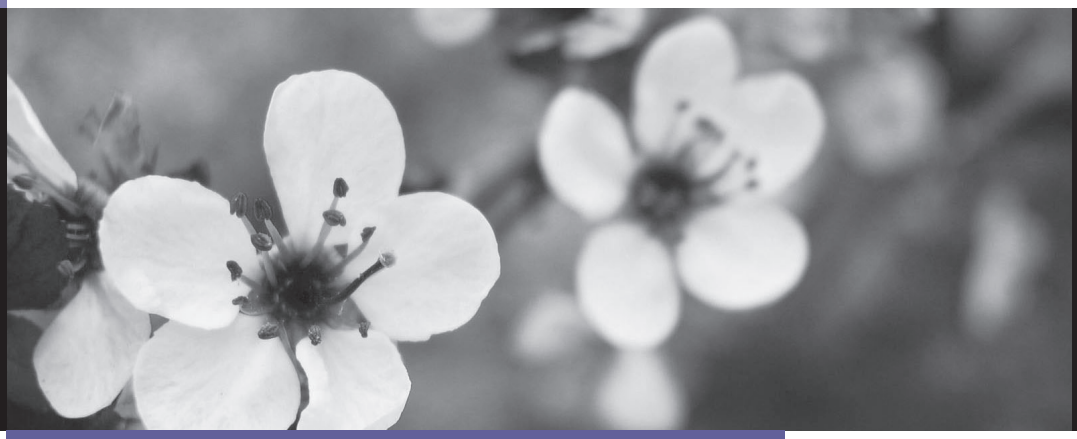
University of California

Sacramento, Yolo and Placer Counties

YOUR MEDICARE HEALTH BENEFITS
AND SERVICES AS A MEMBER OF WHA *CARE+*.

WHA *Care*+



Evidence of Coverage

January 1, 2009 — December 31, 2009

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.

WHA *Care*+ Member Services:
For help or information, please call Member Services at (916) 563-2252 or toll free at (888) 563-2252. TTY/TDD users should call (888) 877-5378. For any Medicare Advantage inquires, Member Services Representatives are available from 8:00 a.m. to 5:00 p.m., Monday through Friday. An interactive voice response system will be available from 5:00 p.m. to 8:00 p.m., Monday through Friday, and from 8:00 a.m. to 8:00 p.m. on weekends and holidays.

Calls to these numbers are free:
888.563.2252
TTY: 888.877.5378

Western Health Advantage

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Changes for 2009

Please make note of the following changes and/or clarifications to your plan effective January 1, 2009.

Changes

General Changes throughout the Booklet

Plan effective date changed from January 1, 2008 to January 1, 2009 ..... All pages

WHA Member Services contact information appears at the bottom of every page ..... All pages

Other Changes

Text under "Eligibility, Enrollment, Termination and Plan Administration Provisions" has been reorganized to improve readability and clarity 6-17

Changes to text describing eligibility requirements for a child 7-8

Moved language describing an involuntary loss of coverage 13-14

Added new text describing an involuntary loss of coverage 13-14

Added language clarifying disenrollment due to loss of eligible status 13-14

Added language clarifying date of termination if due to fraud 14

Deleted language stating that Subscriber and other Family Members would be disenrolled for 12 months if a Family Member commits fraud 14

Added paragraph describing the Grace Period 14-15

Index of commonly-used terms was modified to reflect usage in text and include more terms for reader-friendliness 102-103

If you have any questions, please feel free to contact our Member Services Department at one of the numbers listed below, Monday through Friday between 8 a.m. and 5 p.m.

1. Introduction

Thank you for being a member of our Plan!

This is your Evidence of Coverage which explains how to get your Medicare services through our Plan, a HMO. You are still covered by Medicare, but you are getting your health care and/or Medicare prescription drug coverage through our Plan.

This Evidence of Coverage, together with your enrollment form 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, 2009, through December 31, 2009.

This Evidence of Coverage will explain to you:

- What is covered by our Plan and what isn't 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 that are available including your options for continuing Medicare prescription drug coverage.

If you need this Evidence of Coverage in Spanish, please call us so we can send you a copy.

This Section of the EOC has important information about:

- 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

The geographic service area for our Plan

The counties and parts of counties in our service area are listed below.

Sacramento – All Zip Codes

Yolo – All Zip Codes

Placer, the following Zip Codes only:

95765, 95677, 95650, 95746, 95661, 95678, 95747

How do I keep my membership record up to date?

We have a membership record about you as a plan member. 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/Medical Group/IPA you chose when you enrolled and other information. Doctors, hospitals, pharmacists, and other plan providers use this membership record to know what services or drugs are covered for you. Section 4 tells how we protect the privacy of your personal health information. Please help us keep your membership record up to date by letting Member Services know if there are changes to your name, address, or phone number, or if you go into a nursing home. Also, tell Member Services about any changes in health insurance coverage you have, such as from your employer, your spouse's employer, workers' compensation, Medi-Cal, or liability claims such as claims from an automobile accident.

Materials that you will receive from our Plan

Membership ID card

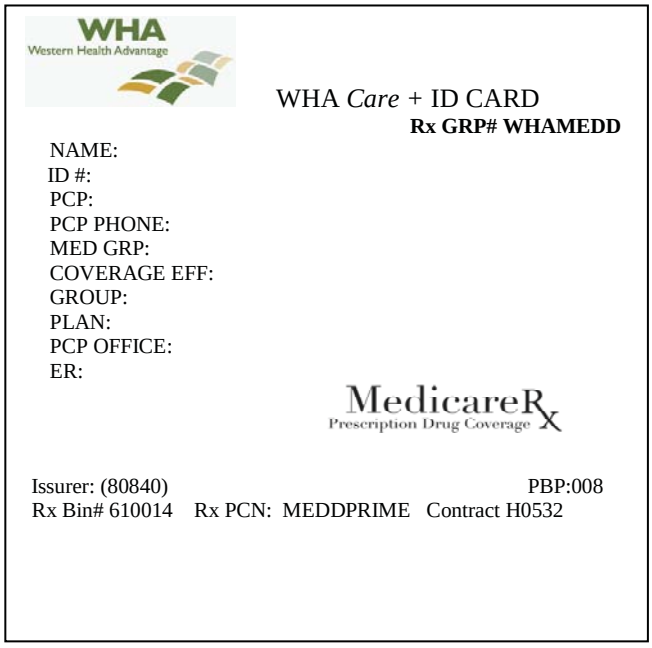
While you are a member of our Plan, you must use our membership ID card for services covered by this plan and/or prescription drug coverage at network pharmacies. While you are a member of our Plan you must not use your red, white, and blue Medicare card to get covered services, items and drugs. Keep 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 your WHA Care+ membership ID card while you are a plan member, the Medicare Program won't pay for these services and you may have to pay the full cost yourself.

Please carry your WHA Care+ membership ID card with you at all times and remember to show your card when you get covered services, items and drugs. If your membership ID card is damaged, lost, or stolen, call Member Services right away and we will send you a new card.

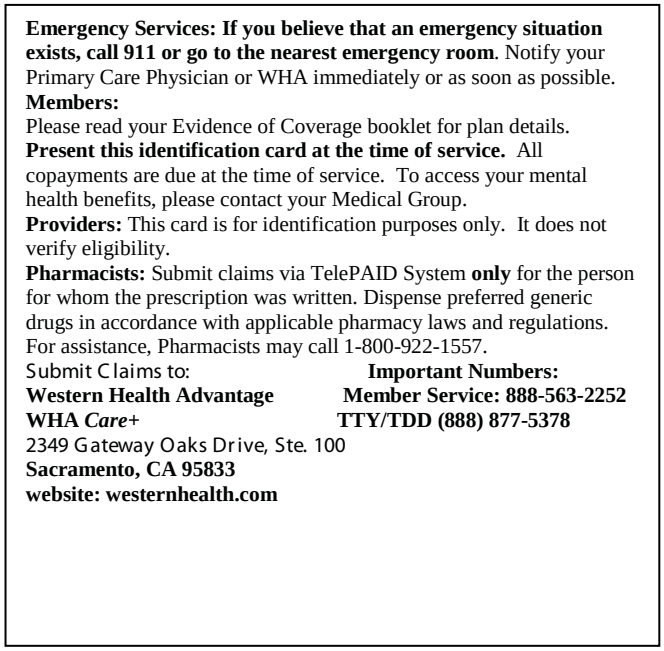
On the following page is an example of what your plan membership card looks like. See above for more information on using your plan membership ID card.

SAMPLE ID CARD

FRONT OF ID CARD



BACK OF ID CARD



The Provider Directory gives you a list of network providers

Every year that you are a member of our Plan, we will send you a Provider Directory, which list our Plan providers. If you don't have the Provider Directory, you can get a copy from Member Services. Contact information is listed at the bottom of this page. A complete list of plan providers is available on our website at westernhealth.com.

You may ask Member Services for more information about Plan providers, including their qualifications and experience. Member Services can give you the most up-to-date information about changes in plan providers and about which ones are accepting new patients.

Part D Explanation of Benefits

What is the Explanation of Benefits?

The Explanation of Benefits is a document you will get 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. You will get your Explanation of Benefits in the mail each month that you use the benefits that we provide. You will not get an Explanation of Benefits if you don't use any benefits that month.

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:

1) A list of prescriptions you filled during the month, as well as the amount paid for each prescription;

2) Information about how to request an exception and appeal our coverage decisions;

3) 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;

4) A summary of your coverage this year, including information about:

- **Annual Deductible** -The amount paid before you start getting prescription coverage.
- **Amount Paid For Prescriptions** -The amounts paid that count towards your initial coverage limit.
- **Total Out-Of-Pocket Costs that count towards 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 deductible, co-payments and co-insurance, 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, government funded health program or other excluded parties.)

Monthly Plan Premium Payment

Your monthly plan premium

As a member of our Plan, you pay a monthly plan premium, (unless you qualify for full extra help, called the Low-Income Subsidy or LIS, from Medicare.)

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".

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 prescription co-payments. If you qualify, this extra help will count toward your out-of-pocket costs.

Do you qualify for extra help?

People with limited income and resources may qualify for extra help one of two ways. The amount of extra help you get will depend on your income and resources.

1) You automatically qualify for extra help and don't need to apply. If you have full coverage from a state Medi-Cal program, get help from Medi-Cal paying your Medicare premiums (belong to a Medicare Savings Program), or get Supplemental Security Income benefits, you automatically qualify for extra help and do not have to apply for it. Medicare mails letters monthly to people who automatically qualify for extra help.

2) You apply and qualify for extra help. You may qualify if your yearly income in 2008 is less than $15,600 (single with no dependents) or $21,000 (married and living with your spouse with no dependents), and your resources are less than $11,990 (single) or $23,970 (married and living with your spouse. These resource amounts include $1,500 per person for burial expenses. Resources include your savings and stocks but not your home or car. If you think you may qualify, call Social Security at 1-800-772-1213 (TTY users should call 1-800-325-0778) or visit www.socialsecurity.gov on the Web. You may also be able to apply at your State Medical Assistance (Medi-Cal) office. After you apply, you will get a letter in the mail letting you know if you qualify and what you need to do next.

The above income and resource amounts are for 2008 and will change in 2009. If you live in Alaska or Hawaii, or pay at least half of the living expenses of dependent family members, income limits are higher.

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 those who Receive Extra Help Paying for their 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 those who Receive Extra Help Paying for their Prescription Drugs".

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

If you believe you have qualified for extra help and you believe that you are paying an incorrect copayment 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.

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

Important Information

We will send you a Coordination of Benefit (COB) form so that we can know what other health and or drug coverage you have besides our Plan. Medicare requires us to collect this information from you, so when you get the form, please fill it out and send it back. If you have additional health or drug coverage, you must provide that information to our Plan. The information you provide helps us calculate how much you and others have paid for your prescription drugs. In addition, if you lose or gain additional health or prescription drug coverage, please call Member Services to update your membership records.

2. Eligibility, Enrollment, Termination and Plan Administration Provisions

The following information applies to the University of California plan and supersedes any corresponding information that may be contained elsewhere in the document to which this insert is attached. The University establishes its own medical plan eligibility, enrollment and termination criteria based on the University of California Group Insurance Regulations ("Regulations") and any corresponding Administrative Supplements. Portions of these Regulations are summarized below.

Eligibility

The following individuals are eligible to enroll in this Plan. If the Plan is a Health Maintenance Organization (HMO) or Exclusive Provider Organization (EPO) Plan, they are only eligible to enroll in the Plan if they meet the Plan's geographic service area criteria. Anyone enrolled in a non-University Medicare Advantage Managed Care contract or enrolled in a non-University Medicare Part D Prescription Drug Plan will be deenrolled from this health plan.

Subscriber Employee

You are eligible if you are appointed to work at least 50% time for twelve months or more or are appointed at 100% time for three months or more or have accumulated 1,000* hours while on pay status in a twelve-month period. To remain eligible, you must maintain an average regular paid time** of at least 17.5 hours per week and continue in an eligible appointment. If your appointment is at least 50% time, your appointment form may refer to the time period as follows: "Ending date for funding purposes only; intent of appointment is indefinite (for more than one year)."

* Lecturers - see your benefits office for eligibility.

** Average Regular Paid Time - For any month, the average number of regular paid hours per week (excluding overtime, stipend or bonus time) worked in the preceding twelve (12) month period. Average regular paid time does not include full or partial months of zero paid hours when an employee works less than 43.75% of the regular paid hours available in the month due to furlough, leave without pay or initial employment.

Retiree

A former University Employee receiving monthly benefits from a University-sponsored defined benefit plan.

You may continue University medical plan coverage as a Retiree when you start collecting retirement or disability benefits from a University-sponsored defined benefit Plan. You must also meet the following requirements:

a) you meet the University's service credit requirements for Retiree medical eligibility;

b) the effective date of your Retiree status is within 120 calendar days of the date employment ends; and

c) you elect to continue medical coverage at the time of retirement.

A **Survivor** - a deceased Employee's or Retiree's Family Member receiving monthly benefits from a University-sponsored defined benefit plan—may be eligible to continue coverage as set forth in the University's Group Insurance Regulations. For more information, see the UC Group Insurance Eligibility Factsheet for Retirees and Eligible Family Members.

If you are eligible for Medicare, you must follow UC's Medicare Rules. See "Effect of Medicare on Retiree Enrollment" below.

Eligible Dependents (Family Members)

When you enroll any Family Member, your signature on the enrollment form or the confirmation number on your electronic enrollment attests that your Family Member meets the eligibility requirements outlined below. The University and/or the Plan reserves the right to periodically request documentation to verify eligibility of Family Members, including any who are required to be your tax dependent(s). Documentation could include a marriage certificate, birth certificate(s), adoption records, Federal Income Tax Return, or other official documentation.

Spouse: Your legal spouse.

Child: All eligible children must be under the limiting age (18 for legal wards, 23 for all others except for a child who is incapable of self-support due to a physical or mentally disabling injury, illness or condition), unmarried, and may not be emancipated minors. The following categories are eligible:

a) your natural or legally adopted children;

b) your stepchildren (natural or legally adopted children of your spouse) if living with you, dependent on you or your spouse for at least 50% of their support and are your or your spouse's dependents for income tax purposes;

c) grandchildren of you or your spouse if living with you, dependent on you or your spouse for at least 50% of their support and are your or your spouse's dependents for income tax purposes;

d) children for whom you are the legal guardian if living with you, dependent on you for at least 50% of their support and are your dependents for income tax purposes.

e) children for whom you are legally required to provide group health insurance pursuant to an administrative or court order. (Child must also meet UC eligibility requirements.)

Any child described above (except a legal ward) who is incapable of self-support due to a physical or mental disability may continue to be covered past age 23 provided:

- the incapacity began before age 23, the child was enrolled in a group medical plan before age 23 and coverage is continuous;

- the child is chiefly dependent upon you for support and maintenance;

- the child is claimed as your dependent for income tax purposes or is eligible for Social Security Income or Supplemental Security Income as a disabled person or working in supported employment which may offset the Social Security or Supplemental Security Income; and

- the child lives with you if he or she is not your or your spouse's natural or adopted child.

The Plan will notify the Employee that the child's coverage will end when the child reaches a University-sponsored medical plan's upper age limit at least 90 days prior to the date the child reaches that age. Application for extended coverage must be made to the Plan within 60 days of the date the Notice is mailed. If Plan does not complete determination of the child's continuing eligibility by the date the child reaches the Plan's upper age limit, the child will remain covered pending Plan's determination. The Plan may periodically request proof of continued disability, but not more than once a year after the initial certification. Incapacitated children approved for continued coverage under a University-sponsored medical plan are eligible for continued coverage under any other University-sponsored medical plan; if enrollment is transferred from one plan to another, a new application for continued coverage is not required.

If you are a newly hired Employee with an incapacitated child, you may also apply for coverage for that child. If age 23 or more, the child must have had continuous group medical coverage since age 23, and you must apply for University coverage during your Period of Initial Eligibility. The Plan may ask for proof that the child is still incapable of self-support due to a physical or mentally disabling injury, illness or condition, but not more than once a year after the initial certification.

You may enroll a same-sex domestic partner (and the same-sex domestic partner's children/grandchildren/stepchildren) as set forth in the University of California Group Insurance Regulations.

Other Eligible Dependents (Family Members)

The University recognizes an opposite-sex domestic partner as a family member that is eligible for coverage in UC-sponsored benefits if the employee/retiree or domestic partner is age 62 or older and eligible to receive Social Security benefits and both the employee/retiree and domestic partner are at least 18 years of age.

An adult dependent relative is no longer eligible for coverage. Only an adult dependent relative who was enrolled as an eligible dependent as of December 31, 2003 may continue coverage in UC-sponsored plans.

No Dual Coverage

Eligible individuals may be covered under only one of the following categories: as an Employee, a Retiree, a Survivor or a Family Member, but not under any combination of these. If an Employee and the Employee's spouse or domestic partner are both eligible Subscribers, each may enroll separately or one may cover the other as a Family Member. If they enroll separately, neither may enroll the other as a Family Member. Eligible children may be enrolled under either parent's or eligible domestic partner's coverage but not under both. Additionally, a child who is also eligible as an Employee may not have dual coverage through two University-sponsored medical plans.

More Information

For information on who qualifies and how to enroll, contact your local Benefits Office or the University of California's Customer Service Center. You may also access eligibility factsheets on the web site: http://atyourservice.ucop.edu.

