A plan for life.

Your Medicare Health Benefits and Services as a Member of CDPHP® Classic PPO

This mailing gives you the details about your Medicare health coverage from January 1–December 31, 2009, and explains how to get the health care you need. This is an important legal document. Please keep it in a safe place.

CDPHP Member Services:

For help or information, please call Member Services or go to our Plan Web site at www.cdphp.com.

(518) 641-3950 or 1-888-248-6522 (Calls to this number are free.)
TTY/TDD users call: (518) 641-4000 or 1-877-261-1164 (Calls to this number are free.)

Hours of Operation:

Monday through Friday, 8 a.m. to 8 p.m. Eastern

This Plan is offered by CDPHP Universal Benefits,® Inc., referred throughout the EOC as "we," "us" or "our." CDPHP Classic PPO is referred to as "Plan" or "our Plan." Our organization contracts with the Federal government.

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

Benefits, formulary, pharmacy network, premium and/or copayments/coinsurance may change on January 1, 2010. Please contact CDPHP Medicare Choices for details.

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This is Your 2009 Evidence of Coverage (EOC)

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1. Introduction

Thank you for being a member of our Plan!

This is your *Evidence of Coverage*, which explains how to get your Medicare health care coverage through our Plan, a Medicare Advantage Preferred Provider Organization (PPO) plan. You are still covered by Medicare, but you are getting your health care through our Plan.

This *Evidence of Coverage*, together with your enrollment form, riders 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—December 31, 2009. Our plan's contract with the Centers for Medicare & Medicaid Services (CMS) is renewed annually, and availability of coverage beyond the end of the current contract year is not guaranteed.

This *Evidence of Coverage* (EOC) will explain to you:

- What is covered by our Plan and what isn't covered.
- How to get the care you need, including some rules you must follow.
- What you will have to pay for your health care.
- What to do if you are unhappy about something related to getting your covered services.
- How to leave our Plan, and other Medicare options that are available.

This Section of the EOC has important information about:

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

Eligibility Requirements

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

The geographic service area for our Plan.

The counties in our service area are listed below:

Broome, Chenango, Columbia, Delaware, Dutchess, Fulton, Greene, Hamilton, Herkimer, Madison, Montgomery, Oneida, Otsego, Tioga, and Ulster counties in New York state.

How do I keep my membership record up to date?

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

Please help us keep your membership record up to date by telling Member Services 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 other health insurance coverage you have, such as from your employer, your spouse's employer, workers' compensation, Medicaid, or liability claims such as claims from an automobile accident.

Materials that you will receive from our Plan

Plan membership card

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

Please carry your membership card that we gave you at all times and remember to show your card when you get covered services, items. If your membership card is damaged, lost, or stolen, call Member Services right away and we will send you a new card. There is a sample card in Section 10 to show you what it looks like.

The Provider Directory gives you a list of network providers

We've attached a postcard on the back cover of this book that you can complete and return to us if you would like to receive a comprehensive *Directory of Plan Practitioners and Providers*. Simply indicate that you would like a directory for CDPHP Medicare Choices PPO Plans, and return the completed postage-paid postcard to us. You also may ask Member Services or visit Find-A-Doc at www.cdphp.com for more information about our network providers, including their qualifications and experience. Member Services can give you the most up-to-date information about changes in our network providers and about which ones are accepting new patients.

You may pay more for services if you do not use a network provider, except in emergencies, urgently needed care when our network is not available, and for out of area dialysis services. See the benefits chart in Section 10 for more specific out-of-network coverage information.

Your monthly plan premium

The following cost sharing amounts are for 2008 and will change January 1, 2009.

As a member of our Plan, you pay:

1) <u>Your monthly Medicare Part B premium.</u> Most people will pay the standard premium amount, which is $96.40 in 2008. (Your Part B premium is typically deducted from your Social Security payment.) (If you receive benefits from your state Medicaid program, all or part of your Part B premium may be paid for you.)

   Your monthly premium will be higher if you are single (file an individual tax return) and your yearly income is more than $82,000, or if you are married (file a joint tax return) and your yearly income is more than $164,000.

If your Yearly Income is*		In 2008, you pay*
File individual tax return	**File joint tax return**	
$82,000 or below	$164,000 or below	$96.40
$82,001–$102,000	$164,001–$204,000	$122.20
$102,001–$153,000	$204,001–$306,000	$160.90
$153,001–$205,000	$306,001–$410,000	$199.70
Above $205,000	Above $410,000	$238.40

*The above income and Part B premium amounts are for 2008 and will change for 2009. If you pay a Part B late-enrollment penalty, the premium amount is higher.

2) Your monthly Medicare Part A premium, if necessary (most people don't have to pay this premium).

3) Your monthly premium for our Plan.

Your monthly premium for our Plan is listed in Section 10. If you have any questions about your Plan premiums or the payment programs, please call Member Services.

Monthly Plan Premium Payment Options

There are two ways to pay your monthly plan premium. If you want to change how you pay your monthly plan premium, please fill out the Plan Change Election Form with your new choice and mail it to us in the enclosed return-reply envelope.

Option one: Pay your monthly plan premium directly to our Plan.

You may decide to pay your monthly plan premium directly to our Plan with a check. You must mail or drop off your payment with the coupon for the month you are paying. Mail or drop off your monthly payment to CDPHP at PO Box 4931, Syracuse, NY 13221-4931. You may pay your monthly premium in advance. Premium payments are due on the first of each month. We will send you premium coupons unless you request one of our other payment options. If you run out or lose your premium coupons, contact Member Services for new ones. If you prefer to make payments in person at our office, such payments would need to be in the form of a check or money order. Cash payments are not allowed.

Instead of paying by check, you can have your monthly plan premium automatically withdrawn from your bank account using Electronic Funds Transfer (EFT). To select the EFT payment method, please contact Member Services for the necessary form to fill out to enroll in this option. You may also download the form on the CDPHP Web site, www.cdphp.com, under the "Members" section. Automatic deductions are made on the 10th day of the month.

Option two: **You may have your monthly plan premium directly deducted from your monthly Social Security payment.**

Contact Member Services for more information on how to pay your monthly plan premium this way.

What is the Medicare Prescription Drug Plan late enrollment penalty?

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

If you must pay a late enrollment penalty, your penalty is calculated when you first join a Medicare drug plan. To estimate your penalty, take 1% of the national base beneficiary premium for the year you join (in 2008, the national base beneficiary premium is $27.93. This amount may change in 2009). Multiply it by the number of full months you were eligible to join a Medicare drug plan but didn't, and then round that amount to the nearest ten cents. This is your estimated penalty amount, which is added each month to your Medicare drug plan's premium for as long as you are in that plan.

You won't have to pay a late enrollment penalty if:

- You had creditable coverage (coverage that expects to pay, on average, at least as much as Medicare's standard prescription drug coverage)
- You had prescription drug coverage but you were not adequately informed that the coverage was not creditable (as good as Medicare's drug coverage)
- Any period of time that you didn't have creditable prescription drug coverage was less than 63 continuous days
- You lived in an area affected by Hurricane Katrina at the time of the hurricane (August 2005) AND you signed up for a Medicare prescription drug plan by December 31, 2006, AND you stay in a Medicare prescription drug plan
- You received or are receiving extra help.

What happens if you don't pay or are late with your monthly plan premiums?

If your monthly plan premiums are late, we will tell you in writing that if you don't pay your monthly plan premium by a certain date, which includes a grace period, we will end your membership in our Plan. Our plan's grace period is 60 days. If we end your membership, you will have Original Medicare Plan coverage. Should you decide later to re-enroll in our Plan, or to enroll in another plan that we offer, you will have to pay any late monthly plan premiums that you didn't pay from your previous enrollment in our Plan.

Important Information

We will send you the Coordination of Benefits Inquiry Form so that we can know what other health coverage you have besides our Plan. Medicare requires us to collect this information from you, so when you get the survey, please fill it out and send it back. If you have additional health coverage, you must provide that information to our Plan. In addition, if you lose or gain additional health coverage, please call Member Services to update your membership records.

2. How You Get Care

How You Get Care

What are "providers"?

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

What are "network providers"?

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

What are "covered services"?

"Covered services" is the term we use for all the medical care, health care services, supplies, and equipment that are covered by our Plan. Covered services are listed in the Benefits Chart in Section 10.

What do you pay for "covered services"?

The amount you pay for covered services is listed in Section 10.

Providers you can use to get services covered by our Plan

We list the providers that participate with our Plan (called network providers) in our provider directory. While you are a member of our Plan you may use either network providers or out-of-network providers. However, your out-of-pocket costs may be higher if you use out-of-network providers, except for emergency care or out-of-area dialysis services. See Section 10 for the costs when you get services from network providers.

