



January 1 – December 31, 2025

Evidence of Coverage:

Your Medicare Health Benefits and Services and Prescription Drug Coverage as a Member of Regence MedAdvantage + Rx Classic (PPO)

This document gives you the details about your Medicare health care and prescription drug coverage from January 1 – December 31, 2025. **This is an important legal document. Please keep it in a safe place.**

For questions about this document, please contact Customer Service at 1-800-541-8981. (TTY users should call 711.) Our hours are 8 a.m. to 8 p.m., Monday through Friday. From October 1 through March 31, our telephone hours are 8 a.m. to 8 p.m., seven days a week. This call is free. Live online chat assistance is also available from 8 a.m. to 5 p.m. PT, Monday through Friday. To access online chat, sign in at regence.com/medicare, select Contact us and click on Chat Now to connect with us.

This plan, Regence MedAdvantage + Rx Classic, is offered by Regence BlueCross BlueShield of Utah. (When this *Evidence of Coverage* says “we”, “us”, or “our”, it means Regence BlueCross BlueShield of Utah. When it says “plan” or “our plan”, it means Regence MedAdvantage + Rx Classic.)

This document is available electronically and may be available in other alternate formats.

Benefits, premiums, deductibles, and/or copayments/coinsurance may change on January 1, 2026.

The formulary, pharmacy network, and/or provider network may change at any time. You will receive notice when necessary. We will notify affected enrollees about changes at least 30 days in advance.

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

- Your plan premium and cost sharing;
- Your medical and prescription drug benefits;
- How to file a complaint if you are not satisfied with a service or treatment;
- How to contact us if you need further assistance; and,
- Other protections required by Medicare law.

BlueCross BlueShield of Utah is an Independent Licensee of the Blue Cross and Blue Shield Association

2025 Evidence of Coverage

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CHAPTER 1:

Getting started as a member

SECTION 1 Introduction

Section 1.1 You are enrolled in Regence MedAdvantage + Rx Classic, which is a Medicare PPO

You are covered by Medicare, and you have chosen to get your Medicare health care and your prescription drug coverage through our plan, Regence MedAdvantage + Rx Classic. We are required to cover all Part A and Part B services. However, cost sharing and provider access in this plan differ from Original Medicare.

Our plan is a Medicare Advantage PPO Plan (PPO stands for Preferred Provider Organization). Like all Medicare health plans, this Medicare PPO is approved by Medicare and run by a private company.

Coverage under this Plan qualifies as Qualifying Health Coverage (QHC) and satisfies the Patient Protection and Affordable Care Act's (ACA) individual shared responsibility requirement. Please visit the Internal Revenue Service (IRS) website at: www.irs.gov/affordable-care-act/individuals-and-families for more information.

Section 1.2 What is the *Evidence of Coverage* document about?

This *Evidence of Coverage* document tells you how to get your medical care and prescription drugs. It explains your rights and responsibilities, what is covered, what you pay as a member of the plan, and how to file a complaint if you are not satisfied with a decision or treatment.

The words *coverage* and *covered services* refer to the medical care and services and the prescription drugs available to you as a member of our plan.

It's important for you to learn what the plan's rules are and what services are available to you. We encourage you to set aside some time to look through this *Evidence of Coverage* document.

If you are confused, concerned, or just have a question, please contact Customer Service.

Section 1.3 Legal information about the *Evidence of Coverage*

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

The contract is in effect for months in which you are enrolled in Regence MedAdvantage + Rx Classic between January 1, 2025, and December 31, 2025.

Each calendar year, Medicare allows us to make changes to the plans that we offer. This means we can change the costs and benefits of our plan after December 31, 2025. We can also choose to stop offering the plan, or to offer it in a different service area, after December 31, 2025.

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

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

Section 2.1 Your eligibility requirements

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

- You have both Medicare Part A and Medicare Part B.
- --and-- You live in our geographic service area (Section 2.2 below describes our service area). Incarcerated individuals are not considered living in the geographic service area even if they are physically located in it.
- --and-- You are a United States citizen or are lawfully present in the United States.

Section 2.2 Here is the plan service area for Regence MedAdvantage + Rx Classic

Our plan is available only to individuals who live in our plan service area. To remain a member of our plan, you must continue to reside in the plan service area. The service area is described below.

Our service area includes these counties in Utah: Box Elder, Cache, Davis, Iron, Morgan, Salt Lake, Summit, Tooele, Utah, Wasatch, Washington, and Weber

If you plan to move out of the service area, you cannot remain a member of this plan. Please contact Customer Service to see if we have a plan in your new area. When you move, you will have a Special Enrollment Period that will allow you to switch to Original Medicare or enroll in a Medicare health or drug plan that is available in your new location.

It is also important that you call Social Security if you move or change your mailing address. You can find phone numbers and contact information for Social Security in Chapter 2, Section 5.

Section 2.3 U.S. citizen or lawful presence

A member of a Medicare health plan must be a U.S. citizen or lawfully present in the United States. Medicare (the Centers for Medicare & Medicaid Services) will notify our plan if you are not eligible to remain a member on this basis. We must disenroll you if you do not meet this requirement.

SECTION 3 Important membership materials you will receive

Section 3.1 Your plan membership card

While you are a member of our plan, you must use your membership card whenever you get services covered by this plan and for prescription drugs you get at network pharmacies. You should also show the provider your Medicaid card, if applicable. Here's a sample membership card to show you what yours will look like:

<div style="display: flex; align-items: center;"> <div> <p>Regence</p> <p>MedAdv+Rx PPO</p> </div> </div> <hr/> <div style="display: flex; justify-content: space-between;"> <div style="width: 45%;"> <p>SUBSCRIBER SAMPLE</p> <p>ID NO ABC 123456789</p> </div> <div style="width: 50%;"> <p>RxBIN xxxxx RxCN xxxxxxxx</p> <p>Issuer (xxxxx)</p> <p>Card Issue Date: mm/dd/yyyy</p> </div> </div> <hr/> <div style="display: flex; justify-content: space-between;"> <div style="width: 45%;"> <p>00 SUBSCRIBER SAMPLE</p> <p>Group No. 12345678</p> <p>In-Network PCP/SPEC \$xx/\$xx</p> </div> <div style="width: 50%;"> <p>M D RX V</p> <p>Y Y Y Y</p> </div> </div> <hr/> <div style="display: flex; justify-content: space-between; align-items: center;"> <div style="width: 40%;"> </div> <div style="width: 20%; text-align: center;"> <p>CMS-H4605-xxx</p> </div> <div style="width: 20%; text-align: center;"> </div> </div>	<div style="display: flex; align-items: center;"> <div> <p>Regence</p> </div> </div> <hr/> <div style="font-size: 0.8em;"> <p>Hospitals or Physicians: File claims with local Blue Cross and/or Blue Shield plan/ANSI 837 transaction.</p> <p>MEDICARE LIMITING CHARGES APPLY</p> <p>This card is for information only and does not certify eligibility or guarantee benefits.</p> <p>Regence BlueCross BlueShield of Utah is an Independent Licensee of the Blue Cross and Blue Shield Association.</p> </div> <div style="font-size: 0.8em;"> <p>www.regence.com</p> <p>Members Call 1-800-541-8981</p> <p>TTY/TDD Line 711</p> <p>Nurse Advice24</p> <p>Dental</p> <p>Providers Call</p> <p>Pharmacies Call</p> <p>VSP Vision Care</p> </div> <hr/> <div style="font-size: 0.8em;"> <p>Members: send inquiries to Mail Administrator: Regence BlueCross BlueShield of Utah PO BOX 1827 Medford, OR 97501</p> <p>Submit RX Claims to: Rx Claims Processing PO BOX 20870 Lehigh Valley, PA 18002-0970</p> </div>
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Do NOT use your red, white, and blue Medicare card for covered medical services while you are a member of this plan. If you use your Medicare card instead of your plan membership card, you may have to pay the full cost of medical services yourself. Keep your Medicare card in a safe place. You may be asked to show it if you need hospital services, hospice services, or participate in Medicare approved clinical research studies also called clinical trials.

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

Section 3.2 Provider Directory

The *Provider Directory* lists our current network providers and durable medical equipment suppliers. **Network providers** are the doctors and other health care professionals, medical groups, durable medical equipment suppliers, hospitals, and other health care facilities that have an agreement with us to accept our payment and any plan cost sharing as payment in full.

As a member of our plan, you can choose to receive care from out-of-network providers. Our plan will cover services from either in-network or out-of-network providers, as long as the services are covered benefits and medically necessary. However, if you use an out-of-network provider, your share of the costs for your covered services may be higher. See Chapter 3 (*Using the plan's coverage for your medical services*) for more specific information.

The most recent list of providers and suppliers is available on our website at regence.com/medicare.

If you don't have your copy of the *Provider Directory*, you can request a copy (electronically or in hardcopy form) from Customer Service. Requests for hard copy Provider Directories will be mailed to you within three business days.

Section 3.3 Pharmacy Directory

The *Pharmacy Directory* (regence.com/medicare) lists our network pharmacies. **Network pharmacies** are all of the pharmacies that have agreed to fill covered prescriptions for our plan members. You can use the *Pharmacy Directory* to find the network pharmacy you want to use. See Chapter 5, Section 2.5 for information on when you can use pharmacies that are not in the plan's network.

The *Pharmacy Directory* will also tell you which of the pharmacies in our network have preferred cost sharing, which may be lower than the standard cost sharing offered by other network pharmacies for some drugs.

If you don't have the *Pharmacy Directory*, you can get a copy from Customer Service. You can also find this information on our website at regence.com/medicare.

Section 3.4 The plan's list of covered drugs (*Formulary*)

The plan has a *List of Covered Drugs (Formulary)*. We call it the “Drug List” for short. It tells which Part D prescription drugs are covered under the Part D benefit included in our plan. The drugs on this list are selected by the plan with the help of a team of doctors and pharmacists. The list must meet requirements set by Medicare. Medicare has approved the plan's Drug List.

The Drug List also tells you if there are any rules that restrict coverage for your drugs.

We will provide you a copy of the Drug List. To get the most complete and current information about which drugs are covered, you can visit the plan's website (regence.com/medicare) or call Customer Service.

SECTION 4 Your monthly costs for Regence MedAdvantage + Rx Classic

Your costs may include the following:

- Plan Premium (Section 4.1)
- Monthly Medicare Part B Premium (Section 4.2)
- Part D Late Enrollment Penalty (Section 4.3)
- Income Related Monthly Adjusted Amount (Section 4.4)
- Medicare Prescription Payment Plan Amount (Section 4.5)

In some situations, your plan premium could be less

The “Extra Help” program helps people with limited resources pay for their drugs. Chapter 2, Section 7 (contact information can also be found in “Exhibit A” in the back of this document) tells more about this program. If you qualify, enrolling in the program might lower your monthly plan premium.

If you are *already enrolled* and getting help from one of these programs, **the information about premiums in this *Evidence of Coverage* does not apply to you.** We sent you a separate insert, called the *Evidence of Coverage Rider for People Who Get “Extra Help” Paying for Prescription Drugs* (also known as the *Low-Income Subsidy Rider* or the *LIS Rider*), which tells you about your drug coverage. If you don't have this insert, please call Customer Service, and ask for the LIS Rider.

Medicare Part B and Part D premiums differ for people with different incomes. If you have questions about these premiums, review your copy of *Medicare & You 2025* handbook, the section called *2025 Medicare Costs*. If you need a copy, you can download it from the Medicare website (www.medicare.gov/medicare-and-you). Or you can order a printed copy by phone at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users call 1-877-486-2048.

Section 4.1 Plan premium

As a member of our plan, you pay a monthly plan premium. For 2025, the monthly premium for Regence MedAdvantage + Rx Classic is \$41

Section 4.2 Monthly Medicare Part B Premium

Many members are required to pay other Medicare premiums

In addition to paying the monthly plan premium, **you must continue paying your Medicare premiums to remain a member of the plan.** This includes your premium for Part B. It may also include a premium for Part A, which affects members who aren't eligible for premium-free Part A.

Section 4.3 Part D Late Enrollment Penalty

Some members are required to pay a Part D **late enrollment penalty**. The Part D late enrollment penalty is an additional premium that must be paid for Part D coverage if at any time after your initial enrollment period is over, there is a period of 63 days or more in a row when you did not have Part D or other creditable prescription drug coverage. Creditable prescription drug coverage is coverage that meets Medicare's minimum standards since it is expected to pay, on average, at least as much as Medicare's standard prescription drug coverage. The cost of the late enrollment penalty depends on how long you went without Part D or other creditable prescription drug coverage. You will have to pay this penalty for as long as you have Part D coverage.

The Part D late enrollment penalty is added to your monthly or quarterly premium. When you first enroll in our plan, we let you know the amount of the penalty. If you do not pay your Part D late enrollment penalty, you could lose your prescription drug benefits.

You **will not** have to pay it if:

- You receive "Extra Help" from Medicare to pay for your prescription drugs.
- You have gone less than 63 days in a row without creditable coverage.
- You have had creditable drug coverage through another source such as a former employer, union, TRICARE, or Veterans Health Administration (VA). Your insurer or your human resources department will tell you each year if your drug coverage is creditable coverage. This information may be sent to you in a letter or included in a newsletter from the plan. Keep this information because you may need it if you join a Medicare drug plan later.
 - **Note:** Any notice must state that you had creditable prescription drug coverage that is expected to pay as much as Medicare's standard prescription drug plan pays.
 - **Note:** The following are *not* creditable prescription drug coverage: prescription drug discount cards, free clinics, and drug discount websites.

Medicare determines the amount of the penalty. Here is how it works:

- If you went 63 days or more without Part D or other creditable prescription drug coverage after you were first eligible to enroll in Part D, the plan will count the number of full months that you did not have coverage. The penalty is 1% for every month that you did not have creditable coverage. For example, if you go 14 months without coverage, the penalty will be 14%.
- Then Medicare determines the amount of the average monthly premium for Medicare drug plans in the nation from the previous year. For 2025, this average premium amount is \$36.78.
- To calculate your monthly penalty, you multiply the penalty percentage and the average monthly premium and then round it to the nearest 10 cents. In the example here, it would be 14% times \$36.78, which equals \$5.14. This rounds to \$5.10. This amount would be added **to the monthly premium for**

someone with a Part D late enrollment penalty.

There are three important things to note about this monthly Part D late enrollment penalty:

- First, **the penalty may change each year** because the average monthly premium can change each year.
- Second, **you will continue to pay a penalty** every month for as long as you are enrolled in a plan that has Medicare Part D drug benefits, even if you change plans.
- Third, if you are under 65 and currently receiving Medicare benefits, the Part D late enrollment penalty will reset when you turn 65. After age 65, your Part D late enrollment penalty will be based only on the months that you don't have coverage after your initial enrollment period for aging into Medicare.

If you disagree about your Part D late enrollment penalty, you or your representative can ask for a review. Generally, you must request this review **within 60 days** from the date on the first letter you receive stating you have to pay a late enrollment penalty. However, if you were paying a penalty before joining our plan, you may not have another chance to request a review of that late enrollment penalty.

Important: Do not stop paying your Part D late enrollment penalty while you're waiting for a review of the decision about your late enrollment penalty. If you do, you could be disenrolled for failure to pay your plan premiums.

Section 4.4 Income Related Monthly Adjustment Amount

Some members may be required to pay an extra charge, known as the Part D Income Related Monthly Adjustment Amount, also known as IRMAA. The extra charge is figured out using your modified adjusted gross income as reported on your IRS tax return from two years ago. If this amount is above a certain amount, you'll pay the standard premium amount and the additional IRMAA. For more information on the extra amount you may have to pay based on your income, visit <https://www.medicare.gov/drug-coverage-part-d/costs-for-medicare-drug-coverage/monthly-premium-for-drug-plans>.

If you have to pay an extra amount, Social Security, not your Medicare plan, will send you a letter telling you what that extra amount will be. The extra amount will be withheld from your Social Security, Railroad Retirement Board, or Office of Personnel Management benefit check, no matter how you usually pay your plan premium, unless your monthly benefit isn't enough to cover the extra amount owed. If your benefit check isn't enough to cover the extra amount, you will get a bill from Medicare. **You must pay the extra amount to the government. It cannot be paid with your monthly plan premium. If you do not pay the extra amount, you will be disenrolled from the plan and lose prescription drug coverage.**

If you disagree about paying an extra amount, you can ask Social Security to review the decision. To find out more about how to do this, contact Social Security at 1-800-772-1213 (TTY 1-800-325-0778).

Section 4.5 Medicare Prescription Payment Plan Amount

If you're participating in the Medicare Prescription Payment Plan, each month you'll pay your plan premium (if you have one) and you'll get a bill from your health or drug plan for your prescription drugs (instead of paying the pharmacy). Your monthly bill is based on what you owe for any prescriptions you get, plus your previous month's balance, divided by the number of months left in the year.

Chapter 2, Section 7 tells more about the Medicare Prescription Payment Plan. If you disagree with the amount billed as part of this payment option, you can follow the steps in Chapter 9 to make a complaint or appeal.

SECTION 5 More information about your monthly premium

Section 5.1	There are several ways you can pay your plan premium
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There are five ways you can pay your plan premium.

Note: Except as required by law, we will not accept payments of premium or other cost sharing obligations on your behalf from a Hospital, Hospital system, health-affiliated aid program, healthcare Provider or other individual or entity that has received or may receive a financial benefit related to your choice of health care. As permitted by the Centers for Medicare and Medicaid Services (CMS), we will accept premium and cost sharing payments made on your behalf by the Ryan White HIV/AIDS Program, other federal and state government programs that provide premium and cost sharing support for specific individuals, Indian Tribes, Tribal Organizations and Urban Indian Organizations.

Option 1: Having your premium automatically withdrawn

You can have your monthly plan premium automatically withdrawn from your checking or savings account, credit card, or debit card. The funds will be deducted from your account on approximately the fifth of each month.

You may set up automatic payments from your bank account, credit card, or debit card by accessing your secure member account on our website regence.com/medicare and following the instructions to access the payment portal. Customer Service can also assist you with setting up automatic payments using your checking or savings account.

Option 2: Paying by check

You may pay your monthly, quarterly, or annual plan premium directly to our plan by check or money order. We will send you a bill on approximately the 15th of the month for monthly billing, or on the first of the month prior to your quarterly or annual payment due date. Your check or money order must be received by the first of the month. Your check or money order should be made payable to our plan and mailed to our plan at P.O. Box 2597, Portland, OR 97208-2597. Do not make checks or money orders payable to CMS, Medicare or HHS.

Option 3: Paying over the phone

You can call our Customer Service department during regular business hours to request that we make a one-time withdrawal from your checking or savings account. Your payment will be posted to our system within one business day.

You can also pay over the phone using your bank account, credit card or debit card by using our automated telephone system at 1-888-431-2063.

Option 4: Paying online

You may make a payment online through our website regence.com/medicare. Sign in to your secure account, click Costs in the navigation menu, then choose Payments. Follow the directions to make a payment using your bank account, credit card, or debit card. Your account number is the numerical portion of your member ID. You can find this number on the front of your member ID card.

Option 5: Having your plan premium taken out of your monthly Social Security check

Changing the way you pay your plan premium. If you decide to change the option by which you pay

your plan premium, it can take up to three months for your new payment method to take effect. While we are processing your request for a new payment method, you are responsible for making sure that your plan premium is paid on time. To change your payment method, contact Customer Service. We will be happy to assist you in making the changes you need.

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

Your plan premium is due in our office by the 1st of the month. If we have not received your payment by the 12th of the month, we will send you a notice telling you that your plan membership will end if we do not receive your plan premium within three (3) calendar months. If you are required to pay a Part D late enrollment penalty, you must pay the penalty to keep your prescription drug coverage.

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

If we end your membership because you did not pay your plan premium you will have health coverage under Original Medicare. In addition, you may not be able to receive Part D coverage until the following year if you enroll in a new plan during the annual enrollment period. (If you go without creditable drug coverage for more than 63 days, you may have to pay a Part D late enrollment penalty for as long as you have Part D coverage.)

At the time we end your membership, you may still owe us for premiums you have not paid. In the future, if you want to enroll again in our plan (or another plan that we offer), you will need to pay the amount you owe before you can enroll.

If you think we have wrongfully ended your membership, you can make a complaint (also called a grievance); see Chapter 9 for how to file a complaint. If you had an emergency circumstance that was out of your control and it caused you to not be able to pay your plan premium within our grace period, you can make a complaint. For complaints, we will review our decision again. Chapter 9, Section 10 of this document tells how to make a complaint, or you can call us at 1-800-541-8981 between 8 a.m. to 8 p.m., Monday through Friday. From October 1 through March 31, our telephone hours are 8 a.m. to 8 p.m., seven days a week. TTY users should call 711. Live online chat assistance is also available from 8 a.m. to 5 p.m. PT, Monday through Friday. To access online chat, sign in at regence.com/medicare, select Contact us and click on Chat Now to connect with us. You must make your request no later than 60 calendar days after the date your membership ends.

Section 5.2	Can we change your monthly plan premium during the year?
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No. We are not allowed to change the amount we charge for the plan's monthly plan premium during the year. If the monthly plan premium changes for next year, we will tell you in September and the change will take effect on January 1.

However, in some cases the part of the premium that you have to pay can change during the year. This happens if you become eligible for the "Extra Help" program or if you lose your eligibility for the "Extra Help" program during the year. If a member qualifies for "Extra Help" with their prescription drug costs, the "Extra Help" program will pay part of the member's monthly plan premium. A member who loses their eligibility during the year will need to start paying their full monthly premium. You can find out more about the "Extra Help" program in Chapter 2, Section 7 (contact information can also be found in "Exhibit A" in the back of this document).

SECTION 6 Keeping your plan membership record up to date

Your membership record has information from your enrollment form, including your address and telephone

number. It shows your specific plan coverage including your Primary Care Provider.

The doctors, hospitals, pharmacists, and other providers in the plan's network need to have correct information about you. **These network providers use your membership record to know what services and drugs are covered and the cost sharing amounts for you.** Because of this, it is very important that you help us keep your information up to date.

Let us know about these changes:

- Changes to your name, your address, or your phone number
- Changes in any other health insurance coverage you have (such as from your employer, your spouse or domestic partner's employer, Workers' Compensation, or Medicaid)
- If you have any liability claims, such as claims from an automobile accident
- If you have been admitted to a nursing home
- If you receive care in an out-of-area or out-of-network hospital or emergency room
- If your designated responsible party (such as a caregiver) changes
- If you are participating in a clinical research study. (**Note:** You are not required to tell your plan about the clinical research studies you intend to participate in, but we encourage you to do so)

If any of this information changes, please let us know by calling Customer Service. You can also let us know online at our secure website regence.com/medicare. Sign in to your account and follow the instructions on the screen.

It is also important to contact Social Security if you move or change your mailing address. You can find phone numbers and contact information for Social Security in Chapter 2, Section 5.

SECTION 7 How other insurance works with our plan

Other insurance

Medicare requires that we collect information from you about any other medical or drug insurance coverage that you have. That's because we must coordinate any other coverage you have with your benefits under our plan. This is called **Coordination of Benefits**.

Once each year, we will send you a letter that lists any other medical or drug insurance coverage that we know about. Please read over this information carefully. If it is correct, you don't need to do anything. If the information is incorrect, or if you have other coverage that is not listed, please call Customer Service. You may need to give your plan member ID number to your other insurers (once you have confirmed their identity) so your bills are paid correctly and on time.

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

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

- If you have retiree coverage, Medicare pays first.

Chapter 1 Getting started as a member

- If your group health plan coverage is based on your or a family member's current employment, who pays first depends on your age, the number of people employed by your employer, and whether you have Medicare based on age, disability, or End-Stage Renal Disease (ESRD):
 - If you're under 65 and disabled and you or your family member is still working, your group health plan pays first if the employer has 100 or more employees or at least one employer in a multiple employer plan that has more than 100 employees.
 - If you're over 65 and you or your spouse or domestic partner is still working, your group health plan pays first if the employer has 20 or more employees or at least one employer in a multiple employer plan that has more than 20 employees.
- If you have Medicare because of ESRD, your group health plan will pay first for the first 30 months after you become eligible for Medicare.

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

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

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

CHAPTER 2:

Important phone numbers and resources

SECTION 1 Regence MedAdvantage + Rx Classic contacts

(How to contact us, including how to reach Customer Service)

How to contact our plan's Customer Service

For assistance with claims, billing, or member card questions, please call or write to our plan's Customer Service. We will be happy to help you.

Method	Customer Service – Contact Information
CALL	<p>1-800-541-8981</p> <p>Calls to this number are free. Our telephone hours are 8 a.m. to 8 p.m., Monday through Friday. From October 1 through March 31, our telephone hours are 8 a.m. to 8 p.m., seven days a week. Live online chat assistance is also available from 8 a.m. to 5 p.m. PT, Monday through Friday. To access online chat, sign in at regence.com/medicare, select Contact us and click on Chat Now to connect with us.</p> <p>Customer Service also has free language interpreter services available for non-English speakers.</p> <p>Dental Customer Service: 1-844-789-1727</p> <p>Calls to this number are free. Telephone hours are 8 a.m. to 8 p.m., Monday through Friday.</p> <p>TruHearing: 1-855-542-1711</p> <p>Calls to this number are free. Live telephone hours are 5 a.m. to 6 p.m. Monday through Friday (Pacific). An answering service is available from 6 p.m. to 8 p.m. Monday through Friday (Pacific) and October 1 to March 31 from 5 a.m. to 8 p.m. Saturday and Sunday.</p> <p>VSP Vision Care: 1-844-872-6065</p> <p>Calls to this number are free. Live telephone hours are 8 a.m. to 8 p.m., seven days a week. The automated system is available 24 hours a day, seven days a week.</p>
TTY	<p>711</p> <p>Calls to this number are free. Our telephone hours are 8 a.m. to 8 p.m., Monday through Friday. From October 1 through March 31, our telephone hours are 8 a.m. to 8 p.m., seven days a week. Live online chat assistance is also available from 8 a.m. to 5 p.m. PT, Monday through Friday. To access online chat, sign in at regence.com/medicare, select Contact us and click on Chat Now to connect with us.</p> <p>Dental Customer Service: 711</p> <p>Calls to this number are free. Telephone hours are 8 a.m. to 8 p.m., Monday through Friday.</p> <p>TruHearing: 711</p> <p>Calls to this number are free. Live telephone hours are 5 a.m. to 6 p.m. Monday through Friday (Pacific). An answering service is available from 6 p.m. to 8 p.m. Monday through Friday (Pacific) and October 1 to March 31 from 5 a.m. to 8 p.m. Saturday and Sunday.</p> <p>VSP Vision Care: 711</p> <p>Calls to this number are free. Live telephone hours are 8 a.m. to 8 p.m., seven days a week. The automated system is available 24 hours a day, seven days a week.</p>
FAX	<p>1-888-335-2985</p>

Method	Customer Service – Contact Information
WRITE	<p>Regence BlueCross BlueShield of Utah P.O. Box 1827 Medford, OR 97501</p> <p>Live chat assistance and secure email is available through the member portal. Sign in at regence.com/medicare, select Contact us and click on Chat Now to connect with us. Live chat is available from 8 a.m. to 5 p.m. PT, Monday through Friday. Emails will receive a response within one business day.</p>
WEBSITE	regence.com/medicare

How to contact us when you are asking for a coverage decision or appeal about your medical care or Part D prescription drugs

A coverage decision is a decision we make about your benefits and coverage or about the amount we will pay for your medical services or Part D prescription drugs. An appeal is a formal way of asking us to review and change a coverage decision we have made. For more information on asking for coverage decisions or appeals about your medical care or Part D prescription drugs, see Chapter 9 (*What to do if you have a problem or complaint (coverage decisions, appeals, complaints)*).

Method	Coverage Decisions for Medical Care – Contact Information
CALL	<p>1-800-541-8981</p> <p>Calls to this number are free. Our telephone hours are 8 a.m. to 8 p.m., Monday through Friday. From October 1 through March 31, our telephone hours are 8 a.m. to 8 p.m., seven days a week. Live online chat assistance is also available from 8 a.m. to 5 p.m. PT, Monday through Friday. To access online chat, sign in at regence.com/medicare, select Contact us and click on Chat Now to connect with us.</p> <p>Utilization Management staff are available from 7 a.m. to 5 p.m. (Pacific) and 8 a.m. to 6 p.m. (Mountain). Voicemail and fax messages received after normal business hours will receive a response on the next business day.</p>
TTY	<p>711</p> <p>Calls to this number are free. Our telephone hours are 8 a.m. to 8 p.m., Monday through Friday. From October 1 through March 31, our telephone hours are 8 a.m. to 8 p.m., seven days a week. Live online chat assistance is also available from 8 a.m. to 5 p.m. PT, Monday through Friday. To access online chat, sign in at regence.com/medicare, select Contact us and click on Chat Now to connect with us.</p> <p>Utilization Management staff are available from 7 a.m. to 5 p.m. (Pacific) and 8 a.m. to 6 p.m. (Mountain). Voicemail and fax messages received after normal business hours will receive a response on the next business day.</p>
FAX	<p>Standard Reviews: 1-855-232-0090</p> <p>Expedited Reviews: 1-855-240-6498</p>

Method	Coverage Decisions for Medical Care – Contact Information
WRITE	Regence BlueCross BlueShield of Utah P.O. Box 1271 Portland, OR 97207-1271
WEBSITE	regence.com/medicare

Method	Appeals for Medical Care – Contact Information
CALL	1-866-749-0355 Calls to this number are free. Our telephone hours are 8 a.m. to 5 p.m., Monday through Friday (Pacific).
TTY	711 Calls to this number are free. Our telephone hours are 8 a.m. to 5 p.m., Monday through Friday (Pacific).
FAX	1-888-309-8784
WRITE	Medicare Advantage Appeals & Grievances P.O. Box 1827 Medford, OR 97501 medicareappeals@regence.com
WEBSITE	regence.com/medicare To access online appeal forms, sign in to your account, click ‘See all claims’, click ‘Appeal a claim action or denial’, then ‘Appeal online’.