Enrollment

For information about enrolling yourself or an eligible Family Member, see the person at your location who handles benefits. If you are a Retiree, contact the University's Customer Service Center. Enrollment transactions may be completed by paper form or electronically, according to current University practice. To complete the enrollment transaction, paper forms must be received by the local Accounting or Benefits office or by the University's Customer Service Center by the last business day within the applicable enrollment period; electronic transactions must be completed by midnight of the last day of the enrollment period.

During a Period of Initial Eligibility (PIE)

A PIE ends 31 days after it begins.

If you are an Employee, you may enroll yourself and any eligible Family Members during your PIE. Your PIE starts the day you become an eligible Employee.

You may enroll any newly eligible Family Member during his or her PIE. The Family Member's PIE starts the day your Family Member becomes eligible, as described below. During this PIE you may also enroll yourself and/or any other eligible Family Member if not enrolled during your own or their own PIE. You must enroll yourself in order to enroll any eligible Family Member. Family members are only eligible for the same plan in which you are enrolled.

a) For a spouse, on the date of marriage.

b) For a natural child, on the child's date of birth.

c) For an adopted child, the earlier of:

   - the date you or your Spouse has the legal right to control the child's health care, or
   - the date the child is placed in your physical custody.

   If the child is not enrolled during the PIE beginning on that date, there is an additional PIE beginning on the date the adoption becomes final.

d) Where there is more than one eligibility requirement, the date all requirements are satisfied.

If you are in a Health Maintenance Organization (HMO), Exclusive Provider Organization (EPO), or Point of Service (POS) Plan and you move or are transferred out of that Plan's service area, or will be away from the Plan's service area for more than two months, you will have a PIE to enroll yourself and your eligible Family Members in another University medical plan. Your PIE starts with the effective date of the move or the date you leave the Plan's service area.

At Other Times for Employees and Retirees

You and your eligible Family Members may also enroll during a group open enrollment period established by the University.

If you are an Employee and opt out of medical coverage or fail to enroll yourself during a PIE or open

enrollment period, you may enroll yourself at any other time upon completion of a 90 consecutive calendar day waiting period.

If you are an Employee or Retiree and fail to enroll your eligible Family Members during a PIE or open enrollment period, you may enroll your eligible Family Members at any other time upon completion of a 90 consecutive calendar day waiting period.

The 90-day waiting period starts on the date the enrollment form is received by the local Accounting or Benefits office and ends 90 consecutive calendar days later.

If you have one or more children enrolled in the Plan, you may add a newly eligible Child at any time. See "Effective Date".

You may enroll without waiting for the University's next open enrollment period if you are otherwise eligible under any one of the circumstances set forth below:

1) You have met all of the following requirements:

    a. You were covered under another health plan as an individual or dependent, including coverage under a COBRA or Cal-COBRA continuation, the Healthy Families Program, or no share-of-cost Medi-Cal coverage.

    b. You certified in writing at the time you became eligible for coverage under this Plan that you were declining coverage under this Plan or disenrolling because you were covered under another health plan as stated above and you were given written notice that if you choose to enroll later, you may be required to wait until the University's next open enrollment period to do so.

    c. Your coverage under the other health plan wherein you were covered as an individual or dependent ended because you lost eligibility under the other plan or employer contributions toward coverage under the other plan terminated, your coverage under a COBRA or Cal-COBRA continuation was exhausted, you lost coverage under the Healthy Families Program as a result of exceeding the program's income or age limits, or you lost no-share-of-cost Medi-Cal coverage.

    d. You properly file an application with the University within 31 days from the date on which you lose coverage.

2) A court has ordered coverage be provided for a spouse, domestic partner or dependent child under your UC-sponsored medical plan and an application is filed within 31 days from the date the court order is issued. (Family member(s) must also meet UC eligibility requirements.)

3) You have a change in family status through marriage or domestic partnership, or the birth, adoption, or placement for adoption of a child:

    a. If you are enrolling following marriage or domestic partnership, you and your new spouse or domestic partner must enroll within 31 days of the date of marriage or domestic partnership. Your new spouse or domestic partner's eligible children may also enroll at that time. Other children may not enroll at that time unless they qualify under another of these circumstances listed above. Coverage will be effective as of the date of marriage or domestic partnership.

    b. If you are enrolling following the birth, adoption, or placement for adoption of a child, your spouse

(if you are already married) or domestic partner, who is eligible but not enrolled, may also enroll at that time. Other children may not enroll at that time unless they qualify under another of these circumstances listed above. Application must be made within 31 days of the birth or date of adoption or placement for adoption; coverage will be effective as of the date of birth, adoption, or placement for adoption.

4) You meet or exceed a lifetime limit on all benefits under another health plan. Application must be made within 31 days of the date a claim or a portion of a claim is denied due to your meeting or exceeding the lifetime limit on all benefits under the other plan. Coverage will be effective on the first day of the month following the date you file the enrollment application.

If you are an Employee or a Retiree and there is a lifetime maximum for all benefits under this plan, and you or a Family Member reaches that maximum, you and your eligible Family Members may be eligible to enroll in another UC-sponsored medical plan. Contact the person who handles benefits at your location (or the University's Customer Service Center if you are a Retiree).

If you are a Retiree, you may continue coverage for yourself and your enrolled Family Members in the same plan (or its Medicare version) you were enrolled in immediately before retiring. You must elect to continue enrollment for yourself and enrolled Family Members before the effective date of retirement (or the date disability or survivor benefits begin).

If you are a Survivor, you may not enroll your legal spouse or domestic partner.

Effective Date

The following effective dates apply provided the appropriate enrollment transaction (paper form or electronic) has been completed within the applicable enrollment period.

If you enroll during a PIE, coverage for you and your Family Members is effective the date the PIE starts.

If you are a Retiree continuing enrollment in conjunction with retirement, coverage for you and your Family Members is effective on the first of the month following the first full calendar month of retirement income.

The effective date of coverage for enrollment during an open enrollment period is the date announced by the University.

For enrollees who complete a 90-day waiting period, coverage is effective on the 91st consecutive calendar day after the date the enrollment transaction is completed.

An Employee or Retiree already enrolled in adult plus child(ren) or family coverage may add additional children, if eligible, at any time after their PIE. Retroactive coverage is limited to the later of:

1) the date the Child becomes eligible, or

2) a maximum of 60 days prior to the date your Child's enrollment transaction is completed.

Change in Coverage

In order to change from single to adult plus child(ren) coverage, or two adult coverage, or family coverage, or to add another Child to existing family coverage, contact the person who handles benefits at your location (or

the University's Customer Service Center if you are a Retiree).

Effect of Medicare on Retiree Enrollment

If you are a Retiree and you and/or an enrolled Family Member is or becomes eligible for premium-free Medicare Part A (Hospital Insurance) as primary coverage, then that individual must also enroll in and remain in Medicare Part B (Medical Insurance). Once Medicare coverage is established, coverage in both Part A and Part B must be continuous. This includes anyone who is entitled to Medicare benefits through their own or their spouse's employment. Individuals enrolled in both Part A and Part B are then eligible for the Medicare premium applicable to this plan.

Retirees or their Family Member(s) who become eligible for premium-free Medicare Part A on or after January 1, 2004 and do not enroll in Part B will permanently lose their UC-sponsored medical coverage.

Retirees and their Family Members who were eligible for premium-free Medicare Part A prior to January 1, 2004, but declined to enroll in Part B of Medicare, are assessed a monthly offset fee by the University to cover increased costs. The offset fee may increase annually, but will stop when the Retiree or Family Member becomes covered under Part B.

Retirees or Family Members who are not eligible for premium-free Part A will not be required to enroll in Part B, they will not be assessed an offset fee, nor will they lose their UC-sponsored medical coverage. Documentation attesting to their ineligibility for Medicare Part A will be required. (Retirees/Family Members who are not entitled to Social Security and premium-free Medicare Part A will not be required to enroll in Part B.)

An exception to the above rules applies to Retirees or Family Members in the following categories who will be eligible for the non-Medicare premium applicable to this plan and will also be eligible for the benefits of this plan without regard to Medicare:

a) Individuals who were eligible for premium-free Part A, but not enrolled in Medicare Part B prior to July 1, 1991.

b) Individuals who are not eligible for premium-free Part A.

You should contact Social Security three months before your or your Family Member's 65th birthday to inquire about your eligibility and how to enroll in the Hospital (Part A) and Medical (Part B) portions of Medicare. If you qualify for disability income benefits from Social Security, contact a Social Security office for information about when you will be eligible for Medicare enrollment.

Upon Medicare eligibility, you or your Family Member must complete a University of California Medicare Declaration form, as well as submit a copy of your Medicare card. This notifies the University that you are covered by Part A and Part B of Medicare. The University's Medicare Declaration form is available through the University's Customer Service Center or from the web site: http://atyourservice.ucop.edu. Completed forms should be returned to University of California, Human Resources and Benefits, Health & Welfare Administration-Retiree Insurance Program, Post Office Box 24570, Oakland, CA 94623-1570.

Any individual enrolled in a University-sponsored Medicare Advantage Managed Care Contract must assign his/her Medicare benefit to that plan or lose UC-sponsored medical coverage. Anyone enrolled in a non-University Medicare Advantage Managed Care contract will be disenrolled from this health plan. Anyone enrolled in a non-University Medicare Part D Prescription Drug Plan will be disenrolled from this health plan.

Medicare Secondary Payer Law (MSP)

The Medicare Secondary Payer (MSP) Law affects the order in which claims are paid by Medicare and an employer group health plan. UC Retirees re-hired into positions making them eligible for UC-sponsored medical coverage, including CORE and mid-level benefits, are subject to MSP. For Employees or their spouses who are age 65 or older and eligible for a group health plan due to employment, MSP indicates that Medicare becomes the secondary payer and the employer plan becomes the primary payer. You should carefully consider the impact on your health benefits and premiums should you decide to return to work after you retire.

Medicare Private Contracting Provision and Providers Who do Not Accept Medicare

Federal Legislation allows physicians or practitioners to opt out of Medicare. Medicare beneficiaries wishing to continue to obtain services (**that would otherwise be covered by Medicare**) from these physicians or practitioners will need to enter into written "private contracts" with these physicians or practitioners. These private agreements will require the beneficiary to be responsible for all payments to such medical providers. Since services provided under such "private contracts" are not covered by Medicare or this Plan, the Medicare limiting charge will not apply.

Some physicians or practitioners have **never** participated in Medicare. Their services (that would be covered by Medicare if they participated) will not be covered by Medicare or this Plan, and the Medicare limiting charge will not apply.

If you are classified as a Retiree by the University (or otherwise have Medicare as a primary coverage), are enrolled in Medicare Part B, and choose to enter into such a "private contract" arrangement as described above with one or more physicians or practitioners, or if you choose to obtain services from a provider who does not participate in Medicare, under the law you have in effect "opted out" of Medicare for the services provided by these physicians or other practitioners. In either case, no benefits will be paid by this Plan for services rendered by these physicians or practitioners with whom you have so contracted, even if you submit a claim. You will be fully liable for the payment of the services rendered. Therefore, it is important that you confirm that your provider takes Medicare prior to obtaining services for which you wish the Plan to pay.

However, even if you do sign a private contract or obtain services from a provider who does not participate in Medicare, you may still see other providers who have not opted out of Medicare and receive the benefits of this Plan for those services.

Termination of Coverage

The termination of coverage provisions that are established by the University of California in accordance with its Regulations are described below. Additional Plan provisions apply and are described elsewhere in the document.

Disenrollment Due to Loss of Eligible Status

If you are an Employee and lose eligibility, your coverage and that of any enrolled Family Member stops at the end of the last month for which premiums are taken from earnings based on an eligible appointment. If you are hospitalized or undergoing treatment of a medical condition covered by this Plan, benefits will cease to be provided and you may have to pay for the cost of those benefits yourself. You may be entitled to continued benefits under terms which are specified elsewhere under "Extension of Benefits" and "HIPAA Coverage and

Conversion". (If you apply for HIPAA coverage and conversion, the benefits may not be the same as you had under this Plan.)

If you are a Retiree or Survivor and your annuity terminates, your coverage and that of any enrolled Family Member stops at the end of the last month in which you are eligible for an annuity.

If your Family Member loses eligibility, you must complete the appropriate transaction to delete him or her within 60 days of the date the Family Member is no longer eligible. Coverage stops at the end of the month in which he or she no longer meets all the eligibility requirements. For information on disenrollment procedures, contact the person who handles benefits at your location (or the University's Customer Service Center if you are a Retiree).

Disenrollment Due to Fraud

Coverage for you or your Family Members may be terminated for fraud or deception in the use of the services of the Plan, or for knowingly permitting such fraud or deception by another. Such termination shall be effective upon the later of (1) the date shown on the written notice to you; or (2) the date of the mailing of written notice to you (and to the University if notice is given by the Plan). A Family Member who commits fraud or deception will be permanently disenrolled. If you commit fraud or deception, you and any Family Members will be disenrolled for 12 months.

Leave of Absence, Layoff or Retirement

Contact your local Benefits Office for information about continuing your coverage in the event of an authorized leave of absence, layoff or retirement.

Optional Continuation of Coverage

If your coverage or that of a Family Member ends, you and/or your Family Member may be entitled to elect continued coverage under the terms of the federal Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), as amended, and if that continued coverage ends, specified individuals may be eligible for further continuation under California law. The terms of these continuation provisions are contained in the University of California notice "Continuation of Group Insurance Coverage", available from the UC "At Your Service" website (http://atyourservice.ucop.edu). The notice is also available from the person in your department who handles benefits and from the University's Customer Service Center. You may also direct questions about these provisions to your local Benefits Office or to the University's Customer Service Center if you are a Retiree.

Grace Period

There shall be a Grace Period which provides additional time to University to complete full payment of monthly premiums to Plan following the premium Due Date. The Due Date is the date the full premium is due and payable to Plan for a coverage month. The Grace Period shall be in force 31 days following the Due Date. The Agreement shall remain in force during the Grace Period. No penalties or late fees shall be charged by Plan to University during the Grace Period. If the University fails to pay Plan the premiums due during the Grace Period, Plan will not end coverage for covered Employee Members or Family Members until the end of the Grace Period. The Employee Members will not be required by Plan to pay the premiums for the University nor will Members be required to pay more than their copay for any services received during the Grace Period.

If premiums due are not paid by the end of the Grace Period, the Agreement will be canceled as described above. If you are hospitalized or undergoing treatment of a medical condition covered by this Plan, benefits will cease to be provided and you may have to pay for the cost of those benefits yourself. You may be entitled to continued benefits under terms which are specified elsewhere under "Extension of Benefits" and "HIPAA Coverage and Conversion". (If you apply for HIPAA coverage and conversion, the benefits may not be the same as you had under this Plan.)

Plan Administration

By authority of the Regents, University of California Human Resources and Benefits, located in Oakland, California, administers this plan in accordance with applicable plan documents and regulations, custodial agreements, University of California Group Insurance Regulations, group insurance contracts/service agreements, and state and federal laws. No person is authorized to provide benefits information not contained in these source documents, and information not contained in these source documents cannot be relied upon as having been authorized by The Regents. The terms of those documents apply if information in this document is not the same. The University of California Group Insurance Regulations will take precedence if there is a difference between its provisions and those of this document and/or the Group Hospital and Professional Service Agreement. What is written in this document does not constitute a guarantee of plan coverage or benefits--particular rules and eligibility requirements must be met before benefits can be received. Health and welfare benefits are subject to legislative appropriation and are not accrued or vested benefit entitlements.

This section describes how the Plan is administered and what your rights are.

Sponsorship and Administration of the Plan

The University of California is the Plan sponsor and administrator for the Plan described in this booklet. If you have a question, you may direct it to:

University of California
Human Resources and Benefits
Health & Welfare Administration
300 Lakeside Drive, 12th Floor
Oakland, CA 94612
(800) 888-8267

Retirees may also direct questions to the University's Customer Service Center at the above phone number.

Claims under the Plan are processed by Western Health Advantage at the following address and phone number:

Western Health Advantage
2349 Gateway Oaks Dr., Ste. 100
Sacramento, CA 95833
916-563-2252/888-563-2252

Group Contract Number

The Group Contract Number for this Plan is: 001121

Type of Plan

This Plan is a health and welfare plan that provides group medical care benefits. This Plan is one of the benefits offered under the University of California's employee health and welfare benefits program.

Plan Year

The plan year is January 1 through December 31.

Continuation of the Plan

The University of California intends to continue the Plan of benefits described in this booklet but reserves the right to terminate or amend it at any time. Plan benefits are not accrued or vested benefit entitlements. The right to terminate or amend applies to all Employees, Retirees and plan beneficiaries. The amendment or termination shall be carried out by the President or his or her delegates. The University of California will also determine the terms of the Plan, such as benefits, premiums and what portion of the premiums the University will pay. The portion of the premiums that University pays is determined by UC and may change or stop altogether, and may be affected by the state of California's annual budget appropriation.

Financial Arrangements

The benefits under the Plan are provided by Western Health Advantage under a Group Service Agreement.

The plan costs are currently shared between you and the University of California.

Agent for Serving of Legal Process

Legal process may be served on Western Health Advantage at the address listed above.

Your Rights under the Plan

As a participant in a University of California medical plan, you are entitled to certain rights and protections. All Plan participants shall be entitled to:

- Examine, without charge, at the Plan Administrator's office and other specified sites, all Plan documents, including the Group Service Agreement, at a time and location mutually convenient to the participant and the Plan Administrator.

- Obtain copies of all Plan documents and other information for a reasonable charge upon written request to the Plan Administrator.

Claims under the Plan

To file a claim or to appeal a denied claim, refer to the Member Satisfaction section of this document.

Nondiscrimination Statement

In conformance with applicable law and University policy, the University of California is an affirmative action/ equal opportunity employer.

Please send inquiries regarding the University's affirmative action and equal opportunity policies for staff to:

Director of Diversity and Employee Programs
University of California
Office of the President
300 Lakeside Drive
Oakland, CA 94612

and for faculty to

Director of Academic Affirmative Action
University of California
Office of the President
1111 Franklin Street
Oakland, CA 94607

3. 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 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 general term we use in this booklet to mean 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 11

What do you pay for "covered services"?

The amount you pay for covered services is listed in Section 11.