In general, you don't need to get a referral or prior authorization for most services when you get care from out-of-network providers, however, before getting services from out-of-network providers you may want to confirm with us that the services you are getting are covered by us and are medically necessary.

If an out-of-network provider sends you a bill that you think we should pay, please contact Member Services or send the bill to us for payment. We will pay your doctor for our share of the bill and will let you know what, if anything, you must pay. You won't have to pay an out-of-network provider any more than what he or she would have gotten if you had been covered with the Original Medicare Plan. It is best to ask an out-of-network provider to bill us first, but if you have already paid for the covered services, we will reimburse you for our share of the cost. (Please note that we cannot pay a provider who has opted out of the Medicare program. Check with your provider before receiving services to confirm that they participate with Medicare.) If we later determine that the services are not covered or were not medically necessary, we may deny coverage and you will be responsible for the entire cost.

Choosing Your Primary Care Physician (PCP)

What is a PCP?

When you become a member of our Plan, you are not required to choose a plan provider to be your PCP. However, you are encouraged to establish yourself with a PCP. A PCP is a provider, specializing in internal medicine, family practice, family practice and osteopathic manipulative treatment, general practice, who meets state requirements and is trained to give you basic medical care. You may choose to get your routine or basic care from a PCP. A PCP can also assist in coordinating the rest of the covered services you need. You are not required to see a PCP before you see any other health care provider.

Generally, you may choose to see a PCP first for most of your routine health care needs. However, you do not need to get a referral from a PCP when you get care from other health care providers.

How can your PCP assist in coordinating covered services?

You are not required to see a PCP before you see any other health care provider, but a PCP can help you arrange or coordinate the rest of the covered services you get as a member of our Plan. This includes: X-rays, laboratory tests, therapies, care from doctors who are specialists, hospital admissions, and follow-up care. "Coordinating" your services include checking or consulting with other plan providers about your care and how it is going.

What if your doctor or other provider leaves your plan?

Sometimes a network provider you are using might leave the Plan. You are allowed to use out-of-network providers, but if this happens, you will have to switch to another provider who is part of our Plan or you may pay more for certain covered services. Member Services can assist you in finding and selecting another provider.

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

What is a "medical emergency"?

A "medical emergency" is when you believe that your health is in serious danger. A medical emergency includes severe pain, a bad injury, a sudden illness, or a medical condition that is quickly getting much worse.

If you have a medical emergency:

- Get medical help as quickly as possible. Call 911 for help or go to the nearest emergency room, hospital, or urgent care center. You don't need to get approval or a referral first from your doctor or other network provider.
- Although it is not required, you or someone else should contact your doctor about your emergency within 48 hours. Your doctor needs to know about your emergency in order to assist you with coordinating follow-up care, if needed. Your doctor's phone number can be found by calling Member Services or visiting Find-A-Doc at www.cdphp.com.

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

What is covered if you have a medical emergency?

- You may get covered emergency medical care whenever you need it, anywhere in the world. See Section 10 for more information.
- **Ambulance** services are covered worldwide in situations where other means of transportation would endanger your health. (See the benefits chart in Section 10 for more detailed information.)

What if it wasn't a medical emergency?

Sometimes it can be hard to know if you have a medical emergency. For example, you might go in for emergency care—thinking that your health is in serious danger—and the doctor may say that it wasn't a medical emergency after all. If 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. However, please note that if you get the care from plan providers, your costs may be lower than if you get the care from non-plan providers.

What is urgently needed care?

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

- Inside the United States or anywhere in the world. See Section 10 for more information;
- 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 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, <u>whether you are in or outside of the service area</u>. "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 <u>generally outside of the service area</u>.

How to get urgently needed care

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

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

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

When you receive emergency or urgently needed health care services from a provider who is not part of our network, you are responsible for paying your plan cost sharing amount and you should tell the provider to bill our Plan for the balance of the payment they are due. However, if you have received a bill from the provider, please send that claim to CDPHP, Attn: Medicare Claims, 500 Patroon Creek Boulevard, Albany, New York, 12206-1057 so we can pay the provider the amount they are owed. If you have any questions about what to pay a provider or where to send a paper claim you may call Member Services.

What is your cost for services that 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 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 Member Services when you want to know how much of your benefit limit you have already used.

How can you participate in a clinical trial?

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

The Original Medicare Plan pays for routine costs if you take part in a clinical trial that meets Medicare requirements (meaning it's a "qualified" clinical trial and Medicare-approved). Routine costs include costs like room and board for a hospital stay that Medicare would pay for even if you 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, like diagnostic services, follow-up care, and care that is unrelated to the clinical trial through our Plan. Our Plan is still responsible for coverage of certain investigational devices exemptions (IDE), called Category B IDE devices, needed by our members.

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

You don't need to get a referral (approval in advance) from a network provider to join a clinical trial, and the clinical trial providers don't need to be network providers. However, please be sure to **tell us before you start participation in a clinical trial** so that we can keep track of your health care services. When you tell us about starting participation in a clinical trial, we can let you know whether the clinical trial is Medicare-approved, and what services you will get from clinical trial providers instead of from our plan.

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

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

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

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

Introduction to your rights and protections

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

Your right to be treated with dignity, respect and fairness

You have the right to be treated with dignity, respect, and fairness at all times. Our Plan must obey laws that protect you from discrimination or unfair treatment. We 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. Member Services can also help if you need to file a complaint about access (such as wheel chair access). You may also call the Office for Civil Rights at 1-800-368-1019 or TTY/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 don't 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 isn't 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 laws that protect your privacy give you rights related to getting information and controlling how your health information is used. We are required to provide you with a notice that tells about these rights and explains how we protect the privacy of your health information. You have the right to look at medical records held at the Plan, and to get a copy of your records (there may be a fee charged for making copies). You also have the right to ask us to make additions or corrections to your medical records (if you ask us to do this, we will review your request and figure out whether the changes are appropriate). You have the right to know how your health information has been given out and used for non-routine purposes. If you have questions or concerns about privacy of your personal information and medical records, please call Member Services.

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

As explained in this booklet, you can get your care from network doctors and other health providers who are part of our Plan. You can also get care from non-network doctors and other health providers who are not part of our Plan. You have the right to choose a network provider (we will tell you which doctors are accepting new patients). You have the right to go to a women's health specialist in our Plan (such as a gynecologist) without a referral. You have the right to timely access to your providers and to see specialists when care from a specialist is needed. "Timely access" means that you can get appointments and services within a reasonable amount of time.

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

You have the right to get full information from your providers when you go for medical care, and the right to participate fully in decisions about your health care. Your providers must explain things in a way that you can understand. Your rights include knowing about all of the treatment options that are recommended for your condition, no matter what they cost or whether they are covered by our Plan. This includes the right to know about the different Medication Therapy Management Programs we offer and in which you may

participate. You have the right to be told about any risks involved in your care. You must be told in advance if any proposed medical care or treatment is part of a research experiment, and be given the choice of refusing experimental treatments.

You have the right to receive a detailed explanation from us if you believe that a provider has denied care that you believe you were entitled to receive or care you believe you should continue to receive. In these cases, you must request an initial decision called an organization determination. Organization determinations are discussed in Section 5.

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

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

You have the right to ask someone such as a family member or friend to help you with decisions about your health care. Sometimes, people become unable to make health care decisions for themselves due to accidents or serious illness. If you want to, you can use a special form to give someone the legal authority to make decisions for you if you ever become unable to make decisions for yourself. You also have the right to give your doctors written instructions about how you want them to handle your medical care if you become unable to make decisions for yourself. The legal documents that you can use to give your directions in advance in these situations are called "advance directives." There are different types of advance directives and different names for them. Documents called "living will" and "power of attorney for health care" are examples of advance directives.

If you want to have an advance directive, you can get a form from your lawyer, from a social worker, or from some office supply stores. You can sometimes get advance directive forms from organizations that give people information about Medicare. You can download the New York *Health Care Proxy* form on our Web site at www.cdphp.com. 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 hasn't followed the instructions in it, you may file a complaint with the New York State Department of Health at (518) 486-9002.

Your right to get information about our Plan

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

Your right to get information in other formats

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

Your right to get information about our network providers

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

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

You have the right to an explanation from us about any Part C medical care or service not covered by our Plan. We must tell you in writing why we will not pay for or approve a Part C medical care or service, and how you can file an appeal to ask us to change this decision. See Section 5 for more information about filing an appeal. You also have the right to this explanation even if you obtain the Part C medical care or service from a provider not affiliated with our organization.