Method	Coverage Decisions and Appeals for Part D prescription drugs – Contact Information
CALL	1-844-765-6824 Calls to this number are free. Our telephone hours are 24 hours a day, seven days a week.
TTY	711 Calls to this number are free. Our telephone hours are 24 hours a day, seven days a week.
FAX	1-855-212-8110
WRITE	Regence BlueCross BlueShield of Utah Attention: Clinical Review Dept. 2900 Ames Crossing Road Eagan, MN 55121
WEBSITE	regence.com/medicare

How to contact us when you are making a complaint about your medical care or Part D prescription drugs

You can make a complaint about us or one of our network providers or pharmacies, including a complaint about the quality of your care. This type of complaint does not involve coverage or payment disputes. For more information on making a complaint about your medical care, see Chapter 9 (*What to do if you have a problem or complaint (coverage decisions, appeals, complaints)*).

Method	Complaints about Medical Care – Contact Information
CALL	1-800-541-8981 Calls to this number are free. Our telephone hours are 8 a.m. to 8 p.m., Monday through Friday. From October 1 through March 31, our telephone hours are 8 a.m. to 8 p.m., seven days a week. Live online chat assistance is also available from 8 a.m. to 5 p.m. PT, Monday through Friday. To access online chat, sign in at regence.com/medicare , select Contact us and click on Chat Now to connect with us.
TTY	711 Calls to this number are free. Our telephone hours are 8 a.m. to 8 p.m., Monday through Friday. From October 1 through March 31, our telephone hours are 8 a.m. to 8 p.m., seven days a week. Live online chat assistance is also available from 8 a.m. to 5 p.m. PT, Monday through Friday. To access online chat, sign in at regence.com/medicare , select Contact us and click on Chat Now to connect with us.
FAX	1-888-309-8784
WRITE	Medicare Advantage Appeals & Grievances P.O. Box 1827 Medford, OR 97501 medicareappeals@regence.com
MEDICARE WEBSITE	You can submit a complaint about us directly to Medicare. To submit an online complaint to Medicare, go to www.medicare.gov/MedicareComplaintForm/home.aspx .

Method	Complaints about Part D prescription drugs – Contact Information
CALL	1-844-765-6824 Calls to this number are free. Our telephone hours are 24 hours a day, seven days a week.
TTY	711 Calls to this number are free. Our telephone hours are 24 hours a day, seven days a week.
FAX	1-888-258-2242
WRITE	Prime Therapeutics c/o Medicare Appeals and Grievance Dept P.O. Box 64813 St. Paul, MN 55164

Method	Complaints about Part D prescription drugs – Contact Information
MEDICARE WEBSITE	You can submit a complaint about us directly to Medicare. To submit an online complaint to Medicare, go to www.medicare.gov/MedicareComplaintForm/home.aspx .

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

If you have received a bill or paid for services (such as a provider bill) that you think we should pay for, you may need to ask us for reimbursement or to pay the provider bill. See Chapter 7 (*Asking us to pay our share of a bill you have received for covered medical services or drugs*).

Please note: If you send us a payment request and we deny any part of your request, you can appeal our decision. See Chapter 9 (*What to do if you have a problem or complaint (coverage decisions, appeals, complaints)*) for more information.

Method	Payment Requests for Medical Care – Contact Information
FAX	1-888-335-2985
WRITE	Regence BlueCross BlueShield of Utah P.O. Box 1827 Medford, OR 97501 Live chat assistance and secure email is available through the member portal. Sign in at regence.com/medicare , select Contact us and click on Chat Now to connect with us. Live chat is available from 8 a.m. to 5 p.m. PT, Monday through Friday. Emails will receive a response within one business day.
WEBSITE	regence.com/medicare

Method	Payment Requests for Prescription Drugs – Contact Information
CALL	1-844-765-6824 Calls to this number are free. Our telephone hours are 24 hours a day, seven days a week.
TTY	711 Calls to this number are free. Our telephone hours are 24 hours a day, seven days a week.
WRITE	Prescription Drug Claims Payment Requests P.O. Box 20970 Lehigh Valley, PA 18002-0970
WEBSITE	regence.com/medicare

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

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

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

Method	Medicare – Contact Information
CALL	1-800-MEDICARE or 1-800-633-4227 Calls to this number are free. 24 hours a day, 7 days a week.
TTY	1-877-486-2048 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free.
WEBSITE	<p>www.Medicare.gov</p> <p>This is the official government website for Medicare. It gives you up-to-date information about Medicare and current Medicare issues. It also has information about hospitals, nursing homes, physicians, home health agencies, and dialysis facilities. It includes documents you can print directly from your computer. You can also find Medicare contacts in your state.</p> <p>The Medicare website also has detailed information about your Medicare eligibility and enrollment options with the following tools:</p> <ul style="list-style-type: none">• Medicare Eligibility Tool: Provides Medicare eligibility status information.• Medicare Plan Finder: Provides personalized information about available Medicare prescription drug plans, Medicare health plans, and Medigap (Medicare Supplement Insurance) policies in your area. These tools provide an <i>estimate</i> of what your out-of-pocket costs might be in different Medicare plans. <p>You can also use the website to tell Medicare about any complaints you have about our plan:</p> <ul style="list-style-type: none">• Tell Medicare about your complaint: You can submit a complaint about us directly to Medicare. To submit a complaint to Medicare, go to www.medicare.gov/MedicareComplaintForm/home.aspx. Medicare takes your complaints seriously and will use this information to help improve the quality of the Medicare program. <p>If you don't have a computer, your local library or senior center may be able to help you visit this website using its computer. Or, you can call Medicare and tell them what information you are looking for. They will find the information on the website and review the information with you. You can call Medicare at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.</p>

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

The State Health Insurance Assistance Program (SHIP) is a government program with trained counselors in every state. Contact information for your State Health Insurance Assistance Program (SHIP) can be found in “Exhibit A” in the back of this document.

SHIP is an independent (not connected with any insurance company or health plan) state program that gets money from the Federal government to give free local health insurance counseling to people with Medicare.

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

METHOD TO ACCESS SHIP and OTHER RESOURCES:

- Visit <https://www.shiphelp.org> (Click on **SHIP LOCATOR** in the middle of the page)
- Select your **STATE** from the list. This will take you to a page with phone numbers and resources specific to your state.

SECTION 4 Quality Improvement Organization

There is a designated Quality Improvement Organization for serving Medicare beneficiaries in each state. Contact information for your state Quality Improvement Organization (QIO) can be found in “Exhibit A” in the back of this document.

The QIO has a group of doctors and other health care professionals who are paid by Medicare to check on and help improve the quality of care for people with Medicare. The QIO is an independent organization. It is not connected with our plan.

You should contact your QIO in any of these situations:

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

SECTION 5 Social Security

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

Social Security is also responsible for determining who has to pay an extra amount for their Part D drug coverage because they have a higher income. If you got a letter from Social Security telling you that you have to pay the extra amount and have questions about the amount or if your income went down because of a life-changing event, you can call Social Security to ask for reconsideration.

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

Method	Social Security – Contact Information
CALL	1-800-772-1213 Calls to this number are free. Available 8:00 am to 7:00 pm, Monday through Friday. You can use Social Security’s automated telephone services to get recorded information and conduct some business 24 hours a day.
TTY	1-800-325-0778 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free. Available 8:00 am to 7:00 pm, Monday through Friday.
WEBSITE	www.ssa.gov

SECTION 6 Medicaid

Medicaid is a joint Federal and state government program that helps with medical costs for certain people with limited incomes and resources. Some people with Medicare are also eligible for Medicaid.

The programs offered through Medicaid help people with Medicare pay their Medicare costs, such as their Medicare premiums. These **Medicare Savings Programs** include:

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

To find out more about Medicaid and its programs, contact your states Medicaid office. Contact information for them can be found in “Exhibit A” in the back of this document.

SECTION 7 Information about programs to help people pay for their prescription drugs

The Medicare.gov website (<https://www.medicare.gov/basics/costs/help/drug-costs>) provides information on how to lower your prescription drug costs. For people with limited incomes, there are also other programs to assist, described below.

Medicare's "Extra Help" Program

Medicare provides "Extra Help" to pay prescription drug costs for people who have limited income and resources. Resources include your savings and stocks, but not your home or car. If you qualify, you get help paying for any Medicare drug plan's monthly premium, yearly deductible, and prescription copayments. This "Extra Help" also counts toward your out-of-pocket costs.

If you automatically qualify for "Extra Help" Medicare will mail you a letter. You will not have to apply. If you do not automatically qualify you may be able to get "Extra Help" to pay for your prescription drug premiums and costs. To see if you qualify for getting "Extra Help," call:

- 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048, 24 hours a day, 7 days a week;
- The Social Security Office at 1-800-772-1213, between 8 am and 7 pm, Monday through Friday. TTY users should call 1-800-325-0778; or
- Your State Medicaid Office. (See Section 6 of this chapter for contact information.)

If you believe you have qualified for "Extra Help" and you believe that you are paying an incorrect cost sharing amount when you get your prescription at a pharmacy, our plan has a process for you to either request assistance in obtaining evidence of your proper copayment level, or, if you already have the evidence, to provide this evidence to us.

- Your "Extra Help" documentation will come from either the Social Security Administration or your State Medicaid office. Please contact Customer Service if you have concerns about your "Extra Help". They will be able to help you determine what information you will need to send us, so we can confirm your proper copayment level. (Contact information for Customer Service is printed on the back cover of this document.)
- When we receive the evidence showing your copayment level, we will update our system so that you can pay the correct copayment when you get your next prescription at the pharmacy. If you overpay your copayment, we will reimburse you. Either we will forward a check to you in the amount of your overpayment, or we will offset future copayments. If the pharmacy hasn't collected a copayment from you and is carrying your copayment as a debt owed by you, we may make the payment directly to the pharmacy. If a state paid on your behalf, we may make the payment directly to the state. Please contact Customer Service if you have questions.

What if you have "Extra Help" and coverage from an AIDS Drug Assistance Program (ADAP)? What is the AIDS Drug Assistance Program (ADAP)?

The AIDS Drug Assistance Program (ADAP) helps ADAP-eligible individuals living with HIV/AIDS have access to life-saving HIV medications. Medicare Part D prescription drugs that are also on the ADAP formulary qualify for prescription cost sharing assistance through your states ADAP. Contact information for them can be found in "Exhibit A" in the back of this document.

Note: To be eligible for the ADAP operating in your State, individuals must meet certain criteria, including proof of State residence and HIV status, low income as defined by the State, and uninsured/under-insured status. If you change plans, please notify your local ADAP enrollment worker so you can continue to receive assistance. For information on eligibility criteria, covered drugs, or how to enroll in the program, please call your states ADAP. Contact information for them can be found in "Exhibit A" in the back of this document.

The Medicare Prescription Payment Plan

The Medicare Prescription Payment Plan is a new payment option that works with your current drug coverage, and it can help you manage your drug costs by spreading them across **monthly payments that vary throughout the year** (January – December). **This payment option might help you manage your expenses, but it doesn't save you money or lower your drug costs.** “Extra Help” from Medicare and help from your SPAP and ADAP, for those who qualify, is more advantageous than participation in the Medicare Prescription Payment Plan. All members are eligible to participate in this payment option, regardless of income level, and all Medicare drug plans and Medicare health plans with drug coverage must offer this payment option. Contact us or visit [Medicare.gov](https://www.regence.com/medicare) to find out if this payment option is right for you.

Method	The Medicare Prescription Payment Plan – Contact Information
CALL	1-800-541-8981 Calls to this number are free. Our telephone hours are 8 a.m. to 8 p.m., Monday through Friday. From October 1 through March 31, our telephone hours are 8 a.m. to 8 p.m., seven days a week. Live online chat assistance is also available from 8 a.m. to 5 p.m. PT, Monday through Friday. To access online chat, sign in at regence.com/medicare , select Contact us and click on Chat Now to connect with us. Customer Service also has free language interpreter services available for non-English speakers.
TTY	711 Calls to this number are free. Our telephone hours are 8 a.m. to 8 p.m., Monday through Friday. From October 1 through March 31, our telephone hours are 8 a.m. to 8 p.m., seven days a week. Live online chat assistance is also available from 8 a.m. to 5 p.m. PT, Monday through Friday. To access online chat, sign in at regence.com/medicare , select Contact us and click on Chat Now to connect with us.
FAX	1-888-335-2988
WRITE	Regence BlueCross BlueShield of Utah P.O. Box 1827 Medford, OR 97501 Live chat assistance and secure email is available through the member portal. Sign in at regence.com/medicare , select Contact us and click on Chat Now to connect with us. Live chat is available from 8 a.m. to 5 p.m. PT, Monday through Friday. Emails will receive a response within one business day.
WEBSITE	regence.com/medicare

SECTION 8 How to contact the Railroad Retirement Board

The Railroad Retirement Board is an independent Federal agency that administers comprehensive benefit programs for the nation's railroad workers and their families. If you receive your Medicare through the Railroad Retirement Board, it is important that you let them know if you move or change your mailing address. If you have questions regarding your benefits from the Railroad Retirement Board, contact the agency.

Method	Railroad Retirement Board – Contact Information
CALL	1-877-772-5772 Calls to this number are free. If you press “0”, you may speak with an RRB representative from 9:00 am to 3:30 pm, Monday, Tuesday, Thursday, and Friday, and from 9:00 am to 12:00 pm on Wednesday. If you press “1”, you may access the automated RRB HelpLine and recorded information 24 hours a day, including weekends and holidays.
TTY	1-312-751-4701 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are <i>not</i> free.
WEBSITE	rrb.gov/

SECTION 9 Do you have group insurance or other health insurance from an employer?

If you (or your spouse or domestic partner) get benefits from your (or your spouse or domestic partner's) employer or retiree group as part of this plan, you may call the employer/union benefits administrator or Customer Service if you have any questions. You can ask about your (or your spouse or domestic partner's) employer or retiree health benefits, premiums, or the enrollment period. (Phone numbers for Customer Service are printed on the back cover of this document.) You may also call 1-800-MEDICARE (1-800-633-4227; TTY: 1-877-486-2048) with questions related to your Medicare coverage under this plan.

If you have other prescription drug coverage through your (or your spouse or domestic partner's) employer or retiree group, please contact **that group's benefits administrator**. The benefits administrator can help you determine how your current prescription drug coverage will work with our plan.

CHAPTER 3:

Using the plan for your medical services

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

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

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

Section 1.1 What are network providers and covered services?

- **Providers** are doctors and other health care professionals licensed by the state to provide medical services and care. The term providers also includes hospitals and other health care facilities.
- **Network providers** are the doctors and other health care professionals, medical groups, hospitals, and other health care facilities that have an agreement with us to accept our payment and your cost sharing amount as payment in full. We have arranged for these providers to deliver covered services to members in our plan. The providers in our network bill us directly for care they give you. When you see a network provider, you pay only your share of the cost for their services.
- **Covered services** include all the medical care, health care services, supplies, equipment, and Prescription Drugs that are covered by our plan. Your covered services for medical care are listed in the benefits chart in Chapter 4. Your covered services for prescription drugs are discussed in Chapter 5.

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

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

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

- **The care you receive is included in the plan's Medical Benefits Chart** (this chart is in Chapter 4 of this document).
- **The care you receive is considered medically necessary.** Medically necessary means that the services, supplies, equipment, or drugs are needed for the prevention, diagnosis, or treatment of your medical condition and meet accepted standards of medical practice.
- **You receive your care from a provider who is eligible to provide services under Original Medicare.** As a member of our plan, you can receive your care from either a network provider or an out-of-network provider (for more about this, see Section 2 in this chapter).
 - The providers in our network are listed in the *Provider Directory* (regence.com/medicare).
 - If you use an out-of-network provider, your share of the costs for your covered services may be higher.
 - **Please note:** While you can get your care from an out-of-network provider, the provider must be eligible to participate in Medicare. Except for emergency care, we cannot pay a provider who is not eligible to participate in Medicare. If you go to a provider who is not eligible to participate in Medicare, you will be responsible for the full cost of the services you receive. Check with your provider before receiving services to confirm that they are eligible to participate in Medicare.

SECTION 2 Using network and out-of-network providers to get your medical care

Section 2.1	You may choose a Primary Care Provider (PCP) to provide and oversee your medical care
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What is a PCP and what does the PCP do for you?

A Primary Care Provider (PCP) is a physician, physician's assistant, or nurse practitioner that you see for all your basic medical needs such as preventive care and illness and injury visits. Though a PCP is not required by our plan, there are many benefits to having one. A PCP can coordinate access to specialists, behavioral health care providers and hospital services when necessary. When prior authorization for a service is needed, your in-network PCP will contact us before you have services to determine if they will be covered.

Our plan considers a physician (M.D. or D.O.), physician's assistant (P.A.), osteopathic physician's assistant – certified (O.P.A.C.), or nurse practitioner (N.P.) with one of the following specialties to be a primary care provider:

- Adult Medicine
- Family Practice
- General Medicine
- Geriatric Medicine
- Internal Medicine

How do you choose your PCP?

You may find an in-network PCP by going online to regence.com/medicare and searching the directory. Once you find your PCP, you are encouraged to let us know your selection and we can help you make an appointment to establish care.

If you need assistance in finding a provider, please contact Customer Service.

Changing your PCP

You may change your PCP for any reason, at any time. Also, it's possible that your PCP might leave our plan's network of providers and you would have to find a new PCP in our plan, or you will pay more for covered services. If you would like to change your PCP you may do so at any time by picking a new provider and contacting their office or by calling Customer Service.

If you need assistance in finding a provider, please contact Customer Service.

Section 2.2	How to get care from specialists and other network providers
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A specialist is a doctor who provides health care services for a specific disease or part of the body. There are many kinds of specialists. Here are a few examples:

- Oncologists care for patients with cancer.
- Cardiologists care for patients with heart conditions.
- Orthopedists care for patients with certain bone, joint, or muscle conditions.

To access specialists and other network providers:

- Contact your PCP. They will often assist you in coordinating your care with specialists, including behavioral health professionals. Our plan does not require you to obtain a referral from a primary doctor to see a specialist. However, a specialist may require you to be referred to their office by your PCP. Your PCP or any specialist you are seeing will make arrangements for access to hospital care when necessary.
- Some services and facility admissions require prior authorization. The plan requires in-network physicians and facilities to coordinate prior authorization requests. If a service you need requires a prior authorization your in-network physician or facility will submit a request for prior authorization to the plan. The plan will review the request your doctor sends. There are no incentives tied to decisions made about your care. We will notify you and your doctor if the service is approved or not.
- Out-of-network providers are encouraged, but not required, to obtain a prior authorization to confirm the services will be covered by the plan. If prior authorization is not obtained and services are determined not medically necessary, you may be responsible for the full cost.
- See Chapter 4, Section 2.1 for information about which services require prior authorization.

What if a specialist or another network provider leaves our plan?

We may make changes to the hospitals, doctors, and specialists (providers) that are part of your plan during the year. If your doctor or specialist leaves your plan you have certain rights and protections that are summarized below:

- Even though our network of providers may change during the year, Medicare requires that we furnish you with uninterrupted access to qualified doctors and specialists.
- We will notify you that your provider is leaving our plan so that you have time to select a new provider.
 - If your primary care or behavioral health provider leaves our plan, we will notify you if you have seen that provider within the past three years.
 - If any of your other providers leave our plan, we will notify you if you are assigned to the provider, currently receive care from them, or have seen them within the past three months.
- We will assist you in selecting a new qualified in-network provider that you may access for continued care.
- If you are currently undergoing medical treatment or therapies with your current provider, you have the right to request, and we will work with you to ensure, that the medically necessary treatment or therapies you are receiving continues.
- We will provide you with information about the different enrollment periods available to you and options you may have for changing plans.
- We will arrange for any medically necessary covered benefit outside of our provider network, but at in-network cost sharing, when an in-network provider or benefit is unavailable or inadequate to meet your medical needs. Prior authorization (or Medicare Benefit Preservice Organization Determination) is required for services in this situation.
- If you find out your doctor or specialist is leaving your plan, please contact us so we can assist you in finding a new provider to manage your care.
- If you believe we have not furnished you with a qualified provider to replace your previous provider or that your care is not being appropriately managed, you have the right to file a quality of care complaint to the QIO, a quality of care grievance to the plan, or both. Please see Chapter 9.

Section 2.3 How to get care from out-of-network providers

As a member of our plan, you can choose to receive care from out-of-network providers. However, please note providers that do not contract with us are under no obligation to treat you, except in emergency situations. Our plan will cover services from either in-network or out-of-network providers, as long as the services are covered benefits and are medically necessary. However, **if you use an out-of-network provider, your share of the costs for your covered services may be higher.** Here are other important things to know about using out-of-network providers:

- You can get your care from an out-of-network provider, however, in most cases that provider must be eligible to participate in Medicare. Except for emergency care, we cannot pay a provider who is not eligible to participate in Medicare. If you receive care from a provider who is not eligible to participate in Medicare, you will be responsible for the full cost of the services you receive. Check with your provider before receiving services to confirm that they are eligible to participate in Medicare.
- You don't need to get a referral or prior authorization when you get care from out-of-network providers. However, before getting services from out-of-network providers you may want to ask for a pre-visit coverage decision to confirm that the services you are getting are covered and are medically necessary. (See Chapter 9, Section 4 for information about asking for coverage decisions.) This is important because:
 - Without a pre-visit coverage decision, 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. If we say we will not cover your services, you have the right to appeal our decision not to cover your care. See Chapter 9 (*What to do if you have a problem or complaint*) to learn how to make an appeal.
- It is best to ask an out-of-network provider to bill the plan first. But, if you have already paid for the covered services, we will reimburse you for our share of the cost for covered services. Or if an out-of-network provider sends you a bill that you think we should pay, you can send it to us for payment. See Chapter 7 (*Asking us to pay our share of a bill you have received for covered medical services or drugs*) for information about what to do if you receive a bill or if you need to ask for reimbursement.
- If you are using an out-of-network provider for emergency care, urgently needed services, or out-of-area dialysis, you may not have to pay a higher cost sharing amount. See Section 3 for more information about these situations.

SECTION 3 How to get services when you have an emergency or urgent need for care or during a disaster

Section 3.1 Getting care if you have a medical emergency

What is a medical emergency and what should you do if you have one?

A **medical emergency** is when you, or any other prudent layperson with an average knowledge of health and medicine, believe that you have medical symptoms that require immediate medical attention to prevent your loss of life (and, if you are a pregnant woman, loss of an unborn child), loss of a limb or function of a limb, or loss of or serious impairment to a bodily function. The medical symptoms may be an illness, injury, severe pain, or a medical condition that is quickly getting worse.

If you have a medical emergency:

- **Get help as quickly as possible.** Call 911 for help or go to the nearest emergency room or hospital. Call for an ambulance if you need it. You do *not* need to get approval or a referral first from your PCP. You do not need to use a network doctor. You may get covered emergency medical care whenever you need it, anywhere in the United States or its territories, and from any provider with an appropriate state license even if they are not part of our network. Our plan also covers emergency and urgently needed services worldwide.

What is covered if you have a medical emergency?

Our plan covers ambulance services in situations where getting to the emergency room in any other way could endanger your health. We also cover medical services during the emergency.

The doctors who are giving you emergency care will decide when your condition is stable, and the medical emergency is over.

After the emergency is over you are entitled to follow-up care to be sure your condition continues to be stable. Your doctors will continue to treat you until your doctors contact us and make plans for additional care. Your follow-up care will be covered by our plan.

If you get your follow-up care from out-of-network providers, you will pay the higher out-of-network cost sharing.

What if it wasn't a medical emergency?

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

However, after the doctor has said that it was *not* an emergency, the amount of cost sharing that you pay will depend on whether you get the care from network providers or out-of-network providers. If you get the care from network providers, your share of the costs will usually be lower than if you get the care from out-of-network providers.

Section 3.2	Getting care when you have an urgent need for services
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What are urgently needed services?

A plan-covered service requiring immediate medical attention that is not an emergency is an urgently needed service if either you are temporarily outside the service area of the plan, or it is unreasonable given your time, place, and circumstances to obtain this service from network providers with whom the plan contracts. Examples of urgently needed services are unforeseen medical illnesses and injuries, or unexpected flare-ups of existing conditions. However, medically necessary routine provider visits, such as annual checkups, are not considered urgently needed even if you are outside the service area of the plan or the plan network is temporarily unavailable.

In an urgent situation you should try to contact your PCP first. If your PCP is not available, or you need care after normal business hours, your plan includes benefits for virtual primary care, behavioral health, and urgent care visits through your telephone or computer with a PCP, a covering provider, or Doctor On Demand (a virtual care provider). You also have access to a free 24-hour nurse advice line. Network urgent care facilities are available throughout our service area. If you need assistance locating a network urgent care facility, contact Customer Service or visit our website at [regence.com/medicare](https://www.regence.com/medicare) for a list of providers.

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

- You have a condition that cannot wait until you return to the service area, such as an illness that is worsening or an infection.
- You need immediate medical help, but your health is not in serious danger, such as a sprained ankle or an injury that requires stitches.
- You believe your health is in serious danger, such as appendicitis or a broken bone.

In short, worldwide coverage for urgently needed services (or emergency services) is when medical services are needed right away because of an illness, injury or for a condition that you did not expect or anticipate, and you cannot wait until you are back in our plan's service area to obtain services. Please note that this is a supplemental benefit not generally covered under traditional Medicare.

Foreign providers may bill you for more than our allowed amount (the amount we will pay for covered services). You will be responsible for your cost sharing (copays or coinsurance) and any costs exceeding our allowed amount. Charges for non-emergency, non-urgent, pre-scheduled or pre-planned treatments (including dialysis for an ongoing condition), any dental services, routine vision services, and prescribed medications **will not be covered**. See Chapter 4, Section 2.1 (*Medical Benefits Chart – What is covered and what you pay*) for more information.

Section 3.3 Getting care during a disaster

If the Governor of your state, the U.S. Secretary of Health and Human Services, or the President of the United States declares a state of disaster or emergency in your geographic area, you are still entitled to care from your plan.

Please visit the following website: regence.com/medicare for information on how to obtain needed care during a disaster.

If you cannot use a network provider during a disaster, your plan will allow you to obtain care from out-of-network providers at in-network cost sharing. If you cannot use a network pharmacy during a disaster, you may be able to fill your prescription drugs at an out-of-network pharmacy. Please see Chapter 5, Section 2.5 for more information.

SECTION 4 What if you are billed directly for the full cost of your services?

Section 4.1 You can ask us to pay our share of the cost of covered services

If you have paid more than your plan cost sharing for covered services, or if you have received a bill for the full cost of covered medical services, go to Chapter 7 (*Asking us to pay our share of a bill you have received for covered medical services or drugs*) for information about what to do.

Section 4.2 If services are not covered by our plan, you must pay the full cost

Our plan covers all medically necessary services as listed in the Medical Benefits Chart in Chapter 4 of this document. If you receive services not covered by our plan, you are responsible for paying the full cost of services.

For covered services that have a benefit limitation, you also pay the full cost of any services you get after you have used up your benefit for that type of covered service. Once a benefit limit has been reached, additional

costs will not count toward your out-of-pocket maximum.

SECTION 5 How are your medical services covered when you are in a clinical research study?

Section 5.1 What is a clinical research study?

A clinical research study (also called a clinical trial) is a way that doctors and scientists test new types of medical care, like how well a new cancer drug works. Certain clinical research studies are approved by Medicare. Clinical research studies approved by Medicare typically request volunteers to participate in the study.

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

If you participate in a Medicare-approved study, Original Medicare pays most of the costs for the covered services you receive as part of the study. If you tell us that you are in a qualified clinical trial, then you are only responsible for the in-network cost sharing for the services in that trial. If you paid more, for example, if you already paid the Original Medicare cost sharing amount, we will reimburse the difference between what you paid and the in-network cost sharing. However, you will need to provide documentation to show us how much you paid. When you are in a clinical research study, you may stay enrolled in our plan and continue to get the rest of your care (the care that is not related to the study) through our plan.