Providers you can use to get services covered by our Plan

While you are a member of our Plan, you must 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-service area dialysis. We list the providers that participate with our Plan in our provider directory. If you get non-emergency care from non-plan (out-of-network) providers without prior authorization you must pay the entire cost yourself, unless the services are urgent and our network is not available, or the services are out-of-area dialysis services. If an out-of-network provider sends you a bill that you think we should pay for emergency services, please contact Member Services or send the bill to us for payment.

What should you do with your provider bills?

You should only pay the provider the cost-sharing allowed by our Plan and listed in Section 11. You should ask your provider to bill us for the rest of the fee and we will pay the provider according to our Plan's terms and conditions of payment. If the provider asks you to pay the full amount of the bill, and have you get paid back by the Plan, tell the provider that you only have to pay the cost-sharing amount. Your membership card in our Plan will indicate how the provider can contact us for information on our terms and conditions of payment. If the provider wants further information on payment for covered services, please have them contact us at the numbers listed at the bottom of this page.

If you get a bill for the services, you may send the bill to us for payment. We will pay your provider for our share of the bill and will let you know if you must pay any cost-sharing.

However, if you have already paid for the covered services we will reimburse you for our share of the cost.

If you have any questions about whether our plan will pay for a certain health care service, you can ask us for a written advance coverage decision before you get the service. We will let you know if our plan will pay for the service.

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 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 plan member. For example, in order to see a specialist, you usually need to get your PCP's approval first (this is called getting a "referral" to a specialist).

You will usually see your PCP first for most of your routine health care needs. Your PCP will provide most of your care and will help arrange or coordinate the rest of the covered services you get as a plan member. This includes your x-rays, laboratory tests, therapies, care from doctors who are specialists, hospital admissions, 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, your PCP must give approval in advance (such as giving you a referral to see a specialist). In some cases, your PCP will need to get prior authorization (prior approval). 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 4 tells how we will protect the privacy of your medical records and personal health information.

How do you choose a PCP?

There are several reliable ways to find out about PCP's in your community. Ask local friends and neighbors about their relationship with their doctors. Listening to the opinions of family and friends is still one of the most common ways to find a doctor you like and trust.

The Plan's Provider Directory is also a valuable resource for selecting the PCP who is right for you. Included are family practice physicians, internal medicine physicians and general medicine physicians. At certain locations the physician or his/her staff may speak other languages in addition to English. If applicable, those languages will be listed next to the physician's address.

Because a physician may not always be able to accept new patients, you should always contact the doctor's office to verify whether the doctor has openings in his/her practice.

If you are currently receiving care, or are an established patient of a PCP listed in the Plan's Provider Directory, you are not considered a new patient and will be able to continue treatment.

If you need assistance finding or changing your PCP, please call the Member Services Department at **the numbers listed at the bottom of this page**.

If there is a particular Plan specialist or hospital that you want to use, check first to be sure your PCP makes referrals to that specialist, or uses that hospital.

The name and office telephone number of your PCP is printed on your membership card.

How to get care from your PCP?

Your PCP will provide or arrange for most or all of your covered services. Care or services you get from non-plan providers will not be covered, with few exceptions such as emergencies. (When we say "non-plan providers," we mean providers that are **not** part of our Plan.)

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 or 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 their medical group or our Plan's Medical Management Department (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 don't have a referral (approval in advance) before you get services from a specialist, you may have to pay for these services yourself.** If the specialist wants you to come back for more care, check first to be sure that the referral (approval in advance) you got from your PCP for the first visit covers more visits to the specialist.

In order to expand the choice of specialists, WHA implemented a unique program called **Advantage Referral**. The Advantage Referral program allows Members to access **most of the specialty physicians within WHA's network (listed in the Provider Directory)**, instead of limiting each Member's access to those specialists who have a direct relationship with the Member's PCP. While your PCP will treat most of your health care needs, if your PCP determines that you require specialty care, your PCP will refer you to an appropriate provider. You may request to be referred to any of the WHA network specialists who participate in the Advantage Referral program. Your WHA Provider Directory designates the providers who do not participate in the Advantage Referral program.

Your PCP will provide a written referral to your selected specialist. Please remember that if you receive care from a specialist without first receiving a referral, you may be liable for the cost of those services. You will receive a notification of the details of your referral and the number of visits as ordered by your physician. You need to bring this referral form to your appointment. If you receive a same-day appointment, the specialist will receive verbal or fax authorization, which is sufficient along with your ID card.

OB/GYN services for women and annual eye exams are included in the **Advantage Referral Program** and do not require a PCP referral or prior authorization, as long as the provider is listed in the WHA Provider

Directory.

How can you switch to another PCP?

You may change your PCP for any reason, once a month. To change your PCP, call Member Services at one of the numbers listed at the bottom of this page. When you call, be sure to tell Member Services if you are seeing a specialists or getting other covered services that needed your PCP's approval (such as home health services and durable medical equipment). Member Services will help make sure that you can continue with the specialty care and other services you have been getting when you change your PCP. They will also 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. They will also send you a new membership card that shows the name and phone number of your new PCP.

What if your doctor or other provider leaves our Plan?

Sometimes a PCP, specialist, clinic, hospital or other plan provider you are using might leave the plan. If this happens, you will have to switch to another provider who is part of our Plan. If your PCP leaves our Plan, we will let you know, and help you switch to another PCP so that you can keep getting covered services.

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

As explained above, you will get most of your routine or basic care from your PCP, and your PCP will coordinate the rest of the covered services you get as a plan member. If you get services from any doctor, hospital, or other health care provider without getting a referral in advance from your PCP, you may have to pay for these services yourself – even if you get the services from a plan provider. *But there are a few exceptions:* you can get the following services on your own, without a referral or approval in advance from your PCP. You still have to pay your share of the cost as appropriate for these services.

- On-call Physician Services: The on-call physician for your PCP can provide care in place of your physician.
- Flu shots and pneumonia vaccinations (as long as you get them from a plan provider).
- Urgent Care: When an Urgent Care situation arises while you are in WHA's Service Area, call your PCP any time of the day, including evenings and weekends. Your doctor or the Physician on call will direct your care. (See Section 8 for definition of Urgent Care.)
- Emergency Care: If you are in an emergency situation, please call "911" or go to the nearest hospital emergency room. Notify your PCP the next business day or as soon as possible. (See Section 8 for definition of Emergency Care.)
- Gynecology Examination: A referral is not needed for gynecological services from a Participating Provider.
- Obstetrical Services: A referral is not needed for obstetrical care from a Participating Provider.
- Vision: An annual eye exam from a Participating Provider does not require a referral.
- Dialysis (kidney) services that you get 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.

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 reasonably believe that your health is in serious danger – when every second counts. A medical emergency includes severe pain, a bad injury, a serious 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 <u>don't need</u> to get approval or a referral first from your PCP or other plan provider.**

- As soon as possible make sure that our Plan knows about your emergency, because we need to be involved in following up on your emergency care. You or someone else should call to tell us or your PCP about your emergency care, preferably within 48 hours. Call the number on the back of your membership card.

We 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, what happens next is called "post-stabilization care." Your follow-up care (post-stabilization care) will be covered according to Medicare guidelines. In general, we will try to arrange for plan 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. You are covered outside of the country for emergencies only. The emergency copay will apply (waived if admitted). Please call Members Services for more information on worldwide coverage.

- **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 11 for more detailed information)

What if it wasn't really a medical emergency?

Sometimes it can be hard to know if you have a real medical emergency. For example, you might go in for emergency care – thinking that your health is in serious danger – and the doctor may say that it wasn't a medical emergency after all. If 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 wasn't a medical emergency, the Plan will pay our portion of the covered additional care **only if you get it from a plan provider**. We will pay our portion of the covered additional care from an out of network provider if you are out of our service area, as long as the additional care you get meets the definition of "urgently needed care" that is given below.

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 isn't 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 an 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. The plan is obligated to cover all out-of-area urgently needed care at the same cost-sharing levels that apply to care received within the Plan network.

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 of this document.

Getting urgently needed care when you are in the plan's service area

If you have a sudden illness or injury that is not a medical emergency, and you are in the plan's service area, please call your PCP.

You can call your PCP at any time of the day, including evenings and weekends. Explain your condition to your doctor or the physician on-call, and they will direct your care. There will always be a doctor on call to help you. This physician will call you back and advise you about what to do.

Keep in mind that if you have an urgent need for care while you are in the Plan's service area, we expect you to get this care from plan providers. In most cases, we will not pay for urgently needed care that you get from a non-plan provider while you are in the plan's service area.

What is your cost for services that aren't 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 aren't 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 aren't medically necessary under Medicare, even if the service is listed as covered by our Plan.

If you need a service that our Plan decides isn't medically necessary based on Medicare's coverage rules, you may have to pay all of the costs of the service if you didn't 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. You can call Members Services when you want to know how much of your benefit limit you have already used.

Hospital care, skilled nursing facility care, and other services

How do you get hospital care?

If you need hospital care, we will cover these services for you. Covered services are listed in the Benefits Chart in Section 11 under the heading "Inpatient Hospital Care." We use "hospital" to mean a facility that is certified by the Medicare program and licensed by the state to provide inpatient, outpatient, diagnostic, and therapeutic services. The term "hospital" does not include facilities that mainly provide custodial care (such as convalescent nursing homes or rest homes). By "custodial care," we mean help with bathing, dressing, using the bathroom, eating, and other activities of daily living.

See Section 8 for definition of Inpatient care.

All inpatient hospitalization requires Prior Authorization, except in an emergency situation. You must use Hospitals in our Plan's service area for all non-emergency medical care.

What is a "benefit period" for hospital care?

Our Plan uses benefit periods to determine your coverage for inpatient services during a hospital stay (generally, you are an inpatient of a hospital if you are receiving inpatient services in the hospital). A **"benefit period"** begins on the first day you go to a Medicare-covered inpatient hospital or a skilled nursing facility (SNF). 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. (Later in this section we explain about SNF services).

What happens if you join or leave our Plan during a hospital stay?

If you either join or leave our Plan during an inpatient hospital stay, special rules apply to your coverage for the stay and to what you owe for this stay. If this situation applies to you, please call Member Services. Member Services can explain how your services are covered for this stay, and what you owe to providers, if anything, for the periods of your stay when you were and were not a plan member.

What is a "hospitalist"?

If you are hospitalized at some of our hospital facilities, a hospitalist may care for you. Hospitalists are physicians that are dedicated to caring for hospitalized patients. A hospitalist will coordinate your care while in the hospital and communicate with your PCP. For more information about hospitalist please refer to the Medicare booklet about hospitalist that is available from the Medicare website or call 1-800-MEDICARE.

What is skilled nursing facility care?

"Skilled nursing facility care" means a level of care in a SNF ordered by a doctor that must be given or supervised by licensed health care professionals. It can 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 include 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.

How do you get skilled nursing facility care (SNF care)?

If you need skilled nursing facility care, we will cover these services for you. Covered services are listed in the Benefits Chart in Section 11 under the heading "Skilled nursing facility care." The purpose of this subsection is to tell you more about some rules that apply to your covered services.

Are Nursing Home stays that provide custodial care covered?

"Custodial care" is 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. Custodial care is not covered by our Plan unless it is provided as other care you are getting *in addition* to daily skilled nursing care and/or skilled rehabilitation services.

What are the benefit period limitations on coverage of skilled nursing facility care?

Inpatient skilled nursing facility coverage is limited to 100 days each benefit period. A **"benefit period"** begins on the first day you go to a Medicare-covered inpatient hospital or a SNF. 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.

What are the situations, when you may be able to get care in a SNF that is not a plan provider?

Generally, you will get your skilled nursing facility care from SNFs that are plan providers for our Plan. However, *if certain conditions are met*, you may be able to get your skilled nursing facility care from a SNF that is not a plan provider. One of the conditions is that the SNF that is not a plan provider must be willing to accept our Plan rates for payment. At your request, we may be able to arrange for you to get your skilled nursing facility care from one of the facilities listed below (in these situations, the facility is called a "Home SNF"):

- A nursing home or continuing care retirement community where you were living right before you went to the hospital (as long as the place gives skilled nursing facility care).

- A SNF where your spouse is living at the time you leave the hospital.

What happens if you join or leave our Plan during a Skilled Nursing Facility (SNF) stay?

If you either join or leave our Plan during a SNF stay, please call Member Services. Member Services can explain how your services are covered for this stay, and what you owe to our Plan, if anything, for the periods of your stay when you were and were not a plan member.

How do you get home health care?

Home health care is 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 11 under the heading "Home health care." If you need home health care services, we will arrange these services for you if the requirements described below are met.

What are the requirements for getting home health agency services?

To get home health agency care benefits, you must meet all of these conditions:

1) You must be **homebound**. This means that you are normally unable to leave your home and that leaving home is a major effort. When you leave home, it must be to get medical treatment or be infrequent, for a short time. You may attend religious services. You can also get care in an adult day care program that is licensed or certified by a state or accredited to furnish adult day care services in a state.

   Occasional absences from the home for non-medical purposes, such as an occasional trip to the barber or a walk around the block or a drive, would not mean that you are not homebound if the absences are infrequent or are of relatively short duration. The absences cannot indicate that you have the capacity to obtain the health care provided outside of your home.

   Generally speaking, you will be considered to be homebound if you have a condition due to an illness or injury that restricts your ability to leave your home except with the aid of supportive devices or if leaving home is medically contraindicated. "Supportive devices" include crutches, canes, wheelchairs, and walkers, the use of special transportation, or the assistance of another person.

2) Your doctor must decide that you need medical care in your home, and must make a plan for your care at home. Your **plan of care** describes the services you need, how often you need them, and what type of health care worker should give you these services.

3) The home health agency caring for you must be approved by the Medicare program.

4) You must need *at least one* of the following types of skilled care:

- Skilled nursing care on an "intermittent" (not full time) basis. Generally, this means that you must need at least one skilled nursing visit every 60 days and not require daily skilled nursing care for more than 21 days. Skilled nursing care includes services that can only be performed by or under the supervision of a licensed nurse.

- Physical therapy, which includes exercise to regain movement and strength to an area of the body, and training on how to use special equipment or do daily activities such as how to use a walker or get in and out of a wheel chair or bathtub.

- Speech therapy, which includes exercise to regain and strengthen speech skills or to treat a swallowing problem.

- Continuing occupational therapy, which helps you learn how to do usual daily activities by yourself. For example, you might learn new ways to eat or new ways to get dressed.

When can home health care include services from a home health aide?

As long as some qualifying skilled services are *also* included, the home health care you get can include services from a home health aide. A home health aide does not have a nursing license or provide therapy. The home health aide provides services that don't need the skills of a licensed nurse or therapist, such as help with personal care such as bathing, using the toilet, dressing, or carrying out the prescribed exercises. The services from a home health aide must be part of the home care of your illness or injury, and they are not covered unless you are *also* getting a covered skilled service. "Home health services" don't include the services of housekeepers, food service arrangements, or full time nursing care at home.

What are "part time" and "intermittent" home health care services?

If you meet the requirements given above for getting covered home health services, you may be eligible for "part time" or "intermittent" skilled nursing services and home health aide services:

"Part-time" or **"Intermittent"** means your skilled nursing and home health aide services combined total less than eight hours per day and 35 or fewer hours each week.

What is hospice care?

"Hospice" is 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 make the most of the last months of life by giving comfort and relief from pain. The focus is on care, not cure.

How do you get hospice care if you are terminally ill?

As a member of our Plan, you may receive care from any Medicare-certified hospice program. Your doctor can help you arrange hospice care. If you are interested in using hospice services, you may call Member Services to

get a list of the Medicare-certified hospice providers in your area or you can call the Regional Home Health Intermediary at 1 (877) 602-7904 or TTY (866) 879-0235.

How is your hospice care paid for?

If you enroll in a 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 plan provider or a non-plan provider. Even if you choose to enroll in a Medicare-certified hospice, 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.

How to get more information on hospice care

Visit www.medicare.gov on the Web. Under "Search Tools," "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).

How to get an Organ transplant if you need it

If you need an organ transplant, we will arrange to have your case reviewed by one of the transplant centers that is approved by Medicare (some hospitals that perform transplants are approved by Medicare, and others aren't). The Medicare-approved transplant center will decide whether you are a candidate for a transplant. When all requirements are met, the following types of transplants are covered: corneal, kidney, kidney-pancreatic, liver, heart, lung, heart-lung, bone marrow, intestinal/multivisceral, and stem cell. The following transplants are covered only if they are performed in a Medicare-approved transplant center: heart, liver, lung, heart-lung, and intestinal/multivisceral transplants.

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.

Medicare pays for routine costs if you take part in a clinical trial that meets Medicare requirements. Routine costs include costs like room and board for a hospital stay that Medicare would pay for even if you weren't 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 that is unrelated to the clinical trial through our Plan.

You will have to pay the same co-insurance amounts charged under Original Medicare for the services you receive when participating in a qualifying clinical trial. You do not have to pay the Original Medicare Part A or Part B deductibles, because you are enrolled in our Plan. For instance, you will be responsible for Part B co-insurance -- generally 20% of the Medicare-approved amount for most doctor services and most other

outpatient services. However, there is no co-insurance for Medicare-covered clinical laboratory services related to the clinical trial. The Medicare program has written a booklet that includes information on Original Medicare co-insurance rules, called "Medicare & You." To get a free copy, call 1-800-MEDICARE (1-800-633-4227) or visit www.medicare.gov on the Web.

You do not need to get a referral (approval in advance) from a plan provider to join a clinical trial, and the clinical trial providers don't need to be plan 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 what services you will get from clinical trial providers and the costs for those services. You may view or download the publication "Medicare and Clinical Trials" at www.medicare.gov on the Web. 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 **R**eligious **N**on-medical **H**ealth **C**are **I**nstitution (RNHCI) is covered by our Plan under certain conditions. Covered services in a 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 care or extended care services, or care in a home health agency. You may get services when 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.) You must also get authorization (approval) in advance from our Plan, or your stay in the RNHCI may not be covered.

How You Get Prescription Drugs

What you pay for covered drugs?

The amount you pay for covered drugs is listed in Section 11

If You Have Medicare and Medi-Cal

Medicare, not Medi-Cal, will pay for most of your prescription drugs. You will continue to get your health coverage under both Medicare and Medi-Cal as long as you qualify for Medi-Cal 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 copayments. Please contact your SPAP to determine what benefits are available to you.

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 11 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?