Your right to make complaints

You have the right to make a complaint if you have concerns or problems related to your coverage or care. See Section 4 and Section 5 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.

How to get more information about your rights

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

1. Call Member Services the number on the cover of this booklet.
2. Get free help and information from your State Health Insurance Assistance Program (SHIP). Contact information for your SHIP is in Section 8 of this booklet.
3. Visit www.medicare.gov to view or download the publication "Your Medicare Rights & Protections."
4. Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

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

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

- If you think you have been treated unfairly due to your race, color, national origin, disability, age, or religion, you can call the Office for Civil Rights at 1-800-368-1019 or TTY/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 also get help from your SHIP.

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. Call Member Services if you have questions.
- Using all of your insurance coverage. If you have additional health insurance 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 expenses. This is called "coordination of benefits" because it involves coordinating all of the health benefits that are available to you.

- **You are required to tell our Plan if you have additional health insurance. 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 membership card to the provider.
- Giving your doctor and other providers the information they need to care for you, and 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 have them explain your treatment in a way you can 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 coinsurance/copayment for your covered services. 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, but we can let you know if we have a plan in that area.
- Letting us know if you have any questions, concerns, problems, or suggestions. If you do, please call Member Services.

4. 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 5 of this manual.

Grievances do not involve problems related to approving or paying for 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 Part C medical care or services you want, you believe that you are being released from the hospital or SNF too soon, or your HHA or CORF services are ending too soon, you must follow the rules outlined in Section 5.

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

- Problems with the service you receive from Member Services.
- If you feel that you are being encouraged to leave (disenroll from) the 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 5.
- 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.
- 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 our Plan

If you have a complaint, you or your representative may call the phone number for **Part C Grievances** (for complaints about Part C medical care or services) in Section 8. 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 CDPHP Medicare Grievance Process**. To

file a Grievance, you may call CDPHP at (518) 641-3950 or 1-888-248-6522. TTY/TDD users may call (518) 641-4000 or toll-free 1-877-261-1164. Or, if you wish, you may write to us at CDPHP, Attn: Appeal and Grievance Dept., 500 Patroon Creek Blvd., Albany, NY 12206-1057.

Please Note: If your complaint involves a behavioral health service or alcohol or substance abuse services, you must contact United Behavioral Health at 1-888-320-9584.

A designated representative of CDPHP will coordinate the review and investigation of your Grievance. One or more qualified personnel will review the Grievance, provided that when the Grievance pertains to clinical matters, the personnel shall include, but not be limited to, one or more licensed, certified, or registered health care professionals. CDPHP will provide to you or your designee a written decision concerning the Grievance within 30 calendar days after receipt of the Grievance. If CDPHP cannot render a decision concerning your Grievance due to a lack of necessary information within 30 calendar days of receipt of your Grievance, a letter will be sent to you by the end of the 30th calendar day explaining the reason for the delay. CDPHP will make any such delayed decision and notify you of the decision within the next 14 calendar days with the case being reviewed on the information available.

You may file a fast or expedited grievance if you disagree with our decision to deny your request for a fast review of an initial determination or if we ask for an additional 14 days to process your initial determination or appeal request. You will receive information on how to file a fast or expedited grievance in your initial determination letter or in the letter we send informing you of the additional time we need to process your initial determination or appeal. You may file a fast or expedited grievance by calling CDPHP at (518) 641-3950 or 1-888-248-6522. TTY/TDD users may call (518) 641-4000 or toll-free 1-877-261-1164. Or, if you wish, you may write to us at CDPHP, Attn: Appeal and Grievance Dept., 500 Patroon Creek Blvd., Albany, NY 12206-1057. We will make our decision within 24 hours after receiving your request.

The grievance must be submitted within 60 days of the event or incident. We must address your grievance as quickly as your case requires based on your health status, but no later than 30 days after receiving your complaint. We may extend the time frame by up to 14 days if you ask for the extension, or if we justify a need for additional information and the delay is in your best interest. If we deny your grievance in whole or in part, our written decision will explain why we denied it, and will tell you about any dispute resolution options you may have.

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 5.

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 file with the QIO, we must help the QIO resolve the complaint. See Section 8 for more information about the QIO and for the name and phone number of the QIO in your state.

5. Complaints and Appeals about your Part C Medical Care and Services

Introduction

This section explains how you ask for coverage of your 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 (CORF) 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 C medical care or services. For more information about grievances, see Section 4.

Part 1. **Requests for 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 medical care or services or payment

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

If you have problems getting the Part C medical care or services you need, or payment for a 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 C medical care or service you need, or paying for a Part C medical care or service you already received. Initial decisions about Part C medical care or services are called "**organization determinations**." With this decision, we explain whether we will provide the Part C medical care or service you are requesting, or pay for the Part C medical care or service you already received.

The following are examples of requests for initial determinations:

- 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.

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, this statement must be sent to us at the address or fax number listed under "**Part C Organization Determinations**" in Section 8. To learn how to name your appointed representative, you may call Member Services.

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.

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

A decision about whether we will give you, or pay for, the 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 C medical care or service you, your doctor, or your representative should call, fax, or write us at the numbers or address listed under **Part C Organization Determinations** (for appeals about Part C medical care or services) in Section 8.

Asking for a fast decision

You may ask for a fast decision **only** if you or your 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 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 **Part C Organization Determinations** (for appeals about Part C medical care or services) in Section 8.

If you are requesting a "fast" decision outside normal business hours, you may call 1-800-274-2332 or (518) 641-4100. TTY/TDD users should call 1-877-261-1164 or (518) 641-4000.

Be sure to ask for a "fast," or "expedited" 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 automatically 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." You have the right 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 4). 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 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 <u>standard</u> 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 4.

  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 <u>fast</u> 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 4.

What happens if we decide completely in your favor?

- For a decision about <u>payment</u> 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 <u>standard</u> 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 <u>fast</u> 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 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 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 the appeal request 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 C medical care or service a signed, written appeal request must be sent to the address listed under **Part C Appeals** (for appeals about medical care or services) in Section 8.

2. **Asking for a fast appeal**

   If you are appealing a decision we made about giving you a 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 **Part C Appeals** (for appeals about Part C medical care or services) in Section 8.

   If you are requesting a "fast" decision outside normal business hours, you may call 1-800-274-2332 or (518) 641-4100. TTY/TDD users should call 1-877-261-1164 or (518) 641-4000.

   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." You have the right 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 4). 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 the doctor a written request to get information.

You may give us your additional information to support your appeal by calling, faxing, or writing us at the numbers or address listed under **Part C Appeals** (for appeals about Part C medical care or services) in Section 8.

You may also deliver additional information in person to the address listed under **Part C Appeals** (for appeals about Part C medical care or services) in Section 8.

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 **Part C Appeals** (for appeals about Part C medical care or services) in Section 8.

How soon must we decide on your appeal?

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

  After we receive your appeal request, we have 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 decision about payment for Part C medical care or services 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.

How to file your appeal

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 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 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 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 or 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 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 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 must 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 co-payments 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 co-payments 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 Quality Improvement Organization. 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 the Plan or the hospital. There is one QIO in each state. QIOs have different names, depending on which state they are in. The doctors and other health experts in the QIO review certain types of complaints made by Medicare patients. These include complaints from Medicare patients who think their hospital stay is ending too soon.

The QIO in New York state is the Island Peer Review Organization (IPRO), Marcus Avenue, Lake Success, NY, 11042-1002, 1-800-331-7767 or (516) 326-7767.

Getting IPRO to review your hospital discharge

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

- You must ask IPRO for a **"fast review"** of your discharge. This "fast review" is also called an "immediate review."
- You must request a review from IPRO 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 IPRO.**
- IPRO will look at your medical information provided to IPRO by us and the hospital.
- During this process you will get a notice, called the Detailed Notice of Discharge, giving the reasons why we believe that your discharge date is medically appropriate. 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/.
- IPRO 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 IPRO decides in your favor?

We will continue to cover your hospital stay (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 10.

What happens if IPRO agrees with the discharge?

You will not be responsible for paying the hospital charges until noon of the day after IPRO gives you its decision. However, you could be financially liable for any inpatient hospital services provided after noon of the day after IPRO 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 IPRO to review its first decision if you make the request within 60 days of receiving IPRO's first denial of your request. However, you could be financially liable for any inpatient hospital services provided after noon of the day after IPRO gave you its first decision.

What happens if you appeal IPRO decision?

IPRO has 14 days to decide whether to uphold its original decision or agree that you should continue to receive inpatient care. If IPRO 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 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 10.

If IPRO upholds its original decision, you may be able to appeal its decision to an 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 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 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 10.

