pay for the cost of giving you the vaccination shot.

How is your out-of-pocket cost calculated?

What type of prescription drug payments count toward your out-of-pocket costs?

The following types of payments for prescription drugs may count toward your out-of-pocket costs and help you qualify for catastrophic coverage as long as the drug you are paying for is a Part D drug or transition drug, on the formulary (or if you get a favorable decision on a coverage-determination request, exception request or appeal), obtained at a network pharmacy (or you have an approved claim from an out-of-network pharmacy), and otherwise meets our coverage requirements:

- Your coinsurance or co-payments up to the initial coverage limit and through the coverage gap
- Payments you made this year under another Medicare prescription drug plan prior to your enrollment in our plan

When you have spent a total of $4,550 for these items, you will reach the catastrophic coverage level.

What type of prescription drug payments will not count toward your out-of-pocket costs?

The amount you pay for your monthly premium does not count toward reaching the catastrophic coverage level. In addition, the following types of payments for prescription drugs **do not count** toward your out-of-pocket costs:

- Prescription drugs purchased outside the United States and its territories
- Prescription drugs not covered by the Plan
- Prescription drugs obtained at an out-of-network pharmacy when that purchase does not meet our requirements for out-of-network coverage
- Prescription drugs covered by Part A or Part B
- Non-Part D drugs that are covered under our additional coverage but are not normally covered in a Medicare Prescription Drug Plan. Payments made for these drugs will also not count toward your initial coverage limit. There is information later in this section on the excluded non-Part D drugs we may cover as part of our additional coverage.

Payments made by the following do not count toward your out-of-pocket costs:

- Group Health Plans;
- Insurance plans and government funded health programs (e.g., TRICARE, the VA, the Indian Health Service, AIDS Drug Assistance Programs); and
- Third party arrangements with a legal obligation to pay for prescription costs (e.g., Workers' Compensation).

Who can pay for your prescription drugs, and how do these payments apply to your out-of-pocket costs?

Except for your premium payments, any payments you make for Part D drugs covered by us count toward your out-of-pocket costs and will help you qualify for catastrophic coverage. In addition, when the following individuals or organizations pay your costs for such drugs, these payments will count toward your out-of-pocket costs and will help you qualify for catastrophic coverage:

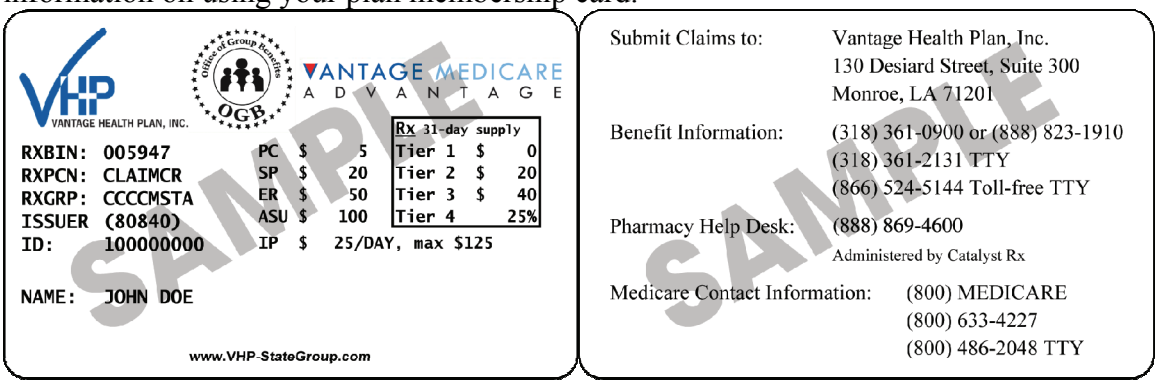
- Family members or other individuals;
- Qualified State Pharmacy Assistance Programs (SPAPs) (SPAPs have different names in different states. See Section 8 for the name and phone number for the SPAP in your area.)
- Medicare programs that provide extra help with prescription drug coverage; and
- Most charities or charitable organizations that pay cost-sharing on your behalf. Please note that if the charity is established, run or controlled by your current or former employer or union, the payments usually will not count toward your out-of-pocket costs.

If you have coverage from a third party, such as those listed above, that pays a part of or all of your out-of-pocket costs, you must let us know.

We will be responsible for keeping track of your out-of-pocket expenses and will let you know when you have qualified for catastrophic coverage. If you are in a coverage gap and have purchased a covered Part D drug at a network pharmacy under a special price or discount card that is outside the Plan's benefit, you may submit documentation and have it count towards qualifying you for catastrophic coverage. In addition, for every month in which you purchase covered prescription drugs through us, you will get an Explanation of Benefits that shows your out-of-pocket cost amount to date.

Sample plan membership card

Here is an example of what your plan membership card looks like. See Section 1 for more information on using your plan membership card.



General Exclusions

Introduction

The purpose of this part of Section 9 is to tell you about medical care and services, items, and drugs that are not covered ("are excluded") or are limited by our Plan. The list below tells about these exclusions and limitations. The list describes services, items, and drugs that are not covered under any conditions, and some services that are covered only under specific conditions. (The Benefits Chart earlier also explains about some restrictions or limitations that apply to certain services).