You may request 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. 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 copayment 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 6 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

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 at the same level of cost-sharing 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 isn't on the formulary?

If your prescription isn't listed on your copy of our formulary, you should first check the formulary on our website which we update at least monthly. In addition, you may contact Member Services to be sure it isn't covered. If Member Services confirms that we don't cover your drug, you have two options:

1) 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.

2) 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 isn't approved, you may appeal the Plan's denial. See Section 6 for more information on how to request an exception or appeal.

In some cases, we will contact you if you are taking a drug that isn't 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 isn't on our formulary.

Transition Policy

New members in our Plan may be taking drugs that aren't on our formulary or that are subject to certain restrictions, such as prior authorization or step therapy. Current members may also be affected by changes in our formulary from one year to the next. Members should talk to their doctors to decide if they should switch to a different drug that we cover or request a formulary exception in order to get coverage for the drug. See Section 6 under "What is an exception?" to learn more about how to request an exception. Please contact Member Services if your drug is not on our formulary, is subject to certain restrictions, such as prior authorization or step therapy, or will no longer be on our formulary next year and you need help switching to a different drug that we cover or requesting a formulary exception.

During the period of time members are talking to their doctors to determine the right course of action, we may provide a temporary supply of the non-formulary drug if those members need a refill for the drug during the first 90 days of new membership in our Plan. If you are a current member affected by a formulary change from one year to the next, we will provide a temporary supply of the non-formulary drug if you need a refill for the drug during the first 90 days of the new plan year.

When a member goes to a network pharmacy and we provide a temporary supply of a drug that isn't on our formulary, or that has coverage restrictions or limits (but is otherwise considered a "Part D drug"), we will cover a 30-day supply (unless the prescription is written for fewer days). After we cover the temporary 30-day supply, we generally will not pay for these drugs as part of our transition policy again. We will provide you

with a written notice after we cover your temporary supply. This notice will explain the steps you can take to request an exception and how to work with your doctor to decide if you should switch to an appropriate drug that we cover.

If a new member is a resident of a long-term-care facility (like a nursing home), we will cover a temporary 31-day transition supply (unless the prescription is written for fewer days). If necessary, we will cover more than one refill of these drugs during the first 90 days a new member is enrolled in our Plan. If the resident has been enrolled in our Plan for more than 90 days and needs a drug that isn't on our formulary or is subject to other restrictions, such as step therapy or dosage limits, we will cover a temporary 31-day emergency supply of that drug (unless the prescription is for fewer days) while the new member pursues a formulary exception.

Please note that our transition policy applies only to those drugs that are "Part D drugs" and bought at a network pharmacy. The transition policy can't be used to buy a non-Part D drug or a drug out of network, unless you qualify for out of network access. See Section 10 for information about non-Part D drugs.

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 don't 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. For example, we will provide up to 8 pills per 30-day period for a formulary drug.

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 aren't 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 6 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 don't 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 Parts A and B of Medicare, as well as Part D. The Part D coverage we offer doesn't 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 have a Medigap (Medicare Supplement Insurance) policy with prescription drug coverage

If you currently have a Medigap policy that includes coverage for prescription drugs, you must contact your Medigap issuer and tell them you have enrolled in our Plan. If you decide to keep your current Medigap policy, your Medigap issuer will remove the prescription drug coverage portion of your Medigap policy and adjust your premium.

Each year (prior to November 15), your Medigap insurance company must send you a letter explaining your options and whether the prescription drug coverage you have is creditable (whether it expects to pay, on average, at least as much as Medicare's standard prescription drug coverage) and how the removal of drug coverage from your Medigap policy will affect your premiums. If you didn't get this letter or can't find it, you have the right to get a copy from your Medigap insurance company.

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 didn't 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 outpatient 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 aren't required to always go to the same pharmacy to fill your prescriptions. 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 Provider 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 Provider 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 ID card at one of our network pharmacies. If you do not have your membership ID card with you when you fill your prescription, you may have to pay the full cost of the prescription (rather than paying just your copayment). If this happens, you can 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 Plan's network mail order pharmacy service?

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

Generally, it takes us 7 to 11 days to process your order and ship it to you. However, sometimes your mail order may be delayed. You should have at least a 14-day supply of medication on hand in case your medication is delayed. If your medication is delayed, you may need to ask your doctor for another prescription for a 14-day supply that you can fill at your local retail pharmacy.

Please note, in order to take advantage of the benefits of a mail order service, you must use the **Medco Home Delivery Pharmacy Service** (described below). Prescription drugs that you get at any other mail order service are not covered.

When you order prescription drugs by mail, you must order no more than a 90-day supply of the drug.

The **Medco Home Delivery Pharmacy Service** offers you convenience and potential cost savings.

Medco By Mail advantages:

- **Get up to a 90-day supply** (compared with a typical 30-day supply at retail) of each covered medication for **just two retail copayments**.
- **Registered pharmacists** are available 24 hours a day, 7 days a week.
- **Order refills** online, by mail, or by phone—anytime day or night. To order online, register at www.medco.com. Refills are usually delivered within 3 to 5 days after your order is received.
- **Choose a convenient payment option**—Medco offers two safe, convenient automatic payment options for prescription orders. You can use e-check to have payments automatically deducted from your checking account. Or you can use AutoCharge to have payments automatically charged to the credit card of your choice. You can also pay for individual orders by money order, personal check, or credit card. For more information, visit www.medco.com or call Member Services.
- **Standard shipping is free**.

Using the Home Delivery Pharmacy Service for the first time

Requesting a new prescription for home delivery is simple whether you're ordering by mail or fax. Just follow these steps:

BY MAIL:

Step 1: Ask your doctor to write a new prescription for up to a 90-day supply, plus refills (if appropriate) for up to 1 year.

Step 2: Fill out the Medco By Mail order form

Step 3: Send the completed form, your prescription, and your payment in the Medco By Mail envelope.

BY FAX:

Step 1: Ask your doctor to write a new prescription for up to a 90-day supply, plus refills (if appropriate) for up to a 90-day supply, plus refills (if appropriate) for up to 1 year. Give your doctor your WHA member ID number, which is on your WHA *Care*+ member ID card.

Step 2: Ask your doctor to call 1-888-EASYRX1 (1-888-327-9791). Medco Health will give him or her directions for faxing your prescription to Medco Health. You will be billed later.

ONLINE:

You can request new prescriptions online by visiting Medco Health at www.medcohealth.com

Step 1: If you haven't already done so, take a few moments to register with Medco Health, making sure you let us know that you are a Medco Health plan member when prompted. Once you are registered, all you need to do when you return is log in using the e-mail address and password you created.

Step 2: Once you registered and logged in, select the "My Benefits" tab at the top of the page. Then choose the "Order new prescriptions" link and follow the online instructions.

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 the 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?"

We will cover your prescription at an out-of-network pharmacy if at least one of the following applies:

- If 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.

- If 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).

What if I need a prescription because of a medical emergency?

We will cover prescriptions that are filled at an out-of-network pharmacy if the prescriptions are related to care for a medical emergency or urgently needed care. In this situation, you will have to pay the full cost (rather than paying just your copayment) when you fill your prescription. You can ask us to reimburse you for our share of the cost by submitting a paper claim form. To learn how to submit a paper claim, please refer to the paper claims process described below.

Getting coverage when you travel or are away from the plan's service area

If you take a prescription drug on a regular basis and you are going on a trip, be sure to check your supply of the drug before you leave. When possible, take along all the medication you will need. You may be able to order your prescription drugs ahead of time through our network mail order pharmacy service.

If you are traveling within the US, but outside of the Plan's service area, and you become ill, lose or run out of your prescription drugs, we will cover prescriptions that are filled at an out-of-network pharmacy if you follow all other coverage rules identified within this document and a network pharmacy is not available. In this situation, you will have to pay the full cost (rather than paying just your copayment) when you fill your prescription. You can ask us to reimburse you for our share of the cost by submitting a claim form. To learn how to submit a paper claim, please refer to the paper claims process described below.

Prior to filling your prescription at an out-of-network pharmacy, call our Member Service to find out if there is a network pharmacy in the area where you are traveling. If there are no network pharmacies in that area, our Member Service may be able to make arrangements for you to get your prescriptions from an out-of-network pharmacy.

Medicare-Covered Outpatient Drugs (Part B Covered Drugs Only)

The following outpatient prescription drugs may be covered under Medicare Part B. This may include, but is not limited to, the following types of drugs. Contact WHA *Care*+ MA-PD Plan for more details.

- Some Antigens: If they are prepared by a doctor and administered by a properly instructed person (who could be the patient) under doctor supervision.

- Osteoporosis Drugs: Injectable drugs for osteoporosis for certain women with Medicare.

- Erythropoietin (Epoetin alpha or Epogen): By injection if you have end-stage renal disease (permanent kidney failure requiring either dialysis or transplantation) and need this drug to treat anemia.

- Hemophilia clotting Factors: Self-administered clotting factors if you have hemophilia.

- Injectable Drugs: Most injectable drugs administered incident to a physician's service.

- Immunosuppressive Drugs: Immunosuppressive drug therapy for transplant patients if the transplant was

paid for by Medicare, or paid by a private insurance that paid as a primary payer to your Medicare Part A coverage, in a Medicare-certified facility.

- Some Oral Cancer Drugs: If the same drug is available in injectable form.
- Oral Anti-Nausea Drugs: Within 48-hours of receipt of anti-cancer chemotherapy.
- Inhalation and infusion drugs provided through DME.

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 ID 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 ID 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 6. You may request claim forms from Medco Health, Member Services at 1-800-592-4526, TTY/TDD 1-800-716-3231, 24 hours a day, and 7 days a week except Thanksgiving and Christmas or you may order claim forms online at www.medcohealth.com.
- **Drugs paid for in full when you don't have your membership card.** If you pay the full cost of the prescription rather than paying just your copayment because you don't 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 6.
- **Drugs paid for in full in other situations.** If you pay the full cost of the prescription rather than paying just your copayment 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 6.
- **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.
- **Copayments for drugs provided under a drug manufacturer patient assistance program.** If you get help from, and pay copayments 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.

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, Medicare Part A will cover the cost of your prescription drugs while you are in the hospital. Once you are released from the hospital, we will cover your prescription drugs as long as all coverage requirements are met (such as the drugs being on our formulary, filled at a network pharmacy, etc.); they are not covered by Medicare Part A or Part B, are part of the formulary and are purchased at one of our network pharmacies. We will also cover your prescription drugs if they are approved under the coverage determination, exceptions, or appeals process.

If you are admitted to a skilled nursing facility for a Medicare-covered stay, after Medicare Part A stops paying for your prescription drug costs, we will cover your prescriptions as long as the drug meets all of our coverage requirements (including the requirement that the skilled nursing facility pharmacy be in our pharmacy network, unless you meet standards for out-of-network care, and that the drug would not otherwise be covered by Medicare Part B coverage). 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 Prescription Drug Plan. Please see Section 7 of this document for more information about leaving this Plan and joining a new Medicare Prescription Drug 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 facilities LTC pharmacy or another network LTC pharmacy. Please refer to your Provider Directory to find out if your LTC pharmacy is part of our network. If it isn't, or for more information, contact Member Services.

Specialty pharmacies – Home infusion pharmacies

Our Plan will cover home infusion therapy if:

- Your prescription drug is on our Plan's formulary,
- You have followed all required coverage rules and our Plan has approved your prescription for home infusion therapy,
- Your prescription is written by a doctor, and
- You get your home infusion services from a Plan network pharmacy.

Please refer to your Provider Directory to find a home infusion pharmacy in your area. For more information, please 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 aren't already covered by Medicare Part B. This coverage includes the cost of vaccine administration. See Section 11 for more information about your costs for covered vaccinations.

4. 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 don't 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 at the phone numbers listed at the bottom of this page. Member Services can also help if you need to file a complaint about access (such as wheel chair access). You can also call the Office for Civil Rights at 1-800-368-1019 or TTY/TDD 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 if for research and other purposes that follow all applicable Federal statues 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 your medical records, and to get a copy of the records (there may be a fee charged for making copies). You also have the right to ask plan providers to make additions or corrections to your medical records (if you ask plan providers to do this, they 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 at the phone number listed at the bottom of this page. The Plan will release your information, including your prescription drug event data, to Medicare, which may release if for research and other purposes that follow all applicable Federal statutes and regulations.

Your right to see plan 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 plan providers, that is, from doctors

and other health providers who are part of our Plan. You have the right to choose a plan provider (we will tell you which doctors are accepting new patients). You have the right to go to a women's health specialist (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. You also have the right to timely access to your prescriptions at any network pharmacy. "Timely access" means that you can get appointments and services within a reasonable amount of time. Section 3 explains how to use plan providers to get the care and services you need. 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 Management Treatment Programs we offer and 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 plan provider has denied care that you believe you are 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. Organization determinations are discussed in Section 6.

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 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 you trust 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, such as HICAP. Section 9 of this booklet tells how to contact HICAP. 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't. 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 the Department of Managed Health Care (DMHC). The DMHC has a toll-free telephone number 1-888-HMO-2219, TDD 1-877-688-9891.

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 at the phone numbers listed at the bottom of this page.

Your right to get information in other formats

You have the right to get your questions answered. Our plan must have individuals and 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 Plan and our network pharmacies

You have the right to get information from us about our Plan. This includes information about our financial condition and about our network pharmacies. To get any of this information, call Member Services at the phone numbers listed at the bottom of this page.

Your right to get information about your prescription drugs and costs

You have the right to an explanation from us about any prescription drugs, not covered by our Plan. We must tell you in writing why we will not pay for or approve a prescription drug, and how you can file an appeal to ask us to change this decision. See Section 6 for more information about filing an appeal. You also have the right to this explanation even if you obtain the prescription drug, 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 6 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 at the phone numbers listed at the bottom of this page.

How to get more information about your rights

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

- Call Member Services at the numbers listed at the bottom of this page.
- Get free help and information from HICAP (Section 9 tells how to contact HICAP).
- Visit www.medicare.gov to view or download the publication "Your Medicare Rights and Protections.
- 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/TDD 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 call Member Services at the numbers listed at the bottom of this page. You can also get help from HICAP (Section 9 tells how to contact HICAP).

Your responsibilities as a member of our Plan include:

- Getting familiar with your coverage and the rules you must follow to get care as a member. You can use this booklet to learn about your coverage, what you have to pay, and the rules you need to follow. Please call Member Services at the phone numbers listed at the bottom of this page if you have any questions.
- Using all of your insurance coverage. If you have additional health insurance coverage or prescription drug coverage besides our Plan, it is important that you use your other coverage in combination with your coverage as a member of our Plan to pay your health care or prescription drug expenses. This is called "coordination of benefits: because it involves coordinating all of the health or drug benefits that are available to you.
- You are required to tell our Plan if you have addition health insurance or drug coverage. Call Member Services.
- Notifying providers when seeking care (unless it is an emergency) that you are enrolled in our Plan and you must present your plan enrollment card to the provider.
- Giving your doctor and other providers the information they need to care for you, and to following the treatment plans and instructions that you and your doctors agree upon. Be sure to ask your doctors and other providers if you have any questions and to explain your treatment in a way you understand.
- Acting in a way that supports the care given to other patients and helps the smooth running of your

doctor's office, hospitals, and other offices.

- Paying your plan premiums and any co-payments you owe for the covered services you get. You must pay for services that aren't covered.

- Notifying us if you move. If you move within our service area, we need to keep your membership record up-to-date. If you move outside of our plan service area, you cannot remain a member of our plan.

- Letting us know if you have any questions, concerns, problems, or suggestions. If you do, please call Member Services at the phone numbers listed at the bottom of this page.

What can you do if you think you have been treated unfairly or your rights aren't being respected?

For concerns or problems related to your Medicare rights and protections described in this section, you may call our Member Services numbers listed at the bottom of this page. You can also get help from HICAP (contact information for HICAP is in Section 9 of this booklet).

5. How to File a Grievance

What is a Grievance?

A grievance is any complaint, other than one that involves a request for an initial determination, or an appeal as described in Section 6 of this EOC.

Grievances do not involve problems related to approving or paying for care or Part D drugs, Part C medical care or services, problems about having to leave the hospital too soon, and problems about having Skilled Nursing Facility (SNF), Home Health Agency (HHA), or Comprehensive Outpatient Rehabilitation Facility (CORF) services ending too soon.

If we will not pay for or give you the services and/or drugs you want, you believe that you are being released from the hospital or SNF too soon, or your HHA, or CORF services ending too soon, you must follow the rules outlined in Section 6.

What types of problems might lead to you filing a grievance?

- Problems with the service you receive from Member Services.
- If you feel that you are being encouraged to leave (disenroll from) our Plan.
- If you disagree with our decision not to give you a "fast" decision or a "fast" appeal. We discuss these fast decisions and appeals in Section 6.
- We don't give you a decision within the required time frame.
- We don't give you required notices.
- You believe our notices and other written materials are hard to understand.
- Waiting too long for prescriptions to be filled.
- Rude behavior by network pharmacist, or other staff.
- We don't forward your case to the Independent Review Entity if we do not give you a decision on time
- Problems with the quality of the medical care or services you receive, including quality of care during a hospital stay.
- Problems with how long you have to wait on the phone, in the waiting room, or in the exam room.
- Problems getting appointments when you need them, or waiting too long for them.
- Rude behavior by doctors, nurses, receptionists, or other staff.
- Cleanliness or condition of doctor's offices, clinics, or hospitals.

If you have one of these types of problems and want to make a complaint, it is called "filing a grievance."

Who may file a grievance?

You or someone you name may file a grievance. The person you name would be your "representative." You may name a relative, friend, lawyer, advocate, doctor, or anyone else to act for you. Other persons may already be authorized by the Court or in accordance with State law to act for you. If you want someone to act for you who is not already authorized by the Court or under State law, then you and that person must sign and date a statement that gives the person legal permission to be your representative. To learn how to name your representative, you may call Member Services.

Filing a grievance with WHA Care+

If you have a complaint, you are your representative may call the phone number for Part D Grievance (for complaints about Part D drugs) in Section 9. We will try to resolve your complaint over the phone. If you ask for a written response, file a written grievance, or your complaint is related to quality of care, we will respond in writing to you. **If we cannot resolve your complaint over the phone, we have a formal procedure to review your complaints. We call this the WHA *Care*+ grievance procedure.**

If we cannot resolve your complaint over the phone, we encourage you to send your grievance in writing to the Member Services Department. We will acknowledge your grievance in writing, within five (5) days after we receive it. We may need to obtain information from your physician or medical group in order to resolve your grievance, but will notify you of the resolution not later than thirty (30) days after we receive it.