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

If you do not ask IPRO 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 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 10.
- 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 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 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 10.

PART 3. Complaints (appeals) if you think coverage for your skilled nursing facility, home health agency, 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 the 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 these services are no longer medically necessary. This part explains what to do if you believe that 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 (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/). 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 IPRO 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 IPRO (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 IPRO review?

You must quickly contact IPRO. The written notice you got from your provider gives the name and telephone number of IPRO 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 IPRO's review?

IPRO 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. IPRO will also look at your medical information, talk to your doctor, and review information that we have given to IPRO. 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/.

IPRO will make a decision within one full day after it receives all the information it needs.

What happens if IPRO decides in your favor?

We will continue to cover your SNF, HHA or CORF services (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 10.

What happens if IPRO agrees that your coverage should end?

You will not be responsible for paying for any 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 IPRO to review its first decision if you make the request within 60 days of receiving IPRO's first denial of your request.

What happens if you appeal IPRO decision?

IPRO has 14 days to decide whether to uphold its original decision or agree that you should continue to receive services. If IPRO 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) for as long as it is medically necessary and you have not exceeded our Plan coverage limitations as described in Section 10

If IPRO upholds its original decision, you may be able to appeal its decision to an 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 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 10.

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

If you do not ask IPRO for a review by the deadline, you may 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 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 10.
- 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 (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 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 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 10.

6. Ending your Membership

Ending your membership in our Plan may be **voluntary** (your own choice) or **involuntary** (not your own choice):

- You might leave our Plan because you have decided that you *want* to leave.
- There are also limited situations where we are required to end your membership. For example, if you move permanently out of our geographic service area.

Voluntarily ending your membership

There are only certain times during the year when you may voluntarily end your membership in our Plan. The key time to make changes is the Medicare fall open enrollment period (also known as the "Annual Election Period"), which occurs every year from November 15 through December 31. This is the time to review your health care and drug coverage for the following year and make changes to your Medicare health or prescription drug coverage. Any changes you make during this time will be effective January 1. Certain individuals, such as those with Medicaid, those who get extra help, or who move, can make changes at other times. For more information on when you can make changes see the enrollment period table later in this section.

If you want to end your membership in our plan during this time, this is what you need to do:

- **If you are planning on enrolling in a new Medicare Advantage plan**: Simply join the new plan. You will be disenrolled from our plan when your new plan's coverage begins on January 1.
- **If you are planning on switching to the Original Medicare Plan and joining a Medicare Prescription drug plan:** Simply join the new Medicare Prescription drug plan. You will be disenrolled automatically from our plan when your new coverage begins on January 1.
- **If you are planning on switching to the Original Medicare Plan without a Medicare Prescription drug plan:** Contact Member Services for information on how to request disenrollment. You may also call 1-800-MEDICARE (1-800-633-4227) to request disenrollment from our plan. TTY users should call 1-877-486-2048. Your enrollment in Original Medicare will be effective January 1.

Enrollment Period	When?	Effective Date
Fall Open Enrollment (Annual Election Period) Time to review health and drug coverage and make changes.	Every year from November 15 to December 31	January 1
Medicare Advantage (MA) Open Enrollment MA-eligible beneficiaries can make one change to their health plan coverage. However, you cannot use this period to add, drop, or change your Medicare prescription drug coverage. Examples: If you are in a MA plan that does not have Medicare prescription drug coverage, you can switch to another Medicare Advantage plan that does not offer drug coverage or go to Original Medicare If you are in Original Medicare Plan and have a Medicare prescription drug plan, you can join a Medicare Advantage Plan that offers Medicare drug coverage If you are in an MA plan that offers Medicare drug coverage, you can leave and join Original Medicare Plan and a Medicare prescription drug plan	Every year from January 1 to March 31	First day of next month after plan receives your enrollment request

Enrollment Period *(continued from previous page)*	When?	Effective Date
Special Enrollment Periods for limited special exceptions, such as: • You have a change in residence • You have Medicaid • You are eligible for extra help with Medicare prescriptions • You live in an institution (such as a nursing home)	Determined by exception.	Generally, first day of next month after plan receives your enrollment request

For more information about the options available to you during these enrollment periods, contact Medicare at 1-800-MEDICARE (1-800-633-4227.) TTY users should call 1-877-486-2048. Additional information can also be found in the *"Medicare & You"* handbook. This handbook is mailed to everyone with Medicare each fall. You may view or download a copy from www.medicare.gov—under "Search Tools," select "Find a Medicare Publication."

Until your membership ends, you must keep getting your Medicare services through our Plan

If you leave our Plan, it may take some time for your membership to end and your new way of getting Medicare to take effect (we discuss when the change takes effect earlier in this section). While you are waiting for your membership to end, you are still a member and must continue to get your care 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.

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

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

Involuntarily ending your membership

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

- If you do not stay continuously enrolled in Medicare A and B
- If you move out of the service area or are away from the service area for more than 6 months you cannot remain a member of our Plan. And we must end your membership ("disenroll" you). If you plan to move or take a long trip, please call Member Services to find out if the place you are moving to or traveling to is in our Plan's service area. Section 10 gives more information about getting care when you are away from the service area.
- If you intentionally give us incorrect information on your enrollment request that would affect your eligibility to enroll in our Plan.
- If you behave in a way that is disruptive, to the extent that you continued enrollment seriously impairs our ability to arrange or provide medical care for you or for others who are members of our Plan. We cannot make you leave our Plan for this reason unless we get permission first from Medicare.
- If you let someone else use your plan membership card to get medical care. If you are disenrolled for this reason, CMS may refer your case to the Inspector General for additional investigation.
- If you do not pay the Plan premiums, we will tell you in writing that you have a 60-day grace period during which you may pay the Plan premiums before your membership ends.

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.

7. Definitions of Important Words Used in the EOC

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/service you think you should be able to receive. Section 5 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 that is covered depends on whether you are considered an <u>inpatient</u> 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.

Centers for Medicare & Medicaid Services (CMS)—The Federal agency that runs the Medicare program. Section 8 explains how to contact CMS.

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

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's prescription drug coverage.

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

Disenroll or **Disenrollment**—The process of ending your membership in our Plan. Disenrollment may be voluntary (your own choice) or involuntary (not your own choice). Section 6 discusses disenrollment.

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

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

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

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

Home health aide—A home health aide provides services that 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 10 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.

Late Enrollment Penalty—An amount added to your monthly premium for Medicare drug coverage if you go without creditable coverage (coverage that expects to pay, on average, at least as much as standard Medicare prescription drug coverage) for a continuous period of 63 days or more. You pay this higher amount as long as you have a Medicare drug plan. There are some exceptions.

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

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

Medicare Advantage (MA) Plan—Sometimes called Medicare Part C. A plan offered by a private company that contracts with Medicare to provide you with all your Medicare Part A (Hospital) and Part B (Medical) benefits. A MA plan offers a specific set of health benefits at the same premium and level of cost-sharing to all people with Medicare who live in the service area covered by the Plan. Medicare Advantage Organizations can offer one or more Medicare Advantage plan in the same service area. A Medicare Advantage Plan can be an HMO, PPO, a Private Fee-for-Service (PFFS) Plan, or a Medicare Medical Savings Account (MSA) plan. In most cases, Medicare Advantage Plans also offer Medicare Part D (prescription drug coverage). These plans are called **Medicare Advantage Plans with Prescription Drug Coverage**. Everyone who has Medicare Part A and Part B is eligible to join any Medicare Health Plan that is offered in their area, except people with End-Stage Renal Disease (unless certain exceptions apply).

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

"Medigap" (Medicare supplement insurance) policy—Medicare supplement insurance sold by private insurance companies to fill "gaps" in the Original Medicare Plan coverage. Medigap policies only work with the Original Medicare Plan. (A Medicare Advantage plan is not a Medigap policy.)

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

Member Services—A department within our Plan responsible for answering your questions about your membership, benefits, grievances, and appeals. See Section 8 for information about how to contact Member Services.

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

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

Original Medicare Plan—("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 2.

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

Preferred Provider Organization Plan—A Preferred Provider Organization plan is an MA plan that has a network of contracted providers that have agreed to treat plan members for a specified payment amount. A PPO plan must cover all plan benefits whether they are received from network or out-of-network providers. Member cost-sharing may be higher when plan benefits are received from out-of-network providers.

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

Prior authorization—Approval in advance to get services. In a PPO, some in-network services are covered only if your doctor or other network provider gets "prior authorization" from our Plan. You generally do not need prior authorization to obtain out-of-network services, but you may want to check with the Plan before obtaining out-of-network services to confirm your cost share responsibility and that the services are covered by the Plan. Covered services that need prior authorization are marked in the Benefits Chart in Section 10.