If you get services, items or drugs that are not covered, you must pay for them yourself

We will not pay for the exclusions that are listed in this section (or elsewhere in this EOC), and neither will the Original Medicare Plan, unless they are found upon appeal to be services, items, or drugs that we should have paid or covered (appeals are discussed in Section 4).

What services are not covered or are limited by our Plan?

In addition to any exclusions or limitations described in the Benefits Chart, or anywhere else in this EOC, **the following items and services are not covered under the Original Medicare Plan or by our plan:**

1. Services that are not reasonable and necessary, according to the standards of the Original Medicare Plan, unless these services are otherwise listed by our Plan as a covered service.
2. Experimental or investigational medical and surgical procedures, equipment and medications, unless covered by the Original Medicare Plan or unless, for certain services, the procedures are covered under an approved clinical trial. Experimental procedures and items are those items and procedures determined by our Plan and the Original Medicare Plan to not be generally accepted by the medical community. See Section 2 for more information on clinical trials.
3. Surgical treatment of morbid obesity unless medically necessary and covered under the Original Medicare plan.
4. Private room in a hospital, unless medically necessary.
5. Private duty nurses.
6. Personal convenience items, such as a telephone or television in your room at a hospital or skilled nursing facility.
7. Nursing care on a full-time basis in your home.
8. Custodial care unless it is provided in conjunction with covered skilled nursing care and/or skilled rehabilitation services. This includes care that helps people with activities of daily living like walking, getting in and out of bed, bathing, dressing, eating and using the bathroom, preparation of special diets, and supervision of medication that is usually self-administered.

9. Homemaker services, including basic household assistance such as light housekeeping or light meal prepraration.
10. Fees charged by immediate relatives or members of your household.
11. Meals delivered to your home.
12. Elective or voluntary enhancement procedures, services, supplies and medications including but not limited to: Weight loss, hair growth, sexual performance, athletic performance, cosmetic purposes, anti-aging and mental performance unless medically necessary.
13. Cosmetic surgery or procedures, unless needed because of accidental injury or to improve the function of a malformed part of the body. All stages of reconstruction are covered for a breast after a mastectomy, as well as for the unaffected breast to produce a symmetrical appearance.
14. Routine dental care (such as cleanings, fillings, or dentures) or other dental services. However, non-routine dental services received at a hospital may be covered.
15. Chiropractic care is generally not covered under the Plan, (with the exception of manual manipulation of the spine,) and is limited according to Medicare guidelines.
16. Routine foot care is generally not covered under the Plan, except for limited coverage provided according to Medicare coverage guidelines.
17. Orthopedic shoes unless they are part of a leg brace and are included in the cost of the brace. Exception: Therapeutic shoes are covered for people with diabetic foot disease.
18. Supportive devices for the feet. Exception: Orthopedic or therapeutic shoes are covered for people with diabetic foot disease.
19. Hearing aids and routine hearing examinations.
20. Eyeglasses (except after cataract surgery), routine eye examinations, radial keratotomy, LASIK surgery, vision therapy and other low vision aids and services.
21. Self-administered prescription medication for the treatment of sexual dysfunction, including erectile dysfunction, impotence, and anorgasmy or hyporgasmy.
22. Reversal of sterilization procedures, sex change operations, and non-prescription contraceptive supplies and devices.
23. Acupuncture.
24. Naturopath services (uses natural or alternative treatments).
25. Services provided to veterans in Veterans Affairs (VA) facilities. However, in the case of emergency services received at a VA hospital, if the VA cost-sharing is more than the cost-sharing required under our Plan, we will reimburse veterans for the difference. Members are still responsible for our Plan cost-sharing amount.
26. Any of the services listed above that are not covered will remain not covered even if received at an emergency facility. For example, non-authorized, routine conditions that do not appear to a reasonable person to be based on a medical emergency are not covered if received at an emergency facility.
27. There is a $5,000 out-of-network limit for services received from non-plan providers, unless that non-plan provider is being treated as an in-plan provider.

Excluded Drugs

This part of Section 9 talks about drugs that are “excluded,” meaning they are not normally covered by a Medicare drug plan. If you get drugs that are excluded, you must pay for them yourself. We will not pay for the exclusions that are listed in this section (or elsewhere in this

EOC), and neither will the Original Medicare Plan, unless they are found upon appeal to be drugs that we should have paid or covered (appeals are discussed in Section 4).

- A Medicare Prescription Drug Plan can not cover a drug that would be covered under Medicare Part A or Part B.
- A Medicare Prescription Drug Plan can not cover a drug purchased outside the United States and its territories.
- A Medicare Prescription Drug Plan can cover off-label uses (meaning for uses other than those indicated on a drug's label as approved by the Food and Drug Administration) of a prescription drug only in cases where the use is supported by certain reference-book citations. Congress specifically listed the reference books that list whether the off-label use would be permitted. (These reference books are: American Hospital Formulary Service Drug Information, the DRUGDEX Information System, and USPDI or its successor.) If the use is not supported by one of these reference books, known as compendia, then the drug is considered a non-Part D drug and cannot be covered by our Plan.