We must notify you of our decision about your grievance as quickly as your case requires based on your health status, but no later than 30 days after receiving your complaint. We may extend the timeframe by up to 14 days if you request the extension, or if we justify a need for additional information and the delay is in your best interest.

Fast Grievances

In certain cases, you have the right to ask for a "fast grievance," meaning we will answer your grievance within 24 hours. We discuss situations where you may request a fast grievance in Section 6.

For quality of care problems, you may also complain to the QIO

You may complain about the quality of care received under Medicare, including care during a hospital stay. You may complain to us using the grievance process, to the Quality Improvement Organization (QIO), or both. If you filed with the QIO, we must help the QIO to resolve the complaint. See Section 9 for more information about the QIO.

6. Complaints and Appeals about your Part D Prescription Drug(s) and/or Part C Medical Care and Services

Introduction

This section explains how you ask for coverage of your Part D drugs(s) and/or Part C medical care or service(s) or payments in different situations. This section also explains how to make complaints when you think you are being asked to leave the hospital too soon, or you think your skilled nursing facility (SNF), home health (HHA) or comprehensive outpatient rehabilitation facility (CORE) services are ending too soon. These types of requests and complaints are discussed below in Part 1, Part 2, or Part 3.

Other complaints that do not involve the types of requests or complaints discussed below in Part 1, Part 2, or Part 3 are considered grievances. You would file a grievance if you have any type of problem with us or one of our network providers that does not relate to coverage for Part D drugs and/or Part C medical care or services. For more information about grievances, see Section 5.

Part 1. Requests for Part D drugs and/or Part C medical care or services or payments.

Part 2. Complaints if you think you are asked to leave the hospital too soon.

Part 3. Complaints if you think your skilled nursing facility (SNF), home health (HHA) or comprehensive outpatient rehabilitation facility (CORF) services are ending too soon.

PART 1. Requests for Part D drugs and/or medical care or services or payment

This part explains what you can do if you have problems getting the Part D drugs and/or Part C medical care or service you request or payment (including the amount you paid) for a Part D drug and/or Part C medical care or service you already received.

If you have problems getting the Part D drugs and/or Part C medical care or services you need, or payment for a Part D drug and/or Part C service you already received, you must request an initial determination with the plan.

Initial Determinations

The initial determination we make is the starting point for dealing with requests you may have about covering a Part D drug and/or Part C medical care or service you need, or paying for a Part D drug and/or Part C medical care or service you already received. Initial decisions about Part D drugs are called **"coverage determinations"**. Initial decisions about Part C medical care or services are called **"organization determinations"**. With this decision, we explain whether we will provide the Part D drug and/or Part C medical care or service you are requesting, or pay for the Part D drug and/or Part C medical care or service you already received.

The following are examples of requests for initial determinations:

- You ask us to pay for a prescription drug you have received.

- You ask for a Part D drug that is not on your plan sponsor's list of covered drugs (called a "formulary"). This is a request for a "formulary exception." **See "What is an exception?" below for more information about the exceptions process.**

- You ask for an exception to our utilization management tools - such as prior authorization, dosage limits, quantity limits, or step therapy requirements. Requesting an exception to a utilization management tool is a type of formulary exception. **See "What is an exception?" below for more information about the exceptions process.**

- You ask for a non-preferred Part D drug at the preferred cost-sharing level. This is a request for a "tiering exception." **See "What is an exception?" below for more information about the exceptions process.**

- You ask us to pay you back for the cost of a drug you bought at an out-of-network pharmacy. In certain circumstances, out-of-network purchases, including drugs provided to you in a physician's office, will be covered by the Plan. See "Filling Prescriptions Outside of Network" in Section 3 for a description of these circumstances.

- You are not getting Part C medical care or services you want, and you believe that this care is covered by the Plan.

- We will not approve the medical treatment your doctor or other medical provider wants to give you, and you believe that this treatment is covered by the Plan.

- You are being told that a medical treatment or service you have been getting will be reduced or stopped, and you believe that this could harm your health.

- You have received Part C medical care or services that you believe should be covered by the Plan, but we have refused to pay for this care.

What is an exception?

An exception is a type of initial determination (also called a "coverage determination") involving a Part D drug. You or your doctor may ask us to make an exception to our Part D coverage rules in a number of situations.

- You may ask us to cover your Part D drug even if it is not on our formulary. Excluded drugs cannot be covered by a Part D plan.

- You may ask us to waive coverage restrictions or limits on your Part D drug. For example, for certain Part D drugs, we limit the amount of the drug that we will cover. If your Part D drug has a quantity limit, you may ask us to waive the limit and cover more. See Section 3 ("Utilization Management") to learn more about our additional coverage restrictions or limits on certain drugs."

Generally, we will only approve your request for an exception if the alternative Part D drugs included on the Plan formulary would not be as effective in treating your condition and/or would cause you to have adverse medical effects.

Your doctor must submit a statement supporting your exception request. In order to help us make a decision more quickly, the supporting medical information from your doctor should be sent to us with the exception request.

If we approve your exception request, our approval is valid for the remainder of the Plan year, so long as your doctor continues to prescribe the Part D drug for you and it continues to be safe for treating your condition. If we deny your exception request, you may appeal our decision.

Note: If we approve your exception request for a Part D non-formulary drug, you cannot request an exception to the copayment or coinsurance amount we require you to pay for the drug.

You may call us at the phone numbers listed at the bottom of this page for any of these requests.

Who may ask for an initial determination?

You your prescribing physician or someone you name may ask us for an initial determination. The person you name would be your "appointed representative". You may name a relative, friend, advocate, doctor, or anyone else to act for you. Other persons may already be authorized under state law to act for you. If you want someone to act for you who is not already authorized under State law, then you and that person must sign and date a statement that gives the person legal permission to be your appointed representative. If you are requesting Part C medical care or services, or Part D drugs, this statement must be sent to us at the address or fax number listed under "Contact Information for our Plan Member Services" in Section 9. To learn how to name your appointed representative, you may call Member Services at the numbers listed at the bottom of this page.

You also have the right to have a lawyer 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. You may want to contact Department of Managed Health Care (DMHC) at 1-888-HMO-2219, (TTY) 1-877-688-9891.

Asking for a "standard" or "fast" initial determination

A decision about whether we will give you, or pay for, the Part D drug and/or Part C medical care or service you are requesting can be a "standard" decision that is made within the standard time frame, or it can be a "fast" decision that is made more quickly. A fast decision is also called an "expedited" decision.

Asking for a standard decision

To ask for a standard decision for a Part D drug and/or Part C medical care or service you, your doctor, or your representative should call, fax, or write us at the numbers or address listed under "Contact Information for our Plan Member Services" in Section 9.

Requests that are made outside of regular weekday business hours may be directed to your PCP. You can call your PCP at any time of the day, including evenings and weekends. Explain your condition to your doctor or the Physician on-call and they will direct your care. There will always be a doctor on call to help you. This physician will call you back and advise you about what to do.

Asking for a fast decision

You can ask for a fast decision **only** if you or any doctor believe that waiting for a standard decision could seriously harm your health or your ability to function. Fast decisions apply only to requests for benefits that you have not yet received. You cannot get a fast decision if you are asking us to pay you back for a benefit that you already received.

If you are requesting a Part D drug and/or Part C medical care or service that you have not yet received, you, your doctor, or your representative may ask us to give you a fast decision by calling, faxing, or writing us at the numbers or address listed under "Contact Information for our Plan Member Services" in Section 9.

Requests that are made outside of regular weekday business hours may be directed to your PCP. You can call your PCP at any time of the day, including evenings and weekends. Explain your condition to your doctor or the Physician on-call and they will direct your care. There will always be a doctor on call to help you. This physician will call you back and advise you about what to do.

Be sure to ask for a "fast" or "72-hour" review. If your doctor asks for a fast decision for you, or supports you in asking for one, and the doctor, indicates that waiting for a standard decision could seriously harm your health or your ability to function, we will give you a fast decision.

If you ask for a fast decision without support from a doctor, we will decide if your health requires 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 informing you that if you get a doctor's support for a fast review, we will automatically give you a fast decision. The letter will also tell you how to file a "fast grievance" if you disagree with our decision to deny your request for a fast review (for more information about fast grievances, see Section 6). If we deny your request for a fast initial determination, we will give you a standard decision.

What happens when you request an initial determination?

- For a standard decision initial determination about a Part D drug (including a request to pay you back for a Part D drug that you have already received).

  Generally, we must give you our decision no later than 72 hours after we receive your request, but we will make it sooner if your request is for a Part D drug that you have not received yet and your health condition requires us to. However, if your request involves a request for an exception, including a formulary exception, tiering exception, or an exception from utilization management rules, such as prior authorization, dosage limits, quantity limits, or step therapy requirements, we must give you our decision no later than 72 hours after we receive your physician's "supporting statement" explaining why the drug you are asking for is medically necessary.

  If you have not received an answer from us within 72 hours after we receive your request (or your physician's supporting statement if your request involves an exception), your request will automatically go to Appeal Level 2.

- For a fast initial determination about a Part D drug that you have not yet received.

  If we give you a fast review, we will give you our decision within 24 hours after you or your doctor ask for a fast review. We will give you the decision sooner if your health condition requires us to. If your request involves a request for an exception, we will give you our decision no later than 24 hours after we have received your physician's "supporting statement" which explains why the drug you are asking for is

medically necessary.

If we decide you are eligible for a fast review and you have not received an answer from us within 24 hours after receiving your request (or your physician's supporting statement if your request involves an exception), your request will automatically go to Appeal Level 2.

- For a decision about payment for Part C medical care or services you already received.

  If we do not need more information to make a decision, we have up to 30 days to make a decision after we receive your request, although a small number of decisions may take longer. However, if we need more information in order to make a decision, we have up to 60 days from the date of the receipt of your request to make a decision. You will be told in writing when we make a decision.

  If you have not received an answer from us within 60 days of your request, you have the right to appeal.

- For a standard decision about Part C medical care or services you have not yet received.

  We have 14 days to make a decision after we receive your request. However, we can take up to 14 more days if you ask for additional time, or if we need more information (such as medical records) that may benefit you. If we take additional days, we will notify you in writing. If you believe that we should not take additional days, you can make a specific type of complaint called a "fast grievance". For more information about fast grievances, see Section 6.

  If you have not received an answer from us within 14 days of your request (or by the end of any extended time period), you have the right to appeal.

- For a fast decision about Part C medical care or services you have not yet received.

  If you receive a "fast" decision, we will give you our decision about your requested medical care or services within 72 hours after we receive the request. 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 more time to prepare for this review. If we take additional days, we will notify you in writing. If you believe that we should not take any extra days, you can file a fast grievance. We will call you as soon as we make the decision.

  If we do not tell you about our decision within 72 hours (or by the end of any extended time period), you have the right to appeal. If we deny your request for a fast decision, you may file a "fast grievance." For more information about fast grievances, see Section 6.

What happens if we decide completely in your favor?

- For a standard decision about a Part D drug (including a request to pay you back for a Part D drug that you have already received).

  We must cover the Part D drug you requested as quickly as your health requires, but no later than 72 hours after we receive the request. If your request involves a request for an exception, we must cover the Part D drug you requested no later than 72 hours after we receive your physician's "supporting statement". If you are asking us to pay you back for a Part D drug that you already paid for and received, we must send payment to you no later than 30 calendar days after we receive the request (or supporting statement if your request involves an exception).

- For a fast decision about a Part D drug that you have not yet received.

  We must cover the Part D drug you requested no later than 24 hours after we receive your request. If your request involves a request for an exception, we must cover the Part D drug you requested no later than 24 hours after we receive your physician's "supporting statement".

- For a decision about payment for Part C medical care or services you already received.

  Generally, we must send payment no later than 30 days after we receive your request, although a small number of decisions may take up to 60 days. If we need more information in order to make a decision, we have up to 60 days from the date of the receipt of your request to make payment.

- For a standard decision about Part C medical care or services you have not yet received.

  We must authorize or provide your requested care within 14 days of receiving your request. If we extended the time needed to make our decision, we will authorize or provide your medical care before the extended time period expires.

- For a fast decision about Part C medical care or services you have not yet received.

  We must authorize or provide your requested care within 72 hours of receiving your request. If we extended the time needed to make our decision, we will authorize or provide your medical care before the extended time period expires.

What happens if we decide against you?

If we decide against you, we will send you a written decision explaining why we denied your request. If an initial determination does not give you all that you requested, you have the right to appeal the decision. (See **Appeal Level 1**.)

Appeal Level 1: Appeal to the Plan

You may ask us to review our initial determination, even if only part of our decision is not what you requested. An appeal to the plan about a Part D drug is also called a plan **"redetermination"**. An appeal to the plan about Part C medical care or services is also called a plan **"reconsideration"**. When we receive your request to review the initial determination, we give the request to people at our organization who were not involved in making the initial determination. This helps ensure that we will give your request a fresh look.

Who may file your appeal of the initial determination?

If you are appealing an initial decision about a Part D drug, you or your representative may file a **standard appeal** request, or you, your representative, or your doctor may file a **fast appeal** request. Please see "Who may ask for an initial determination?" for information about appointing a representative.

If you are appealing an initial decision about Part C medical care or services, the rules about who may file an appeal are the same as the rules about who may ask for an organization determination. Follow the instructions under "Who may ask for an initial determination?" However, providers who do not have a contract with the Plan may also appeal a payment decision as long as the provider signs a "waiver of payment" statement saying it will not ask you to pay for the Part C medical care or service under review, regardless of the outcome of the

appeal.

How soon must you file your appeal?

You must file your appeal within 60 calendar days from the date included on the notice of our initial determination. We may give you more time if you have a good reason for missing the deadline.

How to file your appeal

1) Asking for a standard appeal

   To ask for a standard appeal about a Part D drug and/or Part C medical care or service a signed, written appeal request must be sent to the address listed under "Contact Information for our Plan Member Services" in Section 9.

   You may also ask for a standard appeal by calling us at the phone number listed under "Contact Information for our Plan Member Services" in Section 9.

2) Asking for a "fast" appeal?

   If you are appealing a decision we made about giving you a Part D drug and/or Part C medical care or service that you have not received yet, you and/or your doctor will need to decide if you need a fast appeal. The rules about asking for a fast appeal are the same as the rules about asking for a fast initial determination. You, your doctor, or your representative may ask us for a fast appeal by calling, faxing, or writing us at the numbers or address listed under "Contact Information for our Plan Member Services" in Section 9.

   Requests that are made outside of regular weekday business hours may be directed to your PCP. You can call your PCP at any time of the day, including evenings and weekends. Explain your condition to your doctor or the Physician on-call and they will direct your care. There will always be a doctor on call to help you. This physician will call you back and advise you about what to do.

   Be sure to ask for a "fast" or "expedited" review. Remember, if your doctor provides a written or oral supporting statement explaining that you need the fast appeal, we will automatically give you a fast appeal. If you ask for a fast decision without support from a doctor, we will decide if your health requires 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 informing you that if you get a doctor's support for a fast review, we will automatically give you a fast decision. The letter will also tell you how to file a "fast grievance" if you disagree with our decision to deny your request for a fast review (for more information about fast grievances, see Section 5). If we deny your request for a fast appeal, we will give you a standard appeal.

Getting information to support your appeal

We must gather all the information we need to make a decision about your appeal. If we need your assistance in gathering this information, we will contact you or your representative. You have the right to obtain and include additional information as part of your appeal. For example, you may already have documents related to your request, or you may want to get your doctor's records or opinion to help support your request. You may need to give your doctor a written request to get information.

You can give us your additional information to support your appeal by calling, faxing, or writing to the numbers or address listed under "Contact Information for our Plan Member Services" in Section 9.

You may also deliver additional information in person to the address listed under Part D Appeals (for appeals about Part D drugs) and/or Part C Appeals (for appeals about Part C medical care or services) in Section 9.

You also have the right to ask us for a copy of information regarding your appeal. You may call or write us at the phone number or address listed under "Contact Information for our Plan Member Services" in Section 9. We are allowed to charge a fee for copying and sending this information to you.

How soon must we decide on your appeal?

- For a standard decision about a Part D drug that includes a request to pay you back for a Part drug you have already paid for and received.

  We will give you our decision within seven calendar days of receiving the appeal request. We will give you the decision sooner if you have not received the drug yet and your health condition requires us to. If we do not give you our decision within seven calendar days, your request will automatically go to Appeal Level 2.

- For a fast decision about a Part D drug that you have not yet received.

  We will give you our decision within 72 hours after we receive the appeal request. We will give you the decision sooner if your health condition requires us to. If we do not give you our decision within 72 hours, your request will automatically go to Appeal Level 2.

- For a decision about payment for Part C medical care or services you already received.

  After we receive your appeal request, we have up to 60 days to decide. If we do not decide within 60 days, your appeal automatically goes to Appeal Level 2.

- For a standard decision about Part C medical care or services you have not yet received.

  After we receive your appeal, we have 30 days to decide, but will decide sooner if your health condition requires. However, if you ask for more time, or if we find that helpful information is missing, we can take up to 14 more days to make our decision. If we do not tell you our decision within 30 days (or by the end of the extended time period), your request will automatically go to Appeal Level 2.

- For a fast decision about Part C medical care or services you have not yet received.

  After we receive your appeal, we have 72 hours to decide, but will decide sooner if your health condition requires. However, if you ask for more time, or if we find that helpful information is missing, we can take up to 14 more days to make our decision. If we do not decide within 72 hours (or by the end of the extended time period), your request will automatically go to Appeal Level 2.

What happens if we decide completely in your favor?

- For a standard decision about a Part D drug (including a request to pay you back for a Part D drug that you have already received.

  We must cover the Part D drug you requested as quickly as your health requires, but no later than 7

calendar days after we receive the request. If you are asking us to pay you back for a Part D drug that you already paid for and received, we must send payment to you no later than 30 calendar days after we receive the request.

- For a fast decision about a Part D drug that you have not yet received.

  We must cover the Part D drug you requested no later than 72 hours after we receive your request.

- For a decision about payment for Part C medical care or serves you already received.

  We must pay within 60 days of receiving your appeal request.

- For a standard decision about Part C medical care or services you have not yet received.