If you want to participate in any Medicare-approved clinical research study, you do *not* need to tell us or to get approval from us. The providers that deliver your care as part of the clinical research study do *not* need to be part of our plan's network of providers. Please note that this does not include benefits for which our plan is responsible that include, as a component, a clinical trial or registry to assess the benefit. These include certain benefits specified under national coverage determinations requiring coverage with evidence development (NCDs-CED) and investigational device exemption (IDE) studies and may be subject to prior authorization and other plan rules.

Although you do not need to get our plan's permission to be in a clinical research study covered for Medicare Advantage enrollees by Original Medicare, we encourage you to notify us in advance when you choose to participate in Medicare-qualified clinical trials.

If you participate in a study that Medicare has *not* approved, *you will be responsible for paying all costs for your participation in the study.*

Section 5.2 When you participate in a clinical research study, who pays for what?

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

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

After Medicare has paid its share of the cost for these services, our plan will pay the difference between the

cost sharing in Original Medicare and your in-network cost sharing as a member of our plan. This means you will pay the same amount for the services you receive as part of the study as you would if you received these services from our plan. However, you are required to submit documentation showing how much cost sharing you paid. Please see Chapter 7 for more information for submitting requests for payments.

Here's an example of how the cost sharing works: Let's say that you have a lab test that costs \$100 as part of the research study. Let's also say that your share of the costs for this test is \$20 under Original Medicare, but the test would be \$10 under our plan's benefits. In this case, Original Medicare would pay \$80 for the test, and you would pay the \$20 copay required under Original Medicare. You would then notify your plan that you received a qualified clinical trial service and submit documentation, such as a provider bill, to the plan. The plan would then directly pay you \$10. Therefore, your net payment is \$10, the same amount you would pay under our plan's benefits. Please note that in order to receive payment from your plan, you must submit documentation to your plan, such as a provider bill.

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

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

Do you want to know more?

You can get more information about joining a clinical research study by visiting the Medicare website to read or download the publication *Medicare and Clinical Research Studies*. (The publication is available at: www.medicare.gov/Pubs/pdf/02226-Medicare-and-Clinical-Research-Studies.pdf.) You can also call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

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

Section 6.1 What is a religious non-medical health care institution?

A religious non-medical health care institution is a facility that provides care for a condition that would ordinarily be treated in a hospital or skilled nursing facility. If getting care in a hospital or a skilled nursing facility is against a member's religious beliefs, we will instead provide coverage for care in a religious non-medical health care institution. This benefit is provided only for Part A inpatient services (non-medical health care services).

Section 6.2 Receiving care from a religious non-medical health care institution

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

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

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

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

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

See Chapter 4, section 2.1 (*Medical Benefits Chart – What is covered and what you pay*) for more information about inpatient hospital care cost sharing amounts for these services. You are covered for unlimited days.

SECTION 7 Rules for ownership of durable medical equipment

Section 7.1	Will you own the durable medical equipment after making a certain number of payments under our plan?
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Durable medical equipment (DME) includes items such as oxygen equipment and supplies, wheelchairs, walkers, powered mattress systems, crutches, diabetic supplies, speech generating devices, IV infusion pumps, nebulizers, and hospital beds ordered by a provider for use in the home. The member always owns certain items, such as prosthetics. In this section, we discuss other types of DME that you must rent.

In Original Medicare, people who rent certain types of DME own the equipment after paying copayments for the item for 13 months. As a member of our plan, however, you usually will not acquire ownership of rented DME items no matter how many copayments you make for the item while a member of our plan, even if you made up to 12 consecutive payments for the DME item under Original Medicare before you joined our plan. Under certain limited circumstances we will transfer ownership of the DME item to you. Call Customer Service for more information.

Examples of durable medical equipment items which are immediately owned by the member:

- Prosthetics
- Supply items (e.g., catheter, ostomy, CPAP supplies)

Examples of durable medical equipment items which may have ownership transferred after the Medicare-defined rental period:

- Wheelchairs
- Walkers
- Hospital beds
- CPAP/BiPAP machines

Examples of durable medical equipment items which will never have ownership transferred after the Medicare-defined rental period:

- Oxygen delivery systems
- Continuous Passive Motion (CPM) devices

Example of durable medical equipment items that the rental payment continues monthly for as long as you have the equipment:

- Non-invasive ventilators
- Invasive ventilators

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

If you did not acquire ownership of the DME item while in our plan, you will have to make 13 new consecutive payments after you switch to Original Medicare in order to own the item. The payments made while enrolled in your plan do not count.

Example 1: You made 12 or fewer consecutive payments for the item in Original Medicare and then joined our plan. The payments you made in Original Medicare do not count. You will have to make 13 payments to our plan before owning the item.

Example 2: You made 12 or fewer consecutive payments for the item in Original Medicare and then joined our plan. You were in our plan but did not obtain ownership while in our plan. You then go back to Original Medicare. You will have to make 13 consecutive new payments to own the item once you join Original Medicare again. All previous payments (whether to our plan or to Original Medicare) do not count.

Section 7.2 Rules for oxygen equipment, supplies, and maintenance

What oxygen benefits are you entitled to?

If you qualify for Medicare oxygen equipment coverage we will cover:

- Rental of oxygen equipment
- Delivery of oxygen and oxygen contents
- Tubing and related oxygen accessories for the delivery of oxygen and oxygen contents
- Maintenance and repairs of oxygen equipment

If you leave our plan or no longer medically require oxygen equipment, then the oxygen equipment must be returned.

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

Original Medicare requires an oxygen supplier to provide you services for five years. During the first 36 months you rent the equipment. The remaining 24 months the supplier provides the equipment and maintenance (you are still responsible for the copayment for oxygen). After five years you may choose to stay with the same company or go to another company. At this point, the five-year cycle begins again, even if you remain with the same company, requiring you to pay copayments for the first 36 months. If you join or leave our plan, the five-year cycle starts over.

CHAPTER 4:

Medical Benefits Chart

(what is covered and what you pay)

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

This chapter provides a Medical Benefits Chart that lists your covered services and shows how much you will pay for each covered service as a member of our plan. Later in this chapter, you can find information about medical services that are not covered. It also explains limits on certain services.

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

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

- **Copayment** is the fixed amount you pay each time you receive certain medical services. You pay a copayment at the time you get the medical service. (The Medical Benefits Chart in Section 2 tells you more about your copayments.)
- **Coinsurance** is the percentage you pay of the total cost of certain medical services. You pay a coinsurance at the time you get the medical service. (The Medical Benefits Chart in Section 2 tells you more about your coinsurance.)

Most people who qualify for Medicaid or for the Qualified Medicare Beneficiary (QMB) program should never pay deductibles, copayments, or coinsurance. Be sure to show your proof of Medicaid or QMB eligibility to your provider, if applicable.

Section 1.2 What is the most you will pay for Medicare Part A and Part B covered medical services?

Under our plan, there are two different limits on what you have to pay out-of-pocket for covered medical services:

- Your **in-network maximum out-of-pocket amount** is: \$6,200. This is the most you pay during the calendar year for covered Medicare Part A and Part B services received from network providers. The amounts you pay for copayments and coinsurance for covered services from network providers count toward this in-network maximum out-of-pocket amount. (The amounts you pay for plan premiums, Part D prescription drugs, and services from out-of-network providers do not count toward your in-network maximum out-of-pocket amount. In addition, amounts you pay for some services do not count toward your in-network maximum out-of-pocket amount. These services are marked with an asterisk in the Medical Benefits Chart.) If you have paid \$6,200 for covered Part A and Part B services from network providers, you will not have any out-of-pocket costs for the rest of the year when you see our network providers. However, you must continue to pay your plan premium and the Medicare Part B premium (unless your Part B premium is paid for you by Medicaid or another third party).
- Your **combined maximum out-of-pocket amount** is: \$9,550. This is the most you pay during the calendar year for covered Medicare Part A and Part B services received from both in-network and out-of-network providers. The amounts you pay for copayments and coinsurance for covered services count toward this combined maximum out-of-pocket amount. (The amounts you pay for your plan premiums and your Part D prescription drugs do not count toward your combined maximum out-of-pocket amount. In addition, amounts you pay for some services do not count toward your combined maximum out-of-pocket amount. These services are marked with an asterisk in the Medical Benefits Chart.) If you have paid \$9,550 for covered services, you will have 100% coverage and will not have any out-of-pocket costs for the rest of the year for covered Part A and Part B services. However, you must continue to pay your plan premium and the Medicare Part B premium (unless your Part B premium is paid for you by Medicaid or another third party).

Section 1.3 Our plan does not allow providers to balance bill you

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

Here is how this protection works.

- If your cost sharing is a copayment (a set amount of dollars, for example, \$15.00), then you pay only that amount for any covered services from a network provider. You will generally have higher copays when you obtain care from out-of-network providers.
- If your cost sharing is a coinsurance (a percentage of the total charges), then you never pay more than that percentage. However, your cost depends on which type of provider you see:
 - If you obtain covered services from a network provider, you pay the coinsurance percentage multiplied by the plan's reimbursement rate (as determined in the contract between the provider and the plan).
 - If you obtain covered services from an out-of-network provider who participates with Medicare, you pay the coinsurance percentage multiplied by the Medicare payment rate for participating providers.
 - If you obtain covered services from an out-of-network provider who does not participate with Medicare, then you pay the coinsurance amount multiplied by the Medicare payment rate for non-participating providers.
- If you believe a provider has balance billed you, call Customer Service.

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

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

The Medical Benefits Chart on the following pages lists the services our plan covers and what you pay out-of-pocket for each service. Part D prescription drug coverage is covered in Chapter 5. The services listed in the Medical Benefits Chart are covered only when the following coverage requirements are met:

- Your Medicare covered services must be provided according to the coverage guidelines established by Medicare.
- Your services (including medical care, services, supplies, equipment, and Part B prescription drugs) *must* be medically necessary. Medically necessary means that the services, supplies, or drugs are needed for the prevention, diagnosis, or treatment of your medical condition and meet accepted standards of medical practice.
- For new enrollees, your MA coordinated care plan must provide a minimum 90-day transition period, during which time the new MA plan may not require prior authorization for any active course of treatment, even if the course of treatment was for a service that commenced with an out-of-network provider.

- Some of the services listed in the Medical Benefits Chart are covered as in-network services *only* if your doctor or other network provider gets approval in advance (sometimes called prior authorization) from us.
 - Covered services that need approval in advance to be covered as in-network services are marked with a cross (†) and a footnote in the Medical Benefits Chart. In addition, the following services not listed in the Benefits Chart require approval in advance:
 - Genetic testing
 - Sleep apnea treatment and surgery
 - Potentially cosmetic and reconstructive procedures
 - Gender affirming services
 - Procedures determined to be investigational or experimental by the plan
 - You never need approval in advance for out-of-network services from out-of-network providers.
 - While you don't need approval in advance for out-of-network services, you or your doctor can ask us to make a coverage decision in advance.


Other important things to know about our coverage:

- For benefits where your cost sharing is a coinsurance percentage, the amount you pay depends on what type of provider you receive the services from:
 - If you receive the covered services from a network provider, you pay the coinsurance percentage multiplied by the plan's reimbursement rate (as determined in the contract between the provider and the plan).
 - If you receive the covered services from an out-of-network provider who participates with Medicare, you pay the coinsurance percentage multiplied by the Medicare payment rate for participating providers.
 - If you receive the covered services from an out-of-network provider who does not participate with Medicare, you pay the coinsurance percentage multiplied by the Medicare payment rate for non-participating providers.
- Like all Medicare health plans, we cover everything that Original Medicare covers. For some of these benefits, you pay *more* in our plan than you would in Original Medicare. For others, you pay *less*. (If you want to know more about the coverage and costs of Original Medicare, look in your *Medicare & You 2025* handbook. View it online at www.medicare.gov or ask for a copy by calling 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.)
- For all preventive services that are covered at no cost under Original Medicare, we also cover the service at no cost to you. However, if you also are treated or monitored for an existing medical condition during the visit when you receive the preventive service, a copayment will apply for the care received for the existing medical condition.
- If Medicare adds coverage for any new services during 2025, either Medicare or our plan will cover those services.




You will see this apple next to the preventive services in the benefits chart.

Medical Benefits Chart

Services that are covered for you	What you must pay when you get these services
 Abdominal aortic aneurysm screening A one-time screening ultrasound for people at risk. The plan only covers this screening if you have certain risk factors and if you get a referral for it from your physician, physician assistant, nurse practitioner, or clinical nurse specialist.	In-network: There is no coinsurance, copayment, or deductible for members eligible for this preventive screening. Out-of-network: 50% coinsurance
Acupuncture for chronic low back pain Covered services include: Up to 12 visits in 90 days are covered for Medicare beneficiaries under the following circumstances: For the purpose of this benefit, chronic low back pain is defined as: <ul style="list-style-type: none"> • lasting 12 weeks or longer; • nonspecific, in that it has no identifiable systemic cause (i.e., not associated with metastatic, inflammatory, infectious disease, etc.); • not associated with surgery; and • not associated with pregnancy. An additional eight sessions will be covered for those patients demonstrating an improvement. No more than 20 acupuncture treatments may be administered annually. Treatment must be discontinued if the patient is not improving or is regressing. Provider Requirements: Physicians (as defined in 1861(r)(1) of the Social Security Act (the Act)) may furnish acupuncture in accordance with applicable state requirements. Physician assistants (PAs), nurse practitioners (NPs)/clinical nurse specialists (CNSs) (as identified in 1861(aa)(5) of the Act), and auxiliary personnel may furnish acupuncture if they meet all applicable state requirements and have: <ul style="list-style-type: none"> • a masters or doctoral level degree in acupuncture or Oriental Medicine from a school accredited by the Accreditation Commission on Acupuncture and Oriental Medicine (ACAOM); and, • a current, full, active, and unrestricted license to practice acupuncture in a State, Territory, or Commonwealth (i.e., Puerto Rico) of the United States, or District of Columbia. Auxiliary personnel furnishing acupuncture must be under the appropriate level of supervision of a physician, PA, or NP/CNS required by our regulations at 42 CFR §§ 410.26 and 410.27. <i>See Section 3.1 for exclusions</i>	In-network: \$20 copay per provider per day Out-of-network: 50% coinsurance



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Services that are covered for you	What you must pay when you get these services
<p>Ambulance services † <i>Prior authorization is required for elective fixed-wing air ambulance transport</i></p> <p>Covered ambulance services, whether for an emergency or non-emergency situation, include fixed wing, rotary wing, and ground ambulance services, to the nearest appropriate facility that can provide care only if they are furnished to a member whose medical condition is such that other means of transportation could endanger the person's health or if authorized by the plan. If the covered ambulance services are not for an emergency situation, it should be documented that the member's condition is such that other means of transportation could endanger the person's health and that transportation by ambulance is medically required.</p>	<p>In- and Out-of-network: \$275 copay per Medicare-covered one-way transport</p>
<p>Annual physical exam</p> <p>In addition to the annual wellness visit you are eligible for an annual physical exam once every calendar year.</p> <p>The annual physical exam is a comprehensive physical examination by a physician or other health care professional.</p>	<p>In-network: There is no coinsurance, copayment, or deductible for the annual physical exam.</p> <p>Out-of-network: 50% coinsurance</p> <p>If you are treated, monitored, or have lab work for a new or existing medical condition during this visit, the appropriate cost sharing will apply for care received for that medical condition.</p>
<p> Annual wellness visit</p> <p>If you've had Part B for longer than 12 months, you can get an annual wellness visit to develop or update a personalized prevention plan based on your current health and risk factors. This is covered once every calendar year.</p> <p>Note: Your first annual wellness visit can't take place within 12 months of your Welcome to Medicare preventive visit. However, you don't need to have had a Welcome to Medicare visit to be covered for annual wellness visits after you've had Part B for 12 months.</p>	<p>In-network: There is no coinsurance, copayment, or deductible for the annual wellness visit.</p> <p>Out-of-network: 50% coinsurance</p> <p>If you are treated, monitored, or have lab work for a new or existing medical condition during this visit, the appropriate cost sharing will apply for care received for that medical condition.</p>




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Services that are covered for you	What you must pay when you get these services
<p>Blue FlexDollars™</p> <p>Over-the-counter (OTC) and home and bathroom safety devices</p> <p>You can use your quarterly allowance to buy Medicare-approved non-prescription OTC health and wellness items like vitamins, sunscreen, pain relievers, cough and cold medicine, bandages and more. You can also buy Medicare-approved home and bathroom safety devices. Your coverage includes non-prescription OTC health and wellness items like vitamins, sunscreen, pain relievers, cough and cold medicine, bandages and more.</p> <p>You can shop at participating stores, place an order for OTC products online, over the phone, or by mail through the paper OTC catalog mailed to you. For more information, refer to the Regence Blue FlexDollars 2025 Member Guide, visit BlueFlexDollars.com or call Flex Card Services at 1-866-228-7001.</p> <p>Healthy rewards program</p> <p>With Healthy Rewards, you can earn rewards while taking care of your health. Earn rewards dollars for completing a qualifying health service such as the Annual Wellness Visit. You can spend your reward dollars to purchase anything from groceries to household goods at many popular stores locally and nationwide. For a full list of qualifying health services, visit BlueFlexDollars.com or call Flex Card Services at 1-866-228-7001.</p>	<p><u>OTC and home and bathroom safety devices:</u> \$15 allowance every quarter.</p> <p><u>Healthy Rewards Program:</u> Your Healthy Rewards amount is based on how many healthy activities you complete.</p>
<p> Bone mass measurement</p> <p>For qualified individuals (generally, this means people at risk of losing bone mass or at risk of osteoporosis), the following services are covered every 24 months or more frequently if medically necessary: procedures to identify bone mass, detect bone loss, or determine bone quality, including a physician's interpretation of the results.</p>	<p>In-network: There is no coinsurance, copayment, or deductible for Medicare-covered bone mass measurement.</p> <p>Out-of-network: 50% coinsurance</p>
<p> Breast cancer screening (mammograms)</p> <p>Covered services include:</p> <ul style="list-style-type: none"> • One screening mammogram every calendar year • One clinical breast exam every calendar year 	<p>In-network: There is no coinsurance, copayment, or deductible for covered screening mammograms.</p> <p>Out-of-network: 50% coinsurance</p>
<p>Cardiac rehabilitation services</p> <p>Comprehensive programs of cardiac rehabilitation services that include exercise, education, and counseling are covered for members who meet certain conditions with a doctor's order. The plan also covers intensive</p>	<p><u>In-office visits:</u> In-network: \$20 copay per provider per day</p> <p>Out-of-network: 50% coinsurance</p>


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Services that are covered for you	What you must pay when you get these services
<p>cardiac rehabilitation programs that are typically more rigorous or more intense than cardiac rehabilitation programs.</p>	<p><u>Virtual-office visits:</u> In-network: \$20 copay per provider per day Out-of-network: 50% coinsurance Services rendered in a hospital owned clinic or in an outpatient hospital may have associated facility charges. See the <i>Outpatient surgery, including services provided at hospital outpatient facilities and ambulatory surgical centers</i> section for cost-sharing amounts.</p>
<p> Cardiovascular disease risk reduction visit (therapy for cardiovascular disease) We cover one visit per year with your primary care doctor to help lower your risk for cardiovascular disease. During this visit, your doctor may discuss aspirin use (if appropriate), check your blood pressure, and give you tips to make sure you're eating healthy.</p>	<p>In-network: There is no coinsurance, copayment, or deductible for the intensive behavioral therapy cardiovascular disease preventive benefit. Out-of-network: 50% coinsurance</p>
<p> Cardiovascular disease testing Blood tests for the detection of cardiovascular disease (or abnormalities associated with an elevated risk of cardiovascular disease) once every 5 years (60 months).</p>	<p>In-network: There is no coinsurance, copayment, or deductible for cardiovascular disease testing that is covered once every 5 years. Out-of-network: 50% coinsurance</p>
<p> Cervical and vaginal cancer screening Covered services include:</p> <ul style="list-style-type: none"> For all women: Pap tests and pelvic exams are covered once every 24 months. If you are at high risk of cervical or vaginal cancer or you are of childbearing age and have had an abnormal Pap test within the past 3 years: one Pap test every 12 months. 	<p>In-network: There is no coinsurance, copayment, or deductible for Medicare-covered preventive Pap and pelvic exams. Out-of-network: 50% coinsurance</p>

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Services that are covered for you	What you must pay when you get these services
<p>Chiropractic services</p> <p>Covered services include:</p> <ul style="list-style-type: none"> We cover only manual manipulation of the spine to correct subluxation <p><i>See Section 3.1 for exclusions</i></p>	<p>In-network: \$20 copay per provider per day</p> <p>Out-of-network: 50% coinsurance</p>
<p> Colorectal cancer screening</p> <p>The following screening tests are covered:</p> <ul style="list-style-type: none"> Colonoscopy has no minimum or maximum age limitation and is covered once every 120 months (10 years) for patients not at high risk, or 48 months after a previous flexible sigmoidoscopy for patients who are not at high risk for colorectal cancer, and once every 24 months for high risk patients after a previous screening colonoscopy or barium enema. Flexible sigmoidoscopy for patients 45 years and older. Once every 120 months for patients not at high risk after the patient received a screening colonoscopy. Once every 48 months for high risk patients from the last flexible sigmoidoscopy or barium enema. Screening fecal-occult blood tests for patients 45 years and older. Once every 12 months. Multitarget stool DNA for patients 45 to 85 years of age and not meeting high risk criteria. Once every 3 years. Blood-based Biomarker Tests for patients 45 to 85 years of age and not meeting high risk criteria. Once every 3 years. Barium Enema as an alternative to colonoscopy for patients at high risk and 24 months since the last screening barium enema or the last screening colonoscopy. Barium Enema as an alternative to flexible sigmoidoscopy for patient not at high risk and 45 years or older. Once at least 48 months following the last screening barium enema or screening flexible sigmoidoscopy. <p>Colorectal cancer screening tests include a follow-on screening colonoscopy after a Medicare covered non-invasive stool-based colorectal cancer screening test returns a positive result.</p>	<p>In-network: There is no coinsurance, copayment, or deductible for a Medicare-covered colorectal cancer screening exam.</p> <p>If your doctor finds and removes a polyp or other tissue during the colonoscopy or flexible sigmoidoscopy, the screening exam continues to have no coinsurance, copayment, or deductible. In a hospital outpatient setting, you also will have no coinsurance, copayment, or deductible.</p> <p>Out-of-network: 50% coinsurance</p> <p>See the <i>Outpatient surgery, including services provided at hospital outpatient facilities and ambulatory surgical centers</i> section for costs sharing information when colonoscopy services are considered diagnostic rather than screening (for example personal history or current symptoms).</p>
<p>Dental services</p> <p>In general, preventive dental services (such as cleaning, routine dental exams, and dental x-rays) are not covered by Original Medicare. However, Medicare currently pays for dental services in a limited number of circumstances, specifically when that service is an integral part of specific treatment of a beneficiary's primary medical condition. Some examples include reconstruction of the jaw following fracture or</p>	<p><u>Medicare-covered dental services:</u></p> <p>In-network: \$35 copay per provider per day</p> <p>Out-of-network: 50% coinsurance</p>




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Services that are covered for you	What you must pay when you get these services
<p>injury, tooth extractions done in preparation for radiation treatment for cancer involving the jaw, or oral exams preceding kidney transplantation. In addition, we cover:</p>	<p>Services rendered in a hospital owned clinic or in an outpatient hospital may have associated facility charges. See the <i>Outpatient surgery, including services provided at hospital outpatient facilities and ambulatory surgical centers</i> section for cost-sharing amounts.</p>
<p>Preventive dental services (Class I) *</p> <ul style="list-style-type: none"> • Oral evaluations, 2 every calendar year • Prophylaxis (routine cleaning or periodontal maintenance), any combination, 2 every calendar year • Bitewing x-rays, 1 set every calendar year • Full mouth (FMX) or panoramic x-ray, 1 every 36 months • Topical fluoride, 1 every calendar year 	<p><u>Preventive dental services:</u> In-network: \$0 copay per provider per day Out-of-network: 50% coinsurance</p>
<p>Basic comprehensive dental services (Class II) *</p> <ul style="list-style-type: none"> • Periodontal scaling and root planing services, each quadrant once every 24 months • Restorative fillings, 2 every calendar year • Restorative crowns, 1 every calendar year and once per tooth every 5 years 	<p><u>Basic comprehensive dental services:</u> In- and Out-of-network: 50% coinsurance</p>
<p>Major comprehensive dental services (Class III) *</p> <ul style="list-style-type: none"> • Dentures (full or partial, new), 1 every 5 years • Endodontics (root canals), 1 every calendar year • Extractions (including local anesthesia), 2 every calendar year • Periodontal full mouth debridement, 1 every 3 years 	<p><u>Major comprehensive dental services:</u> In- and Out-of-network: 50% coinsurance</p>
<p>Preventive, basic, and major dental services have a combined \$1,250 benefit limit every calendar year.</p> <p>Additional services may be covered. Coverage for <i>all</i> non-Medicare covered dental services are limited to specific dental codes and may have restrictions/limitations. Contact Customer Service for more information. Out-of-network providers may bill you for any balances remaining over the allowed amount for covered services. You are responsible for any amounts beyond the benefit limits.</p> <p><i>See Section 3.1 for exclusions</i></p>	

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Services that are covered for you	What you must pay when you get these services
<p> Depression screening</p> <p>We cover one screening for depression per year. The screening must be done in a primary care setting that can provide follow-up treatment and/or referrals.</p>	<p>In-network: There is no coinsurance, copayment, or deductible for an annual depression screening visit.</p> <p>Out-of-network: 50% coinsurance</p>
<p> Diabetes screening</p> <p>We cover this screening (includes fasting glucose tests) if you have any of the following risk factors: high blood pressure (hypertension), history of abnormal cholesterol and triglyceride levels (dyslipidemia), obesity, or a history of high blood sugar (glucose). Tests may also be covered if you meet other requirements, like being overweight and having a family history of diabetes.</p> <p>You may be eligible for up to two diabetes screenings every 12 months following the date of your most recent diabetes screening test.</p>	<p>In-network: There is no coinsurance, copayment, or deductible for the Medicare covered diabetes screening tests.</p> <p>Out-of-network: 50% coinsurance</p>
<p> Diabetes self-management training, diabetic services, and supplies †</p> <p>For all people who have diabetes (insulin and non-insulin users). Covered services include:</p> <ul style="list-style-type: none"> Supplies to monitor your blood glucose: Blood glucose monitor, blood glucose test strips and glucose-control solutions for checking the accuracy of test strips and monitors Lancets and lancet devices For people with diabetes who have severe diabetic foot disease: One pair per calendar year of therapeutic custom-molded shoes (including inserts provided with such shoes) and two additional pairs of inserts, or one pair of depth shoes and three pairs of inserts (not including the non-customized removable inserts provided with such shoes). Coverage includes fitting. Diabetes self-management training is covered under certain conditions. <p>For diabetic monitoring supplies only: Generally, our plan covers any DME covered by Original Medicare from the brands and manufacturers on this list. We will not cover other brands and manufacturers unless your doctor or other provider tells us that the brand is appropriate for your medical needs. However, if you are new to our plan and are using a brand of DME that is not on our list, we will continue to cover this brand for you for up to 90 days. During this time, you should talk with your doctor to decide what brand is medically appropriate for you after this</p>	<p><u>Monitoring supplies:</u> <i>From a retail pharmacy:</i></p> <p>In-network: \$0 copay (covered supplies limited to):</p> <ul style="list-style-type: none"> Ascensia (Contour) LifeScan (OneTouch) <p>Out-of-network: 50% coinsurance</p> <p><i>From a durable medical equipment supplier:</i></p> <p>In-network: \$0 copay</p> <p>Out-of-network: 50% coinsurance</p> <p><u>Continuous glucose monitor and supplies:</u></p> <p>In-network: \$0 copay (covered supplies limited to):</p> <ul style="list-style-type: none"> Dexcom Abbott FreeStyle Libre