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 8 for information about how to contact the QIO in your state and Section 5 for information about making complaints to the QIO.

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

Service area—"Service area" is the geographic area approved by the Centers for Medicare & Medicaid Services (CMS) within which an eligible individual may enroll in a certain plan.

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.

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

Urgently needed care—Section 2 explains about "urgently needed" services. These are different from emergency services.

8. Helpful Phone Numbers and Resources

Contact Information for our Plan Member Services

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

CALL (518) 641-3950 or 1-888-248-6522 (Calls to this number are free.)
Monday through Friday, 8 a.m. to 8 p.m. Eastern

TTY/TDD (518) 641-4000 or 1-877-261-1164 (Calls to this number are free.)
These numbers require special telephone equipment.

FAX (518) 641-3507

WRITE 500 Patroon Creek Boulevard, Albany, NY 12206-1057

VISIT 500 Patroon Creek Boulevard, Albany, NY 12206-1057

WEB SITE www.cdphp.com

Contact Information for Grievances, Organizations Determinations, and Appeals

Part C Grievances, Organization Determinations and Appeals (about your Medical Care and Services)

CALL (518) 641-3950 or 1-888-248-6522 (Calls to this number are free.)
Monday through Friday, 8 a.m. to 8 p.m. Eastern

TTY/TDD (518) 641-4000 or 1-877-261-1164 (Calls to this number are free.)
These numbers require special telephone equipment

FAX (518) 641-3507

WRITE 500 Patroon Creek Boulevard, Albany, NY 12206-1057

For information about Part C grievances, see Section 4. For information about Part C organization determinations and appeals, see Section 5.

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.

New York State Health Insurance Information Counseling & Assistance Program (HIICAP)

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

You may contact HIICAP at:

Broome: Broome County Office for the Aging, 44 Hawley Street, 4th Floor, P.O. Box 1766, Binghamton, NY 13902-1766, (607) 778-2411.

Chenango: Chenango County Area Agency on Aging, County Office Bldg., 5 Court St., Norwich, NY 13815-1794, (607) 337-1770.

Columbia: Columbia County Office for the Aging, 325 Columbia Street, Hudson, NY 12534, (518) 828-4258.

Delaware: Delaware County Office for the Aging, 6 Court Street, Delhi, NY 13753-1066, (607) 746-6333.

Dutchess: Dutchess County Office for the Aging, 27 High Street, Poughkeepsie, NY 12601-1962, (845) 486-2555.

Fulton: Fulton County Office for Aging, 19 N. William Street, Johnstown, NY 12095-2534, (518) 736-5650.

Greene: Greene County Department for the Aging, 411 Main Street, Catskill, NY 12414, (518) 719-3555.

Hamilton: Warren/Hamilton Counties Offices for the Aging, 333 Glen Street, 3rd Floor, Suite 306, Glens Falls, NY 12801, (518) 761-6347.

Herkimer: Herkimer County Office for the Aging, 109 Mary Street, Suite 1101, Herkimer, NY 13350-2924, (315) 867-1121.

Madison: Madison County Office for the Aging, 138 Dominick Bruno Blvd., Canastota, NY 13032, (315) 697-5700.

Montgomery: Montgomery County Office for the Aging, Inc., 135 Guy Park Avenue, Amsterdam, NY 12010, (518) 843-7478.

Oneida: Oneida County Office for Aging and Continuing Care, 235 Elizabeth Street, Utica, NY 13501, (315) 798-5456.

Otsego: Otsego County Office for the Aging, Meadows Office Complex—Suite 5, 140 Co Hwy 33 W, Cooperstown, NY 13326, (607) 547-4232.

Tioga: Tioga Opportunities, Inc., Department of Aging Services, Countryside Community Center, 9 Sheldon Guile Blvd., Owego, NY 13827, (607) 687-4120.

Ulster: Ulster County Office for the Aging, 1003 Development Court, Kingston, NY 12401, (845) 340-3456.

You may also find the Web site for the HIICAP at www.medicare.gov under "Search Tools" by selecting "Helpful Phone Numbers and Web Sites."

Island Peer Review Organization (IPRO) or Quality Improvement Organization

"QIO" stands for Quality Improvement Organization. The QIO is a group of doctors and health professionals in your state that reviews medical care and handles certain types of complaints from patients with Medicare, and is paid by the federal government to check on and help improve the care given to Medicare patients. There is a QIO in each state. QIOs have different names, depending on which state they are in. The doctors and other health experts in the QIO review certain types of complaints made by Medicare patients. These include complaints about quality of care and appeals filed by Medicare patients who think the coverage for their hospital, skilled nursing facility, home health agency, or comprehensive outpatient rehabilitation stay is ending too soon. See Sections 4 and 5 for more information about complaints, appeals and grievances.

You may contact IPRO at Island Peer Review Organization, Marcus Avenue, Lake Success, NY, 11042-1002, 1-800-331-7767 or (516) 326-7767.

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 Web site for Medicare. This Web site 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 Web Sites." If you don't have a computer, your local library or senior center may be able to help you visit this Web site using its computer.

Medicaid

Medicaid is a state government program that helps with medical costs for some people with limited incomes and resources. Some people with Medicare are also eligible for Medicaid. Medicaid has programs that can help pay for your Medicare premiums and other costs, if you qualify. To find out more about Medicaid and its programs, contact the New York State Medicaid Office at (518) 486-9057 or 1-800-541-2831.

Social Security

Social Security programs include retirement benefits, disability benefits, family benefits, survivors' benefits, and benefits for the aged and blind. You may call Social Security at 1-800-772-1213. TTY users should call 1-800-325-0778. You may also visit www.socialsecurity.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 get, or your spouse gets, benefits from your current or former employer or union, or from your spouse's current or former employer or union, call the employer/union benefits administrator or Member Services if you have any questions about your employer/union benefits, plan premiums, or the open enrollment season. Important Note: You (or your spouse's) employer/union benefits may change, or you (or your spouse) may lose the benefits, if you enroll in Medicare Part D. Call your employer/union benefits administrator or Member Services to find out whether the benefits will change or be terminated if you or your spouse enrolls in Part D.

9. Legal Notices

Notice about governing law

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

Notice about nondiscrimination

We 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, 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.

10. How Much You Pay for Your Part C Medical Benefits

Your Monthly Premium for Our Plan

Your monthly premium for our Plan is $31.

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

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

How Much You Pay for Part C Medical Benefits

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

What do you pay for covered services?

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

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

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

There is a limit to how much you have to pay out-of-pocket for "certain" covered health care services each year. For most covered medical services received both in- and out-of-network, you pay no more than $2,500 total per year. Any services not included will be noted in the Benefits Chart.

Benefits Chart

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

- Services must be provided according to the Medicare coverage guidelines established by the Medicare Program.
- The medical care, services, supplies, and equipment that are listed as covered services must be medically necessary. Certain preventive care and screening tests are also covered.
- Some of the covered services listed in the Benefits Chart are covered only if your doctor or other network provider gets "prior authorization" (approval in advance) from our Plan. Covered services that need prior authorization are marked in the Benefits Chart by an asterisk.

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

Benefits chart—your covered services	What you must pay when you get these covered services
Inpatient Services	
Inpatient hospital care No limit to the number of days covered by the plan each benefit period. A benefit period *begins* on the first day you go to a Medicare-covered inpatient hospital. The benefit period *ends* when you have not been an inpatient at any hospital for 60 days in a row. If you go to the hospital after one benefit period has ended, a new benefit period begins. Except in an emergency, your doctor must tell the plan that you are going to be admitted to the hospital. Covered services include: • Semi-private room (or a private room if medically necessary) • Meals including special diets • Regular nursing services • Costs of special care units (such as intensive or coronary care units) • Drugs and medications • Lab tests • X-rays and other radiology services • Necessary surgical and medical supplies • Use of appliances, such as wheelchairs • Operating and recovery room costs • Physical, occupational, and speech language therapy • Under certain conditions, the following types of transplants are covered: corneal, kidney, kidney-pancreatic, heart, liver, lung, heart/lung, bone marrow, stem cell, and intestinal/multivisceral. If you need a transplant, we will arrange to have your case reviewed by a Medicare-approved transplant center that will decide whether you are a candidate for a transplant. If you are sent outside of your community for a transplant, we will arrange or pay for appropriate lodging and transportation costs for you and a companion. • 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	**In-Network** $250 copayment for each Medicare-covered hospital stay. No copayment for additional hospital days. $750 out-of-pocket limit every year. **Out-of-Network** $500 copayment for each Medicare-covered hospital stay. If you get authorized inpatient care at a non-plan hospital after your emergency condition is stabilized, your cost is the cost-sharing you would pay at a plan hospital.
Inpatient mental health care* Covered services include mental health care services that require a hospital stay. You are covered for unlimited days each benefit period in a psychiatric unit of a general hospital. There is a 190-day lifetime limit for inpatient services in a psychiatric hospital. Contact the plan for details about coverage in a psychiatric hospital beyond 190 days. 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 doctor must tell the plan that you are going to be admitted to the hospital.	**In-Network** $250 copayment for each Medicare-covered hospital stay. No copayment for additional hospital days. $750 out-of-pocket limit every year. **Out-of-Network** $500 copayment for each Medicare-covered hospital stay.