  We must authorize or provide your requested care within 30 days of receiving your appeal request. If we extended the time needed to decide your appeal, we will authorize or provide your requested care before the extended time period expires.

- For a fast decision about Part C medical care or services you have not yet received.

  We must authorize or provide your requested care within 72 hours of receiving your appeal request. If we extended the time needed to decide your appeal, we will authorize or provide your requested care before the extended time period expires.

Appeal Level 2: Independent Review Entity (IRE)

At the second level of appeal, your appeal is reviewed by an outside, Independent Review Entity (IRE) that has a contract with the Centers for Medicare & Medicaid Services (CMS), the government agency that runs the Medicare program. The IRE has no connection to us. You have the right to ask us for a copy of your case file that we sent to this entity. We are allowed to charge you a fee for copying and sending this information to you.

How to file your appeal

If you asked for Part D drugs or payment for Part D drugs and we did not rule completely in your favor at Appeal Level 1, you may file an appeal with the IRE. If you choose to appeal, you must send the appeal request to the IRE. The decision you receive from the plan (Appeal Level 1) will tell you how to file this appeal, including who can file the appeal and how soon it must be filed.

If you asked for Part C medical care or services, or payment for Part C medical care or services, and we did not rule completely in your favor at Appeal Level 1, your appeal is automatically sent to the IRE.

How soon must the IRE decide?

The IRE has the same amount of time to make its decision as the plan had at **Appeal Level 1**.

If the IRE decides completely in your favor:

The IRE will tell you in writing about its decision and the reasons for it.

- For a decision to pay you back for a Part D drug you already paid for and received.

  We must send payment to you within 30 calendar days from the date we receive notice reversing our decision.

- For a standard decision about a Part D drug you have not yet received.

  We must cover the Part D drug you asked for within 72 hours after we receive notice reversing our decision.

- For a fast decision about a Part D drug you have not yet received.

  We must cover the Part D drug you asked for within 24 hours after we receive notice reversing our decision.

- For a decision about payment for Part C medical care or services you already received.

  We must pay within 30 days after we receive notice reversing our decision.

- For a standard decision about Part C medical care or services you have not yet received.

  We must authorize your requested Part C medical care or service within 72 hours, or provide it to you within 14 days after we receive notice reversing our decision.

- For a fast decision about Part C medical care or services.

  We must authorize or provide your requested Part C medical care or services within 72 hours after we receive notice reversing our decision.

Appeal Level 3: Administrative Law Judge (ALJ)

If the IRE does not rule completely in your favor, you or your representative may ask for a review by an Administrative Law Judge (ALJ) if the dollar value of the Part D drug and/or Part C medical care or service you asked for meets the minimum requirement provided in the IRE's decision. During the ALJ review, you may present evidence, review the record (by either receiving a copy of the file or accessing the file in person when feasible), and be represented by counsel.

How to file your appeal

The request must be filed with an ALJ within 60 calendar days of the date you were notified of the decision made by the IRE (Appeal Level 2). The ALJ may give you more time if you have a good reason for missing the deadline. The decision you receive from the IRE will tell you how to file this appeal, including who can file it.

The ALJ will not review your appeal if the dollar value of the requested Part D drug and/or Part C medical care or service does not meet the minimum requirement specified in the IRE's decision. If the dollar value is less than the minimum requirement, you may not appeal any further.

How soon will the Judge make a decision?

The ALJ will hear your case, weigh all of the evidence, and make a decision as soon as possible.

If the Judge decides in your favor

See the section **"Favorable Decisions by the ALJ, MAC, or a Federal Court Judge"** below for information about what we must do if our decision denying what you asked for is reversed by an ALJ.

Appeal Level 4: Medicare Appeals Council (MAC)

If the ALJ does not rule completely in your favor, you are your representative may ask for a review by the Medicare Appeals Council (MAC)

How to file your appeal

The request must be filed with the MAC within 60 calendar days of the date you were notified of the decision made by the ALJ (Appeal Level 3). The MAC may give you more time if you have a good reason for missing the deadline. The decision you receive from the ALJ will tell you how to file this appeal, including who can file it.

How soon will the Council make a decision?

The MAC will first decide whether to review your case (it does not review every case it receives). If the MAC reviews your case, it will make a decision as soon as possible. If it decides not to review your case, you may request a review by a Federal Court Judge (see Appeal Level 5). The MAC will issue a written notice explaining any decision it makes. The notice will tell you how to request a review by a Federal Court Judge.

If the Council decides in your favor:

See the section **"Favorable Decisions by the ALJ, MAC, or a Federal Court Judge"** below for information about what we must do if our decision denying what you asked for is reversed by the MAC.

Appeal Level 5: Federal Court

You have the right to continue your appeal by asking a Federal Court Judge to review your case if the amount involved meets the minimum requirement specified in the Medicare Appeals Council's decision, you received a decision from the Medicare Appeals Council (Appeal Level 4), and:

- The decision is not completely favorable to you, or
- The decision tells you that the MAC decided not to review your appeal request.

How to file your appeal

In order to request judicial review of your case, you must file a civil action in a United States district court within 60 calendar days after the date you were notified of the decision made by the Medicare Appeals Council (Appeal Level 4). The letter you get from the Medicare Appeals Council will tell you how to request this review, including who can file the appeal.

Your appeal request will not be reviewed by a Federal Court if the dollar value of the requested Part D drug and/or Part C medical care or service does not meet the minimum requirement specified in the MAC's decision.

How soon will the Judge make a decision?

The Federal Court Judge will first decide whether to review your case. If it reviews your case, a decision will be made according to the rules established by the Federal judiciary.

If the Judge decides in your favor:

See the section **"Favorable Decisions by the ALJ, MAC, or a Federal Court Judge"** below for information about what we must do if our decision denying what you asked for is reversed by a Federal Court Judge.

If the Judge decides against you:

You may have further appeal rights in the Federal Courts. Please refer to the Judge's decision for further information about your appeal rights.

Favorable Decisions by the ALJ, MAC or a Federal Court Judge

This section explains what we must do if our initial decision denying what you asked for is reversed by the ALJ, MAC, or a Federal Court Judge.

- For a decision to pay you back for a Part D drug you already paid for and received.

  We must send payment to you within 30 calendar days from the date we receive notice reversing our decision.

- For a standard decision about a Part D drug you have not yet received.

  We must cover the Part D drug you asked for within 72 hours after we receive notice reversing our decision.

- For a fast decision about a Part D drug you have not yet received.

  We must cover the Part D drug you asked for within 24 hours after we receive notice reversing our decision.

- For a decision about Part C medical care or services.

  We must pay for, authorize, or provide the medical care or service you have asked for within 60 days of the date we receive the decision.

PART 2. Complaints (appeals) if you think you are being discharged from the hospital too soon

When you are admitted to the hospital, you have the right to get all the hospital care covered by the Plan that is necessary to diagnose and treat your illness or injury. The day you leave the hospital (your "discharge date") is based on when your stay in the hospital is no longer medically necessary. This part explains what to do if you believe that you are being discharged too soon.

Information you should receive during your hospital stay

Within two days of admission as an inpatient or during pre-admission, someone at the hospital should give you a notice called the Important Message from Medicare (call Member Services or 1-800-MEDICARE (1-800-633-4227) to get a sample notice or see it online at http://www.cms.hhs.gov/BNI/).
This notice explains:

- Your right to get all medically necessary hospital services paid for by the Plan (except for any applicable copayments or deductibles).
- Your right to be involved in any decisions that the hospital, your doctor, or anyone else makes about your hospital services and who will pay for them.
- Your right to get services you need after you leave the hospital.
- Your right to appeal a discharge decision and have your hospital services paid for by us during the appeal (except for any applicable copayments or deductibles).

You (or your representative) will be asked to sign the Important Message from Medicare to show that you received and understood this notice. **Signing the notice does not mean that you agree that the coverage for your services should end – only that you received and understand the notice.** If the hospital gives you the Important Message from Medicare more than 2 days before your discharge day, it must give you a copy of your signed Important Message from Medicare before you are scheduled to be discharged.

Review of your hospital discharge by the Quality Improvement Organization

You have the right to request a review of your discharge. You may ask a Quality Improvement Organization to review whether you are being discharged too soon.

What is the "Quality Improvement Organization"?

"QIO" stands for **Q**uality **I**mprovement **O**rganization. The QIO is a group of doctors and other health care experts paid by the federal government to check on and help improve the care given to Medicare patients. They are not part of our Plan or the hospital. There is one QIO in each state. QIOs have different names, depending on which state they are in. In California, the QIO is called Lametra. The doctors and other health experts in Lametra review certain types of complaints made by Medicare patients. These include complaints about quality of care and complaints from Medicare patients who think their hospital stay is ending too soon. Section 9 tells how to contact the QIO.

Getting a QIO review of your hospital discharge

- You must quickly contact the QIO. The Important Message from Medicare gives the name and telephone number of your QIO and tells you what you must do.

- You must ask the QIO for a **"fast review"** of your discharge. This "fast review" is also called an "immediate review".

- You must request a review from the QIO **no later** than the day you are scheduled to be discharged from the hospital. **If you meet this deadline, you may stay in the hospital after your discharge date without paying for it while you wait to get the decision from the QIO.**

- The QIO will look at your medical information provided to the QIO by us and the hospital.

- During this process, you will get a notice giving our reasons why we believe that your discharge date is medically appropriate.

- The QIO will decide, within one day after receiving the medical information it needs, whether it is medically appropriate for you to be discharged on the date that has been set for you.

What happens if the QIO decides in your favor?

We will continue to cover your hospital stay (except for any applicable copayments or deductibles) for as long as it is medically necessary and you have not exceeded our Plan coverage limitations as described in Section 11.

What happens if the QIO agrees with the discharge?

You will not be responsible for paying the hospital charges until noon of the day after the QIO gives you its decision. However, you could be financially liable for any inpatient hospital services provided after noon of the day after the QIO gives you its decision. You may leave the hospital on or before that time and avoid any possible financial liability.

If you remain in the hospital, you may still ask the QIO to review its first decision if you make the request within 60 days of receiving the QIO's first denial of your request. However, you could be financially liable for any inpatient hospital services provided after noon of the day after the QIO gave you its first decision.

What happens if you appeal the QIO decision?

The QIO has 14 days to decide whether to uphold its original decision or agree that you should continue to receive inpatient care. If the QIO agrees that your care should continue, we must pay for or reimburse you for any care you have received since the discharge date on the Important Message from Medicare, and provide you with inpatient care (except for any applicable copayments or deductibles) for as long as it is medically necessary and you have not exceeded our Plan coverage limitations as described in Section 11.

If the QIO upholds its original decision, you may be able to appeal its decision to the Administrative Law Judge. Please see Appeal Level 3 in Part 1 of this section for guidance on the ALJ appeal. If the ALJ upholds the decision, you may also be able to ask for a review by the Medicare Appeals Council (MAC) or a Federal Court. If any of these decision makers agree that your stay should continue, we must pay for or reimburse you for any care you have received since the discharge date, and provide you with inpatient care (except for any

applicable copayments or deductibles) for as long as it is medically necessary and you have not exceeded our Plan coverage limitations as described in Section 11.

What if you do not ask the QIO for a review by the deadline?

If you do not ask the QIO for a fast review of your discharge by the deadline, you may ask us for a "fast appeal" of your discharge which is discussed in Part 1 of this section. If you ask us for a fast appeal of your discharge and you stay in the hospital past your discharge date, you may have to pay for the hospital care you receive past your discharge date. Whether you have to pay or not depends on the decision we make.

- If we decide, based on the fast appeal, that you need to stay in the hospital, we will continue to cover your hospital care (except for any applicable copayments or deductibles) for as long as it is medically necessary and you have not exceeded our Plan coverage limitations as described in Section 11.

- If we decide that you should not have stayed in the hospital beyond your discharge date, we will not cover any hospital care you received after the discharge date.

If we uphold our original decision, we will forward our decision and case file to the Independent Review Entity (IRE) within 24 hours. Please see Appeal Level 2 in Part 1 of this section for guidance on the IRE appeal. If the IRE upholds our decision, you may also be able to ask for a review by an ALJ, MAC or a Federal court. If any of these decision makers agree that your stay should continue, we must pay for or reimburse you for any care that you have received since the discharge date on the notice you got from your provider, and provide you with any services you ask for (except for any applicable co-payments or deductibles) for as long as they are medically necessary and you have not exceeded our Plan coverage limitations as described in Section 11.

PART 3. Complaints (appeals) if you think your coverage for skilled nursing facility, home health or comprehensive outpatient rehabilitation facility services is ending too soon

When you are a patient in a Skilled Nursing Facility (SNF), Home Health Agency (HHA), or Comprehensive Outpatient Rehabilitation Facility (CORF), you have the right to get all the SNF, HHA or CORF care covered by our Plan that is necessary to diagnose and treat your illness or injury. The day we end coverage for your SNF, HHA or CORF services is based on when services are no longer medically necessary. This part explains what to do if you believe that your coverage for your services is ending too soon.

Information you will receive during your SNF, HHA or CORF stay

Your provider will give you written notice called the Notice of Medicare Non-Coverage at least 2 days before coverage for your services ends (Member Services or 1-800 MEDICARE (1-800-633-4227) to get a sample notice or see it online at http://www.cms.hhs.gov/BNI/). You (or your representative) will be asked to sign and date this notice to show that you received it. **Signing the notice does not mean that you agree that coverage for your services should end – only that you received and understood the notice.**

Getting QIO review of our decision to end coverage

You have the right to appeal our decision to end coverage for your services. As explained in the notice you get from your provider, you may ask the **Q**uality **I**mprovement **O**rganization (the "QIO") to do an independent

review of whether it is medically appropriate to end coverage for your services.

How soon do you have to ask for QIO review?

You must quickly contact the QIO. The written notice you got from your provider gives the name and telephone number of your QIO and tells you what you must do.

- If you get the notice 2 days before your coverage ends, you must contact the QIO no later than noon of the day after you get the notice.

- If you get the notice more than 2 days before your coverage ends, you must make your request no later than noon of the day before the date that your Medicare coverage ends.

What will happen during the QIO's review?

The QIO will ask why you believe coverage for the services should continue. You don't have to prepare anything in writing, but you may do so if you wish. The QIO will also look at your medical information, talk to your doctor, and review information that we have given to the QIO. During this process, you will get a notice called the Detailed Explanation of Non-Coverage giving the reasons why we believe coverage for your services should end (call Member Services or 1-800-MEDICARE (1-800-633-4227 – TTY users should call 1-877-486-2048) to get a sample notice or see it online at http:www.cms.hhs.gov/BNI/).

The QIO will make a decision within one full day after it receives the information it needs.

What happens if the QIO decides in your favor?

We will continue to cover your SNF, HHA or CORF services for as long as medically necessary (except for any applicable co-payments or deductibles) for as long as it is medically necessary and you have not exceeded our Plan coverage limitations as described in Section 11.

What happens if the QIO agrees that your coverage should end?

You will not be responsible for paying the SNF, HHA or CORF services provided before the termination date on the notice you get from your provider. You may stop getting services on or before the date given on the notice and avoid any possible financial liability. If you continue receiving services, you may still ask the QIO to review its first decision if you make the request within 60 days of receiving the QIO's first denial of your request.

What happens if you appeal the QIO decision?

The QIO has 14 days to decide whether to uphold its original decision or agree that you should continue to receive services. If the QIO agrees that your services should continue, we must pay for or reimburse you for any care you have received since the termination date on the notice you got from your provider, and provide you with any services you asked for (except for any applicable co-payments or deductibles) as long as they are medically necessary and you have not exceeded our Plan coverage limitations as described in Section 11.

If the QIO upholds its original decision, you may be able to appeal its decision to the Administrative Law Judge (ALJ). Please see Appeal Level 3 in Part 1 of this section for guidance on the ALJ appeal. If the ALJ upholds our decision, you may also be able to ask for a review by the Medicare Appeals Council (MAC) or a Federal Court.

If either the MAC or Federal Court agrees that your stay should continue, we must pay for or reimburse you for any care you have received since the termination date on the notice you got from your provider, and provide you with any services you asked for (except for any applicable copayments or deductibles) as long as they are medically necessary and you have not exceeded our Plan coverage limitations as described in Section 11.

What if you do not ask the QIO for a review by the deadline?

If you do not ask the QIO for a, review by the deadline, you can ask us for a fast appeal, which is discussed in Part 1 of this section.

If you ask us for a fast appeal of your coverage ending and you continue getting services from the SNF, HHA, or CORF, you may have to pay for the care you get after your termination date. Whether you have to pay or not depends on the decision we make.

- If we decide, based on the fast appeal, that coverage for your services should continue, we will continue to cover your SNF, HHA, or CORF services (except for any applicable copayments or deductibles) as long as they are medically necessary and you have not exceeded our Plan coverage limitations as described in Section 11.

- If we decide that you should not have continued getting services, we will not cover any services you received after the termination date.

If we uphold our original decision, we will forward our decision and case file to the Independent Review Entity within 24 hours. Please see Appeal Level 2 in Part 1 of this section for guidance on the IRE appeal. If the IRE upholds our decision, you may also be able to ask for a review by an AJL, MAC, or a Federal court. If any of these decision makers agree that your stay should continue, we must pay for or reimburse you for any care you have received since the discharge date on the notice you got from your provider, and provide you with any services you asked for (except for any applicable copayments or deductibles) as long as they are medically necessary and you have not exceeded our Plan coverage limitations as described in Section 11.

7. Ending Your Membership

Voluntarily ending your membership

Ending your membership in our Plan can 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 we are *required* to end your membership. For example, if you move permanently out of our geographic service area.

Until your membership ends, you must keep getting your Medicare services through our Plan or you will have to pay for them yourself.

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 later in this section). While you are waiting for your membership to end, you are still a member and must continue to get your care 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 [or through our mail-order-pharmacy service], 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.

What should I do if I decide to leave WHA *Care*+?

If you want to leave our Plan:

- The first step is to **be sure that the type of change you want to make and when you want to make it fit with the new rules** explained below about changing how you get Medicare. If the change does not fit with these rules, you won't be allowed to make the change.
- Then, what you must do to leave our Plan depends on whether you want to switch to Original Medicare or to one of your other choices.

What are your choices for receiving your Medicare services if you leave our Plan?