In addition, by law, certain types of drugs or categories of drugs are not normally covered by Medicare Prescription Drug Plans. These drugs are not considered Part D drugs and may be referred to as "exclusions" or "non-Part D drugs." These drugs include:

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

If you receive extra help, your state Medicaid program may cover some prescription drugs not normally covered in a Medicare drug plan. Please contact your state Medicaid program to determine what drug coverage may be available to you.

10. Asking the Plan to Pay Its Share of a Bill You Have Received for Covered Services or Drugs

Situations in which you should ask our plan to pay our share of the cost of your covered services or drugs

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

Sometimes when you get medical care or a prescription drug, 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 have paid more than your share of the cost for medical services or drugs 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 have received emergency or urgently needed medical care from a provider who is not in our plan's network

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

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

- If you have already paid more than your share of the cost of the service, we will determine how much you owed and pay you back for our share of the cost.

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

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

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

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

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

- Save your receipt and send a copy to us when you ask us to pay you back for our share of the cost.

4. When you pay the full cost for a prescription because you do not have your plan membership card with you

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

- Save your receipt and send a copy to us when you ask us to pay you back for our share of the cost.

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

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

- For example, the drug may not be on the plan's *List of Covered Drugs (Formulary)*; or it could have a requirement or restriction that you did not know about or do not think should apply to you. If you decide to get the drug immediately, you may need to pay the full cost for it.

- Save your receipt and send a copy to us when you ask us to pay you back. In some situations, we may need to get more information from your doctor in order to pay you back for our share of the cost.

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. Section 4 of this booklet (*What to do if you have a problem or complaint*) has information about how to make an appeal.

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

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 is 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 do not have to use the form, but it is helpful for our plan to process the information faster.
- Either download a copy of the form from our website (www.vhp-medicare.com) or call Member Services and ask for the form. The phone numbers for Member Services are on the cover of this booklet.

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

130 DeSiard Street, Suite 300, Monroe, LA 71201

Please be sure to contact Member Services if you have any questions. If you do not know what you owe, or you receive bills and you do not 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.

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

We check to see whether we should cover the service or drug 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 decide whether to pay it and how much we owe.

- If we decide that the medical care or drug is covered and you followed all the rules for getting the care or drug, we will pay for our share of the cost. If you have already paid for the service or drug, we will mail your reimbursement of our share of the cost to you. If you have not paid for the service or drug yet, we will mail the payment directly to the provider. (Sections 2 and 9 explain the rules you need to follow for getting your medical services and Part D prescription drugs.)
- If we decide that the medical care or drug is *not* covered, or you did *not* follow all the rules, we will not pay for 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.

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

If you think we have made a mistake in turning down your request for payment, 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 Section 4 of this booklet (*What to do if you have a problem or complaint*). The appeals process is a legal process with detailed procedures and important deadlines. If making an appeal is new to you, you will find it helpful to start by reading Section 4 (D). Section 4 (D) 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 (D), you can go to Section 4 (E-H) 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 4 (E).
- If you want to make an appeal about getting paid back for a drug, go to Section 4 (F).

Other situations in which you should save your receipts and send them to the plan

In some cases, you should send your receipts to the plan to help us track your out-of-pocket drug costs

There are some situations when you should let us know about payments you have made for your drugs. In these cases, you are not asking us for payment. Instead, you are telling us about your payments so that we can calculate your out-of-pocket costs correctly. This may help you to qualify for the Catastrophic Coverage Stage more quickly.

Here are two situations when you should send us receipts to let us know about payments you have made for your drugs:

1. When you buy the drug for a price that is lower than the plan's price

Sometimes, you can buy your drug **at a network pharmacy** for a price that is lower than the plan's price.

- For example, a pharmacy might offer a special price on the drug. Or you may have a discount card that is outside the plan's benefit that offers a lower price.
- Unless special conditions apply, you must use a network pharmacy in these situations and your drug must be on our Drug List.
- Save your receipt and send a copy to us so that we can have your out-of-pocket expenses count toward qualifying you for the Catastrophic Coverage Stage.

2. When you get a drug through a patient assistance program offered by a drug manufacturer

Some members are enrolled in a patient assistance program offered by a drug manufacturer that is outside the plan benefits. If you get any drugs through a program offered by a drug manufacturer, you may pay a copayment to the patient assistance program.

- Save your receipt and send a copy to us so that we can have your out-of-pocket expenses count toward qualifying you for the Catastrophic Coverage Stage.
- **Please note:** Because you are getting your drug through the patient assistance program and not through the plan's benefits, the plan will not pay for any share of these drug costs. But sending the receipt allows us to calculate your out-of-pocket costs correctly and may help you qualify for the Catastrophic Coverage Stage more quickly.

Since you are not asking for payment in the two cases described above, these situations are not considered coverage decisions. Therefore, you cannot make an appeal if you disagree with our decision.

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