<table>
<tr><th>Benefits chart—your covered services</th><th>What you must pay when you get these covered services</th></tr>
<tr><td colspan="2">Inpatient Services</td></tr>
<tr><td>Skilled nursing facility (SNF) care*
Plan covers up to 100 days each benefit period.
A benefit period begins on the first day you go to a Medicare-covered inpatient hospital or a skilled nursing facility. The benefit period ends when you have not been an inpatient at a hospital or skilled nursing facility for 60 days in a row. If you go to the hospital after one benefit period has ended, a new benefit period begins.
No prior hospital stay is required. Custodial and long-term care are not covered.
Covered services include:
• Semiprivate room (or a private room if medically necessary)
• Meals, including special diets
• Regular nursing services
• Physical therapy, occupational therapy, and speech therapy
• Drugs administered to you as part of your plan of care (This includes substances that are naturally present in the body, such as blood clotting factors)
• Blood—including storage and administration. 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 ordinarily provided by SNFs
• Laboratory tests ordinarily provided by SNFs
• X-rays and other radiology services ordinarily provided by SNFs
• Use of appliances such as wheelchairs ordinarily provided by SNFs
• Physician services
Generally, you will get your SNF care from plan facilities. However, under certain conditions listed below, you may be able to pay in-network cost-sharing for a facility that isn't a plan provider, if the facility accepts our Plan's amounts for payment.
• A nursing home or continuing care retirement community where you were living right before you went to the hospital (as long as it provides skilled nursing facility care).
• A SNF where your spouse is living at the time you leave the hospital.</td><td>In- and Out-of-Network
For Medicare-covered SNF stays:
• $0 copayment per day for days 1–20;
• $65 copayment per day for days 21–100.</td></tr>
</table>

Benefits chart—your covered services	What you must pay when you get these covered services
Inpatient Services	
Inpatient services covered when the hospital or SNF days aren't, or are no longer, covered	
Covered services include:	**In- and Out-of-Network**
• Physician services	• $5 copayment for each primary care physician visit; $10 copayment for each specialist visit.
• Tests (like X-ray or lab tests)	• $10 copayment for each Medicare-covered laboratory or radiology service. (Copayment waived if services provided by Preferred Laboratory or Radiology Network Provider. A listing of Preferred Laboratory or Radiology Network Providers will be provided upon request.)
• X-ray, radium, and isotope therapy including technician materials and services	• $10 copayment for radiation therapy services.
• Surgical dressings, splints, casts and other devices used to reduce fractures and dislocations	• No copayment.
• Prosthetics and Orthotics devices (other than dental) that replace all or part of an internal body organ (including contiguous tissue), or all or part of the function of a permanently inoperative or malfunctioning internal body organ, including replacement or repairs of such devices	• 20% of the Medicare-allowed fee, up to a maximum of $200, for each Medicare-covered device.
• 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	• 20% of the Medicare-allowed fee, up to a maximum of $200, for each Medicare-covered item.
• Physical therapy, speech therapy, and occupational therapy	• $10 copayment for each Medicare-covered therapy session.

Benefits chart—your covered services	What you must pay when you get these covered services
Inpatient Services	
Home health agency care Covered services include: • Part-time or intermittent skilled nursing and home health aide services (To be covered under the home health care benefit, your skilled nursing and home health aide services combined must total less than eight hours per day and 35 or fewer hours per week) • Physical therapy, occupational therapy, and speech therapy • Medical social services • Medical equipment and supplies	**In- and Out-of-Network** • For Medicare-covered home health visits: • $0 copayment per day for days 1–20; • $25 copayment per day after 20 days.
Hospice care You may receive care from any Medicare-certified hospice program. The Original Medicare Plan (rather than our Plan) will pay the hospice provider for the services you receive. Your hospice doctor can be a network provider or an out-of-network provider. You will still be a plan member and will continue to get the rest of your care that is unrelated to your terminal condition through our Plan. Covered services include: • Drugs for symptom control and pain relief, short-term respite care, and other services not otherwise covered by the Original Medicare Plan • Home care	When you enroll in a Medicare-certified Hospice program, your hospice services are paid for by the Original Medicare Plan, not your Medicare Advantage plan.

<table>
<tr><th>Benefits chart—your covered services</th><th>What you must pay when you get these covered services</th></tr>
<tr><td colspan="2">Outpatient Services</td></tr>
<tr><td>Physician services, including doctor office visits
Covered services include:
• Office visits, including medical and surgical care in a physician’s office or certified ambulatory surgical center
• Consultation, diagnosis, and treatment by a specialist
• Hearing and balance exams, if your doctor orders it to see if you need medical treatment.
• Telehealth office visits including consultation, diagnosis and treatment by a specialist
• Second opinion by another network provider prior to surgery
• Outpatient hospital services
• Non-routine dental care (covered services are limited to surgery of the jaw or related structures, setting fractures of the jaw or facial bones, extraction of teeth to prepare the jaw for radiation treatments of neoplastic cancer disease, or services that would be covered when provided by a doctor)</td><td>In- and Out-of-Network
$5 copayment for each primary care doctor visit for Medicare-covered benefits.
$10 copayment for each specialist visit for Medicare-covered benefits.
$35 copayment for each visit at a network Urgent Care facility for Medicare-covered benefits.
Physician copayments do not apply for ambulatory surgical center and outpatient hospital visits.</td></tr>
<tr><td>Chiropractic services
Covered services include:
• Manual manipulation of the spine to correct subluxation or displacement or misalignment of a joint or body part.</td><td>In- and Out-of-Network
$10 copayment for each Medicare-covered visit.</td></tr>
</table>

Benefits chart—your covered services	What you must pay when you get these covered services
Outpatient Services	
Podiatry services Covered services include: • Treatment of injuries and diseases of the feet (such as hammer toe or heel spurs). • Routine foot care for members with certain medical conditions affecting the lower limbs.	**In- and Out-of-Network** $10 copayment for each Medicare-covered visit for medically necessary foot care.
Outpatient mental health care (including Partial Hospitalization Services) Covered services include: • Mental health services provided by a doctor, clinical psychologist, clinical social worker, clinical nurse specialist, nurse practitioner, physician assistant, or other Medicare-qualified mental health care professional as allowed under applicable state laws. "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.	**In- and Out-of-Network** For Medicare-covered individual therapy: • $10 copayment for each visit for visits 1–10. • $25 copayment for each visit for visits 11 and over. For Medicare-covered group therapy: • $5 copayment for each visit for visits 1–10. • $10 copayment for each visit for visits 11 and over.
Outpatient substance abuse services	**In- and Out-of-Network** For Medicare-covered individual therapy: • $10 copayment for each visit for visits 1–10. • $25 copayment for each visit for visits 11 and over. For Medicare-covered group therapy: • $5 copayment for each visit for visits 1–10. • $10 copayment for each visit for visits 11 and over.
Outpatient surgery (including services provided at ambulatory surgical centers)	**In- and Out-of-Network** $100 copayment for each Medicare-covered ambulatory surgical center visit. $100 copayment for each Medicare-covered outpatient hospital facility visit.