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Services that are covered for you	What you must pay when you get these services
<p>90-day period. (If you disagree with your doctor, you can ask him or her to refer you for a second opinion.)</p> <p>If you (or your provider) don't agree with the plan's coverage decision, you or your provider may file an appeal. You can also file an appeal if you don't agree with your provider's decision about what product or brand is appropriate for your medical condition. (For more information about appeals, see Chapter 9, <i>What to do if you have a problem or complaint (coverage decisions, appeals, complaints).</i>)</p>	<p>Out-of-network: 50% coinsurance</p> <p><u>Lancets, lancet devices, therapeutic shoes, and inserts:</u></p> <p>In-network: \$0 copay</p> <p>Out-of-network: 50% coinsurance</p> <p><u>Diabetes self-management training:</u></p> <p>In-network: \$0 copay per visit when diabetic education services are received from a Medicare-eligible educator, as part of a program certified by the American Diabetes Association and Medicare.</p> <p>Out-of-network: 50% coinsurance</p>
<p>Durable medical equipment (DME) and related supplies †</p> <p>(For a definition of durable medical equipment, see Chapter 12 of this document as well as Chapter 3, Section 7.)</p> <p>Covered items include, but are not limited to: wheelchairs, crutches, powered mattress systems, diabetic supplies (see <i>Diabetes self-management training, diabetic services and supplies</i> for more information), hospital beds ordered by a provider for use in the home, IV infusion pumps, speech generating devices, oxygen equipment, nebulizers, and walkers.</p> <p>We cover all medically necessary DME covered by Original Medicare. If our supplier in your area does not carry a particular brand or manufacturer, you may ask them if they can special order it for you. The most recent list of suppliers is available on our website at regence.com/medicare.</p>	<p>In-network: 20% coinsurance</p> <p>Out-of-network: 50% coinsurance</p> <p>Your cost sharing for Medicare oxygen equipment coverage is 20% coinsurance for in-network and 50% coinsurance for out-of-network providers every month for 36 months.</p> <p>You have no additional cost sharing for Medicare-covered oxygen equipment for months 37-60. During this time a maintenance visit is allowed once every 6 months at the normal cost sharing amount.</p>
<p>Emergency care</p> <p>Emergency care refers to services that are:</p>	<p>In- and Out-of-network: \$125 copay per visit</p>

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Services that are covered for you	What you must pay when you get these services
<ul style="list-style-type: none"> Furnished by a provider qualified to furnish emergency services, and Needed to evaluate or stabilize an emergency medical condition. <p>A medical emergency is when you, or any other prudent layperson with an average knowledge of health and medicine, believe that you have medical symptoms that require immediate medical attention to prevent loss of life (and, if you are a pregnant woman, loss of an unborn child), loss of a limb, or loss of function of a limb. The medical symptoms may be an illness, injury, severe pain, or a medical condition that is quickly getting worse.</p> <p>Cost sharing for necessary emergency services furnished out-of-network is the same as for such services furnished in-network.</p> <p>The benefits listed in this section are for services within the United States and its territories. See <i>Worldwide emergency and urgent care</i> for coverage information while outside the U.S. and its territories.</p>	<p>Your copay is waived if you are admitted to the hospital within 48 hours for the same condition.</p>
<p> Health and wellness education programs *</p> <p>The Silver&Fit® Healthy Aging and Exercise Program</p> <p>As a Silver&Fit member, you have the following options available at no cost or a low cost to you:</p> <ul style="list-style-type: none"> Fitness Center Membership: You can visit participating fitness centers or YMCAs near you that take part in the program. ** You also have access to the Premium Fitness Network, which includes additional fitness center and studio choices and unique experiences like swimming centers, rock climbing gyms, and rowing centers, each with a buy-up price. Many participating fitness centers may also offer low-impact classes focused on improving and increasing muscular strength and endurance, mobility, flexibility, range of motion, balance, agility, and coordination. Well-Being Club: By setting your preferences for well-being topics on the website, you will see resources tailored to your interests and healthy aging goals including articles, videos, live virtual classes and events, and social groups. *** Workout Plans: By answering a few online questions about your areas of interest, you will receive a customized workout plan, including instructions on how to get started and suggested workout videos. Digital Workouts: You can view on-demand videos through the website's digital workout library, including Silver&Fit Signature Series Classes®. FitnessCoach™ Virtual Personal Training: You can participate in up to 8 live virtual sessions per year with a certified personal trainer. 	<p>In-network only:</p> <p>There is no coinsurance, copayment, or deductible for the health and wellness education programs.</p>


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Services that are covered for you	What you must pay when you get these services
<ul style="list-style-type: none"> Well-Being Coaching: You can participate in sessions by phone, video, or chat with a trained coach where you can discuss topics like exercise, nutrition, and social isolation. Silver&Fit Connected!™: The Silver&Fit Connected! tool can assist with tracking your activity.**** Rewards: Earn a hat and pins for reaching new activity milestones. The Silver&Fit program has Something for Everyone®! <p>**Non-standard membership services that call for an added fee are not part of the Silver&Fit program and will not be reimbursed.</p> <p>***American Specialty Health Fitness, Inc. (ASH Fitness) has no affiliations, interest, endorsements, or sponsorships with any of the organizations or clubs. Some social groups may require a fee to join. Such fees are not part of the Silver&Fit programs and will not be reimbursed by ASH Fitness.</p> <p>****Purchase of some wearable fitness trackers or apps may be required to use the Connected! tool and are not reimbursable by the Silver&Fit program. Your use of the Silver&Fit Connected! tool serves as your consent for ASH Fitness to receive information about your tracked activity and to use that data to process and administer available rewards to you under the program.</p> <p>The Silver&Fit program is provided by ASH Fitness, a subsidiary of American Specialty Health Incorporated (ASH). Silver&Fit, Silver&Fit Signature Series Classes, FitnessCoach, Silver&Fit Connected!, and Something for Everyone are trademarks of ASH. Limitations, member fees, and restrictions may apply. Fitness center participation may vary by location and is subject to change. Kits and rewards are subject to change.</p>	
<p>Hearing services</p> <p>Diagnostic hearing and balance evaluations performed by your provider to determine if you need medical treatment are covered as outpatient care when furnished by a physician, audiologist, or other qualified provider.</p>	<p><u>Medicare-covered hearing services:</u></p> <p>In-network: \$35 copay per provider per day</p> <p>Out-of-network: 50% coinsurance</p> <p>Services rendered in a hospital owned clinic or in an outpatient hospital may have associated facility charges. See the <i>Outpatient surgery, including services provided at hospital outpatient facilities and ambulatory surgical centers</i> section for cost-sharing amounts.</p>

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Services that are covered for you	What you must pay when you get these services
<p>In addition to the Medicare-covered hearing services, we also cover:</p> <p>Routine hearing exam *</p> <p>We cover 1 routine hearing exam every calendar year</p> <p><i>See Section 3.1 for exclusions</i></p> <p>Routine hearing aids *</p> <p>Up to two TruHearing-branded hearing aids every year (one per ear per year). Benefit is limited to TruHearing's Standard, Advanced and Premium hearing aids, which come in various styles and colors. Advanced and Premium hearing aids are available in rechargeable style options for an additional cost. Call 1-855-542-1711 to schedule an appointment (for TTY, dial 711).</p> <p>Hearing aid purchase includes:</p> <ul style="list-style-type: none"> • First year of follow-up provider visits • 60-day trial period • 3-year extended warranty • 80 batteries per aid for non-rechargeable models <p>Benefit does not include or cover any of the following:</p> <ul style="list-style-type: none"> • Additional cost for optional hearing aid rechargeability • Ear molds • Hearing aid accessories • Additional provider visits • Additional batteries or batteries when a rechargeable hearing aid is purchased • Hearing aids that are not TruHearing-branded hearing aids • Costs associated with loss & damage warranty claims • Costs associated with excluded items are the responsibility of the member and not covered by the plan. <p><i>See Section 3.1 for exclusions</i></p>	<p><u>Routine hearing exam:</u></p> <p>In-network: \$0 copay</p> <p>Out-of-network: \$150 copay</p> <p>TruHearing providers must be used to receive the in-network benefit.</p> <p><u>Routine hearing aids:</u></p> <p>In-network only: \$499 copay per aid for TruHearing Standard Aids \$699 copay per aid for TruHearing Advanced Aids \$999 copay per aid for TruHearing Premium Aids \$50 additional cost per aid for optional hearing aid rechargeability</p> <p><u>Fitting and evaluation:</u></p> <p>In-network only: \$0 copay</p> <p>Unlimited visits for the first 12 months.</p> <p>TruHearing provider must be used to receive the hearing aid and fitting benefits.</p>
<p> HIV screening</p> <p>For people who ask for an HIV screening test or who are at increased risk for HIV infection, we cover:</p> <ul style="list-style-type: none"> • One screening exam every 12 months <p>For women who are pregnant, we cover:</p> <ul style="list-style-type: none"> • Up to three screening exams during a pregnancy 	<p>In-network: There is no coinsurance, copayment, or deductible for members eligible for Medicare-covered preventive HIV screening.</p> <p>Out-of-network: 50% coinsurance</p>

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Services that are covered for you	What you must pay when you get these services
<p>Home health agency care †</p> <p>Prior to receiving home health services, a doctor must certify that you need home health services and will order home health services to be provided by a home health agency. You must be homebound, which means leaving home is a major effort.</p> <p>Covered services include, but are not limited to:</p> <ul style="list-style-type: none"> • Part-time or intermittent skilled nursing and home health aide services (to be covered under the home health care benefit, your skilled nursing and home health aide services combined must total fewer than 8 hours per day and 35 hours per week) • Physical therapy, occupational therapy, and speech therapy • Medical and social services • Medical equipment and supplies 	<p>In-network: \$0 copay per visit</p> <p>Out-of-network: 50% coinsurance</p>
<p>Home infusion therapy</p> <p>Home infusion therapy involves the intravenous or subcutaneous administration of drugs or biologicals to an individual at home. The components needed to perform home infusion include the drug (for example, antivirals, immune globulin), equipment (for example, a pump), and supplies (for example, tubing and catheters).</p> <p>Covered services include, but are not limited to:</p> <ul style="list-style-type: none"> • Professional services, including nursing services, furnished in accordance with the plan of care • Patient training and education not otherwise covered under the durable medical equipment benefit • Remote monitoring • Monitoring services for the provision of home infusion therapy and home infusion drugs furnished by a qualified home infusion therapy supplier 	<p><u>Equipment and supplies:</u></p> <p>In-network: 20% coinsurance</p> <p>Out-of-network: 50% coinsurance</p> <p><u>Professional services:</u></p> <p>In-network: \$0 copay per visit</p> <p>Out-of-network: 50% coinsurance</p> <p><u>Home infusion drugs:</u> <i>For Medicare Part B drugs</i></p> <p>In-network: 20% coinsurance (certain drugs may have a coinsurance lower than 20%) (including administration)</p> <p>Out-of-network: 50% coinsurance</p> <p><i>For Medicare Part D drugs:</i> See Chapter 6 for more information</p>
<p>Hospice care</p> <p>You are eligible for the hospice benefit when your doctor and the hospice medical director have given you a terminal prognosis certifying that you're terminally ill and have 6 months or less to live if your illness runs its normal course. You may receive care from any Medicare-certified hospice program.</p>	<p>When you enroll in a Medicare-certified hospice program, your hospice services and your Part A and Part B services related to your terminal prognosis are paid</p>


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Services that are covered for you	What you must pay when you get these services
<p>Your plan is obligated to help you find Medicare-certified hospice programs in the plan's service area, including those the MA organization owns, controls, or has a financial interest in. Your hospice doctor can be a network provider or an out-of-network provider.</p> <p>Covered services include:</p> <ul style="list-style-type: none"> • Drugs for symptom control and pain relief • Short-term respite care • Home care <p>When you are admitted to a hospice you have the right to remain in your plan; if you chose to remain in your plan you must continue to pay plan premiums.</p> <p><u>For hospice services and for services that are covered by Medicare Part A or B and are related to your terminal prognosis:</u> Original Medicare (rather than our plan) will pay your hospice provider for your hospice services and any Part A and Part B services related to your terminal prognosis. While you are in the hospice program, your hospice provider will bill Original Medicare for the services that Original Medicare pays for. You will be billed Original Medicare cost sharing.</p> <p><u>For services that are covered by Medicare Part A or B and are not related to your terminal prognosis:</u> If you need non-emergency, non-urgently needed services that are covered under Medicare Part A or B and that are not related to your terminal prognosis, your cost for these services depends on whether you use a provider in our plan's network and follow plan rules (such as if there is a requirement to obtain prior authorization).</p> <ul style="list-style-type: none"> • If you obtain the covered services from a network provider and follow plan rules for obtaining service, you only pay the plan cost sharing amount for in-network services. • If you obtain the covered services from an out-of-network provider, you pay the plan cost sharing for out-of-network services. <p><u>For services that are covered by our plan but are not covered by Medicare Part A or B:</u> We will continue to cover plan-covered services that are not covered under Part A or B whether or not they are related to your terminal prognosis. You pay your plan cost sharing amount for these services.</p> <p><u>For drugs that may be covered by the plan's Part D benefit:</u> If these drugs are unrelated to your terminal hospice condition you pay cost sharing. If they are related to your terminal hospice condition then you pay Original Medicare cost sharing. Drugs are never covered by both hospice and our plan at the same time. For more information, please see Chapter 5, Section 9.4 (<i>What if you're in Medicare-certified hospice</i>).</p> <p>Note: If you need non-hospice care (care that is not related to your terminal prognosis), you should contact us to arrange the services.</p>	<p>for by Original Medicare, not our plan.</p>

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Services that are covered for you	What you must pay when you get these services
<p>Our plan covers hospice consultation services (one time only) for a terminally ill person who hasn't elected the hospice benefit.</p>	<p><u>One-time hospice consultation:</u> In- and Out-of-network: \$0 copay</p>
<p> Immunizations</p> <p>Covered Medicare Part B services include:</p> <ul style="list-style-type: none"> • Pneumonia vaccines • Flu/influenza shots (or vaccines), once each flu/influenza season in the fall and winter, with additional flu/influenza shots (or vaccines) if medically necessary • Hepatitis B vaccines if you are at high or intermediate risk of getting Hepatitis B • COVID-19 vaccines • Other vaccines if you are at risk and they meet Medicare Part B coverage rules <p>We also cover most other adult vaccines under our Part D prescription drug benefit. Refer to Chapter 6, Section 7 for additional information.</p>	<p>In-network: There is no coinsurance, copayment, or deductible for the pneumonia, flu/influenza, Hepatitis B, and COVID-19 vaccines.</p> <p><u>Other Part B vaccines (including administration):</u> 0%-20% coinsurance</p> <p>Out-of-network: 50% coinsurance</p>
<p>Inpatient hospital care †</p> <p>Includes inpatient acute, inpatient rehabilitation, long-term care hospitals, and other types of inpatient hospital services. Inpatient hospital care starts the day you are formally admitted to the hospital with a doctor's order. The day before you are discharged is your last inpatient day.</p> <p>You are covered for unlimited days per stay. Your stay must meet medical necessity requirements to be considered an inpatient stay, even with a physician order.</p> <p>Covered services include but are not limited to:</p> <ul style="list-style-type: none"> • Semi-private room (or a private room if medically necessary) • Meals including special diets • Regular nursing services • Costs of special care units (such as intensive care or coronary care units) • Drugs and medications • Lab tests • X-rays and other radiology services • Necessary surgical and medical supplies • Use of appliances, such as wheelchairs • Operating and recovery room costs • Physical, occupational, and speech language therapy • Inpatient substance use disorder services • Under certain conditions, the following types of transplants are covered: corneal, kidney, kidney-pancreatic, heart, liver, lung, 	<p>In-network: Days 1–4: \$350 copay per day Days 5 and beyond: \$0 copay per day</p> <p>Out-of-network: 50% coinsurance</p> <p>Cost sharing is applied to each inpatient stay and is assessed from the date of admission through the last full day stayed.</p> <p>If you get inpatient care at an out-of-network hospital after your emergency condition is stabilized, your cost is the cost sharing you would pay at a network hospital.</p>


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Services that are covered for you	What you must pay when you get these services
<p>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. Transplant providers may be local or outside of the service area. If our in-network transplant services are outside the community pattern of care, you may choose to go locally as long as the local transplant providers are willing to accept the Original Medicare rate. If our plan provides transplant services at a location outside the pattern of care for transplants in your community and you choose to obtain transplants at this distant location, we will arrange or pay for appropriate lodging and transportation costs for you and a companion. Note: Lodging and transportation costs are reimbursable only in the event Regence BlueCross BlueShield of Utah directs you to receive transplant services at a distant facility or location even though those services are available closer to your home.</p> <ul style="list-style-type: none"> • Blood - including storage and administration. Coverage for whole blood, packed red cells and all other components of blood are covered beginning with the first unit used. • Physician services <p>Note: To be an inpatient, your provider must write an order to admit you formally as an inpatient of the hospital. Even if you stay in the hospital overnight, you might still be considered an <i>outpatient</i>. If you are not sure if you are an inpatient or an outpatient, you should ask the hospital staff.</p> <p>You can also find more information in a Medicare fact sheet called <i>Are You a Hospital Inpatient or Outpatient? If You Have Medicare – Ask!</i> This fact sheet is available on the Web at https://es.medicare.gov/publications/11435-Medicare-Hospital-Benefits.pdf or by calling 1-800-MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048. You can call these numbers for free, 24 hours a day, 7 days a week.</p>	
<p>Inpatient services in a psychiatric hospital †</p> <p>Covered services include mental health care services that require a hospital stay</p> <ul style="list-style-type: none"> • There is a 190-day lifetime limit for inpatient services in a psychiatric hospital. • The 190-day limit does not apply to inpatient mental health services provided in a psychiatric unit of a general hospital. 	<p>In-network: Days 1–4: \$350 copay per day Days 5–190: \$0 copay per day</p> <p>Out-of-network: Days 1–190: 50% coinsurance</p> <p>Cost sharing is applied to each inpatient stay and is assessed from the date of admission through the last full day stayed.</p>


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Services that are covered for you	What you must pay when you get these services
<p>Inpatient stay: Covered services received in a hospital or SNF during a non-covered inpatient stay †</p> <p>If you have exhausted your inpatient benefits or if the inpatient stay is not reasonable and necessary, we will not cover your inpatient stay. However, in some cases, we will cover certain services you receive while you are in the hospital or the skilled nursing facility (SNF).</p> <p>Covered services include, but are not limited to:</p> <ul style="list-style-type: none"> • Physician services • Diagnostic tests (like lab tests) • X-ray, radium, and isotope therapy including technician materials and services • Surgical dressings • Splints, casts and other devices used to reduce fractures and dislocations • Prosthetics and orthotics devices (other than dental) that replace all or part of an internal body organ (including contiguous tissue), or all or part of the function of a permanently inoperative or malfunctioning internal body organ, including replacement or repairs of such devices • Leg, arm, back, and neck braces; trusses, and artificial legs, arms, and eyes including adjustments, repairs, and replacements required because of breakage, wear, loss, or a change in the patient's physical condition • Physical therapy, speech therapy, and occupational therapy 	<p>The listed services will be covered at the cost sharing amounts shown in the Medical Benefits Chart for the specific service.</p> <p>For surgical dressings, splints, casts, and other devices to reduce fractures and dislocations, benefits are determined by the location/provider they are received from.</p>
<p>Meal delivery service – Post discharge meals *</p> <p>Mom's Meals delivery program is available for qualified beneficiaries who have been discharged from an inpatient, skill nursing, or rehabilitation facility stay within the last 30 days.</p> <ul style="list-style-type: none"> • Two meals per day for up to 14 days • 28 total meals per episode/discharge 	<p>In-network only: \$0 copay per meal</p> <p>Meal benefits provided exclusively through Mom's Meals</p>
<p> Medical nutrition therapy</p> <p>This benefit is for people with diabetes, renal (kidney) disease (but not on dialysis), or after a kidney transplant when ordered by your doctor.</p> <p>We cover 3 hours of one-on-one counseling services during your first year that you receive medical nutrition therapy services under Medicare (this includes our plan, any other Medicare Advantage plan, or Original Medicare), and 2 hours each year after that. If your condition, treatment, or diagnosis changes, you may be able to receive more hours of treatment with a physician's order. A physician must prescribe these services and renew their order yearly if your treatment is needed into the next calendar year.</p>	<p>In-network: There is no coinsurance, copayment, or deductible for members eligible for Medicare-covered medical nutrition therapy services.</p> <p>Out-of-network: 50% coinsurance</p>


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Services that are covered for you	What you must pay when you get these services
<p> Medicare diabetes prevention program (MDPP)</p> <p>MDPP services will be covered for eligible Medicare beneficiaries under all Medicare health plans.</p> <p>MDPP is a structured health behavior change intervention that provides practical training in long-term dietary change, increased physical activity, and problem-solving strategies for overcoming challenges to sustaining weight loss and a healthy lifestyle.</p>	<p>In- and Out-of-network: There is no coinsurance, copayment, or deductible for the MDPP benefit.</p> <p>Contact Customer Service for assistance locating an eligible MDPP supplier</p>
<p>Medicare Part B prescription drugs †</p> <p>These drugs are covered under Part B of Original Medicare. Members of our plan receive coverage for these drugs through our plan.</p> <p>Covered drugs include:</p> <ul style="list-style-type: none"> • Drugs that usually aren't self-administered by the patient and are injected or infused while you are getting physician, hospital outpatient, or ambulatory surgical center services • Insulin furnished through an item of durable medical equipment (such as a medically necessary insulin pump) • Other drugs you take using durable medical equipment (such as nebulizers) that were authorized by the plan • The Alzheimer's drug, Leqembi®, (generic name lecanemab), which is administered intravenously. In addition to medication costs, you may need additional scans and tests before and/or during treatment that could add to your overall costs. Talk to your doctor about what scans and tests you may need as part of your treatment • Clotting factors you give yourself by injection if you have hemophilia • Transplant/Immunosuppressive drugs: Medicare covers transplant drug therapy if Medicare paid for your organ transplant. You must have Part A at the time of the covered transplant, and you must have Part B at the time you get immunosuppressive drugs. Keep in mind, Medicare drug coverage (Part D) covers immunosuppressive drugs if Part B doesn't cover them • 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 • Some Antigens: Medicare covers antigens if a doctor prepares them and a properly instructed person (who could be you, the patient) gives them under appropriate supervision • Certain oral anti-cancer drugs: Medicare covers some oral cancer drugs you take by mouth if the same drug is available in injectable form or the drug is a prodrug (an oral form of a drug that, when ingested, breaks down into the same active ingredient found in the injectable drug) of the injectable drug. As new oral cancer drugs 	<p><u>Part B prescription drugs:</u></p> <p>In-network: 20% coinsurance (certain drugs may have a coinsurance lower than 20%)</p> <p>Out-of-network: 50% coinsurance</p> <p>Benefit includes administration of drugs. Please note some drugs may require step therapy.</p> <p><u>Part B insulin drugs:</u></p> <p>In-network: 20% coinsurance up to a \$35 copay for a one-month supply</p> <p>Out-of-network: 50% coinsurance</p>

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Services that are covered for you	What you must pay when you get these services
<p>become available, Part B may cover them. If Part B doesn't cover them, Part D does</p> <ul style="list-style-type: none"> • Oral anti-nausea drugs: Medicare covers oral anti-nausea drugs you use as part of an anti-cancer chemotherapeutic regimen if they're administered before, at, or within 48 hours of chemotherapy or are used as a full therapeutic replacement for an intravenous anti-nausea drug • Certain oral End-Stage Renal Disease (ESRD) drugs if the same drug is available in injectable form and the Part B ESRD benefit covers it • Calcimimetic medications under the ESRD payment system, including the intravenous medication Parsabiv®, and the oral medication Sensipar® • Certain drugs for home dialysis, including heparin, the antidote for heparin, when medically necessary, and topical anesthetics • Erythropoiesis-stimulating agents: Medicare covers erythropoietin by injection if you have End-Stage Renal Disease (ESRD) or you need this drug to treat anemia related to certain other conditions (such as Epogen®, Procrit®, Retacrit®, Epoetin Alfa, Aranesp®, Darbepoetin Alfa, Mircera®, or Methoxy polyethylene glycol-epoetin beta) • Intravenous Immune Globulin for the home treatment of primary immune deficiency diseases • Parenteral and enteral nutrition (intravenous and tube feeding) <p>The following link will take you to a list of Part B Drugs that may be subject to Step Therapy: https://www.regence.com/go/all/2025/step-therapy.pdf</p> <p>We also cover some vaccines under our Part B and most adult vaccines under our Part D prescription drug benefit.</p> <p>Chapter 5 explains the Part D prescription drug benefit, including rules you must follow to have prescriptions covered. What you pay for your Part D prescription drugs through our plan is explained in Chapter 6.</p>	
<p> Obesity screening and therapy to promote sustained weight loss</p> <p>If you have a body mass index of 30 or more, we cover intensive counseling to help you lose weight. This counseling is covered if you get it in a primary care setting, where it can be coordinated with your comprehensive prevention plan. Talk to your primary care doctor or practitioner to find out more.</p>	<p>In-network: There is no coinsurance, copayment, or deductible for preventive obesity screening and therapy.</p> <p>Out-of-network: 50% coinsurance</p>
<p>Opioid treatment program services †</p> <p>Members of our plan with opioid use disorder (OUD) can receive coverage of services to treat OUD through an Opioid Treatment Program (OTP) which includes the following services:</p>	<p>In-network: \$35 copay per provider per day</p> <p>Out-of-network: 50% coinsurance</p>

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Services that are covered for you	What you must pay when you get these services
<ul style="list-style-type: none"> • U.S. Food and Drug Administration (FDA)-approved opioid agonist and antagonist medication-assisted treatment (MAT) medications. • Dispensing and administration of MAT medications (if applicable) • Substance use disorder counseling • Individual and group therapy • Toxicology testing • Intake activities • Periodic assessments 	<p>Services rendered in a hospital owned clinic or in an outpatient hospital may have associated facility charges. See the <i>Outpatient surgery, including services provided at hospital outpatient facilities and ambulatory surgical centers</i> section for cost-sharing amounts.</p>
<p>Outpatient diagnostic tests and therapeutic services and supplies</p> <p>Covered services include, but are not limited to:</p> <ul style="list-style-type: none"> • X-rays • Radiation (radium and isotope) therapy including technician materials and supplies † • Surgical supplies, such as dressings • Splints, casts, and other devices used to reduce fractures and dislocations • Laboratory tests † 	

In-network:
\$10 copay per provider per day

Out-of-network:
50% coinsurance

In-network:
20% coinsurance

Out-of-network:
50% coinsurance

You may also have an office visit copay associated with this service. See the *Physician/Practitioner services* section for information on copay amounts

For these items and services, benefits are determined by the location/provider they are received from. For example, supplies during an outpatient surgery will apply to the outpatient surgical benefit.