Universities of California Retirees, please check with the University's Customer Service Center regarding your choices if you leave our Plan. You may direct your questions to:

University of California
Health & Welfare Administration
300 Lakeside Drive, 12th Floor
Oakland, CA 94612
1-800-888-8267

What happens to you if our Plan leaves the Medicare program or our Plan leaves the area where you live?

If we leave the Medicare program or change our service area so that it no longer includes the area where you live, we will tell you in writing. If this happens, your membership in our Plan will end, and you will have to change to another way of getting your Medicare benefits. All of the benefits and rules described in this booklet will continue until your membership ends. This means that you must continue to get your medical care in the usual way through our Plan until your membership ends.

Your choices for how to get your Medicare will always include Original Medicare and joining a Prescription Drug Plan to complement your Original Medicare coverage. You may also choose another Medicare Advantage Plan, offered by the University. Once we have told you in writing that we are leaving the Medicare program or the area where you live, you will have a chance to change to another way of getting your Medicare benefits. If you decide to change from our Plan to Original Medicare, you will have the right to buy a Medigap policy regardless of your health.

Our Plan has a contract with the Centers for Medicare & Medi-Cal Services (CMS), the government agency that runs Medicare. This contract renews each year. At the end of each year, the contract is reviewed, and either our Plan or CMS can decide to end it. You will get 90 days advance notice in this situation. It is also possible for our contract to end at some other time during the year, too. In these situations we will try to tell you 90 days in advance, but your advance notice may be as little as 30 or fewer days if CMS must end our contract in the middle of the year.

Whenever a Medicare health plan leaves the Medicare program or stops serving your area, you will be provided a special enrollment period to make choices about how you get Medicare, including choosing a Medicare Prescription Drug Plan and guaranteed issue rights to a Medigap policy.

We *can* ask you to leave the plan under certain special conditions.

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

- **If you move out of the service area or are away from the service area for more than six months in a row.** If you plan to move or take a long trip, please call Member Services at the number on the cover of this booklet to find out if the place you are moving to or traveling to is in our Plan's service area. If you move permanently out of our geographic service area, or if you are away from our service area for more than six months in a row, you generally cannot remain a member of our Plan. In these situations, if you do not leave on your own, we must end your membership ("disenroll" you). An earlier part of this section tells about the choices you have if you leave our Plan and explains how to leave. Section 3 gives more information about getting care when you are away from the service area.

- If you do *not* stay continuously enrolled in both Medicare Part A and Medicare Part B

- If you give us information on your enrollment request that you know is false or deliberately misleading, and it affects whether or not you can enroll in our Plan.

- If you behave in a way that is disruptive, to the extent that your 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 the Centers for Medicare & Medi-Cal Services, the government agency that runs 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 will tell you our reasons in writing and explain how you may file a complaint against us if you want to.

8. Definitions of Important Words Used in the EOC

For the terms listed below, this section either gives a definition or directs you to a place in this booklet that explains the term.

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 or payment for services 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 doesn't pay for an item or service you think you should be able to receive. Section 6 explains appeals, including the process involved in making an appeal.

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. A benefit period *begins* on the first day you go to a Medicare-covered inpatient hospital or a skilled nursing facility. The benefit period *ends* when you haven't been an inpatient at any hospital or SNF for 60 days in a row. If you go to the hospital (or SNF) after one benefit period has ended, a new benefit period begins. There is no limit to the number of benefit periods you can have. The type of care you actually get during the stay determines whether you are considered to be an inpatient for SNF stays, but not for hospital stays.

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 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 $4,350 in covered drugs during the covered year.

Centers for Medicare & Medi-Cal Services (CMS) – The Federal agency that runs the Medicare program. Section 9 explains how to contact CMS.

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.

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 isn't covered under your plan, that isn't a coverage determination. You need to call or write to your plan to ask for a formal decision about the coverage if you disagree.

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

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

Creditable Prescription Drug Coverage – Coverage (for example, from an employer or union) that is at least as good as Medicare prescription drug coverage.

Deductible – The amount you must pay for the health care services or drugs you receive before our Plan begins to pay its share of your covered services or drugs.

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 7 tells about disenrollment.

Durable Medical Equipment – Equipment needed for medical reasons, which is sturdy enough to be used many times without wearing out. A person normally needs this kind of equipment only when ill or injured. It can be used in the home. Examples of durable medical equipment are wheelchairs, hospital beds, or equipment that supplies a person with oxygen.

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

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

Exception – A type of coverage determination that, if approved, allows you to obtain a drug that is not on our 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 we require 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.

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 Plan providers, including a complaint concerning the quality of your care. This type of complaint doesn't involve coverage or payment disputes. See Section 5 for more information about grievances.

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

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 11 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 aren't covered unless you are also getting a covered skilled service. Home health services don't 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)

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

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

Initial Coverage Period – This is the period after you have met your deductible and before your total drug expenses, have reached $2,700, including amounts you've paid and what our Plan has paid on your behalf.

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 the convenience of you or 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 Organization – Medicare Advantage Plans are run by private companies. They give you more options, and sometimes, extra benefits. These plans are still part of the Medicare Program and are also called "Part C." They provide all your Part A (Hospital) and Part B (Medical) coverage. Some may also provide Part D (prescription drug) coverage. Medicare Advantage Organizations can offer one or more Medicare Advantage Plans in the same service area. We are a Medicare Advantage Organization.

Medicare Advantage Plan – A benefit package offered by a Medicare Advantage Organization that 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 Managed Care Plan – Means a Medicare Advantage HMO, Medicare Cost Plan, or Medicare Advantage PPO.

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.

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 **C**enters for **M**edicare & Medi-Cal **S**ervices (CMS).

Member Services – A department within our Plan responsible for answering your questions about your

membership, benefits, grievances, and appeals. See Section 9 for information about how to contact Member Services.

Network Pharmacy – A network pharmacy is a pharmacy where members of our Plan can receive covered 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."

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. Non-plan providers are providers that are not employed, owned, or operated by our Plan or are not under contract to deliver covered services to you. As explained in this booklet, most services you get from non-plan providers are not covered by our Plan or Original Medicare.

Organization Determination – The Medicare Advantage organization has made an organization determination when it, or one of its providers, makes a decision about MA services or payment that you believe you should receive.

Original Medicare – ("Traditional Medicare" or "Fee-for-service" Medicare) The Original Medicare Plan is the way many people get their health care coverage. It is the national pay-per-visit program that lets you go to 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** – A provider or facility with which we have not arranged to coordinate or provide covered services to members of our Plan. Out-of-network providers are providers that are not employed, owned, or operated by our Plan or are not under contract to deliver covered services to you. Using out-of-network providers or facilities is explained in this EOC in Section 3.

Out-of-Network Pharmacy – A pharmacy that doesn't 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 D – The voluntary Medicare Prescription Drug Benefit Program. (For ease of reference, we will refer to the new prescription drug benefit program as Part D.)

Part D Drugs – Drugs that Congress permitted our Plan to offer as part of a standard Medicare prescription drug benefit. We may or may not offer all Part D drugs. (See your formulary for a specific list of covered drugs.) Certain categories of drugs, such as benzodiazepines, barbiturates, and over-the-counter drugs were specifically excluded by Congress from the standard prescription drug package (see Section 11 for a listing of these drugs). These drugs are not considered Part D drugs.

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 3 tells more about PCPs

Prior Authorization – Approval in advance to get services AND/OR certain drugs that may or may not be on our formulary. Some in-network 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 11.

Quality Improvement Organization (QIO) – Groups of practicing doctors and other health care experts that are paid by the federal government to check and improve the care given to Medicare patients. They must review your complaints about the quality of care given by Medicare Providers. See Section 9 for information about how to contact the QIO in your state and Section 6 for information about making complaints to the QIO

Referral – Your PCP's "or his/her plan medical group" or "IPA's" approval for you to see a certain plan specialist or to receive certain covered services from plan providers.

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

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.

Service Area – Section 3 tells about our Plan service area. "Service area" is the geographic area approved by the **C**enters for **M**edicare & Medi-Cal **S**ervices (CMS) within which an eligible individual may enroll in a particular plan offered by a Medicare Health Plan.

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.

Urgently Needed Care – Section 3 explains about urgently needed services. These are different from emergency services.

9. Helpful Phone Numbers and Resources

Contact Information for our Plan Member Services

If you have any questions or concerns, please call or write to WHA *Care*+ Member Services. We will be happy to help you.

CALL **(916) 563-2252**

1 (888) 563-2252 Calls to this number are free.

For any Medicare Advantage inquires, Member Services Representatives are available from 8:00 a.m. to 5:00 p.m., Monday through Friday. An interactive voice response system will be available from 5:00 p.m. to 8:00 p.m., Monday through Friday, and from 8:00 a.m. to 8:00 p.m. on weekends and holidays.

TTY **1 (888) 877-5378**
This number requires special telephone equipment. Calls to this number are free.

FAX **(916) 563-2207**

WRITE/VISIT WHA *Care*+
2349 Gateway Oaks, Suite 100
Sacramento, CA 95833

WEBSITE **westernhealth.com**

Contact Information for Grievances, Organizations Determinations, Coverage Determinations and Appeals, Part C and Part D issues

CALL **(916) 563-2252**

1 (888) 563-2252 Calls to this number are free.

TTY **1 (888) 877-5378**
This number requires special telephone equipment. It is on the cover of this booklet for easy reference. Calls to this number are free.

FAX **(916) 563-2207**

WRITE WHA *Care*+
2349 Gateway Oaks, Suite 100
Sacramento, CA 95833

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

HICAP – an organization in your state that provides free Medicare help and information

HICAP is a state organization paid by the federal government to give free health insurance information and help to people with Medicare. HICAP can explain your Medicare rights and protections, help you make complaints about care or treatment, and help straighten out problems with Medicare bills. HICAP has information about Medicare Advantage Plans and about Medigap (Medicare supplement insurance) policies. This includes information about whether to drop your Medigap policy while enrolled in the Medicare Advantage plan. This also includes special Medigap rights for people who have tried a Medicare Advantage Plan (like WHA *Care*+) for the first time. (Medicare Advantage is the new name for Medicare + Choice). Section 3 has more information about your Medigap guaranteed issue rights.

You can contact HICAP at:
2862 Arden Way, Suite 200
Sacramento, CA 95825
1-800- 424-0222

You can also find the website for HICAP at www.medicare.gov on the web.

Lumetra – a group of doctors and health professionals in your state who review medical care and handle certain types of complaints from patients with Medicare

"QIO" stands for **Q**uality **I**mprovement **O**rganization. The QIO is a group of doctors and other health care experts 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. In California, the QIO is called Lumetra. The doctors and other health experts in Lumetra review certain types of complaints made by Medicare patients. These include complaints about quality of care and complaints from 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 6 for more information about complaints.

You can contact Lumetra at:
One Sansome Street, Suite 600
San Francisco, CA 94104-4448
1-800-841-1602
1-800-881-5980 TDD

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 don't have a computer, your local library or senior center may be able to help you visit this website using its computer.

Other organizations (including Medi-Cal, Social Security Administration)

Medi-Cal agency – a state government agency that handles health care programs for people with low incomes

Medi-Cal is a joint federal and state program that helps with medical costs for some people with low incomes and limited resources. Some people with Medicare are also eligible for Medi-Cal. Most health care costs are covered if you qualify for both Medicare and Medi-Cal. Medi-Cal also has programs that can help pay for your Medicare premiums and other costs, if you qualify. To find out more about Medi-Cal and its programs, contact:

Placer County:
Health and Human Services
11519 B Avenue
Auburn, CA 95603
(530) 889-7610

100 Stonehouse Court, Suite A
Roseville, CA 95678
(916) 784-6000
www.placer.ca.gov/hhs/hhs.htm

Sacramento County:
Department of Human Assistance
2433 Marconi Avenue
Sacramento, CA 95821-4807
(916) 874-2072

Yolo County:
Department of Employment and Social Services
25 N. Cottonwood Street
Woodland, CA 95695
(530) 661-2750
www.yolocounty.org/org/dess

Social Security Administration

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

Railroad Retirement Board

If you get benefits from the Railroad Retirement Board, you may call your local Railroad Retirement Board office or 1-800-808-0772. TTY users should call 312-751-4701. You may also visit www.rrb.gov on the Web.

Employer (or "Group") Coverage

If you or your spouse gets your benefits from your current or former employer, or union, or from your spouse's current or former employer, call the University of California's Customer Service Center at 1-800-888-8267, if you have any questions about your benefits, plan premiums, or the open enrollment season.

10. 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 & Medi-Cal Services, or CMS. In addition, other federal laws may apply and, under certain circumstances, the laws of the State of California may apply.

Notice about non-discrimination

We don't 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 or Medicare Prescription Drug 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.

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

Paying the plan premium for your coverage as a member of WHA *Care*+

To be a member of our Plan, you must continue to pay your Medicare Part B premium.

Paying your share of the cost when you get covered services

What are "copayments"?

A **"copayment"** is a payment you make for your share of the cost of certain covered services you receive. A copayment is **a set amount per service** (such as paying $15 for a doctor visit). You pay it when you get the service. The Benefits Chart in this section gives your copayments for covered services. Copayments for prescription drugs are listed later in this section.

What is the most you will pay for covered care?

There is a limit to how much you will have to pay for your covered health care each year. During the year, if the amount that you spend on your copayments, as a member of our Plan goes over $1,000 for an Individual or $3,000 for a family, we will begin to pay for all of your covered health care for the rest of the calendar year.

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

If you qualify for extra help with your drug costs, your costs for your drugs may be different than those described below. (See "What extra help is available?" later in this section).

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, 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 and your drug costs for each coverage level is described below.

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 **copayment**. Your copayment will vary depending on the drug and where the prescription is filled.

Once your total drug costs reach $2,700, 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.

When you fill a prescription for a covered drug, you pay a copayment for your drug. Your drug costs for each coverage level are described below.

Drug Tier	Retail Copayment (30-day supply)	Retail Copayment (90-day supply)	Mail-Order Copayment (90-day supply)
Preferred Generic	$10	$20	$20
Preferred Brand Name	$20	$40	$40
Non-Preferred	$35	$70	$70

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 $4,350 out-of-pocket for the year. When the total amount you have paid toward your co-payments and the cost for covered Part D drugs after you reach the initial coverage limit reaches $4,350, you will qualify for catastrophic coverage. During catastrophic coverage you will pay the greater of $2.40 for generics for drugs that are treated like generics and $6.00 for all other drugs or 5% coinsurance. We will pay the rest.

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 can count toward your out-of-pocket costs and help you qualify for catastrophic coverage so long as the drug you are paying for is a Part D drug, on the formulary (or if you get a favorable decision on a coverage determination, 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 copayments; payments you make after the initial coverage limit.

When you have spent a total of $4,350 for these items, you will reach the catastrophic coverage level. The amount you pay for your monthly premium does not count toward reaching the catastrophic coverage level.

Purchases that will **not** count toward your out-of-pocket costs include:

- Prescription drugs purchased outside the United States and its territories;
- Prescription drugs not covered by the Plan

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 a footnote.

What if you have problems getting services you believe are covered for you?

If you have any concerns or problems getting the services you believe are covered as a member, we want to help. Please call us at Member Services at the telephone numbers listed at the bottom of this page. You have the right to make a complaint if you have problems related to getting services or payments for services that you believe are covered as a member. See Section 6 for information about making a complaint.

Can your benefits change during the year?

Generally your benefits will not change during the year. The Medicare program does not allow us to *decrease* your benefits during the calendar year. We are allowed to decrease your benefits only on January 1, at the beginning of the next calendar year.

At any time during the year, the Medicare program can change its national coverage. Since we cover what Original Medicare covers, we would have to make any change that the Medicare program makes. These changes could be to increase or decrease your benefits, depending on what change the Medicare program makes. In some cases, if your benefits increase, Original Medicare will pay for the benefit for the rest of the calendar year. In those cases, you will have to pay Original Medicare out-of-pocket amounts for those services. We will let you know in advance if you will have to pay Original Medicare out-of-pocket amounts for an increased benefit.

Can the prescription drugs that we cover change during the year?

The Medicare program allows us to make changes in our prescription drug formulary list at any time during the calendar year. As we explain in Section 3, the formulary is a list of drugs. A change in our drug formulary list could affect how much you have to pay when you fill a covered prescription. Note that the formulary list applies only to the covered services listed in the Benefits Chart under the heading that says, "WHA *Care*+ Prescription Drug Benefit (outpatient prescription drugs)."

Benefits Chart – **your covered services**	**What you must pay** when you get these covered services
# Inpatient Services ## Inpatient hospital care Covered services include, but are not limited to, the following: • Semiprivate 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 therapy, occupational therapy, and speech therapy. • *Under certain conditions, the following types of transplants are covered*: corneal, kidney, pancreas, heart, liver, lung, heart/lung, bone marrow, stem cell, intestinal/multivisceral. See Section 3 for more information about transplants. • Blood - including storage and administration. Coverage of whole blood and packed red cells begins only with the fourth pint of blood that you need - you pay for the first 3 pints of unreplaced blood. All other components of blood are covered beginning with the first pint used. • Physician Services. Except in an emergency, your provider must obtain prior authorization from WHA.	You pay **$250** for each Medicare-covered stay in a network hospital. A **benefit period** begins the day you go to a hospital or skilled nursing facility. The benefit period ends when you have not received hospital or skilled nursing care for 60 days in a row. If you go into the hospital after one benefit period has ended, a new benefit period begins. You must pay the inpatient hospital copayment for each benefit period. There is no limit to the number of benefit periods you can have. If you get inpatient care at a non-plan hospital after your emergency condition is stabilized, you are responsible for full cost.

Benefits Chart – **your covered services**	**What you must pay** when you get these covered services
Inpatient Transgender Surgery Inpatient Transgender surgery requires prior authorization from WHA. Transgender surgery and services related to the surgery that are authorized by WHA are subject to a combined Inpatient and Outpatient lifetime benefit maximum of $75,000 for each Member. WHA covers certain transgender surgery and services related to the surgery to change a Member's physical characteristics to those of the opposite gender. Travel expense reimbursement is limited to reasonable expenses for transportation, meals, and lodging for the Member to obtain authorized surgical consultation, transgender reassignment surgical procedure(s), and follow-up care, when the authorized surgeon and facility are located more than 200 miles from the Member's Primary Residence. The transportation and lodging arrangements must be arranged by or approved in advance by WHA. Reimbursement excludes coverage for alcohol and tobacco. Food and housing expenses are not covered for any day a Member is not receiving authorized transgender reassignment services. Travel expenses are included in the $75,000 lifetime benefit maximum.	You pay **$250** for each Medicare-covered stay in a network hospital.
Inpatient mental health care Covered services include mental health care services that require a hospital stay. There is a 190-day lifetime limit in a psychiatric hospital. (The 190-day limit does not apply to Mental Health services provided in a psychiatric unit of a general hospital.) Except in an emergency, your provider must obtain prior authorization from WHA.	You pay **$250** for each Medicare-covered stay in a network hospital.