Benefits chart—your covered services	What you must pay when you get these covered services
Outpatient Services	
Ambulance services Covered ambulance services include fixed wing, rotary wing, and ground ambulance services, to the nearest appropriate facility that can provide care only if they are furnished to a member whose medical condition is such that other means of transportation are contraindicated (could endanger the person's health). The member's condition must require both the ambulance transportation itself and the level of service provided in order for the billed service to be considered medically necessary. Non-emergency transportation by ambulance is appropriate if it is documented that the member's condition is such that other means of transportation are contraindicated (could endanger the person's health) and that transportation by ambulance is medically required.	**In- and Out-of-Network** $50 copayment per one-way trip for Medicare-covered ambulance benefits. Prior authorization is required only for air ambulance services. Contact the plan for more information.
Emergency care Worldwide coverage.	**In- and Out-of-Network** $50 copayment for Medicare-covered emergency room visits. If you are admitted to the hospital within 24 hours for the same condition, you pay $0 for the emergency room visit. If you need inpatient care at a non-plan hospital after your emergency condition is stabilized, you must have your inpatient care at the non-plan hospital authorized by the plan and your cost is the cost-sharing you would pay at a plan hospital.
Urgently needed care For urgent care visits to participating plan providers, or to non-plan providers with prior authorization. Worldwide coverage.	**In- and Out-of-Network** $5 copayment for each visit at a physician's office. $10 copayment for each visit at the specialist's office. $35 copayment for each visit at a network Urgent Care facility. If you are admitted to the hospital within 24 hours for the same condition, you pay $0 for the urgent care visit.

Benefits chart—your covered services	What you must pay when you get these covered services
Outpatient Services	
Outpatient rehabilitation services Covered services include: physical therapy, occupational therapy, speech language therapy, and cardiac rehabilitative therapy	**In- and Out-of-Network** $10 copayment for Medicare-covered Occupational Therapy visits. $10 copayment for Medicare-covered Physical and/or Speech/Language Therapy visits.
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 7.)	**In- and Out-of-Network** 20% of the Medicare-allowed fee, up to a maximum of $200, for each Medicare-covered item. Prior authorization is required for purchases or rental of each covered item totaling $500 or more.
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.	**In- and Out-of-Network** 20% of the Medicare-allowed fee, up to a maximum of $200, for each Medicare-covered item. All colostomy supplies are covered in full. Prior authorization is required for purchases or rental of each covered item totaling $500 or more.

Benefits chart—your covered services	What you must pay when you get these covered services
Outpatient Services	
Diabetes self-monitoring, training and supplies—for all people who have diabetes (insulin and non-insulin users). Covered services include:	**In- and Out-of-Network**
• Blood glucose monitor, blood glucose test strips, lancet devices and lancets, and glucose-control solutions for checking the accuracy of test strips and monitors	• 20% of the Medicare-allowed fee for each diabetic monitoring item. • $10 or 20% of the allowed fee (whichever is less) for test strips, lancets, and glucose-control solutions for up to a 30-day supply. These items are not included in the annual out-of-pocket limit.
• One pair per calendar year of therapeutic shoes for people with diabetes who have severe diabetic foot disease, including fitting of shoes or inserts	• No copayment for diabetes self-monitoring training.
• Self-management training is covered under certain conditions	The above does not apply to your Part D prescription drug coverage.
• For persons at risk of diabetes: Fasting plasma glucose tests. There is no limit to frequency testing.	If these services are the only services rendered during your visit to a physician's office, then the office visit copayment for that physician also may apply.
Medical nutrition therapy—for people with diabetes, renal (kidney) disease (but not on dialysis), and after a transplant when referred by your doctor.	**In- and Out-of-Network** $10 copayment.

Benefits chart—your covered services	What you must pay when you get these covered services
Outpatient Services	
Outpatient diagnostic tests and therapeutic services and supplies Covered services include: • X-rays • Radiation therapy • Surgical supplies, such as dressings • Supplies, such as splints and casts • Laboratory tests • Blood—Coverage begins with the 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. • Other outpatient diagnostic tests	**In- and Out-of-Network** $10 copayment for Medicare-covered lab, X-rays, and other diagnostic procedures and tests. $10 copayment for Medicare-covered radiation therapy services. Copayment waived if services performed by a Preferred Laboratory or Radiology Network Provider. A listing of preferred providers is available upon request. (Copayment waiver does NOT apply to radiation therapy services.) If these services are the only services rendered during your visit to a physician's office, then the office visit copayment for that physician also may apply.

Benefits chart—your covered services	What you must pay when you get these covered services
Outpatient Services	
Vision care Covered services include:	**In- and Out-of-Network**
• Outpatient physician services for eye care.	• $10 copayment for exams to diagnose and treat diseases and conditions of the eye.
• 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	• No copayment for Medicare-covered glaucoma screenings.
• One pair of eyeglasses or contact lenses after each cataract surgery that includes insertion of an intraocular lens. Corrective lenses/frames (and replacements) needed after a cataract removal without a lens implant.	• 20% of the allowed fee for each Medicare-covered item, including one pair of eyeglasses or contact lenses after each cataract surgery.
• Annual routine eye exam. (No prior authorization required if services are rendered by a Plan Provider.)	• $25 copayment.
• Eye wear (glasses, lenses, frames, contacts). Covers one pair of frames and lenses or contact lenses (not both) when a new prescription or prescription change is determined to be medically necessary by a plan provider.	• You are reimbursed up to $80 for each pair of eyeglass frames or lenses every year. You must pay for the eyeglasses, then submit your receipt and proof of payment to CDPHP MEDICARE CLAIMS for reimbursement. For more information, please contact Member Services. This benefit can be used at any optical vendor in- or out-of-network.

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, the one-time physical exam for members within the first 12 months that they have Medicare Part B.	**In- and Out-of-Network** No copayment for Medicare covered abdominal aortic aneurysm screenings. If these services are the only services rendered during your visit to a physician's office, then the office visit copayment for that physician also may apply.
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.	**In- and Out-of-Network** No copayment for Medicare covered bone mass measurements. No referral necessary for network providers. If these services are the only services rendered during your visit to a physician's office, then the office visit copayment for that physician also may apply.
Colorectal screening For people 50 and older, the following are covered: • Flexible sigmoidoscopy (or screening barium enema as an alternative) every 48 months • Fecal occult blood test, every 12 months For people at high risk of colorectal cancer, we cover: • Screening colonoscopy (or screening barium enema as an alternative) every 24 months For people not at high risk of colorectal cancer, we cover: • Screening colonoscopy every 10 years, but not within 48 months of a screening sigmoidoscopy	**In- and Out-of-Network** No copayment for Medicare-covered colorectal screenings. For non-screening exams or diagnostic procedures for acute conditions, an outpatient or office visit copayment will apply.

Benefits chart—your covered services	What you must pay when you get these covered services
Preventive Care and Screening Tests	
Immunizations Covered services include: • Pneumonia vaccine • Flu shots, once a year in the fall or winter • Hepatitis B vaccine if you are at high or intermediate risk of getting Hepatitis B • Other vaccines if you are at risk	**In- and Out-of-Network** No copayment for flu, pneumonia, Hepatitis B, and Zostavax vaccines. No referrals necessary for network providers. Except for flu and pneumonia vaccinations, if these services are the only services rendered during your visit to a physician's office, then the office visit copayment for that physician also may apply.
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	**In- and Out-of-Network** No copayment for Medicare-covered screening mammograms. No referrals necessary for network providers. If these services are the only services rendered during your visit to a physician's office, then the office visit copayment for that physician also may apply.
Pap tests, pelvic exams, and clinical breast exam Covered services include: • For all women, Pap tests, pelvic exams, and clinical breast exams are covered once every 24 months • If you are at high risk of cervical cancer or have had an abnormal Pap test and are of childbearing age: one Pap test every 12 months • Up to 1 additional Pap smear and pelvic exam every two years.	**In- and Out-of-Network** No copayment for Medicare-covered Pap smears and pelvic exams. The Plan covers two Pap smears every 24 months and two pelvic exams every 24 months. No referrals necessary for network providers. If these services are the only services rendered during your visit to a physician's office, then the office visit copayment for that physician also may apply.

Benefits chart—your covered services	What you must pay when you get these covered services
Preventive Care and Screening Tests	
Prostate cancer screening exams For men age 50 and older, covered services include the following—once every 12 months: • Digital rectal exam • Prostate Specific Antigen (PSA) test	**In- and Out-of-Network** No copayment for Medicare-covered prostate cancer screenings. No referrals necessary for network providers. If these services are the only services rendered during your visit to a physician's office, then the office visit copayment for that physician also may apply.
Cardiovascular disease testing Blood tests for the detection of cardiovascular disease (or abnormalities associated with an elevated risk of cardiovascular disease). There is no limit to the frequency of testing.	**In- and Out-of-Network** No copayment for Medicare-covered cardio-vascular disease testing. No referrals necessary for network providers. If these services are the only services rendered during your visit to a physician's office, then the office visit copayment for that physician also may apply.
Physical exams One routine physical exam every year.	**In- and Out-of-Network** No copayment for routine physical exams.