In-network:
\$0 copay per provider per day for HbA1C testing
\$5 copay per provider per day for all other tests

Out-of-network:
50% coinsurance

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Services that are covered for you	What you must pay when you get these services
<ul style="list-style-type: none"> Blood – including storage and administration. Coverage for whole blood, packed red cells and all other components of blood are covered beginning with the first unit used Other outpatient diagnostic tests † 	<p>In-network: \$0 copay</p> <p>Out-of-network: 50% coinsurance</p> <p><u>Diagnostic tests and procedures:</u></p> <p>In-network: \$5 copay per provider per day</p> <p>Out-of-network: 50% coinsurance</p> <p><u>Complex imaging – (MRI/ CT/ PET/ nuclear tests/ etc.):</u></p> <p>In-network: \$0 copay per provider per day for diagnostic mammography \$250 copay per provider per day for all other complex imaging</p> <p>Out-of-network: 50% coinsurance</p>
<p>Outpatient hospital observation †</p> <p>Observation services are hospital outpatient services given to determine if you need to be admitted as an inpatient or can be discharged. For outpatient hospital observation services to be covered, they must meet the Medicare criteria and be considered reasonable and necessary. Observation services are covered only when provided by the order of a physician or another individual authorized by state licensure law and hospital staff bylaws to admit patients to the hospital or order outpatient tests.</p> <p>Note: Unless the provider has written an order to admit you as an inpatient to the hospital, you are an outpatient and pay the cost sharing amounts for outpatient hospital services. Even if you stay in the hospital overnight, you might still be considered an outpatient. If you are not sure if you are an outpatient, you should ask the hospital staff.</p> <p>You can also find more information in a Medicare fact sheet called <i>Are You a Hospital Inpatient or Outpatient? If You Have Medicare – Ask!</i> This fact sheet is available on the Web at https://es.medicare.gov/publications/11435-Medicare-Hospital-Benefits.pdf or by calling 1-800-MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048. You can call these numbers for free, 24 hours a day, 7 days a week.</p>	<p>In-network: \$400 copay per visit</p> <p>Out-of-network: 50% coinsurance</p>

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Services that are covered for you	What you must pay when you get these services
<p>Outpatient hospital services †</p> <p>We cover medically necessary services you get in the outpatient department of a hospital for diagnosis or treatment of an illness or injury. Covered services include, but are not limited to:</p> <ul style="list-style-type: none"> • Services in an emergency department or outpatient clinic, such as observation services or outpatient surgery • Laboratory and diagnostic tests billed by the hospital • Mental health care, including care in a partial-hospitalization program, if a doctor certifies that inpatient treatment would be required without it • X-rays and other radiology services billed by the hospital • Medical supplies such as splints and casts • Certain drugs and biologicals that you can't give yourself <p>Note: Unless the provider has written an order to admit you as an inpatient to the hospital, you are an outpatient and pay the cost sharing amounts for outpatient hospital services. Even if you stay in the hospital overnight, you might still be considered an outpatient. If you are not sure if you are an outpatient, you should ask the hospital staff.</p> <p>You can also find more information in a Medicare fact sheet called <i>Are You a Hospital Inpatient or Outpatient? If You Have Medicare – Ask!</i> This fact sheet is available on the Web at https://es.medicare.gov/publications/11435-Medicare-Hospital-Benefits.pdf or by calling 1-800-MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048. You can call these numbers for free, 24 hours a day, 7 days a week.</p>	<p>The listed services will be covered at the cost sharing amounts shown in the Medical Benefits Chart for the specific service.</p> <p>For surgical dressings, splints, casts and other devices to reduce fractures and dislocations, benefits are determined by the location/provider they are received from.</p>
<p>Outpatient mental health care †</p> <p>Covered services include:</p> <p>Mental health services provided by a state-licensed psychiatrist or doctor, clinical psychologist, clinical social worker, clinical nurse specialist, licensed professional counselor (LPC), licensed marriage and family therapist (LMFT), nurse practitioner (NP), physician assistant (PA), or other Medicare-qualified mental health care professional as allowed under applicable state laws.</p> <p>Additionally, your plan offers virtual visits through your providers office, if they are able. If your provider does not offer virtual visits, you may use Doctor On Demand. Through Doctor On Demand, you can access a doctor 24 hours a day, 7 days a week, by secure video, using your computer or mobile device such as a cellphone or tablet. Contact Doctor On Demand at 1-800-310-2973.</p>	<p><u>In-office visits:</u></p> <p>In-network: \$30 copay per provider per day</p> <p>Out-of-network: 50% coinsurance</p> <p><u>Virtual-office visits:</u></p> <p>In-network: \$0 copay per provider per day</p> <p>Out-of-network: 50% coinsurance</p> <p><u>Doctor On Demand telehealth visit:</u></p> <p>In-network only: \$0 copay per visit</p> <p>Services rendered in a hospital owned clinic or in an outpatient hospital may have associated</p>

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Services that are covered for you	What you must pay when you get these services
	<p>facility charges. See the <i>Outpatient surgery, including services provided at hospital outpatient facilities and ambulatory surgical centers</i> section for cost-sharing amounts.</p>
<p>Outpatient rehabilitation services †</p> <p>Covered services include physical therapy, occupational therapy, and speech language therapy.</p> <p>Outpatient rehabilitation services are provided in various outpatient settings, such as hospital outpatient departments, independent therapist offices, and Comprehensive Outpatient Rehabilitation Facilities (CORFs).</p>	<p><u>In-office visits:</u> In-network: \$35 copay per provider per day Out-of-network: 50% coinsurance</p> <p><u>Virtual-office visits:</u> In-network: \$35 copay per provider per day Out-of-network: 50% coinsurance</p> <p>Services rendered in a hospital owned clinic or in an outpatient hospital may have associated facility charges. See the <i>Outpatient surgery, including services provided at hospital outpatient facilities and ambulatory surgical centers</i> section for cost-sharing amounts.</p>
<p>Outpatient substance use disorder services †</p> <p>Covered services include outpatient services, diagnostic evaluation and education, organized individual, and group counseling.</p> <p><i>See Section 3.1 for provider exclusions</i></p>	<p>In-network: \$30 copay per provider per day Out-of-network: 50% coinsurance</p> <p>Services rendered in a hospital owned clinic or in an outpatient hospital may have associated facility charges. See the <i>Outpatient surgery, including services provided at hospital outpatient facilities and ambulatory surgical centers</i> section for cost-sharing amounts.</p>

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Services that are covered for you	What you must pay when you get these services
<p>Outpatient surgery, including services provided at hospital outpatient facilities and ambulatory surgical centers †</p> <p>Note: If you are having surgery in a hospital facility, you should check with your provider about whether you will be an inpatient or outpatient. Unless the provider writes an order to admit you as an inpatient to the hospital, you are an outpatient and pay the cost sharing amounts for outpatient surgery. Even if you stay in the hospital overnight, you might still be considered an outpatient.</p>	<p><u>Ambulatory Surgical Center (including diagnostic colonoscopy):</u></p> <p>In-network: \$35 copay for certain wound care services 15% coinsurance for all other services (including associated professional fees)</p> <p>Out-of-network: 50% coinsurance</p> <p><u>Outpatient hospital services (including diagnostic colonoscopy):</u></p> <p>In-network: \$35 copay for certain wound care services 15% coinsurance for all other services (including associated professional fees)</p> <p>Out-of-network: 50% coinsurance</p>
<p>Palliative care and support *</p> <p>Palliative care and support are designed to provide specialized medical care through the provider network for people living with serious illness, focusing on providing relief from symptoms and stress, and to improve quality of life.</p> <p>Covered services include:</p> <ul style="list-style-type: none"> • A Specialty Palliative Care provider care team that works with you and your caregivers to: <ul style="list-style-type: none"> ○ Coordinate with current providers for care discussions and pain/symptom management (please note: some services are only available in a home, domiciliary, or rest home setting). ○ Find additional resources that may be beneficial to your family including psychosocial support to manage social, emotional, and spiritual needs ○ Advanced care planning assistance <p>For more information or to find out if you are eligible for this benefit, contact Customer Service or your provider's office.</p>	<p>In-network: \$0 copay per visit</p> <p>Out-of-network: 50% coinsurance</p>

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Services that are covered for you	What you must pay when you get these services
<p>Partial hospitalization services and Intensive outpatient services †</p> <p><i>Partial hospitalization</i> is a structured program of active psychiatric treatment provided as a hospital outpatient service, or by a community mental health center, that is more intense than the care received in your doctor's, therapist's, licensed marriage and family therapist's (LMFT), or licensed professional counselor's office and is an alternative to inpatient hospitalization.</p> <p><i>Intensive outpatient service</i> is a structured program of active behavioral (mental) health therapy treatment provided in a hospital outpatient department, a community mental health center, a Federally qualified health center, or a rural health clinic that is more intense than the care received in your doctor's, therapist's, licensed marriage and family therapist's (LMFT), or licensed professional counselor's office but less intense than partial hospitalization.</p>	<p>In-network: \$105 copay per day</p> <p>Out-of-network: 50% coinsurance</p>
<p>Physician/Practitioner services, including doctor's office visits</p> <p>Covered services include:</p> <ul style="list-style-type: none"> • Medically-necessary medical care or surgery services furnished in a physician's office, certified ambulatory surgical center, hospital outpatient department, or any other location • Consultation, diagnosis, and treatment by a specialist • Basic hearing and balance exams performed by your PCP or specialist, if your doctor orders it to see if you need medical treatment • Certain telehealth services, including specialist, cardiac rehabilitation, occupational therapy, physical and speech-language therapy, psychiatric, mental health, and urgent care services <ul style="list-style-type: none"> ○ You have the option of getting these services through an in-person visit or by telehealth. If you choose to get one of these services by telehealth, you must use a network provider who offers the service by telehealth. • Some telehealth services including consultation, diagnosis, and treatment by a physician or practitioner, for patients in certain rural areas or other places approved by Medicare • Telehealth services for monthly end-stage renal disease-related visits for home dialysis members in a hospital-based or critical access hospital-based renal dialysis center, renal dialysis facility, or the member's home • Telehealth services to diagnose, evaluate, or treat symptoms of a stroke, regardless of your location • Telehealth services for members with a substance use disorder or co-occurring mental health disorder, regardless of their location • Telehealth services for diagnosis, evaluation, and treatment of mental 	<p><u>Primary care provider (PCP):</u></p> <p>In-network: \$0 copay per provider per day</p> <p>Out-of-network: 50% coinsurance</p> <p><u>In-office Specialist visits:</u></p> <p>In-network: \$35 copay per provider per day</p> <p>Out-of-network: 50% coinsurance</p> <p><u>Virtual specialist visits:</u></p> <p>In-network: \$30 copay per provider per day</p> <p>Out-of-network: 50% coinsurance</p> <p><u>Professional services at an ASC or Outpatient hospital:</u></p> <p>In-network: 15% coinsurance</p> <p>Out-of-network: 50% coinsurance</p> <p>Services rendered in a hospital owned clinic or in an outpatient hospital may have associated facility charges. See the <i>Outpatient surgery, including</i></p>


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Services that are covered for you	What you must pay when you get these services
<p>health disorders if:</p> <ul style="list-style-type: none"> ○ You have an in-person visit within 6 months prior to your first telehealth visit ○ You have an in-person visit every 12 months while receiving these telehealth services ○ Exceptions can be made to the above for certain circumstances <ul style="list-style-type: none"> • Telehealth services for mental health visits provided by Rural Health Clinics and Federally Qualified Health Centers • Virtual check-ins (for example, by phone or video chat) with your doctor for 5-10 minutes if: <ul style="list-style-type: none"> ○ You're not a new patient and ○ The check-in isn't related to an office visit in the past 7 days and ○ The check-in doesn't lead to an office visit within 24 hours or the soonest available appointment • Evaluation of video and/or images you send to your doctor, and interpretation and follow-up by your doctor within 24 hours if: <ul style="list-style-type: none"> ○ You're not a new patient and ○ The evaluation isn't related to an office visit in the past 7 days and ○ The evaluation doesn't lead to an office visit within 24 hours or the soonest available appointment • Consultation your doctor has with other doctors by phone, internet, or electronic health record • Second opinion prior to surgery • Non-routine dental care (covered services are limited to surgery of the jaw or related structures, setting fractures of the jaw or facial bones, extraction of teeth to prepare the jaw for radiation treatments of neoplastic cancer disease, or services that would be covered when provided by a physician) 	<p><i>services provided at hospital outpatient facilities and ambulatory surgical centers</i></p> <p>section for cost-sharing amounts.</p>
<p>Podiatry services</p> <p>Covered services include:</p> <ul style="list-style-type: none"> • Diagnosis and the medical or surgical treatment of injuries and diseases of the feet (such as hammer toe or heel spurs) • Routine foot care for members with certain medical conditions affecting the lower limbs 	<p><u>Medicare-covered podiatry:</u></p> <p>In-network: \$35 copay per provider per day</p> <p>Out-of-network: 50% coinsurance</p> <p>Services rendered in a hospital owned clinic or in an outpatient hospital may have associated facility charges. See the <i>Outpatient surgery, including services provided at hospital outpatient facilities and ambulatory surgical centers</i> section for cost-sharing amounts.</p>




† Prior authorization is required for (certain) services

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Services that are covered for you	What you must pay when you get these services
<p>In addition to the Medicare-covered Podiatry services, we also cover:</p> <p>Routine podiatry services</p> <p>Additional routine foot care is covered for members with a diabetes diagnosis.</p> <p>Covered services limited to:</p> <ul style="list-style-type: none"> • Trimming/debridement of nails/tissue • 6 visits every calendar year. <p>Once limit is met, certain services may be covered with the <i>Podiatry services</i> benefit</p>	<p><u>Routine podiatry:</u></p> <p>In-network: \$0 copay per provider per day</p> <p>Out-of-network: 50% coinsurance</p>
<p> Prostate cancer screening exams</p> <p>For men aged 50 and older, covered services include the following once every calendar year:</p> <ul style="list-style-type: none"> • Digital rectal exam • Prostate Specific Antigen (PSA) test 	<p>In-network: There is no coinsurance, copayment, or deductible for an annual PSA test.</p> <p>Out-of-network: 50% coinsurance</p>
<p>Prosthetic and orthotic devices and related supplies †</p> <p>Devices (other than dental) that replace all or part of a body part or function. These include but are not limited to testing, fitting, or training in the use of prosthetic and orthotic devices; as well as: colostomy bags and supplies directly related to colostomy care, pacemakers, braces, prosthetic shoes, artificial limbs, and breast prostheses (including a surgical brassiere after a mastectomy). Includes certain supplies related to prosthetic and orthotic devices, and repair and/or replacement of prosthetic and orthotic devices. Also includes some coverage following cataract removal or cataract surgery – see Vision Care later in this section for more detail.</p>	<p>In-network: 20% coinsurance</p> <p>Out-of-network: 50% coinsurance</p>
<p>Pulmonary rehabilitation services</p> <p>Comprehensive programs of pulmonary rehabilitation are covered for members who have moderate to very severe chronic obstructive pulmonary disease (COPD) and an order for pulmonary rehabilitation from the doctor treating the chronic respiratory disease.</p>	<p>In-network: \$15 copay per provider per day</p> <p>Out-of-network: 50% coinsurance</p> <p>Services rendered in a hospital owned clinic or in an outpatient hospital may have associated facility charges. See the <i>Outpatient surgery, including services provided at hospital outpatient facilities and ambulatory surgical centers</i> section for cost-sharing amounts.</p>

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Services that are covered for you	What you must pay when you get these services
<p>Remote access technologies – Nursing hotline Regence Advice24</p> <p>Licensed nurses are available 24 hours a day, 7 days a week, to provide immediate support to answer health questions, assess symptoms and recommend care. This program can also serve as an early warning system to flag health conditions before they become serious. Call 1-800-310-2973 (TTY users should call 711.)</p>	<p>In-network only: There is no coinsurance, copayment, or deductible for the nursing hotline.</p>
<p> Screening and counseling to reduce alcohol misuse</p> <p>We cover one alcohol misuse screening for adults with Medicare (including pregnant women) who misuse alcohol but aren't alcohol dependent.</p> <p>If you screen positive for alcohol misuse, you can get up to four (4) brief face-to-face counseling sessions per year (if you're competent and alert during counseling) provided by a qualified primary care doctor or practitioner in a primary care setting.</p>	<p>In-network: There is no coinsurance, copayment, or deductible for the Medicare-covered screening and counseling to reduce alcohol misuse preventive benefit.</p> <p>Out-of-network: 50% coinsurance</p>
<p> Screening for lung cancer with low dose computed tomography (LDCT)</p> <p>For qualified individuals, a LDCT is covered every 12 months.</p> <p>Eligible members are: people aged 50 – 77 years who have no signs or symptoms of lung cancer, but who have a history of tobacco smoking of at least 20 pack-years and who currently smoke or have quit smoking within the last 15 years, who receive an order for LDCT during a lung cancer screening counseling and shared decision-making visit that meets the Medicare criteria for such visits and be furnished by a physician or qualified non-physician practitioner.</p> <p><i>For LDCT lung cancer screenings after the initial LDCT screening:</i> the member must receive an order for LDCT lung cancer screening, which may be furnished during any appropriate visit with a physician or qualified non-physician practitioner. If a physician or qualified non-physician practitioner elects to provide a lung cancer screening counseling and shared decision-making visit for subsequent lung cancer screenings with LDCT, the visit must meet the Medicare criteria for such visits.</p>	<p>In-network: There is no coinsurance, copayment, or deductible for the Medicare covered counseling and shared decision-making visit or for the LDCT.</p> <p>Out-of-network: 50% coinsurance</p>
<p> Screening for sexually transmitted infections (STIs) and counseling to prevent STIs</p> <p>We cover sexually transmitted infection (STI) screenings for chlamydia, gonorrhea, syphilis, and Hepatitis B. These screenings are covered for pregnant women and for certain people who are at increased risk for an STI when the tests are ordered by a primary care provider. We cover</p>	<p>In-network: There is no coinsurance, copayment, or deductible for the Medicare-covered screening for STIs and counseling for STIs preventive benefit.</p>


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Services that are covered for you	What you must pay when you get these services
<p>these tests once every 12 months or at certain times during pregnancy. We also cover up to two individual 20 to 30 minute, face-to-face high-intensity behavioral counseling sessions each year for sexually active adults at increased risk for STIs. We will only cover these counseling sessions as a preventive service if they are provided by a primary care provider and take place in a primary care setting, such as a doctor's office.</p>	<p>Out-of-network: 50% coinsurance</p>
<p>Services to treat kidney disease</p> <p>Covered services include:</p> <ul style="list-style-type: none"> Kidney disease education services to teach kidney care and help members make informed decisions about their care. For members with stage IV chronic kidney disease when referred by their doctor, we cover up to six sessions of kidney disease education services per lifetime Outpatient dialysis treatments (including dialysis treatments when temporarily out of the service area, as explained in Chapter 3) or when your provider for this service is temporarily unavailable or inaccessible Inpatient dialysis treatments (if you are admitted as an inpatient to a hospital for special care) † Self-dialysis training (includes training for you and anyone helping you with your home dialysis treatments) Home dialysis equipment and supplies Certain home support services (such as, when necessary, visits by trained dialysis workers to check on your home dialysis, to help in emergencies, and check your dialysis equipment and water supply) <p>Certain drugs for dialysis are covered under your Medicare Part B drug benefit. For information about coverage for Part B Drugs, please go to the section, Medicare Part B prescription drugs.</p>	<p>In-network: \$0 copay per session</p> <p>Out-of-network: 50% coinsurance</p> <p>In-network: 20% coinsurance</p> <p>Out-of-network: <u>Within the service area:</u> 50% coinsurance <u>Outside the service area temporarily:</u> 20% coinsurance</p> <p>In-network: Days 1–4: \$350 copay per day Days 5 and beyond: \$0 copay per day</p> <p>Out-of-network: 50% coinsurance</p> <p>Cost sharing is applied to each inpatient stay and is assessed from the date of admission through the last full day stayed.</p> <p>In-network: 20% coinsurance</p> <p>Out-of-network: 50% coinsurance</p>

† Prior authorization is required for (certain) services

* Copays, coinsurance and amounts beyond the benefit limits do not apply to any out-of-pocket maximums.

Services that are covered for you	What you must pay when you get these services
<p>Skilled nursing facility (SNF) care † (For a definition of skilled nursing facility care, see Chapter 12 of this document. Skilled nursing facilities are sometimes called SNFs.) No prior hospital stay is required. Covered services include but are not limited to:</p> <ul style="list-style-type: none"> • Semiprivate room (or a private room if medically necessary) • Meals, including special diets • Skilled 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 for whole blood, packed red cells and all other components of blood are covered beginning with the first unit used. • Medical and surgical supplies ordinarily provided by SNFs • Laboratory tests ordinarily provided by SNFs • X-rays and other radiology services ordinarily provided by SNFs • Use of appliances such as wheelchairs ordinarily provided by SNFs • Physician/Practitioner services <p>Generally, you will get your SNF care from network facilities. However, under certain conditions listed below, you may be able to pay in-network cost sharing for a facility that isn't a network provider, if the facility accepts our plan's amounts for payment.</p> <ul style="list-style-type: none"> • A nursing home or continuing care retirement community where you were living right before you went to the hospital (as long as it provides skilled nursing facility care) • A SNF where your spouse or domestic partner is living at the time you leave the hospital 	<p>In-network: Days 1–20: \$10 copay per day Days 21–49: \$214 copay per day Days 50–100: \$0 copay per day</p> <p>Out-of-network: 50% coinsurance</p> <p>You are covered up to 100 days each benefit period as long as you continue to meet medical necessity criteria.</p> <p>Benefit Period – The way that both our plan and Original Medicare measures your use of skilled nursing facility (SNF) services. A benefit period begins the day you go into a skilled nursing facility. The benefit period ends when you have not received any skilled care in a SNF for 60 days in a row. If you go into a skilled nursing facility after one benefit period has ended, a new benefit period begins. There is no limit to the number of benefit periods.</p>
<p> Smoking and tobacco use cessation (counseling to stop smoking or tobacco use)</p> <p><u>If you use tobacco, but do not have signs or symptoms of tobacco-related disease:</u> We cover two counseling quit attempts within a 12-month period as a preventive service with no cost to you. Each counseling attempt includes up to four face-to-face visits.</p> <p><u>If you use tobacco and have been diagnosed with a tobacco-related disease or are taking medicine that may be affected by tobacco:</u> We cover cessation counseling services. We cover two counseling quit attempts within a 12-month period, however, you will pay the applicable cost sharing. Each counseling attempt includes up to four face-to-face visits.</p>	<p>In-network: There is no coinsurance, copayment, or deductible for the Medicare-covered smoking and tobacco use cessation preventive benefits.</p> <p>Out-of-network: 50% coinsurance</p>


† Prior authorization is required for (certain) services

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Services that are covered for you	What you must pay when you get these services
<p>Supervised exercise therapy (SET)</p> <p>SET is covered for members who have symptomatic peripheral artery disease (PAD).</p> <p>Up to 36 sessions over a 12-week period are covered if the SET program requirements are met.</p> <p>The SET program must:</p> <ul style="list-style-type: none"> • Consist of sessions lasting 30-60 minutes, comprising a therapeutic exercise-training program for PAD in patients with claudication • Be conducted in a hospital outpatient setting or a physician's office • Be delivered by qualified auxiliary personnel necessary to ensure benefits exceed harms, and who are trained in exercise therapy for PAD • Be under the direct supervision of a physician, physician assistant, or nurse practitioner/clinical nurse specialist who must be trained in both basic and advanced life support techniques <p>SET may be covered beyond 36 sessions over 12 weeks for an additional 36 sessions over an extended period of time if deemed medically necessary by a health care provider.</p>	<p>In-network: \$25 copay per session</p> <p>Out-of-network: 50% coinsurance</p> <p>Services rendered in a hospital owned clinic or in an outpatient hospital may have associated facility charges. See the <i>Outpatient surgery, including services provided at hospital outpatient facilities and ambulatory surgical centers</i> section for cost-sharing amounts.</p>
<p>Urgently needed services</p> <p>A plan-covered service requiring immediate medical attention that is not an emergency is an urgently needed service if either you are temporarily outside the service area of the plan, or even if you are inside the service area of the plan, it is unreasonable given your time, place, and circumstances to obtain this service from network providers with whom the plan contracts with. Your plan must cover urgently needed services and only charge you in-network cost sharing. Examples of urgently needed services are unforeseen medical illnesses and injuries, or unexpected flare-ups of existing conditions. However, medically necessary routine provider visits, such as annual checkups, are not considered urgently needed even if you are outside the service area of the plan or the plan network is temporarily unavailable.</p> <p>Additionally, your plan offers virtual visits for urgent care, if your local care center is able. If they do not offer virtual visits, you may use Doctor On Demand. Through Doctor On Demand, you can access a doctor 24 hours a day, 7 days a week, by secure video, using your computer or mobile device such as a cellphone or tablet. Contact Doctor On Demand at 1-800-310-2973.</p> <p>The benefits listed in this section are for services within the United States and its territories. See <i>Worldwide emergency and urgent care</i> for coverage information while outside the U.S. and its territories.</p>	<p><u>Urgent care center office visit:</u> In- and Out-of-network: \$35 copay per visit</p> <p><u>Urgent care center virtual visit:</u> In- and Out-of-network: \$0 copay per visit</p> <p><u>Doctor On Demand telehealth visit:</u> In-network only: \$0 copay per visit</p>


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Services that are covered for you	What you must pay when you get these services
<p> Vision care</p> <p>Covered services include:</p> <ul style="list-style-type: none"> • Outpatient physician services for the diagnosis and treatment of diseases and injuries of the eye, including treatment for age-related macular degeneration. Original Medicare doesn't cover routine eye exams (eye refractions) for eyeglasses/contacts • For people who are at high risk of glaucoma, we will cover one glaucoma screening each year. People at high risk of glaucoma include people with a family history of glaucoma, people with diabetes, African Americans who are age 50 and older, and Hispanic Americans who are 65 or older • For people with diabetes, screening for diabetic retinopathy is covered once per year • One pair of eyeglasses or contact lenses after each cataract surgery that includes insertion of an intraocular lens. (If you have two separate cataract operations, you cannot reserve the benefit after the first surgery and purchase two eyeglasses after the second surgery.) <p>In addition to the Medicare-covered vision care services, we also cover:</p> <p>Routine vision exam *</p> <p>We cover 1 routine vision exam every calendar year</p> <p>Out-of-network services may require reimbursement from VSP.</p> <p><i>See Section 3.1 for exclusions</i></p> <p>Routine vision hardware *</p> <p>Covered services include:</p> <ul style="list-style-type: none"> • Frames – 1 set of frames every calendar year up to the allowance • Lenses – 1 set every calendar year – includes basic single vision, lined bifocal, lined trifocal and lenticular lenses only (additional upgrades, extra charges and/or any customizations are not covered, e.g., tintings, coatings and/or special lens materials). <ul style="list-style-type: none"> ○ Frames and lenses must be purchased from the same provider/location <p>OR</p> <ul style="list-style-type: none"> • Elective contact lenses – Limited to the allowance every calendar year. Charges for contact lens fitting evaluation are applied to the contact benefit and are subject to the benefit limit. 	<p><u>Medicare-covered vision care:</u></p> <p>In-network: \$0 copay per provider per day</p> <p>Out-of-network: 50% coinsurance</p> <p>Services rendered in a hospital owned clinic or in an outpatient hospital may have associated facility charges. See the <i>Outpatient surgery, including services provided at hospital outpatient facilities and ambulatory surgical centers</i> section for cost-sharing amounts.</p> <p><u>Routine vision exam:</u></p> <p>In-network: \$0 copay per visit</p> <p>Out-of-network: 50% coinsurance (based on billed charges)</p> <p>VSP providers must be used to receive the in-network benefit.</p> <p><u>Frames OR Elective contact lenses (in lieu of glasses):</u></p> <p>In- and Out-of-network: \$100 allowance every calendar year</p> <p><u>Lenses:</u></p> <p>In-network: \$0 copay</p> <p>Out-of-network: 50% coinsurance (based on billed charges)</p> <p><u>Contact lenses that are visually necessary when you have certain eye conditions (in lieu of glasses):</u></p>

† Prior authorization is required for (certain) services

* Copays, coinsurance and amounts beyond the benefit limits do not apply to any out-of-pocket maximums.

Services that are covered for you	What you must pay when you get these services
<ul style="list-style-type: none"> Contact lenses are in lieu of glasses <p>You are responsible for any amounts beyond the benefit limits. VSP providers must be used to receive the in-network benefit. Out-of-network services may require reimbursement from VSP.</p> <p><i>See Section 3.1 for exclusions</i></p>	<p>In-network: \$0 copay</p> <p>Out-of-network: 50% coinsurance (based on billed charges)</p>
<p> Welcome to Medicare preventive visit</p> <p>The plan covers the one-time Welcome to Medicare preventive visit. The visit includes a review of your health, as well as education and counseling about the preventive services you need (including certain screenings and shots (or vaccines)), and referrals for other care if needed.</p> <p>Important: We cover the Welcome to Medicare preventive visit only within the first 12 months you have Medicare Part B. When you make your appointment, let your doctor's office know you would like to schedule your Welcome to Medicare preventive visit.</p>	<p>In-network: There is no coinsurance, copayment, or deductible for the Welcome to Medicare preventive visit.</p> <p>Out-of-network: 50% coinsurance</p> <p>If you also are treated, monitored or have lab work for a new or existing medical condition during the same visit, the appropriate cost sharing will apply for care received for that medical condition.</p>
<p>Worldwide emergency and urgent care</p> <p>(For a definition of Emergency, Emergency care, and Urgently needed services, see Chapter 12 of this document)</p> <p>Worldwide urgent and emergency care is covered by our plan outside the United States and its territories.</p> <p>Coverage is limited to services that would be classified as emergency, urgently needed, or post-stabilization care had the services been provided in the United States.</p> <p>Ambulance services are only covered in situations when getting to the emergency room in any other manner could endanger your health. Certain transports will require prior authorization.</p> <p>You may need to pay for services upfront and submit to our plan for reimbursement (see Chapter 7, Section 2 <i>How to ask us to pay you back or to pay a bill you have received</i>).</p> <p>Please Note: We may not reimburse you for all your out-of-pocket expenses. See Chapter 3, Section 3.2 <i>Getting care when you have an urgent need for services</i> for more information.</p>	<p><u>Emergency or urgent care:</u> In- and Out-of-network: \$125 copay per visit</p> <p><u>Ambulance services:</u> In- and Out-of-network: \$275 copay per covered one-way transport</p> <p>You will be responsible for your cost sharing (copays or coinsurance) and any costs exceeding our allowed amount.</p> <p>See the <i>Inpatient hospital care</i> section for cost sharing information when your emergency care requires inpatient hospitalization. Additional benefit information is also located in the <i>Ambulance services</i>, <i>Emergency care</i>, or <i>Urgently needed services</i> sections.</p>

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Section 2.2 Getting care using our plan's optional visitor/traveler benefit

If you do not permanently move, but you are continuously away from our plan's service area for more than six months, we usually must disenroll you from our plan. However, we offer as a supplemental benefit, a visitor/traveler program which will allow you to remain enrolled in our plan when you are outside of our service area for less than 12 months. This program is available to all plan members who are temporarily in the visitor/traveler area. Under our visitor/traveler program, you may receive all plan covered services at in-network cost sharing when you use a participating network-sharing provider. Please contact the plan for assistance in locating a provider when using the visitor/traveler benefit.

If you are in the visitor/traveler area, you can stay enrolled in our plan for up to 12 months. If you have not returned to the plan's service area within 12 months, you will be disenrolled from the plan.

When traveling outside the plan service area, you can see any participating Blue Medicare Advantage PPO Network doctor or hospital and receive the highest level of benefits (in-network) through our visitor/traveler program. **However, be aware in some states the PPO network is not statewide.** You can also see non-contracted Medicare-eligible providers when you are in a Blue Medicare Advantage PPO Network service area but will have higher out-of-pocket costs.