Benefits Chart – **your covered services**	**What you must pay** when you get these covered services
Skilled nursing facility (SNF) care **You are covered for 100 days each benefit period.** Covered services include, but are not limited to the following: • Semiprivate room (or a private room if medically necessary). • Meals, including special diets. • Regular nursing services. • Physical therapy, occupational therapy, and speech therapy. • Drugs (this includes substances that are naturally present in the body, such as blood clotting factors). • Blood - including storage and administration. Coverage of whole blood and packed red cells begins only with the fourth pint of blood that you need - you pay for the first 3 pints of unreplaced blood. All other components of blood are covered beginning with the first pint used. • Medical and surgical supplies. • Laboratory tests. • X-rays and other radiology services. • Use of appliances such as wheelchairs. • Physician services. Authorization rules may apply for services. Contact plan for details.	There is **no copayment** for Medicare-covered stay in a network Skilled Nursing Facility. A **benefit period** begins the day you go to a hospital or skilled nursing facility. The benefit period ends when you have not received hospital or skilled nursing care for 60 days in a row. If you go into the hospital after one benefit period has ended, a new benefit period begins. You must pay the inpatient hospital copayment for each benefit period. There is no limit to the number of benefit periods you can have.

Benefits Chart – **your covered services**	**What you must pay** when you get these covered services
Inpatient services covered when the hospital or SNF days aren't, or are no longer, covered Covered services include, but aren't limited to, the following: • 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 • Prosthetic devices (other than dental) that replace all or part of an internal body organ (including contiguous tissue), or all or part of the function of a permanently inoperative or malfunctioning internal body organ, including replacement or repairs of such devices • Leg, arm, back, and neck braces; trusses, and artificial legs, arms, and eyes including adjustments, repairs, and replacements required because of breakage, wear, loss, or a change in the patient's physical condition • Physical therapy, speech therapy, and occupational therapy.	You pay **$15** for each primary care doctor visit for Medicare-covered services. There is **no copayment** for Medicare-covered diagnostic tests, X-ray, radium, isotope therapy, surgical splints, casts (and other devices used to reduce fractures and dislocations), prosthetic devices, braces, trusses, artificial legs, arms and eyes. You pay **$15** for each Medicare-covered physical therapy and/or speech/ occupational therapy visit.
Home health care Covered services include, but aren't limited to, the following: • Part-time or intermittent skilled nursing and home health aide services. • Physical therapy, occupational therapy, and speech therapy. • Medical social services. • Medical equipment and supplies. Authorization rules may apply for services. Contact plan for details.	There is **no copayment** for Medicare-covered home health visits.

Benefits Chart – **your covered services**	**What you must pay** when you get these covered services
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 Our Plan covers hospice consultation services (one time only) for a terminally ill person who hasn't elected the hospice benefit.	When you enroll in a Medicare-certified Hospice, your hospice services are paid by Medicare.

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, but are not limited to, the following: • Office visits, including medical and surgical care in a physician's office or certified ambulatory surgical center. • Consultation, diagnosis, and treatment by a specialist. • Second opinion by another plan 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). Authorization rules may apply for services. Contact plan for details.	You pay **$15** for each primary care doctor office visit for Medicare-covered services.
Chiropractic services Covered services include, but aren't limited to, the following: • Manual manipulation of the spine to correct subluxation. Chiropractors in WHA's provider network must be used, please consult with your PCP or Medical Group for available chiropractors. **(Landmark Chiropractors are NOT network providers.)** Authorization rules may apply for services. Contact plan for details.	You pay **$15** for each Medicare-covered visit.

Benefits Chart – **your covered services**	**What you must pay** when you get these covered services
Podiatry services Covered services include, but are not limited to, the following: • 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. Authorization rules may apply for services. Contact plan for details.	You pay **$15** for each Medicare-covered visit (medically necessary for foot care).
Outpatient mental health care (including Partial Hospitalization Services) Covered services include, but aren't limited to, the following: • Mental health services provided by a doctor, clinical psychologist, clinical social worker, clinical nurse specialist, nurse practitioner, physician assistant, or other mental health care professional as allowed under applicable state laws. "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. Mental Health Providers in WHA's provider network, must be used, please consult your WHA *Care*+ Provider Directory for available Mental Health Providers. **(Magellan Behavioral Health or UBH providers are NOT network providers).** Authorization rules may apply for services. Contact plan for details.	For Medicare-covered mental health services, you pay **$15** for each individual/ group therapy visit.
Outpatient substance abuse services • Except in emergency, your provider must obtain authorization from WHA.	For Medicare-covered Mental health services, you pay **$15** for each individual/ group therapy visit.

Benefits Chart – **your covered services**	**What you must pay** when you get these covered services
Outpatient surgery Authorization rules may apply for services. Contact plan for details.	For Medicare-covered Outpatient surgery, you pay **$15** for each visit.
Outpatient surgical procedures **Outpatient Transgender Services** - Outpatient Services including outpatient surgery services for transgender surgery, services related to the surgery, outpatient office visits, and related services, require prior authorization by WHA and are subject to a combined Inpatient and Outpatient lifetime benefit maximum of $75,000 for each Member. WHA covers certain transgender surgery and services related to the surgery to change a Member's physical characteristics to those of the opposite gender. **Transgender surgery and services related to the surgery require prior authorization by WHA *Care*+ and are subject to a combined Inpatient and Outpatient lifetime benefit maximum of $75,000 for each Member, and applicable copayment, if any.**	You pay **$15** for each Medicare-covered visit to an ambulatory surgical center. You pay **$15** for each Medicare-covered visit to an outpatient hospital facility.
Ambulance services Covered services include ambulance services to free standing Renal Dialysis facilities when medically necessary, to an institution (like a hospital or SNF), from an institution to another institution, from an institution to your home, and services dispatched through 911, where other means of transportation could endanger your health. Authorization rules may apply for services. Contact plan for details.	There is **no copayment** for Medicare-covered ambulance services.

Benefits Chart – **your covered services**	**What you must pay** when you get these covered services
Emergency care • Covered inpatient or outpatient services that are: 1) given by a provider qualified to give emergency services; and 2) needed to evaluate or stabilize a medical emergency condition. • Worldwide coverage	You pay **$50** for each Medicare-covered emergency room visit; you do not pay this amount if you are admitted to the hospital within 24 hours for the same condition. If you get inpatient care at a non-plan hospital after your emergency condition is stabilized, you are responsible for the full cost.
Urgently needed care Worldwide coverage	You pay **$15** for each Medicare-covered urgently needed care visit; you do not pay this amount if you are admitted to the hospital within 24 hours for the same condition.
Outpatient rehabilitation services Covered services include: physical therapy, occupational therapy, speech language therapy, and cardiac rehabilitative therapy Authorization rules may apply for services. Contact plan for details.	You pay **$15** for each Medicare-covered visit.
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 8.) Authorization rules may apply for services. Contact plan for details.	There is **no copayment** for each Medicare-covered item.

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 for services. Contact plan for details.	There is **no copayment** for each Medicare-covered item.
Diabetes self-monitoring, training and supplies – for all people who have diabetes (insulin and non-insulin users). Covered services include, but aren't limited to, the following: • 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. Authorization rules may apply for services. Contact plan for details.	You pay $15 for each Medicare-covered diabetes supply item. There is no copayment for diabetes self-monitoring training.
Medical nutrition therapy – for people with diabetes, renal (kidney) disease (but not on dialysis), and after a transplant when referred by your doctor.	There is **no copayment** for Medicare-covered items.

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, but are not limited to, the following: • X-rays. • Radiation therapy. • Surgical supplies, such as dressings. • Supplies, such as splints and casts. • Laboratory tests. • Blood - Coverage begins with the fourth pint of blood that you need – you pay for the first 3 pints of unreplaced blood. Coverage of storage and administration begins with the first pint of blood that you need.	There is **no copayment** for Medicare-covered items.
Vision care Covered services include, but aren't limited to, the following: 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 Routine eye exam, limited to 1 exam every year. You can get this service on your own, without a referral from your PCP, as long as you get it from a plan provider. 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.	**$15** copayment for each Medicare-covered eye exam (diagnosis and treatment for disease and conditions of the eye). **$15** copayment for each routine eye exam, limited to 1 exam every year. There is **no copayment** for Medicare-covered eyewear (one pair of eyeglasses or contact lenses after each cataract surgery).

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. Medicare only covers this screening if you get a referral for it as a result of your "Welcome to Medicare" physical exam.	There is **no copayment** for each 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.	There is **no copayment** for each Medicare-covered bone mass measurement.
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, the following are covered: • Screening colonoscopy (or screening barium enema as an alternative) every 24 months. For people not at high risk of colorectal cancer, the following is covered: • Screening colonoscopy every 10 years, but not within 48 months of a screening sigmoidoscopy.	There is **no copayment** for each Medicare-covered colorectal screening exam.

Benefits Chart – **your covered services**	**What you must pay** when you get these covered services
Immunizations • Pneumonia vaccine • Flu shots, once a year in the fall or winter • Hepatitis B vaccine • Other vaccines if you are at risk Authorization rules may apply for services. Contact plan for details. We also cover some vaccines under our outpatient prescription drug benefit.	There is **no copayment** for the pneumonia and flu vaccines.
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	There is **no copayment** for Medicare-covered mammograms screening.
Pap tests, pelvic exams, and clinical breast exam Covered services include, but aren't limited to, the following: • 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. Authorization rules may apply for services. Contact plan for details.	**$0** for each Medicare-covered Pap smear. **$0** for each additional Pap smear up to 1 Pap smear every year. **$15** for each Medicare-covered pelvic exam.

Benefits Chart – **your covered services**	**What you must pay** when you get these covered services
Prostate cancer screening exams For men age 50 and older, the following are covered once every 12 months: • Digital rectal exam • Prostate Specific Antigen (PSA) tests Authorization rules may apply for services. Contact plan for details.	There is **no copayment** for: • Medicare-covered prostate cancer screening exams • Additional screening exam up to 1 exam every year
Cardiovascular disease testing • Blood tests for the detection of cardiovascular disease (or abnormalities associated with an elevated risk of cardiovascular disease). Testing by plan provider is as often as medically necessary.	There is **no copayment** for cardiovascular disease testing.
Physical exams You are covered for an unlimited number of exams.	There is **no copayment** for preventive physical exams.

Benefits Chart – **your covered services**	**What you must pay** when you get these covered services
Other Services Dialysis (Kidney) Covered services include, but aren't limited to, the following: • Outpatient dialysis treatments (including dialysis treatments when temporarily out of the service area), as explained in Sections 3. • Inpatient dialysis treatments (if you are admitted to a hospital for special care). • Self-dialysis training (includes training for you and others for the person 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).	$100 for Medicare-covered outpatient services. $250 for Medicare-covered inpatient services.

Benefits Chart – **your covered services**	**What you must pay** when you get these covered services
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 receiving physician services. WHA Care+ also covers some drugs that are "usually not self-administered" even if you inject them at home. • Drugs you take using durable medical equipment (such as nebulizers) that was authorized by WHA *Care*+. • Clotting factors you give yourself by injection if you have hemophilia. • Immunosuppressive drugs, if you have had an organ transplant that was covered by Medicare. • 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, Erythropoietin (Epogen) or Epoetin alfa, and Darboetin Alfa (Aranesp). • Intravenous Immune Globulin for the treatment of primary immune deficiency diseases in your home. Section 3 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.	There is no benefit limit on drugs covered under Original Medicare. For prescription drugs you pay for each prescription or refill: **Retail (30-day supply)** • **$10 copayment** for Preferred Generic drugs • **$20 copayment** for Preferred Brand Name • **$35 copayment** for Non-Preferred Medications **Mail-order (90-day supply)** • **$20 copayment** for Preferred Generic • **$40 copayment** for Preferred Brand Name • **$70 copayment** for Non-Preferred Medications **Retail UC Pharmacies (90-day supply)** • **$20 copayment** for Preferred Generic • **$40 copayment** for Preferred Brand Name • **$70 copayment** for Non-Preferred Medications

Benefits Chart – **your covered services**	**What you must pay** when you get these covered services
Additional Benefits Dental Services Services by a dentist 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.	In general, you pay 100% for dental services.
Hearing Services • Diagnostic hearing exams. • Routine hearing test up to 1 test every year. • Hearing aids.	**$15 copayment** for each Medicare-covered diagnostic hearing exam. **$15 copayment** for each routine hearing test up to 1 test every year. **$15 copayment** for one device per ear every 36 months. ($2000 benefit maximum)
Health and wellness education programs These are programs focused on clinical health conditions such as hypertension, cholesterol, asthma, and special diets. Programs designed to enrich the health and lifestyles of members include weight management, smoking cessation, fitness, and stress management.	There is **no copayment** for the following: • Health Ed classes • Newsletter

Getting care when you are outside of our Service Area

You are covered for Urgent Care and Emergency Care services wherever you are outside of our Service Area. Please note that Emergency room visits are not covered for non-Emergency situations. (See the "Definitions" section of this booklet for explanation of "Urgent Care" and "Emergency"). If care is obtained from a non-Participating Provider, WHA will reimburse the provider for covered services received for Urgent Care or Emergency situations, less the applicable Copayment.

Follow-Up Care

Follow-up care after an emergency room visit is not considered an Emergency situation. If you receive Emergency treatment from an emergency room physician or non-Participating Physician and you return to the emergency room or physician for follow-up care (for example, removal of stitches or redressing a wound), you will be responsible for the cost of the service.

Call your PCP for all follow-up care. If your health problem requires a specialist, your PCP will refer you to an appropriate Participating Provider as needed. If you have questions about your medical costs when you travel, please call Member Services at the numbers listed at the bottom of this page.

General Exclusions

Introduction

The purpose of this part of Section 11 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 and drugs that are not covered, you must pay for them yourself

We won't 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 that we should have paid or covered (appeals are discussed in Section 6).

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

In addition to any exclusions or limitations described in the Benefits Chart in this Section, or anywhere else in this EOC, **the following items and services are <u>not</u> covered except as indicated by our Plan**:

1) Services that aren't reasonable and necessary, according to the standards of the Original Medicare Plan, *unless* these services are otherwise listed by our Plan as 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. In 2009 CMS will continue to pay through Original Medicare for clinical trial items and services covered under the September 2000 National Coverage Determination that are provided to MA plan members. 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.

3) Surgical treatment of morbid obesity *unless* medically necessary and covered under Original Medicare.

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 skilled nursing care and/or skilled rehabilitation services. "Custodial care" 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.

10) Charges imposed 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 it is 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 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, as outlined in the benefit chart) and is limited according to Medicare guidelines.

16) Routine foot care is generally not covered under the Plan and is limited according to Medicare guidelines.

17) Orthopedic shoes unless they are part of a leg brace and are included in the cost of the leg brace. There is an exception: Orthopedic or therapeutic shoes are covered for people with diabetic foot disease

18) Supportive devices for the feet. There is an exception: orthopedic or therapeutic shoes are covered for people with diabetic foot disease.

19) Hearing aid batteries.

20) Eyeglasses (*except* after cataract surgery), 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, and non-prescription contraceptive supplies and devices. (Medically necessary services for infertility are covered according to Original Medicare guidelines.)

23) Acupuncture.

24) Naturopath services.

25) Services that you get from non-plan providers, *except* for care for a medical emergency and urgently needed care, renal (kidney) dialysis services that you get when you are temporarily outside the plan's service area, and care from non-plan providers that is arranged or approved by a plan provider. See other parts of this booklet (especially Sections 3) for information about using plan providers and the exceptions that apply.

26) Services that you get without a referral from your PCP, when a referral from your PCP is required for getting that service.

27) Services that you get without prior authorization, when prior authorization is required for getting that service.

28) Services that are not reasonable and necessary according to the standards of original Medicare unless these services are otherwise listed by our Plan as a covered service. As noted in Section 3, we provide all covered services according to Medicare guidelines.

29) Emergency facility services for non-authorized, routine conditions that do not appear to a reasonable person to be based on a medical emergency. (See Section 4 for more information about getting care for a medical emergency).

30) Services provided to veterans in Veteran's 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 the Plan cost-sharing amount.

31) Exclusions related to transgender surgery services:

   a. liposuction to reshape waist, hips, thighs and buttocks

   b. cosmetic chest reconstruction or augmentation mammoplasty;

   c. electrolysis and laser hair removal, except when required as part of covered transgender genital reconstruction surgery;

   d. drugs for hair loss or growth;

   e. voice therapy or voice modification surgery;

   f. sperm or gamete procurement for future infertility or storage of sperm, gametes or embryos;

   g. penile implant devices, penile device implantation, and penile implant revision or reinsertion;

h. intersex surgery (transsexual operations) except as specifically provided under the "Inpatient Transgender Surgery" and "Outpatient Transgender Services" sections of the "Principal Benefits and Covered Services" section or treatment of any resulting complications, unless that treatment is determined to be medically necessary.

32) Any of the services listed above that aren't 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.

Excluded Drugs

This part of Section 11 talks about drugs that are "excluded," meaning they aren't normally covered by a Medicare drug plan. If you get drugs that are excluded, you must pay for them yourself. We won't 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 6).

- A Medicare Prescription Drug Plan can't cover a drug that would be covered under Medicare Part A or Part B.

- A Medicare Prescription Drug Plan can't 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:

1) Non-prescription drugs (or over-the counter drugs).

2) Drugs when used to promote fertility.

3) Drugs when used for the symptomatic relief of cough or colds.

4) 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.

5) Drugs, such as Viagra, Cialis, Levitra, and Caverject, when used for the treatment of sexual or erectile dysfunction.

6) Drugs when used for treatment of anorexia, weight loss, or weight gain.

7) Drugs when used for cosmetic purposes or to promote hair growth.

8) Prescription vitamins and mineral products, except prenatal vitamins and fluoride preparations.

9) Barbiturates and Benzodiazepines.

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