Benefits chart—your covered services	What you must pay when you get these covered services
Other Services	
Dialysis (Kidney) Covered services include: • Outpatient dialysis treatments (including dialysis treatments when temporarily out of the service area, as explained in Section 2)	**In- and Out-of-Network** • $10 copayment for in- and out-of-area renal dialysis. Out-of-area renal dialysis services are covered only in the United States.
• Inpatient dialysis treatments (if you are admitted to a hospital for special care)	• See the "Inpatient Hospital Care" benefit above for specific cost-sharing information.
• Self-dialysis training (includes training for you and anyone helping you with your home dialysis treatments) • Home dialysis equipment and supplies • Certain home support services (such as, when necessary, visits by trained dialysis workers to check on your home dialysis, to help in emergencies, and check your dialysis equipment and water supply)	• 20% of the allowed fee for each Medicare-covered item.
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 aren't self-administered by the patient and are injected while you are getting physician services • Drugs you take using durable medical equipment (such as nebulizers) that was authorized by the plan • Clotting factors you give yourself by injection if you have hemophilia • Immunosuppressive Drugs, if you were enrolled in Medicare Part A at the time of the organ transplant • Injectable osteoporosis drugs, if you are homebound, have a bone fracture that a doctor certifies was related to post-menopausal osteoporosis, and cannot self-administer the drug • Antigens • Certain oral anti-cancer drugs and anti-nausea drugs • Certain drugs for home dialysis, including heparin, the antidote for heparin when medically necessary, topical anesthetics, and erythropoisis-stimulating agents (such as Epogen®, Procrit®, Epoetin Alfa, Aranesp®, or Darbepoetin Alfa) • Intravenous Immune Globulin for the home treatment of primary immune deficiency diseases	**In- and Out-of-Network** No copayment; limited to a 30-day supply per prescription.

Benefits chart—your covered services	What you must pay when you get these covered services
Additional Benefits	
Dental Services • Services by a dentist or oral surgeon are limited to surgery of the jaw or related structures, setting fractures of the jaw or facial bones, extraction of teeth to prepare the jaw for radiation treatments of neoplastic disease, or services that would be covered when provided by a doctor. • Routine dental care, including: — Two oral exams every year — Two cleanings every year	**In- and Out-of-Network** • No copayment for Medicare-covered dental benefits. • You are reimbursed up to $150 for routine, preventive dental benefits every year. You must pay for the dental services, then submit your receipt and proof of payment to CDPHP MEDICARE CLAIMS for reimbursement. This benefit may be used at any dental provider, in- or out-of-network.
Hearing Services • Diagnostic and routine hearing exams. • Hearing aids and hearing aid repair.	**In- and Out-of-Network** • $10 copayment for Medicare-covered diagnostic hearing exams. • $10 copayment for 1 routine hearing exam and 1 routine hearing aid fitting exam each year. • No referral necessary for hearing exams for network providers. • You are covered up to a $600 limit for routine hearing aids every three years. The benefit can also be used to cover the cost of hearing aid repairs. You must pay for the new hearing aid, or repair to an existing one, then submit your receipt and proof of payment to CDPHP MEDICARE CLAIMS for reimbursement. This benefit may be used at any hearing aid vendor, in- or out-of-network.

Benefits chart—your covered services	What you must pay when you get these covered services
Additional Benefits	
Vision care See above "Vision care" on page 50.	
Health and wellness education programs The following health and wellness programs are covered:	**In- and Out-of-Network**
• Written health education materials, including newsletters	• No copayment.
• Complementary Alternative Medicine Program (CAM) includes discounts on acupuncture, massage therapy, diet and holistic health. For more information, call 1-800-274-7526 (TTY: 1-877-440-5580).	• Discounts available.
• The CDPHP Senior Fit℠ program, featuring:	
○ SilverSneakers® health club membership/fitness classes, including classes at participating fitness centers nationwide. For more information or a complete list of participating fitness center locations, call 1-888-423-4632 or go online at www.silversneakers.com.	• No copayment.
○ Capital District YMCA (CDYMCA) no–cost access to services, including full utilization of any one of nine participating CDYMCA facilities. For more information, contact CDYMCA at (518) 869-3500 or www.cdymca.org.	• No copayment.
• Smoking cessation counseling sessions	• No copayment for each Medicare-covered session.
• Disease/weight management programs. Call the CDPHP wellness line at (518) 641-4800 for more details.	• Partial program reimbursement available following successful completion of approved program.
• Health Coach Connection℠ includes one-on-one health information, and online health coaching, 24 hours a day, 7 days a week. Your health coach can be reached by calling 1-800-365-4180 or online at www.cdphp.com/HealthCoachConnection.	• No copayment.
Nutritional training—medical nutrition therapy for people with diabetes.	• Office copayment will apply.
Preventive counseling.	• Office copayment will apply.

Benefits chart—your covered services	What you must pay when you get these covered services
Other Services	
Medical Transportation (routine)* Non-emergency transportation to a provider's office or facility within the plan's service area.	**In-Network** No copayment for one-way and round trips to plan-approved locations. Prior authorization is required. Any routine transportation not pre-approved by the plan will not be covered. Routine medical transportation is covered only when you are enrolled in the Plan's case management services and any other means of transportation would endanger your health. For details, contact the Resource Coordination department at 1-800-274-2332.

Sample plan membership card

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

Here is a sample card to show for medical services.

Enrollees: Review your benefit materials for a description of covered services or call Member Services at the telephone number on this card.
Providers: Call 518-641-3500 or 1-800-926-7526 for verification of eligibility. Balance Billing beyond Medicare Allowed Charges is not permitted per Medicare regulations.
Hospitals: Call 518-641-4100 or 1-800-274-2332 for approval within 24 hours of an emergency admission.
Mental Health/Chemical Dependency services: Call United Behavioral Health at 1-888-320-9584 (TTY/TDD 1-800-486-7914).
Fraud/Compliance Hotline: 1-800-280-6885 Unauthorized or fraudulent use of this card to obtain services is punishable by law.

General Exclusions

Introduction

The purpose of this part of Section 10 is to tell you about medical care and services and items, that aren't covered ("are excluded") or are limited by our Plan. The list below tells about these exclusions and limitations. The list describes services and items that aren't 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 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/items that we should have paid or covered (appeals are discussed in Section 5).

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

In addition to any exclusions or limitations described in the Benefits Chart, or anywhere else in this EOC, **the following items and services aren't covered under the Original Medicare Plan or 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 a covered service.
2. Experimental or investigational medical and surgical procedures, equipment and medications, unless covered by the Original Medicare Plan or unless, for certain services, the procedures are covered under an approved clinical trial. The Centers for Medicare and Medicaid Services (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 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 the Original Medicare plan.
4. Private room in a hospital, unless medically necessary.
5. Private duty nurses.

6. Personal convenience items, such as a telephone or television in your room at a hospital or skilled nursing facility.
7. Nursing care on a full-time basis in your home.
8. Custodial care unless it is provided in conjunction with covered skilled nursing care and/or skilled rehabilitation services. This includes care that helps people with activities of daily living like walking, getting in and out of bed, bathing, dressing, eating and using the bathroom, preparation of special diets, and supervision of medication that is usually self-administered.
9. Homemaker services.
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 needed because of accidental injury or to improve the function of a malformed part of the body. All stages of reconstruction are covered for a breast after a mastectomy, as well as for the unaffected breast to produce a symmetrical appearance.
14. Certain routine dental care (such as periodontics, fillings, or dentures) or other dental services. However, non-routine dental services received at a hospital may be covered.
15. Chiropractic care is generally not covered under the Plan, (with the exception of manual manipulation of the spine,) and is limited according to Medicare guidelines.
16. Routine foot care is generally not covered under the Plan 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 brace. Exception: Therapeutic shoes are covered for people with diabetic foot disease.
18. Supportive devices for the feet. Exception: Orthopedic or therapeutic shoes are covered for people with diabetic foot disease.
19. Hearing aids and routine hearing examinations.
20. Eyeglasses (except after cataract surgery), routine eye examinations, radial keratotomy, LASIK surgery, vision therapy and other low vision aids and services.
21. Self-administered prescription medication for the treatment of sexual dysfunction, including erectile dysfunction, impotence, and anorgasmy or hyporgasmy.
22. Reversal of sterilization procedures, sex change operations, and non-prescription contraceptive supplies and devices.
23. Acupuncture, except limited coverage as part of the discount Complementary Alternative Medicine Program.
24. Naturopath services.
25. Services provided to veterans in Veterans Affairs (VA) facilities. However, in the case of emergency services received at a VA hospital, if the VA cost-sharing is more than the cost-sharing required under our Plan, we will reimburse veterans for the difference. Members are still responsible for our Plan cost-sharing amount.
26. Any of the services listed above that 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.

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