To find a Blue Medicare Advantage PPO Network participating provider in your area, you can:

- Call 1-800-810-BLUE (1-800-810-2583)
- Visit www.bcbs.com to search online for participating providers
- Visit regence.com/member/finding-doctors (choose National Medicare Advantage)
- Call Customer Service

Your liability calculation

When you receive covered healthcare services outside of our service area from a Medicare Advantage PPO network provider, the cost of the service, on which your liability (copayment/coinsurance) is based, will be either:

- The Medicare allowable amount for covered services; or
- The amount the local Blue Medicare Advantage plan negotiates with its provider on behalf of our members. The amount negotiated may be either higher than, lower than, or equal to the Medicare allowable amount.

Nonparticipating healthcare providers outside our service area

When covered healthcare services are provided outside of our service area by nonparticipating healthcare providers, the amount(s) you pay for such services will be based on either Medicare's limiting charge where applicable or the provider's billed charge. Payments for out-of-network emergency services will be governed by applicable federal and state law.

SECTION 3 What services are not covered by the plan?

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

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

The chart below lists services and items that either are not covered under any condition or are covered only under specific conditions.

If you get services that are excluded (not covered), you must pay for them yourself except under the specific conditions listed below. Even if you receive the excluded services at an emergency facility, the excluded services are still not covered, and our plan will not pay for them.

The only exception is if the service is appealed and decided upon appeal to be a medical service that we should have paid for or covered because of your specific situation. (For information about appealing a decision we have made to not cover a medical service, go to Chapter 9, Section 5.3 in this document.)

Services not covered by Medicare	Not covered under any condition	Covered only under specific conditions
Acupuncture		Available for people with chronic low back pain under certain circumstances.
Cosmetic surgery or procedures		Covered in cases of an accidental injury or for improvement of the functioning of a malformed body member. Covered for all stages of reconstruction for a breast after a mastectomy, as well as for the unaffected breast to produce a symmetrical appearance.
Custodial care Custodial care is personal care that does not require the continuing attention of trained medical or paramedical personnel, such as care that helps you with activities of daily living, such as bathing or dressing.	Not covered under any condition	
Experimental medical and surgical procedures, equipment, and medications. Experimental procedures and items are those items and procedures determined by Original Medicare to not be generally accepted by the medical community.		May be covered by Original Medicare under a Medicare-approved clinical research study or by our plan. (See Chapter 3, Section 5 for more information on clinical research studies.)
Fees charged for care by your immediate relatives or members of your household. Medicare considers the following to be immediate relatives/household members: <ul style="list-style-type: none"> • Spouse • Natural or adoptive parent, child, and siblings • Stepparent, stepchild, and stepsiblings • Father-in-law, mother-in-law, son-in- 	Not covered under any condition	

Services not covered by Medicare	Not covered under any condition	Covered only under specific conditions
law, daughter-in-law, brother-in-law, and sister-in-law • Grandparent and grandchild • Spouse of grandparent and grandchild		
Full-time nursing care in your home	Not covered under any condition	
Home-delivered meals		Home delivered meals are covered only as described in Section 2.1 (<i>Medical Benefits Chart</i>) under Meal delivery service.
Homemaker services including basic household assistance, such as light housekeeping or light meal preparation	Not covered under any condition	
Naturopath services (uses natural or alternative treatments)	Not covered under any condition	
Non-routine dental care		Dental care required to treat illness or injury may be covered as inpatient or outpatient care. Coverage for dental care is limited to non-routine dental care as described in Section 2.1 (<i>Medical Benefits Chart</i>) under Dental Services and Physician/Practitioner services, including doctor's office visits. Additional dental care services, such as basic (Class II) and major (Class III) dental care services (e.g., fillings, crowns, dentures), are covered only as described in Section 2.1 (<i>Medical Benefits Chart</i>) under Dental services.
Non-transport ambulance calls, stretcher car, wheelchair transport or other transport for convenience	Not covered under any condition	
Orthopedic shoes or supportive devices for the feet		Shoes (orthopedic shoes, modifications, and inserts) that are part of a leg brace and are included in the cost of the brace. Orthopedic or therapeutic shoes for people with diabetic foot disease.
Personal items in your room at a hospital or a skilled nursing facility, such as a telephone or a television	Not covered under any condition	

Services not covered by Medicare	Not covered under any condition	Covered only under specific conditions
Private room in a hospital		Covered only when medically necessary.
Reproduction prevention services (e.g., intrauterine device (IUD), implants, vasectomy, tubal ligation)		May be covered when medically necessary for a Medicare-approved condition or diagnosis.
Reversal of sterilization procedures and/or non-prescription contraceptive supplies	Not covered under any condition	
Reward dollars cannot be used to purchase alcohol, cigarettes, firearms, ammunition, lottery, pornography, or prescription drugs	Not covered under any condition	
Routine chiropractic care		Manual manipulation of the spine to correct a subluxation is covered.
Routine dental care, such as cleanings, fillings, or dentures		Preventive dental services are covered only as described in Section 2.1 (<i>Medical Benefits Chart</i>) under Dental services. Preventive (Class I) dental care is limited to those services listed in the chart. Additional services, such as basic (Class II) and major (Class III) dental care services (e.g., fillings, crowns, dentures), are not covered under the preventive dental benefit.
Routine eye examinations, eyeglasses, radial keratotomy, LASIK surgery, and other low vision aids		Eye exam and one pair of eyeglasses (or contact lenses) are covered for people after cataract surgery. Additional routine vision services are covered only as described in Section 2.1 (<i>Medical Benefits Chart</i>) under Vision care.
Routine foot care		Some limited coverage provided according to Medicare guidelines (e.g., if you have diabetes). Additional routine podiatry services are covered only as described in Section 2.1 (<i>Medical Benefits Chart</i>) under Podiatry services.
Routine hearing exams, hearing aids, or exams to fit hearing aids		Routine hearing services are covered only as described in Section 2.1 (<i>Medical Benefits Chart</i>) under Hearing

Services not covered by Medicare	Not covered under any condition	Covered only under specific conditions
		services. Hearing aids and provider visits to service hearing aids (except as specifically described in the Covered Benefits), ear molds, hearing aid accessories, warranty claim fees, and hearing aid batteries (beyond the 80 free batteries per non-rechargeable aid purchased).
Services considered not reasonable and necessary, according to Original Medicare standards	Not covered under any condition	
Therapeutic massage	Not covered under any condition	

In addition to the exclusions in the General Exclusions listed above, we will not provide benefits for **any of the following conditions, treatments, services, supplies or accommodations, including any direct complications or consequences that arise from them**, for comprehensive dental services:

Aesthetic dental procedures – Services and supplies provided in connection with dental procedures that are primarily aesthetic, including bleaching of teeth.

Anesthesia – Services and supplies provided in connection with delivering the following types of anesthesia:

- regional and trigeminal division blocks
- evaluations
- deep sedation/ general
- nitrous oxide; and
- either intravenous or non-intravenous sedation

Antimicrobial agents – Localized delivery of antimicrobial agents into diseased crevicular tissue via a controlled release vehicle

Collection of cultures and specimens

Connector bar or stress breaker

Cosmetic/reconstructive services and supplies – Except for dentally appropriate services and supplies to treat a congenital anomaly and to restore a physical bodily function lost as a result of Injury or Illness, we do not cover cosmetic and/or reconstructive services and supplies.

Cosmetic means services or supplies that are applied to normal structures of the body primarily to improve or change appearance (for example, bleaching of teeth).

Reconstructive means services, procedures or surgery performed on abnormal structures of the body, caused by congenital anomalies, developmental abnormalities, trauma, infection, tumors or disease. It is generally performed to restore function, but, in the case of significant malformation, is also done to approximate a normal appearance.

Desensitizing – Application of desensitizing medicaments or desensitizing resin for cervical and/or root surface.

Diagnostic casts or study models

Duplicate x-rays – same date of service

Endodontic (root canal treatments) – Services and supplies provided in connection with certain endodontic treatments including, but not limited to:

- apicoectomy
- direct pulp capping
- indirect pulp capping; and
- pulp vitality tests

Expenses before coverage begins or after coverage ends – Services and supplies incurred before your effective date under the plan or after your termination under the plan.

Facility charges – Services and supplies provided in connection with facility services, including hospitalization for dentistry and extended-care facility visits.

Fees, taxes, interest – Charges for shipping and handling, postage, interest, or finance charges that a dentist might bill.

Fixed prosthodontics – Services and supplies provided in connection with the treatment of fixed partial denture pontics, retainers – inlays/onlays, and crowns.

Fractures of the mandible (Jaw) – Treatment may be covered under medical benefits. Services and supplies provided in connection with the treatment of simple or compound fractures of the mandible.

Gold-foil restorations

Home visits

Implants – Services and supplies provided in connection with implants, whether or not the implant itself is covered, including, but not limited to:

- pre-surgical services
- surgical services
- implant supported prosthetics
- implant/abutment supported dentures
- implant/abutment supported fixed dentures (hybrid prosthesis)
- single crowns, abutment supported
- single crowns, implant supported
- fixed partial denture retainer, abutment supported
- fixed partial denture retainer, implant supported; and
- other implant services

Inlay/Onlay restorations – Services associated with restorative inlay or onlay procedures.

Medications and supplies – Charges in connection with medication, including take home drugs, pre-medications, therapeutic drug injections and supplies associated with dental services are not covered.

Non-direct patient care – Charges or fees incurred for missed appointments, preparing or duplicating medical report/chart notes, and visits or consultations that are not in person, including telephone consultations and

email exchanges.

Not dentally appropriate – Services that are not considered dentally appropriate.

Occlusal treatment – Services and supplies provided in connection with dental occlusion, including the following:

- occlusal analysis and adjustments; and
- occlusal guards

Oral hygiene instructions

Oral surgery – Oral surgery treating any fractured jaw and orthognathic surgery. "Orthognathic surgery" means surgery to manipulate facial bones, including the jaw, in patients with facial bone abnormalities performed to restore the proper anatomic and functional relationship of the facial bones.

Orthodontic dental services – Services and supplies provided in connection with orthodontics, including the following:

- correction of malocclusion
- craniomandibular orthopedic treatment
- other orthodontic treatment
- preventive orthodontic procedures; and
- procedures for tooth movement, regardless of purpose

Out-of-network services – Services performed by an out-of-network dentist if your plan does not have out-of-network coverage.

Photographic images

Precision attachments

Procedures that are considered experimental, investigational, or unproven. This includes pharmacological regimens not accepted by the American Dental Association Council on dental therapeutics. The fact that an experimental, investigational or unproven service, treatment, device or pharmacological regimen is the only available treatment for a particular condition will not result in coverage if the procedure is considered to be experimental, investigational or unproven in the treatment of that particular condition.

Prosthesis – Services and supplies provided in connection with dental prosthesis, including the following:

- maxillofacial prosthetic procedures; and
- modification of removable prosthesis following implant surgery

Provisional splinting

Replacements – Services and supplies provided in connection with the replacement of any dental appliance (including, but not limited to, dentures and retainers), whether lost or stolen.

Self-help, self-care, training or instructional programs

Separate charges – Services and supplies that may be billed as separate charges (these are considered inclusive of the billed procedure), including the following:

- any supplies
- local anesthesia; and
- sterilization

Services for injuries or conditions covered by Workers' Compensation or employer liability laws, and service that are provided without cost to the covered persons by any municipality, county, or other political subdivision.

Services performed in a laboratory

Services rendered by a provider with the same legal residence – as a covered person or who is a member of a covered person's family, including a spouse, brother, sister, parent, or child.

Surgical procedures – Services and supplies provided in connection with the following surgical procedures:

- exfoliative cytology sample collection or brush biopsy
- incision and drainage of abscess extraoral soft tissue, complicated or non-complicated
- radical resection of maxilla or mandible
- removal of nonodontogenic cyst, tumor or lesion
- surgical stent; or
- surgical procedures for isolation of a tooth with rubber dam

Temporomandibular Joint (TMJ) disorder treatment – Treatment may be covered under medical benefits. Services and supplies provided in connection with temporomandibular joint (TMJ) disorder.

Tooth transplantation – Services and supplies provided in connection with tooth transplantation, including reimplantation from one site to another and splinting and/or stabilization.

Veneers

CHAPTER 5:

*Using the plan's coverage for Part D
prescription drugs*

SECTION 1 Introduction

This chapter **explains rules for using your coverage for Part D drugs**. Please see Chapter 4 for Medicare Part B drug benefits and hospice drug benefits.

Section 1.1 Basic rules for the plan's Part D drug coverage
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The plan will generally cover your drugs as long as you follow these basic rules:

- You must have a provider (a doctor, dentist, or other prescriber) write you a prescription, which must be valid under applicable state law.
- Your prescriber must not be on Medicare's Exclusion or Preclusion Lists.
- You generally must use a network pharmacy to fill your prescription. (See Section 2 in this chapter.)
Or you can fill your prescription through the plan's mail-order service.
- Your drug must be on the plan's *List of Covered Drugs (Formulary)* (we call it the Drug List for short). (See Section 3 in this chapter.)
- Your drug must be used for a medically accepted indication. A medically accepted indication is a use of the drug that is either approved by the Food and Drug Administration or supported by certain references. (See Section 3 in this chapter for more information about a medically accepted indication.)
- Your drug may require approval before we will cover it. (See Section 4 in this chapter for more information about restrictions on your coverage.)

SECTION 2 Fill your prescription at a network pharmacy or through the plan's mail-order service

Section 2.1 Use a network pharmacy

In most cases, your prescriptions are covered *only* if they are filled at the plan's network pharmacies. (See Section 2.5 for information about when we would cover prescriptions filled at out-of-network pharmacies.)

A network pharmacy is a pharmacy that has a contract with the plan to provide your covered prescription drugs. The term covered drugs means all of the Part D prescription drugs that are on the plan's Drug List.

Section 2.2 Network pharmacies

How do you find a network pharmacy in your area?

To find a network pharmacy, you can look in your *Pharmacy Directory*, visit our website (regence.com/medicare), and/or call Customer Service.

You may go to any of our network pharmacies. Some of our network pharmacies provide preferred cost sharing, which may be lower than the cost sharing at a pharmacy that offers standard cost sharing. The *Pharmacy Directory* will tell you which of the network pharmacies offer preferred cost sharing. Contact us to find out more about how your out-of-pocket costs could vary for different drugs.

What if the pharmacy you have been using leaves the network?

If the pharmacy you have been using leaves the plan's network, you will have to find a new pharmacy that is in the network. Or if the pharmacy you have been using stays within the network but is no longer offering preferred cost sharing, you may want to switch to a different network or preferred pharmacy, if available. To find another pharmacy in your area, you can get help from Customer Service or use the *Pharmacy Directory*. You can also find information on our website at regence.com/medicare.

What if you need a specialized pharmacy?

Some prescriptions must be filled at a specialized pharmacy. Specialized pharmacies include:

- Pharmacies that supply drugs for home infusion therapy.
- Pharmacies that supply drugs for residents of a long-term care (LTC) facility. Usually, a LTC facility (such as a nursing home) has its own pharmacy. If you have any difficulty accessing your Part D benefits in an LTC facility, please contact Customer Service.
- Pharmacies that serve the Indian Health Service / Tribal / Urban Indian Health Program (not available in Puerto Rico). Except in emergencies, only Native Americans or Alaska Natives have access to these pharmacies in our network.
- Pharmacies that dispense drugs that are restricted by the FDA to certain locations or that require special handling, provider coordination, or education on their use. To locate a specialized pharmacy, look in your *Pharmacy Directory* (regence.com/medicare) or call Customer Service.

Section 2.3	Using the plan's mail-order service
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Our plan's mail-order service allows you to order **up to a 100-day supply**.

We offer mail-order services in with two cost sharing options: Preferred *and* Standard. Costs may be less when you receive your prescription from our preferred mail-order pharmacy. To find a participating preferred mail-order pharmacy, please contact Customer Service or visit our website regence.com/medicare to view the *Pharmacy Directory*.

To get order forms and information about filling your prescriptions by mail please contact Customer Service or visit regence.com/medicare.

Usually, a mail-order pharmacy order will be delivered to you in no more than 10 days. If your order is delayed, you can request a 7-day supply from your doctor to fill at a retail pharmacy while you wait for your mail-order prescription to arrive

For Preferred mail-order pharmacies:

New prescriptions the pharmacy receives directly from your doctor's office.

After the pharmacy receives a prescription from a health care provider, it will contact you to see if you want the medication filled immediately or at a later time. It is important that you respond each time you are contacted by the pharmacy, to let them know whether to ship, delay, or stop the new prescription.

Refills on mail-order prescriptions.

For refills, please contact your pharmacy 10 days before your current prescription will run out to make sure your next order is shipped to you in time.

For Standard mail-order pharmacies:

New prescriptions the pharmacy receives directly from your doctor's office.

The pharmacy will automatically fill and deliver new prescriptions it receives from health care providers, without checking with you first, if either:

- You used mail-order services with this plan in the past, or
- You sign up for automatic delivery of all new prescriptions received directly from health care providers. You may request automatic delivery of all new prescriptions at any time by contacting your mail-order pharmacy directly.

If you receive a prescription automatically by mail that you do not want, and you were not contacted to see if you wanted it before it shipped, you may be eligible for a refund.

If you used mail order in the past and do not want the pharmacy to automatically fill and ship each new prescription, please contact your mail-order pharmacy directly, either by phone or by logging into your account.

If you have never used our mail-order delivery and/or decide to stop automatic fills of new prescriptions, the pharmacy will contact you each time it gets a new prescription from a health care provider to see if you want the medication filled and shipped immediately. It is important that you respond each time you are contacted by the pharmacy, to let them know whether to ship, delay, or cancel the new prescription.

To opt out of automatic deliveries of new prescriptions received directly from your health care provider's office, please contact your mail-order pharmacy directly, either by phone or by logging into your account.

Refills on mail-order prescriptions.

For refills of your drugs, you have the option to sign up for an automatic refill program. Under this program we will start to process your next refill automatically when our records show you should be close to running out of your drug. The pharmacy will contact you prior to shipping each refill to make sure you need more medication, and you can cancel scheduled refills if you have enough of your medication or if your medication has changed.

If you choose not to use our auto-refill program but still want the mail-order pharmacy to send you your prescription, please contact your pharmacy 10 business days before your current prescription will run out. This will ensure your order is shipped to you in time.

To opt out of our program that automatically prepares mail-order refills, please contact your mail-order pharmacy directly by phone or by logging into your account.

If you receive a refill automatically by mail that you do not want, you may be eligible for a refund.

Section 2.4	How can you get a long-term supply of drugs?
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When you get a long-term supply of drugs, your cost sharing may be lower. The plan offers two ways to get a long-term supply (also called an extended supply) of maintenance drugs on our plan's Drug List. (Maintenance drugs are drugs that you take on a regular basis, for a chronic or long-term medical condition.)

1. Some retail pharmacies in our network allow you to get a long-term supply of maintenance drugs (which offer preferred cost sharing) at a lower cost sharing amount. Other retail pharmacies may not agree to the lower cost sharing amounts. In this case you will be responsible for the difference in price. Your *Pharmacy Directory* (regence.com/medicare) tells you which pharmacies in our network can give you a long-term supply of maintenance drugs. You can also call Customer Service for more information.

2. You may also receive maintenance drugs through our mail-order program. Please see Section 2.3 for more information.

Section 2.5	When can you use a pharmacy that is not in the plan's network?
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Your prescription may be covered in certain situations

Generally, we cover drugs filled at an out-of-network pharmacy *only* when you are not able to use a network pharmacy. To help you, we have network pharmacies outside of our service area where you can get your prescriptions filled as a member of our plan. **Please check first with Customer Service** to see if there is a network pharmacy nearby. You may be required to pay the difference between what you pay for the drug at the out-of-network pharmacy and the cost that we would cover at an in-network pharmacy.

Here are the circumstances when we would cover prescriptions filled at an out-of-network pharmacy:

- When you fill a prescription at an out-of-network pharmacy, you are limited to a maximum 30-day supply.
- We will cover prescriptions that are filled at an out-of-network pharmacy if you are traveling within the United States and territories and become ill, lose or run out of your prescription drugs. In this situation, you may have to pay the full cost (rather than paying just your copayment or coinsurance) when you fill your prescription. **We cannot pay for any prescriptions that are filled by pharmacies, or are obtained, outside of the United States and territories, including cruise ships, even for a medical emergency.**
- We will cover prescriptions that are filled at an out-of-network pharmacy if the prescriptions are related to care for a medical emergency or urgent care. In this situation, you may have to pay the full cost (rather than paying just your co-payment or coinsurance) when you fill your prescription. (See Chapter 7, Section 2 for information on how to ask the plan to pay you back.)
- We will cover prescriptions that are filled at an out-of-network pharmacy if you are unable to obtain a covered drug in a timely manner within our service area because there is no network pharmacy within a reasonable driving distance that provides 24-hour service, or because the in-network pharmacies do not have the covered drug in stock.
- Hospitals and physician's offices are generally considered out-of-network pharmacies and drugs or immunizations dispensed in these locations may be paid at the out-of-network benefit. We will cover eligible drugs that are considered take home, self-administered, or that are dispensed while admitted as an outpatient at the out-of-network benefit. See Chapter 6, Section 7 "*Part D Vaccines. What you pay for depends on how and where you get them*".
- We will cover prescriptions that are filled at an out-of-network pharmacy during any Federal disaster declaration or other public health emergency declaration in which you are evacuated or otherwise displaced from your place of residence.

How do you ask for reimbursement from the plan?

If you must use an out-of-network pharmacy, you will generally have to pay the full cost (rather than your normal cost share) at the time you fill your prescription. You can ask us to reimburse you for our share of the cost. (Chapter 7, Section 2 explains how to ask the plan to pay you back.)

SECTION 3 Your drugs need to be on the plan's Drug List

Section 3.1 The Drug List tells which Part D drugs are covered

The plan has a *List of Covered Drugs (Formulary)*. In this *Evidence of Coverage*, we call it the **Drug List for short**.

The drugs on this list are selected by the plan with the help of a team of doctors and pharmacists. The list meets Medicare's requirements and has been approved by Medicare.

The drugs on the Drug List are only those covered under Medicare Part D.

We will generally cover a drug on the plan's Drug List as long as you follow the other coverage rules explained in this chapter and the drug is used for a medically accepted indication. A medically accepted indication is a use of the drug that is *either*:

- Approved by the Food and Drug Administration for the diagnosis or condition for which it is being prescribed, or
- Supported by certain references, such as the American Hospital Formulary Service Drug Information and the Micromedex DRUGDEX Information System.

The Drug List includes brand name drugs, generic drugs, and biological products (which may include biosimilars).

A brand name drug is a prescription drug that is sold under a trademarked name owned by the drug manufacturer. Biological products are drugs that are more complex than typical drugs. On the Drug List, when we refer to drugs, this could mean a drug or a biological product.

A generic drug is a prescription drug that has the same active ingredients as the brand name drug. Biological products have alternatives that are called biosimilars. Generally, generics and biosimilars work just as well as the brand name drug or original biological product and usually cost less. There are generic drug substitutes available for many brand name drugs and biosimilar alternatives for some original biological products. Some biosimilars are interchangeable biosimilars and, depending on state law, may be substituted for the original biological product at the pharmacy without needing a new prescription, just like generic drugs can be substituted for brand name drugs.

See Chapter 12 for definitions of the types of drugs that may be on the Drug List.

Over-the-Counter Drugs

Our plan also covers certain over-the-counter drugs. Some over-the-counter drugs are less expensive than prescription drugs and work just as well. For more information, call Customer Service. For over-the-counter items covered by the medical part of your benefits, refer to Chapter 4, Section 2.1 (*Medical Benefits Chart*) under Blue FlexDollars™ for Over-the-counter (OTC) and home and bathroom safety devices. Coverage for insulin pens, syringes and needles, alcohol swabs and pads, and gauze pads related to insulin injections, is provided under the Part D prescription benefits.

What is *not* on the Drug List?

The plan does not cover all prescription drugs.

- In some cases, the law does not allow any Medicare plan to cover certain types of drugs. (For more

information about this, see Section 7.1 in this chapter.)

- In other cases, we have decided not to include a particular drug on the Drug List. In some cases, you may be able to obtain a drug that is not on the Drug List. (For more information, please see Chapter 9.)

Section 3.2 There are five cost sharing tiers for drugs on the Drug List

Every drug on the plan's Drug List is in one of five cost sharing tiers. In general, the higher the cost sharing tier, the higher your cost for the drug:

- **Tier 1: Preferred Generic** – Contains only preferred generic products. A generic drug is a drug that has been approved by the FDA as having the same active ingredient (chemically identical) as the brand name drug and meets the same standards for safety, purity, and effectiveness. Generic drugs marketed without brand names are generally less expensive than brand name drugs.
- **Tier 2: Generic** – Contains drugs that are higher in cost than our preferred generic products. A generic drug is a drug that has been approved by the FDA as having the same active ingredient (chemically identical) as the brand name drug and meets the same standards for safety, purity and effectiveness. Generic drugs marketed without brand names are generally less expensive than brand name drugs.
- **Tier 3: Preferred Brand** – A drug that has been selected by an independent panel of physicians and pharmacists who recommended it to be the best overall value. This is based upon its clinical value, safety, and cost effectiveness. This tier may contain generic products.
- **Tier 4: Non-Preferred Drugs** – A drug that has been reviewed by an independent panel of physicians and pharmacists. Based on clinical value, safety and cost effectiveness, they have determined that the drugs in this category have a therapeutic alternative in Tier 1–Preferred Generics, Tier 2–Generics or Tier 3–Preferred Brands. Some of the drugs in this category also have a generic equivalent in Tier 1–Preferred Generics or Tier 2–Generics that is often a better value.
- **Tier 5: Specialty** - Specialty tier drugs are high-cost medications and biologicals, regardless of how they are administered (injectable, infusible, oral, transdermal or inhaled). These medications are often used to treat complex clinical conditions and may require close management by a physician because of their potential side effects or the need for frequent dosage adjustments. This tier may contain generic products and is limited to a 30-day supply.

To find out which cost sharing tier your drug is in, look it up in the plan's Drug List.

The amount you pay for drugs in each cost sharing tier is shown in Chapter 6 (*What you pay for your Part D prescription drugs*).

Section 3.3 How can you find out if a specific drug is on the Drug List?

You have four ways to find out:

1. Check the most recent Drug List we provided electronically.
2. Visit the plan's website (regence.com/medicare). The Drug List on the website is always the most current.
3. Call Customer Service to find out if a particular drug is on the plan's Drug List or to ask for a copy of the list.
4. Use the plan's "Real-Time Benefit Tool" (regence.com/medicare or by calling Customer Service). With this tool you can search for drugs on the Drug List to see an estimate of what you will pay and if

there are alternative drugs on the Drug List that could treat the same condition.

SECTION 4 There are restrictions on coverage for some drugs

Section 4.1 Why do some drugs have restrictions?
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For certain prescription drugs, special rules restrict how and when the plan covers them. A team of doctors and pharmacists developed these rules to encourage you and your provider to use drugs in the most effective ways. To find out if any of these restrictions apply to a drug you take or want to take, check the Drug List. If a safe, lower-cost drug will work just as well medically as a higher-cost drug, the plan's rules are designed to encourage you and your provider to use that lower-cost option.

Please note that sometimes a drug may appear more than once in our Drug List. This is because the same drugs can differ based on the strength, amount, or form of the drug prescribed by your health care provider, and different restrictions or cost sharing may apply to the different versions of the drug (for instance, 10 mg versus 100 mg; one per day versus two per day; tablet versus liquid).

Section 4.2 What kinds of restrictions?

The sections below tell you more about the types of restrictions we use for certain drugs.

If there is a restriction for your drug, it usually means that you or your provider will have to take extra steps in order for us to cover the drug. Contact Customer Service to learn what you or your provider would need to do to get coverage for the drug. If you want us to waive the restriction for you, you will need to use the coverage decision process and ask us to make an exception. We may or may not agree to waive the restriction for you. (See Chapter 9.)

Getting plan approval in advance

For certain drugs, you or your provider need to get approval from the plan before we will agree to cover the drug for you. This is called **prior authorization**. This is put in place to ensure medication safety and help guide appropriate use of certain drugs. If you do not get this approval, your drug might not be covered by the plan.

Quantity limits

For certain drugs, we limit how much of a drug you can get each time you fill your prescription. For example, if it is normally considered safe to take only one pill per day for a certain drug, we may limit coverage for your prescription to no more than one pill per day.

SECTION 5 What if one of your drugs is not covered in the way you'd like it to be covered?

Section 5.1 There are things you can do if your drug is not covered in the way you'd like it to be covered
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There are situations where there is a prescription drug you are taking, or one that you and your provider think you should be taking that is not on our formulary or is on our formulary with restrictions. For example:

- The drug might not be covered at all. Or maybe a generic version of the drug is covered but the brand name version you want to take is not covered.
- The drug is covered, but there are extra rules or restrictions on coverage for that drug, as explained in Section 4.
- The drug is covered, but it is in a cost sharing tier that makes your cost sharing more expensive than you think it should be.
- There are things you can do if your drug is not covered in the way that you'd like it to be covered. If your drug is not on the Drug List or if your drug is restricted, go to Section 5.2 to learn what you can do.
- If your drug is in a cost sharing tier that makes your cost more expensive than you think it should be, go to Section 5.3 to learn what you can do.

Section 5.2	What can you do if your drug is not on the Drug List or if the drug is restricted in some way?
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If your drug is not on the Drug List or is restricted, here are options:

- You may be able to get a temporary supply of the drug.
- You can change to another drug.
- You can request an exception and ask the plan to cover the drug or remove restrictions from the drug.

You may be able to get a temporary supply

Under certain circumstances, the plan must provide a temporary supply of a drug that you are already taking. This temporary supply gives you time to talk with your provider about the change.

To be eligible for a temporary supply, the drug you have been taking **must no longer be on the plan's Drug List OR is now restricted in some way.**

- **If you are a new member**, we will cover a temporary supply of your drug during the first **90 days** of your membership in the plan.
- **If you were in the plan last year**, we will cover a temporary supply of your drug during the first 90 days of the calendar year.

This temporary supply will be for a maximum of a one-month (30-day) supply. If your prescription is written for fewer days, we will allow multiple fills to provide up to a maximum of a one-month (30-day) supply of medication. The prescription must be filled at a network pharmacy. (Please note that the long-term care pharmacy may provide the drug in smaller amounts at a time to prevent waste.)

- **For those members who have been in the plan for more than 90 days and reside in a long-term care facility and need a supply right away:**

We will cover one 31-day supply emergency supply of a particular drug, or less if your prescription is written for fewer days. This is in addition to the above temporary supply.

- **For those members who have been in the plan for more than 90 days and have a level-of-care change from one treatment setting to another:**

You may have changes that take you from one treatment setting to another. During this level of care change, drugs may be prescribed that are not covered by your plan. If this happens, you and your doctor must use your plan's exception and appeals processes. However, when you are admitted to, or discharged

from, a long-term care setting, you may not have access to the drugs you were previously given. You may get a refill upon admission or discharge to prevent a gap in care.

For questions about a temporary supply, call Customer Service.

During the time when you are using a temporary supply of a drug, you should talk with your provider to decide what to do when your temporary supply runs out. You have two options:

1) You can change to another drug

Talk with your provider about whether there is a different drug covered by the plan that may work just as well for you. You can call Customer Service to ask for a list of covered drugs that treat the same medical condition. This list can help your provider find a covered drug that might work for you.

2) You can ask for an exception

You and your provider can ask the plan to make an exception and cover the drug in the way you would like it covered. If your provider says that you have medical reasons that justify asking us for an exception, your provider can help you request an exception. For example, you can ask the plan to cover a drug even though it is not on the plan's Drug List. Or you can ask the plan to make an exception and cover the drug without restrictions.

If you are a current member and a drug you are taking will be removed from the formulary or restricted in some way for next year, we will tell you about any change prior to the new year. You can ask for an exception before next year and we will give you an answer within 72 hours after we receive your request (or your prescriber's supporting statement). If we approve your request, we will authorize the coverage before the change takes effect.

If you and your provider want to ask for an exception, Chapter 9, Section 6.4 tells you what to do. It explains the procedures and deadlines that have been set by Medicare to make sure your request is handled promptly and fairly.

Section 5.3	What can you do if your drug is in a cost sharing tier you think is too high?
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If your drug is in a cost sharing tier you think is too high, here are things you can do:

You can change to another drug

If your drug is in a cost sharing tier you think is too high, talk to your provider. There may be a different drug in a lower cost sharing tier that might work just as well for you. Call Customer Service to ask for a list of covered drugs that treat the same medical condition. This list can help your provider find a covered drug that might work for you.

You can ask for an exception

You and your provider can ask the plan to make an exception in the cost sharing tier for the drug so that you pay less for it. If your provider says that you have medical reasons that justify asking us for an exception, your provider can help you request an exception to the rule.

If you and your provider want to ask for an exception, Chapter 9, Section 6.4 tells what to do. It explains the procedures and deadlines that have been set by Medicare to make sure your request is handled promptly and fairly.

Drugs in our Tier 5 – Specialty tier are not eligible for this type of exception. We do not lower the cost sharing amount for drugs in this tier.

SECTION 6 What if your coverage changes for one of your drugs?

Section 6.1 The Drug List can change during the year

Most of the changes in drug coverage happen at the beginning of each year (January 1). However, during the year, the plan can make some changes to the Drug List. For example, the plan might:

- **Add or remove drugs from the Drug List.**
- **Move a drug to a higher or lower cost sharing tier.**
- **Add or remove a restriction on coverage for a drug.**
- **Replace a brand name drug with a generic version of the drug.**
- **Replace an original biological product with an interchangeable biosimilar version of the biological product.**

We must follow Medicare requirements before we change the plan's Drug List.

See Chapter 12 for definitions of the drug types discussed in this chapter.

Section 6.2 What happens if coverage changes for a drug you are taking?

Information on changes to drug coverage

When changes to the Drug List occur, we post information on our website about those changes. We also update our online Drug List regularly. This section describes the types of changes we may make to the Drug List and when you will get direct notice if changes are made for a drug that you are taking.

Changes we may make to the Drug List that affect you during the current plan year

- **Adding new drugs to the Drug List and immediately removing or making changes to a like drug on the Drug List.**
 - When adding a new version of a drug to the Drug List, we may immediately remove a like drug from the Drug List, move the like drug to a different cost sharing tier, add new restrictions, or both. The new version of the drug will be on the same or a lower cost sharing tier and with the same or fewer restrictions.
 - We will make these immediate changes only if we are adding a new generic version of a brand name or adding certain new biosimilar versions of an original biological product that was already on the Drug List.
 - We may make these changes immediately and tell you later, even if you are taking the drug that we are removing or making changes to. If you are taking the like drug at the time we make the change, we will tell you about any specific change we made.
- **Adding drugs to the Drug List and removing or making changes to a like drug on the Drug List with advance notice.**
 - When adding another version of a drug to the Drug List, we may remove a like drug from the Drug List, move it to a different cost sharing tier, add new restrictions, or both. The version of the drug that we add will be on the same or a lower cost sharing tier and with the same or fewer restrictions.

- We will make these changes only if we are adding a new generic version of a brand name drug or adding certain new biosimilar versions of an original biological product that was already on the Drug List.
- We will tell you at least 30 days before we make the change, or tell you about the change and cover a 30-day fill of the version of the drug you are taking.
- **Removing unsafe drugs and other drugs on the Drug List that are withdrawn from the market.**
 - Sometimes a drug may be deemed unsafe or taken off the market for another reason. If this happens, we may immediately remove the drug from the Drug List. If you are taking that drug, we will tell you after we make the change.
- **Making other changes to drugs on the Drug List.**
 - We may make other changes once the year has started that affect drugs you are taking. For example, we based on FDA boxed warnings or new clinical guidelines recognized by Medicare.
 - We will tell you at least 30 days before we make these changes, or tell you about the change and cover an additional 30-day fill of the drug you are taking.

If we make any of these changes to any of the drugs you are taking, talk with your prescriber about the options that would work best for you, including changing to a different drug to treat your condition, or requesting a coverage decision to satisfy any new restrictions on the drug you are taking. You or your prescriber can ask us for an exception to continue covering the drug or version of the drug you have been taking. For more information on how to ask for a coverage decision, including an exception, see Chapter 9.

Changes to the Drug List that do not affect you during the current plan year

We may make certain changes to the Drug List that are not described above. In these cases, the change will not apply to you if you are taking the drug when the change is made; however, these changes will likely affect you starting January 1 of the next plan year if you stay in the same plan.

In general, changes that will not affect you during the current plan year are:

- We move your drug into a higher cost sharing tier.
- We put a new restriction on the use of your drug.
- We remove your drug from the Drug List.

If any of these changes happen for a drug you are taking (except for market withdrawal, a generic drug replacing a brand name drug, or other change noted in the sections above), the change won't affect your use or what you pay as your share of the cost until January 1 of the next year.

We will not tell you about these types of changes directly during the current plan year. You will need to check the Drug List for the next plan year (when the list is available during the open enrollment period) to see if there are any changes to the drugs you are taking that will impact you during the next plan year.

SECTION 7 What types of drugs are *not* covered by the plan?

Section 7.1	Types of drugs we do not cover
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This section tells you what kinds of prescription drugs are excluded. This means Medicare does not pay for these drugs.

If you get drugs that are excluded, you must pay for them yourself. If you appeal and the requested drug is found not to be excluded under Part D, we will pay for or cover it. (For information about appealing a decision, go to Chapter 9.)

Here are three general rules about drugs that Medicare drug plans will not cover under Part D:

- Our plan's Part D drug coverage cannot cover a drug that would be covered under Medicare Part A or Part B.
- Our plan cannot cover a drug purchased outside the United States or its territories.
- Our plan cannot cover *off-label* use of a drug when the use is not supported by certain references, such as the American Hospital Formulary Service Drug Information and the Micromedex DRUGDEX Information System. *Off-label* use is any use of the drug other than those indicated on a drug's label as approved by the Food and Drug Administration.

In addition, by law, the following categories of drugs are not covered by Medicare drug plans:

- Non-prescription drugs (also called over-the-counter drugs).
- Drugs used to promote fertility.
- Drugs used for the relief of cough or cold symptoms.
- Drugs used for cosmetic purposes or to promote hair growth.
- Prescription vitamins and mineral products, except prenatal vitamins and fluoride preparations.
- Drugs used for the treatment of sexual or erectile dysfunction.
- Drugs used for treatment of anorexia, weight loss, or weight gain.
- Outpatient drugs for which the manufacturer seeks to require that associated tests or monitoring services be purchased exclusively from the manufacturer as a condition of sale.

If you are receiving "Extra Help" to pay for your prescriptions, the "Extra Help" program will not pay for the drugs not normally covered. However, if you have drug coverage through Medicaid, your state Medicaid program may cover some prescription drugs not normally covered in a Medicare drug plan. Please contact your state Medicaid program to determine what drug coverage may be available to you. (You can find phone numbers and contact information for Medicaid in Chapter 2, Section 6 (contact information can also be found in "Exhibit A" in the back of this document).)

SECTION 8 Filling a prescription

Section 8.1 Provide your membership information

To fill your prescription, provide your plan membership information, which can be found on your membership card, at the network pharmacy you choose. The network pharmacy will automatically bill the plan for *our* share of your drug cost. You will need to pay the pharmacy *your* share of the cost when you pick up your prescription.

Section 8.2 What if you don't have your membership information with you?

If you don't have your plan membership information with you when you fill your prescription, you or the pharmacy can call the plan to get the necessary information, or you can ask the pharmacy to look up your plan

enrollment information.

If the pharmacy is not able to get the necessary information, **you may have to pay the full cost of the prescription when you pick it up.** (You can then **ask us to reimburse you** for our share. See Chapter 7, Section 2 for information about how to ask the plan for reimbursement.)

SECTION 9 Part D drug coverage in special situations

Section 9.1	What if you're in a hospital or a skilled nursing facility for a stay that is covered by the plan?
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If you are admitted to a hospital or to a skilled nursing facility for a stay covered by the plan, we will generally cover the cost of your prescription drugs during your stay. Once you leave the hospital or skilled nursing facility, the plan will cover your prescription drugs as long as the drugs meet all of our rules for coverage described in this Chapter.

Section 9.2	What if you're a resident in a long-term care (LTC) facility?
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Usually, a long-term care (LTC) facility (such as a nursing home) has its own pharmacy or uses a pharmacy that supplies drugs for all of its residents. If you are a resident of an LTC facility, you may get your prescription drugs through the facility's pharmacy or the one it uses, as long as it is part of our network.

Check your *Pharmacy Directory* (regence.com/medicare) to find out if your LTC facility's pharmacy or the one that it uses is part of our network. If it isn't, or if you need more information or assistance, please contact Customer Service. If you are in an LTC facility, we must ensure that you are able to routinely receive your Part D benefits through our network of LTC pharmacies.

What if you're a resident in a long-term care (LTC) facility and need a drug that is not on our Drug List or is restricted in some way?

Please refer to Section 5.2 about a temporary or emergency supply.

Section 9.3	What if you're also getting drug coverage from an employer or retiree group plan?
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If you currently have other prescription drug coverage through your (or your spouse or domestic partner's) employer or retiree group, please contact **that group's benefits administrator**. They can help you determine how your current prescription drug coverage will work with our plan.

In general, if you have employee or retiree group coverage, the drug coverage you get from us will be *secondary* to your group coverage. That means your group coverage would pay first.

Special note about creditable coverage:

Each year your employer or retiree group should send you a notice that tells if your prescription drug coverage for the next calendar year is creditable.

If the coverage from the group plan is creditable, it means that the plan has drug coverage that is expected to pay, on average, at least as much as Medicare's standard prescription drug coverage.

Keep this notice about creditable coverage because you may need it later. If you enroll in a Medicare plan that includes Part D drug coverage, you may need these notices to show that you have maintained creditable coverage. If you didn't get the creditable coverage notice, request a copy from the employer or retiree group's benefits administrator or the employer or union.

Section 9.4 What if you're in Medicare-certified hospice?

Hospice and our plan do not cover the same drug at the same time. If you are enrolled in Medicare hospice and require certain drugs (e.g., anti-nausea drugs, laxatives, pain medication or anti-anxiety drugs) that are not covered by your hospice because it is unrelated to your terminal illness and related conditions, our plan must receive notification from either the prescriber or your hospice provider that the drug is unrelated before our plan can cover the drug. To prevent delays in receiving these drugs that should be covered by our plan, ask your hospice provider or prescriber to provide notification before your prescription is filled.

In the event you either revoke your hospice election or are discharged from hospice, our plan should cover your drugs as explained in this document. To prevent any delays at a pharmacy when your Medicare hospice benefit ends, bring documentation to the pharmacy to verify your revocation or discharge.

SECTION 10 Programs on drug safety and managing medications

Section 10.1 Programs to help members use drugs safely

We conduct drug use reviews for our members to help make sure that they are getting safe and appropriate care.

We do a review each time you fill a prescription. We also review our records on a regular basis. During these reviews, we look for potential problems such as:

- Possible medication errors
- Drugs that may not be necessary because you are taking another similar drug to treat the same condition
- Drugs that may not be safe or appropriate because of your age or gender
- Certain combinations of drugs that could harm you if taken at the same time
- Prescriptions for drugs that have ingredients you are allergic to
- Possible errors in the amount (dosage) of a drug you are taking
- Unsafe amounts of opioid pain medications

If we see a possible problem in your use of medications, we will work with your provider to correct the problem.

Section 10.2 Drug Management Program (DMP) to help members safely use their opioid medications

We have a program that helps make sure members safely use prescription opioids and other frequently abused medications. This program is called a Drug Management Program (DMP). If you use opioid medications that you get from several prescribers or pharmacies, or if you had a recent opioid overdose, we may talk to your prescribers to make sure your use of opioid medications is appropriate and medically necessary. Working with

your prescribers, if we decide your use of prescription opioid or benzodiazepine medications may not be safe, we may limit how you can get those medications. If we place you in our DMP, the limitations may be:

- Requiring you to get all your prescriptions for opioid or benzodiazepine medications from a certain pharmacy(ies)
- Requiring you to get all your prescriptions for opioid or benzodiazepine medications from a certain prescriber(s)
- Limiting the amount of opioid or benzodiazepine medications we will cover for you

If we plan on limiting how you may get these medications or how much you can get, we will send you a letter in advance. The letter will tell you if we will limit coverage of these drugs for you, or if you'll be required to get the prescriptions for these drugs only from a specific prescriber or pharmacy. You will have an opportunity to tell us which prescribers or pharmacies you prefer to use, and about any other information you think is important for us to know. After you've had the opportunity to respond, if we decide to limit your coverage for these medications, we will send you another letter confirming the limitation. If you think we made a mistake or you disagree with our decision or with the limitation, you and your prescriber have the right to appeal. If you appeal, we will review your case and give you a new decision. If we continue to deny any part of your request related to the limitations that apply to your access to medications, we will automatically send your case to an independent reviewer outside of our plan. See Chapter 9 for information about how to ask for an appeal.

You will not be placed in our DMP if you have certain medical conditions, such as cancer-related pain or sickle cell disease, you are receiving hospice, palliative, or end-of-life care, or live in a long-term care facility.

Section 10.3	Medication Therapy Management (MTM) and other programs to help members manage their medications
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We have programs that can help our members with complex health needs. One program is called a Medication Therapy Management (MTM) program. These programs are voluntary and free. A team of pharmacists and doctors developed the programs for us to help make sure that our members get the most benefit from the drugs they take.

Some members who have certain chronic diseases and take medications that exceed a specific amount of drug costs or are in a DMP to help members use their opioids safely, may be able to get services through an MTM program. If you qualify for the program, a pharmacist or other health professional will give you a comprehensive review of all your medications. During the review, you can talk about your medications, your costs, and any problems or questions you have about your prescription and over-the-counter medications. You'll get a written summary which has a recommended to-do list that includes steps you should take to get the best results from your medications. You'll also get a medication list that will include all the medications you're taking, how much you take, and when and why you take them. In addition, members in the MTM program will receive information on the safe disposal of prescription medications that are controlled substances.

It's a good idea to talk to your doctor about your recommended to-do list and medication list. Bring the summary with you to your visit or anytime you talk with your doctors, pharmacists, and other health care providers. Also, keep your medication list up to date and with you (for example, with your ID) in case you go to the hospital or emergency room.

If we have a program that fits your needs, we will automatically enroll you in the program and send you information. If you decide not to participate, please notify us and we will withdraw you. If you have any questions about these programs, please contact Customer Service.

CHAPTER 6:

*What you pay for your Part D prescription
drugs*

Are you currently getting help to pay for your drugs?

If you are in a program that helps pay for your drugs, **some information in this *Evidence of Coverage* about the costs for Part D prescription drugs does not apply to you.** We sent you a separate insert, called the *Evidence of Coverage Rider for People Who Get “Extra Help” Paying for Prescription Drugs* (also known as the *Low-Income Subsidy Rider* or the *LIS Rider*), which tells you about your drug coverage. If you don’t have this insert, please call Customer Service and ask for the LIS Rider.

SECTION 1 Introduction

Section 1.1	Use this chapter together with other materials that explain your drug coverage
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This chapter focuses on what you pay for Part D prescription drugs. To keep things simple, we use drug in this chapter to mean a Part D prescription drug. As explained in Chapter 5, not all drugs are Part D drugs – some drugs are covered under Medicare Part A or Part B and other drugs are excluded from Medicare coverage by law.

To understand the payment information, you need to know what drugs are covered, where to fill your prescriptions, and what rules to follow when you get your covered drugs. Chapter 5, Sections 1 through 4 explain these rules. When you use the plan’s “Real-Time Benefit Tool” to look up drug coverage (see Chapter 5, Section 3.3), the cost shown is provided in “real time”, meaning the cost you see in the tool reflects a moment in time to provide an estimate of the out-of-pocket costs you are expected to pay. You can also obtain information provided by the “Real-Time Benefit Tool” by calling Customer Service.

Section 1.2	Types of out-of-pocket costs you may pay for covered drugs
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There are different types of out-of-pocket costs for Part D drugs. The amount that you pay for a drug is called **cost sharing**, and there are three ways you may be asked to pay.

- **Deductible** is the amount you pay for drugs before our plan begins to pay its share.
- **Copayment** is a fixed amount you pay each time you fill a prescription.
- **Coinsurance** is a percentage of the total cost you pay each time you fill a prescription.

Section 1.3	How Medicare calculates your out-of-pocket costs
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Medicare has rules about what counts and what does *not* count toward your out-of-pocket costs. Here are the rules we must follow to keep track of your out-of-pocket costs.

These payments are included in your out-of-pocket costs

Your out-of-pocket costs include the payments listed below (as long as they are for Part D covered drugs and you followed the rules for drug coverage that are explained in Chapter 5):

- The amount you pay for drugs when you are in the following drug payment stages:
 - The Deductible Stage
 - The Initial Coverage Stage

- Any payments you made during this calendar year as a member of a different Medicare prescription drug plan before you joined our plan.

It matters who pays:

- If you make these payments **yourself**, they are included in your out-of-pocket costs.
- These payments are *also included* in your out-of-pocket costs if they are made on your behalf by **certain other individuals or organizations**. This includes payments for your drugs made by a friend or relative, by most charities, by AIDS drug assistance programs, employer or union health plans, TRICARE, or by the Indian Health Service. Payments made by Medicare's "Extra Help" Program are also included.

Moving on to the Catastrophic Coverage Stage:

When you (or those paying on your behalf) have spent a total of \$2,000 in out-of-pocket costs within the calendar year, you will move from the Initial Coverage Stage to the Catastrophic Coverage Stage.

These payments are not included in your out-of-pocket costs

Your out-of-pocket costs **do not include** any of these types of payments:

- Your monthly premium.
- Drugs you buy outside the United States and its territories.
- Drugs that are not covered by our plan.
- Drugs you get at an out-of-network pharmacy that do not meet the plan's requirements for out-of-network coverage.
- Non-Part D drugs, including prescription drugs covered by Part A or Part B and other drugs excluded from Part D coverage by Medicare if you are enrolled.
- Payments you make toward prescription drugs not normally covered in a Medicare Prescription Drug Plan.
- Payments for your drugs that are made by the Veterans Health Administration (VA).
- Payments for your drugs made by a third-party with a legal obligation to pay for prescription costs (for example, Workers' Compensation).
- Payments made by drug manufacturers under the Manufacturer Discount Program.

Reminder: If any other organization such as the ones listed above pays part or all of your out-of-pocket costs for drugs, you are required to tell our plan by calling Customer Service.

How can you keep track of your out-of-pocket total?

- **We will help you.** The Part D Explanation of Benefits (EOB) report you receive includes the current amount of your out-of-pocket costs. When this amount reaches \$2,000, this report will tell you that you have left the Initial Coverage Stage and have moved on to the Catastrophic Coverage Stage.
- **Make sure we have the information we need.** Section 3.2 tells what you can do to help make sure that our records of what you have spent are complete and up to date.

SECTION 2 What you pay for a drug depends on which drug payment stage you are in when you get the drug

Section 2.1 What are the drug payment stages for Regence MedAdvantage + Rx Classic members?

There are three **drug payment stages** for your prescription drug coverage under our plan. How much you pay depends on what stage you are in when you get a prescription filled or refilled. Details of each stage are in Sections 4 through 6 of this chapter. The stages are:

Stage 1: Yearly Deductible Stage

Stage 2: Initial Coverage Stage

Stage 3: Catastrophic Coverage Stage

SECTION 3 We send you reports that explain payments for your drugs and which payment stage you are in

Section 3.1 We send you a monthly summary called the <i>Part D Explanation of Benefits</i> (the Part D EOB)

Our plan keeps track of the costs of your prescription drugs and the payments you have made when you get your prescriptions filled or refilled at the pharmacy. This way, we can tell you when you have moved from one drug payment stage to the next. In particular, there are two types of costs we keep track of:

- We keep track of how much you have paid. This is called your **Out-of-Pocket Costs**. This includes what you paid when you get a covered Part D drug, any payments for your drugs made by family or friends, and any payments made for your drugs by “Extra Help” from Medicare, employer or union health plans, TRICARE, Indian Health Service, AIDS drug assistance programs, charities, and most State Pharmaceutical Assistance Programs (SPAPs).
- We keep track of your **Total Drug Costs**. This is the total of all payments made for your covered Part D drugs. It includes what the plan paid, what you paid, and what other programs or organizations paid for your covered Part D drugs.

If you have had one or more prescriptions filled through the plan during the previous month, we will send you a Part D EOB. The Part D EOB includes:

- **Information for that month.** This report gives the payment details about the prescriptions you have filled during the previous month. It shows the total drug costs, what the plan paid, and what you and others on your behalf paid.
- **Totals for the year since January 1.** This is called year-to-date information. It shows the total drug costs and total payments for your drugs since the year began.
- **Drug price information.** This information will display the total drug price, and information about increases in price from first fill for each prescription claim of the same quantity.
- **Available lower cost alternative prescriptions.** This will include information about other available drugs with lower cost sharing for each prescription claim, if applicable.

Section 3.2 Help us keep our information about your drug payments up to date

To keep track of your drug costs and the payments you make for drugs, we use records we get from pharmacies. Here is how you can help us keep your information correct and up to date:

- **Show your membership card every time you get a prescription filled.** This helps us make sure we know about the prescriptions you are filling and what you are paying.
- **Make sure we have the information we need.** There are times you may pay for the entire cost of a prescription drug. In these cases, we will not automatically get the information we need to keep track of your out-of-pocket costs. To help us keep track of your out-of-pocket costs, give us copies of your receipts. Here are examples of when you should give us copies of your drug receipts:
 - When you purchase a covered drug at a network pharmacy at a special price or using a discount card that is not part of our plan's benefit.
 - When you made a copayment for drugs that are provided under a drug manufacturer patient assistance program.
 - Any time you have purchased covered drugs at out-of-network pharmacies or other times you have paid the full price for a covered drug under special circumstances.
 - If you are billed for a covered drug, you can ask our plan to pay our share of the cost. For instructions on how to do this, go to Chapter 7, Section 2.
- **Send us information about the payments others have made for you.** Payments made by certain other individuals and organizations also count toward your out-of-pocket costs. For example, payments made by an AIDS drug assistance program (ADAP), the Indian Health Service, and charities count toward your out-of-pocket costs. Keep a record of these payments and send them to us so we can track your costs.
- **Check the written report we send you.** When you receive a Part D EOB look it over to be sure the information is complete and correct. If you think something is missing or you have any questions, please call us at Customer Service. You may opt in to receiving and viewing your Part D EOB online. Sign in to your secure account and select paperless pharmacy EOB's. Be sure to keep these reports.

SECTION 4 During the Deductible Stage, you pay the full cost of your Tier 3–Preferred Brand through Tier 5–Specialty drugs

The Deductible Stage is the first payment stage for your drug coverage. The deductible doesn't apply to covered insulin products and most adult Part D vaccines, including shingles, tetanus, and travel vaccines. You will pay a yearly deductible of \$100 on Tier 3 – Preferred Brand through Tier 5 – Specialty drugs. **You must pay the full cost of your Tier 3 through Tier 5 drugs** until you reach the plan's deductible amount. For all other drugs you will not have to pay any deductible. The **full cost** is usually lower than the normal full price of the drug since our plan has negotiated lower costs for most drugs at network pharmacies.

Once you have paid \$100 for your Tier 3 through Tier 5 drugs, you leave the Deductible Stage and move on to the Initial Coverage Stage.

SECTION 5 During the Initial Coverage Stage, the plan pays its share of your drug costs and you pay your share

Section 5.1 What you pay for a drug depends on the drug and where you fill your prescription
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During the Initial Coverage Stage, the plan pays its share of the cost of your covered prescription drugs, and you pay your share (your copayment or coinsurance amount). Your share of the cost will vary depending on the drug and where you fill your prescription.

The plan has five cost sharing tiers

Every drug on the plan's Drug List is in one of five cost sharing tiers. In general, the higher the cost sharing tier number, the higher your cost for the drug:

- **Tier 1: Preferred Generic** – Contains only preferred generic products. A generic drug is a drug that has been approved by the FDA as having the same active ingredient (chemically identical) as the brand name drug and meets the same standards for safety, purity, and effectiveness. Generic drugs marketed without brand names are generally less expensive than brand name drugs.
- **Tier 2: Generic** – Contains drugs that are higher in cost than our preferred generic products. A generic drug is a drug that has been approved by the FDA as having the same active ingredient (chemically identical) as the brand name drug and meets the same standards for safety, purity and effectiveness. Generic drugs marketed without brand names are generally less expensive than brand name drugs.
- **Tier 3: Preferred Brand** – A drug that has been selected by an independent panel of physicians and pharmacists who recommended it to be the best overall value. This is based upon its clinical value, safety, and cost effectiveness. This tier may contain generic products. You pay \$35 per month supply of each covered insulin product on this tier.
- **Tier 4: Non-Preferred Drugs** – A drug that has been reviewed by an independent panel of physicians and pharmacists. Based on clinical value, safety and cost effectiveness, they have determined that the drugs in this category have a therapeutic alternative in Tier 1–Preferred Generics, Tier 2–Generics or Tier 3–Preferred Brands. Some of the drugs in this category also have a generic equivalent in Tier 1–Preferred Generics or Tier 2–Generics that is often a better value. You pay \$35 per month supply of each covered insulin product on this tier.
- **Tier 5: Specialty** - Specialty tier drugs are high-cost medications and biologicals, regardless of how they are administered (injectable, infusible, oral, transdermal or inhaled). These medications are often used to treat complex clinical conditions and may require close management by a physician because of their potential side effects or the need for frequent dosage adjustments. This tier may contain generic products and is limited to a 30-day supply.

To find out which cost sharing tier your drug is in, look it up in the plan's Drug List.

Your pharmacy choices

How much you pay for a drug depends on whether you get the drug from:

- A network retail pharmacy that offers standard cost sharing.
- A network retail pharmacy that offers preferred cost sharing. Costs may be less at pharmacies that offer

preferred cost sharing.

- A pharmacy that is not in the plan's network. We cover prescriptions filled at out-of-network pharmacies in only limited situations. Please see Chapter 5, Section 2.5 to find out when we will cover a prescription filled at an out-of-network pharmacy.
- The plan's mail-order pharmacy.

For more information about these pharmacy choices and filling your prescriptions, see Chapter 5 and the plan's *Pharmacy Directory* (regence.com/medicare).

Section 5.2 A table that shows your costs for a *one-month* supply of a drug

During the Initial Coverage Stage, your share of the cost of a covered drug will be either a copayment or coinsurance.

As shown in the table below, the amount of the copayment or coinsurance depends on the cost sharing tier.

Sometimes the cost of the drug is lower than your copayment. In these cases, you pay the lower price for the drug instead of the copayment.

Your share of the cost when you get a *one-month* supply of a covered Part D prescription drug:

Tier	Standard retail and mail-order cost sharing (in-network) (up to a 30-day supply)	Preferred retail and mail-order cost sharing (in-network) (up to a 30-day supply)	Long-term care (LTC) cost sharing (up to a 31-day supply)	Out-of-network cost sharing (Coverage is limited to certain situations; see Chapter 5 for details.) (up to a 30-day supply)
Cost-Sharing Tier 1 (Preferred Generic)	\$3 copay	\$0 copay	\$3 copay	\$3 copay
Cost-Sharing Tier 2 (Generic)	\$13 copay	\$5 copay	\$13 copay	\$13 copay
Cost-Sharing Tier 3 (Preferred- Brand)	25% coinsurance	22% coinsurance	25% coinsurance	25% coinsurance
Cost-Sharing Tier 4 (Non-Preferred Drug)	43% coinsurance	40% coinsurance	43% coinsurance	43% coinsurance
Cost-Sharing Tier 5 (Specialty)	31% coinsurance	31% coinsurance	31% coinsurance	31% coinsurance

You won't pay more than \$35 for a one-month supply of each covered insulin product regardless of the cost sharing tier, even if you haven't paid your deductible.

Please see Section 7 of this chapter for more information on cost sharing for Part D vaccines.

Section 5.3 If your doctor prescribes less than a full month's supply, you may not have to pay the cost of the entire month's supply

Typically, the amount you pay for a prescription drug covers a full month's supply. There may be times when you or your doctor would like you to have less than a month's supply of a drug (for example, when you are trying a medication for the first time). You can also ask your doctor to prescribe, and your pharmacist to dispense, less than a full month's supply of your drugs, if this will help you better plan refill dates for different prescriptions.

If you receive less than a full month's supply of certain drugs, you will not have to pay for the full month's supply.

- If you are responsible for coinsurance, you pay a *percentage* of the total cost of the drug. Since the coinsurance is based on the total cost of the drug, your cost will be lower since the total cost for the drug will be lower.
- If you are responsible for a copayment for the drug, you will only pay for the number of days of the drug that you receive instead of a whole month. We will calculate the amount you pay per day for your drug (the daily cost sharing rate) and multiply it by the number of days of the drug you receive.

Section 5.4 A table that shows your costs for a *long-term* (up to a 100-day) supply of a drug

For some drugs, you can get a long-term supply (also called an extended supply). A long-term supply is up to a 100-day supply.

The table below shows what you pay when you get a long-term supply of a drug.

- Sometimes the cost of the drug is lower than your copayment. In these cases, you pay the lower price for the drug instead of the copayment.

Your share of the cost when you get a *long-term* supply of a covered Part D prescription drug:

Tier	Standard retail and mail-order cost sharing (in-network) (up to a 60/ up to a 100-day supply)	Preferred retail and mail-order cost sharing (in-network) (up to a 60/up to a 100-day supply)
Cost-Sharing Tier 1 (Preferred Generic)	\$6 / \$6 copay	\$0 / \$0 copay
Cost-Sharing Tier 2 (Generic)	\$26 / \$26 copay	\$10 / \$10 copay
Cost-Sharing Tier 3 (Preferred Brand)	25% coinsurance	22% coinsurance
Cost-Sharing Tier 4 (Non-Preferred Drug)	43% coinsurance	40% coinsurance
Cost-Sharing Tier 5 (Specialty)	A long-term supply is not available for drugs in Tier 5.	A long-term supply is not available for drugs in Tier 5.

You won't pay more than \$70 for up to a two-month supply or \$105 for up to a three-month supply of each

covered insulin product regardless of the cost sharing tier, even if you haven't paid your deductible.

Section 5.5	You stay in the Initial Coverage Stage until your out-of-pocket costs for the year reach \$2,000
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You stay in the Initial Coverage Stage until your total out-of-pocket costs reach \$2,000. You then move on to the Catastrophic Coverage Stage.

The *Part D EOB* that you receive will help you keep track of how much you, the plan, and any third parties have spent on your behalf for your drugs during the year. Not all members will reach the \$2,000 out-of-pocket limit in a year.

We will let you know if you reach this amount. If you do reach this amount, you will leave the Initial Coverage Stage and move on to the Catastrophic Coverage Stage. See Section 1.3 on how Medicare calculates your out-of-pocket costs.

SECTION 6	During the Catastrophic Coverage Stage, you pay nothing for your covered Part D drugs
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You enter the Catastrophic Coverage Stage when your out-of-pocket costs have reached the \$2,000 limit for the calendar year. Once you are in the Catastrophic Coverage Stage, you will stay in this payment stage until the end of the calendar year.

- During this payment stage, you pay nothing for your covered Part D drugs.

SECTION 7	Part D Vaccines. What you pay for depends on how and where you get them
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Important Message About What You Pay for Vaccines – Some vaccines are considered medical benefits and are covered under Part B. Other vaccines are considered Part D drugs. You can find these vaccines listed in the plan's Drug List. Our plan covers most adult Part D vaccines at no cost to you even if you haven't paid your deductible. Refer to your plan's Drug List or contact Customer Service for coverage and cost sharing details about specific vaccines.

There are two parts to our coverage of Part D vaccinations:

- The first part of coverage is the cost of **the vaccine itself**.
- The second part of coverage is for the cost of **giving you the vaccine**. (This is sometimes called the administration of the vaccine.)

Your costs for a Part D vaccination depend on three things:

1. **Whether the vaccine is recommended for adults by an organization called the Advisory Committee on Immunization Practices (ACIP).**
 - Most adult Part D vaccinations are recommended by ACIP and cost you nothing.
2. **Where you get the vaccine.**
 - The vaccine itself may be dispensed by a pharmacy or provided by the doctor's office.

3. Who gives you the vaccine.

- A pharmacist or another provider may give the vaccine in the pharmacy. Alternatively, a provider may give it in the doctor's office.

What you pay at the time you get the Part D vaccination can vary depending on the circumstances and what **drug payment stage** you are in.

- Sometimes when you get a vaccination, you have to pay for the entire cost for both the vaccine itself and the cost for the provider to give you the vaccine. You can ask our plan to pay you back for our share of the cost. For most adult Part D vaccines, this means you will be reimbursed the entire cost you paid.
- Other times, when you get a vaccination, you will pay only your share of the cost under your Part D benefit. For most adult Part D vaccines, you will pay nothing.

Below are three examples of ways you might get a Part D vaccine.

Situation 1: You get the Part D vaccination at the network pharmacy. (Whether you have this choice depends on where you live. Some states do not allow pharmacies to give certain vaccines.)

- For most adult Part D vaccines, you will pay nothing.
- For other Part D vaccines, you will pay the pharmacy your copayment for the vaccine itself which includes the cost of giving you the vaccine.
- Our plan will pay the remainder of the costs.

Situation 2: You get the Part D vaccination at your doctor's office.

- When you get the vaccine, you may have to pay for the entire cost of the vaccine itself and the cost for the provider to give it to you.
- You can then ask our plan to pay our share of the cost by using the procedures that are described in Chapter 7.
- For most adult Part D vaccines, you will be reimbursed the full amount you paid. For other Part D vaccines, you will be reimbursed the amount you paid less any copayment for the vaccine (including administration), and less any difference between the amount the doctor charges and what we normally pay. (If you get "Extra Help," we will reimburse you for this difference.)

Situation 3: You buy the Part D vaccine itself at the network pharmacy, and then take it to your doctor's office where they give you the vaccine.

- For most adult Part D vaccines, you will pay nothing for the vaccine itself.
- For other Part D vaccines, you will pay the pharmacy your copayment for the vaccine itself.
- When your doctor gives you the vaccine, you may have to pay the entire cost for this service.
- You can then ask our plan to pay our share of the cost by using the procedures described in Chapter 7.
- For most adult Part D vaccines, you will be reimbursed the full amount you paid. For other Part D vaccines, you will be reimbursed the amount you paid less any coinsurance for the vaccine administration, and less any difference between the amount the doctor charges and what we normally pay. (If you get "Extra Help," we will reimburse you for this difference.)

Examples of Part D vaccines covered under your plan:

Chapter 6 What you pay for your Part D prescription drugs

- Shingles
- MMR (Measles/Mumps/Rubella)
- Tetanus/TDaP (Tetanus, Diptheria, Pertussis) as a preventive service. Note: TDaP vaccines received as part of treatment for an injury or direct exposure to a disease or condition (e.g., tetanus) would be covered under your medical benefits rather than your Part D prescription benefits. (See Chapter 4, Section 2.1, *Medical Benefit Charts* for more information on immunizations that are covered under Medicare Part B.)

You will usually have the lowest out of pocket cost if you get your Part D immunizations at a network pharmacy.

Other commercially available vaccines may be covered. We recommend you call Customer Service to confirm coverage if you plan to get any other immunization.

CHAPTER 7:

*Asking us to pay our share of a bill you
have received for covered medical
services or drugs*

Chapter 7 Asking us to pay our share of a bill you have received for covered medical services or drugs

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

Sometimes when you get medical care or a prescription drug, you may need to pay the full cost. Other times, you may find that you have paid more than you expected under the coverage rules of the plan, or you may receive a bill from a provider. In these cases, you can ask our plan to pay you back (paying you back is often called reimbursing you). It is your right to be paid back by our plan whenever you've paid more than your share of the cost for medical services or drugs that are covered by our plan. There may be deadlines that you must meet to get paid back. Please see Section 2 of this chapter.

There may also be times when you get a bill from a provider for the full cost of medical care you have received or possibly for more than your share of cost sharing as discussed in this document. First try to resolve the bill with the provider. If that does not work, send the bill to us instead of paying it. We will look at the bill and decide whether the services should be covered. If we decide they should be covered, we will pay the provider directly. If we decide not to pay it, we will notify the provider. You should never pay more than plan-allowed cost sharing. If this provider is contracted, you still have the right to treatment.

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

1. When you've received medical care from a provider who is not in our plan's network

When you receive care from a provider who is not part of our network, you are only responsible for paying your share of the cost. (Your share of the cost may be higher for an out-of-network provider than for a network provider.) Ask the provider to bill the plan for our share of the cost.

- Emergency providers are legally required to provide emergency care. You are only responsible for paying your share of the cost for emergency or urgently needed services. If you pay the entire amount yourself at the time you receive the care, ask us to pay you back for our share of the cost. Send us the bill, along with documentation of any payments you have made.
- You may get a bill from the provider asking for payment that you think you do not owe. Send us this bill, along with documentation of any payments you have already made.
 - If the provider is owed anything, we will pay the provider directly.
 - If you have already paid more than your share of the cost of the service, we will determine how much you owed and pay you back for our share of the cost.
- Please note: While you can get your care from an out-of-network provider, the provider must be eligible to participate in Medicare. Except for emergency care, we cannot pay a provider who is not eligible to participate in Medicare. If the provider is not eligible to participate in Medicare, you will be responsible for the full cost of the services you receive.

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

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

- You only have to pay your cost sharing amount when you get covered services. We do not allow providers to add additional separate charges, called balance billing. This protection (that you never pay

Chapter 7 Asking us to pay our share of a bill you have received for covered medical services or drugs

more than your cost sharing amount) applies even if we pay the provider less than the provider charges for a service and even if there is a dispute and we don't pay certain provider charges.

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

3. If you are retroactively enrolled in our plan

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

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

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

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

Save your receipt and send a copy to us when you ask us to pay you back for our share of the cost. Remember that we only cover out-of-network pharmacies in limited circumstances. See Chapter 5, Section 2.5 for a discussion of these circumstances. We may not pay you back the difference between what you paid for the drug at the out-of-network pharmacy and the amount that we would pay at an in-network pharmacy.

5. When you pay the full cost for a prescription because you don't have your plan membership card with you

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

Save your receipt and send a copy to us when you ask us to pay you back for our share of the cost. We may not pay you back the full cost you paid if the cash price you paid is higher than our negotiated price for the prescription.

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

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

- For example, the drug may not be on the plan's Drug List or it could have a requirement or restriction that you didn't know about or don't think should apply to you. If you decide to get the drug immediately, you may need to pay the full cost for it.
- Save your receipt and send a copy to us when you ask us to pay you back. In some situations, we may need to get more information from your doctor in order to pay you back for our share of the cost. We may not pay you back the full cost you paid if the cash price you paid is higher than our negotiated price for the prescription.

Chapter 7 Asking us to pay our share of a bill you have received for covered medical services or drugs

7. When you pay the full cost for a vaccine covered under your Part D benefit

If you receive a vaccine at your doctor's office that's covered by your Part D (pharmacy) benefit, you may have to pay the full cost of the vaccine, as well as the fee your doctor charges to give it to you. Make sure to save your receipt when this happens. If you send us a copy of your receipt, you may be reimbursed the amount you paid less your normal coinsurance or copayment for the vaccine (including administration) less any difference between the amount the doctor charges and what we normally pay. (If you get "Extra Help", we will reimburse you for this difference.)

All of the examples above are types of coverage decisions. This means that if we deny your request for payment, you can appeal our decision. Chapter 9 of this document has information about how to make an appeal.

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

You may request us to pay you back by sending us a request in writing. If you send a request in writing, send your bill and documentation of any payment you have made. It's a good idea to make a copy of your bill and receipts for your records.

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

- You don't have to use the form, but it will help us process the information faster. If you wish to submit your request without the form, please include your name, member ID (including the 3-letter prefix), date of birth, and address; your provider's name, address, phone number, and NPI; the NPI of any referring provider; the date of service, place of service, any service CPT/HCPC codes and/or descriptions, and the total amount billed. You can ask your provider to give you a "superbill" which generally will contain most of the needed information required.
- Either download a copy of the form from our website (regence.com/medicare) or call Customer Service and ask for the form.

Mail your request for payment together with any bills or paid receipts to us at these addresses for each specific service:

Medical claims	<p>Regence BlueCross BlueShield of Utah P.O. Box 1827 Medford, OR 97501</p> <p>You must submit your claim to us within 12-months of the date you received the service, item, or drug.</p> <p>You may also submit your claim online by logging into your account at regence.com/medicare.</p>
Dental claims	<p>Dental Claim Administrator P.O. Box 69436 Harrisburg, PA 17106-9436</p> <p>You must submit your claim to us within 12-months of the date you received the service.</p>

Chapter 7 Asking us to pay our share of a bill you have received for covered medical services or drugs

Out-of-network routine vision claims (exam or hardware)	<p>VSP P.O. Box 495918 Cincinnati, OH 45249-5918</p> <p>You must submit your claim to VSP within 12 months of the date you received the service or item.</p>
Part D prescription drugs claims	<p>Regence BlueCross BlueShield of Utah Prescription Drug Claims Payment Requests P.O. Box 20970 Lehigh Valley, PA 18002-0970</p> <p>You must submit your claim to us within 36-months of the date you received the item, or drug.</p> <p>You may also call our plan to request payment. For details, go to Chapter 2, Section 1 and look for the section called <i>Where to send a request asking us to pay for our share of the cost for medical care or a drug you have received</i>.</p>

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

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

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

- If we decide that the medical care or drug is covered and you followed all the rules, we will pay for our share of the cost. Our share of the cost might not be the full amount you paid (for example, if you obtained a drug at an out-of-network pharmacy or if the cash price you paid for a drug is higher than our negotiated price). If you have already paid for the service or drug, we will mail your reimbursement of our share of the cost to you. If you have not paid for the service or drug yet, we will mail the payment directly to the provider.
- If we decide that the medical care or drug is *not* covered, or you did *not* follow all the rules, we will not pay for our share of the cost. We will send you a letter explaining the reasons why we are not sending the payment and your rights to appeal that decision.

Section 3.2 If we tell you that we will not pay for all or part of the medical care or drug, you can make an appeal

If you think we have made a mistake in turning down your request for payment or the amount we are paying, you can make an appeal. If you make an appeal, it means you are asking us to change the decision we made when we turned down your request for payment. The appeals process is a formal process with detailed procedures and important deadlines. For the details on how to make this appeal, go to Chapter 9 of this document.

CHAPTER 8:

Your rights and responsibilities

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

Section 1.1	We must provide information in a way that works for you and consistent with your cultural sensitivities (in languages other than English, in braille, in large print, or other alternate formats, etc.)
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Your plan is required to ensure that all services, both clinical and non-clinical, are provided in a culturally competent manner and are accessible to all enrollees, including those with limited English proficiency, limited reading skills, hearing incapacity, or those with diverse cultural and ethnic backgrounds. Examples of how a plan may meet these accessibility requirements include, but are not limited to provision of translator services, interpreter services, teletypewriters, or TTY (text telephone or teletypewriter phone) connection.

Our plan has free interpreter services available to answer questions from non-English speaking members. We can also give you information in braille, in large print, or other alternate formats at no cost if you need it. We are required to give you information about the plan's benefits in a format that is accessible and appropriate for you. To get information from us in a way that works for you, please call Customer Service.

Our plan is required to give female enrollees the option of direct access to a women's health specialist within the network for women's routine and preventive health care services.

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

If you have any trouble getting information from our plan in a format that is accessible and appropriate for you, please call to file a grievance with Medicare Advantage Appeals & Grievances at 1-866-749-0355 or write P.O. Box 1827, Medford, OR 97501 or medicareappeals@regence.com. You may also file a complaint with Medicare by calling 1-800-MEDICARE (1-800-633-4227) or directly with the Office for Civil Rights 1-800-368-1019 or TTY 1-800-537-7697.

You have the right to receive information about our member rights and responsibilities policy. You may also make recommendations regarding the plan's member rights and responsibilities. If you have suggestions or recommendations regarding the plan's member rights, you can contact Customer Service at the phone numbers printed on the back cover of this booklet.

Section 1.2	We must ensure that you get timely access to your covered services and drugs
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You have the right to choose a provider in the plan's network. You also have the right to go to a women's health specialist (such as a gynecologist) without a referral and still pay the in-network cost sharing amount.

You have the right to get appointments and covered services from your providers *within a reasonable amount of time*. This includes the right to get timely services from specialists when you need that care. You also have the right to get your prescriptions filled or refilled at any of our network pharmacies without long delays.

If you think that you are not getting your medical care or Part D drugs within a reasonable amount of time, Chapter 9 tells what you can do.

When we make decisions to approve or deny benefits for health services or drugs, it is called a “coverage decision”. Our decisions are based on two things:

- If the care and /or service or drug requested is right for your condition; and
- If your plan’s benefits cover the care or drug being requested

Our doctors and other health care staff are focused on appropriate care and keeping health coverage affordable for our members. They do not get money or other rewards when making decisions about your care. Our plan does not reward staff for making decisions that result in care that is different from or less than what is requested.

Section 1.3	We must protect the privacy of your personal health information
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Federal and state laws protect the privacy of your medical records and personal health information. We protect your personal health information as required by these laws.

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

How do we protect the privacy of your health information?

- We make sure that unauthorized people don’t see or change your records.
- Except for the circumstances noted below, if we intend to give your health information to anyone who isn’t providing your care or paying for your care, *we are required to get written permission from you or someone you have given legal power to make decisions for you first.*
- There are certain exceptions that do not require us to get your written permission first. These exceptions are allowed or required by law.
 - We are required to release health information to government agencies that are checking on quality of care.
 - Because you are a member of our plan through Medicare, we are required to give Medicare your health information including information about your Part D prescription drugs. If Medicare releases your information for research or other uses, this will be done according to Federal statutes and regulations; typically, this requires that information that uniquely identifies you not be shared.

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

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

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

If you have questions or concerns about the privacy of your personal health information, please call Customer Service.

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY.

We, at Regence, know you value your privacy. That is why we are committed to the confidentiality and security of information that we collect about you (“protected health information”). We maintain physical, administrative and technical safeguards to protect against unauthorized access, use, or disclosure of your personal information, including information we share internally either orally, electronically, or in writing.

We are required by law to maintain the privacy of protected health information and to explain our legal duties and privacy practices. We are also required by law to notify affected individuals following a breach of unsecured protected health information. This notice applies to all protected health information that we maintain, including information of former members who are no longer covered by us. We hope this notice will clarify our responsibilities to you and give you an understanding of your rights. We are required to abide by the notice that is currently in effect. This notice is in effect as of January 1, 2023.

Your Rights

You may exercise the following rights by calling our Customer Service department or writing our Privacy Official. See “Contacting Us” at the end of this notice.

Inspection and Copies. You have the right to request, to inspect, or receive a copy of protected health information that we maintain about you in a “designated record set.” A “designated record set” generally includes the information we use to administer your health benefits, such as enrollment information and claims. We are permitted to charge a fee for copies you request.

Amendment. If you believe that protected health information we maintain about you in a designated record set is inaccurate or incomplete, you have the right to request an amendment to correct or complete the information. You must submit your request in writing and explain the reason for the amendment. If we agree to make the change, we will make reasonable efforts to inform others, including people you identify, that the information has been amended and we will use our best efforts to include the amendment with any future disclosure. If we decline to amend information (for example, if we did not create the original record), you have the right to submit a statement of disagreement which we will include in future disclosures of the relevant information. We may attach a rebuttal statement to your statement of disagreement.

Notice. You have the right to receive a paper copy of this notice upon request.

Accounting. You have the right to request a list of certain disclosures of your protected health information. The list will not include disclosures we made for treatment, payment, or health care operations, that took place more than six years ago, or that were made for certain other reasons (as permitted by law). We will supply this

list free of charge once a year at your request. If you request an accounting more than once in a 12-month period, we may charge a reasonable fee.

Special Handling. You have the right to request restrictions on our use or disclosure of protected health information in addition to the restrictions imposed by law. We are not required to agree to your request and we may be unable to do so. If we do agree, we will comply with your request except in the case of emergency. You also have the right to request that we communicate with you in confidence with respect to communications you believe may endanger you. We will make every effort to accommodate your request if it is reasonable and you provide an alternate means to communicate. You should know that redirecting communication may not prevent others on your policy from discovering that you sought medical care. Accumulated deductibles and co-payment information may reveal that you obtained services. In addition, historic claims reports may include services that were obtained during the time communications were redirected.

Complaints. You have the right to submit a complaint if you believe we have violated your privacy rights. To submit a complaint, write to: Regence, Privacy Office, 200 SW Market Street, 11th Floor, Portland, OR 97201 or call our Customer Service department at the phone number provided at the end of this notice. You also have the right to submit a complaint to the Secretary of the U.S. Department of Health & Human Services. Be assured that we will not retaliate against you for submitting a complaint.

Permitted Uses and Disclosures

To administer health benefits, we collect, use and disclose protected health information for a variety of purposes:

Treatment. We may disclose protected health information to a health care provider in order for the provider to treat you, including providing case management to you. For example, we may provide information about your prescriptions to your provider to ensure the provider has information that may affect your treatment.

Payment. We may use or disclose protected health information for payment purposes, including to adjudicate claims, issue Explanation of Benefits, or coordinate benefits with other entities responsible for paying your claims.

Health Care Operations. We may use or disclose protected health information to facilitate operations, including underwriting, customer service, and detection or prevention of fraud or abuse. We may not, however, use or disclose genetic information for underwriting purposes.

Joint Activities. Regence engages in arrangements with other covered entities (such as health care providers and employer-based health plans) to improve health or reduce costs. We may exchange protected health information with other participants in these arrangements for treatment, payment, and health care operations related to our joint activities.

Business Associates. We contract with business associates to perform health plan-related functions on our behalf. We disclose protected health information to these business associates and we permit them to collect, use, or disclose protected health information on our behalf to perform these functions. We contractually obligate our business associates (and they are required by law) to provide the same privacy protections that we provide.

Employers and Other Plan Sponsors. If you are enrolled in an employer-sponsored group health plan (or a group health plan sponsored by another entity), we may disclose protected health information to the group health plan or plan sponsor to facilitate administration of the plan. When we provide your personal information to your employer or other plan sponsors we comply with the required safeguards to protect your information.

As Permitted or Required by Law. We use or disclose protected health information as permitted or required by law. For example, some laws permit or require us to disclose protected health information for workers' compensation programs or to certain government agencies, such as the Food and Drug Administration.

Public Health Activities. We may disclose protected health information for public health activities, such as to: (a) public health agencies for the prevention and control of disease; (b) coroners or medical examiners for their duties; (c) agencies that engage in the procurement, banking, or transportation of organs or tissue for donation and transplantation services; (d) researchers for research intended to improve the health care system; and (e) third parties as necessary to avert a serious threat to the health or safety of a person.

Health Oversight. We may disclose protected health information to health oversight agencies, which regulate health plans, health care providers, and the health system and investigate healthcare fraud. These agencies include: State Commissioner of Insurance, State Board of Medicine, the U.S. Department of Health and Human Services, and the FBI.

Legal Proceedings. We may disclose protected health information in the course of a judicial or administrative proceeding, and in response to a court order, subpoena, discovery request, or other lawful process.

Law Enforcement. We may disclose protected health information to law enforcement officials in response to an administrative subpoena, a warrant, or an administrative request intended to identify or locate a suspect, victim, or witness. We also may disclose protected health information for the purpose of reporting a crime on our premises.

Military and National Security. We may disclose protected health information to armed forces personnel for military activities and to authorized federal officials for national security and intelligence activities.

Correctional Institution. We may disclose protected health information of an inmate to a correctional institution for treatment purposes or to ensure the safety of the inmate and others.

You. We may disclose your protected health information to you at your request, to inform you about the status of your claims, or for other purposes.

Others Involved in Your Health Care. We may disclose protected health information to personal representatives such as court-appointed guardians, executors, conservators, and in many cases parents of minor children, as well as to attorneys in fact when a valid power of attorney exists. In addition, if you give us verbal permission or if your permission can be implied (for example, if you call Customer Service with a family member or friend on the line), we may disclose protected health information to them on your behalf. This permission is valid only for a limited time. If you want to authorize on-going disclosures to family members or friends, you must submit written authorization.

Authorizations. You may give us written authorization to use protected health information or disclose protected health information about yourself to anyone for any purpose. An authorization remains valid for two years unless the authorization states otherwise or you revoke it. You may revoke an authorization at any time by submitting a written revocation (see "Contacting Us," below), but a revocation will not affect any use or disclosure that we made relying on the authorization while it was in effect. An authorization is required for us to use or disclose your protected health information for purposes other than those described in this notice. In particular, we need your written authorization to use or disclose psychotherapy notes, except in limited circumstances such as when the disclosure is required by law. We would also need to obtain your written authorization if we wanted to sell information about you to a third party or send you communications about products and services that are not related to your health.

Future Changes

We reserve the right to change our privacy practices and this notice at any time without advance notice. Before we make any material change in our privacy practices, we will change this notice and post the new notice on our website. We will provide a copy of the new notice (or information about the changes to our privacy practices and how to obtain the new notice) in our next annual mailing to members who are then covered by one of our health plans. The new notice will apply to all protected health information in our possession, including any information created or received before the new notice became effective.

Contacting Us

You may reach us during regular business hours by calling our Customer Service department at 1-800-541-8981.

For more information about this notice or matters described in the notice, you may write to: Regence Privacy Official, 200 SW Market Street, 11th Floor, Portland, OR 97201; E-mail: privacy_office@regence.com; Fax: 1-888-875-6893.

Section 1.4	We must give you information about the plan, its network of providers, and your covered services
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As a member of our plan, you have the right to get several kinds of information from us.

If you want any of the following kinds of information, please call Customer Service:

- **Information about our plan.** This includes, for example, information about the plan's financial condition.
- **Information about our network providers and pharmacies.** You have the right to get information about the qualifications of the providers and pharmacies in our network and how we pay the providers in our network.
- **Information about your coverage and the rules you must follow when using your coverage.** Chapters 3 and 4 provide information regarding medical services. Chapters 5 and 6 provide information about Part D prescription drug coverage.
- **Information about why something is not covered and what you can do about it.** Chapter 9 provides information on asking for a written explanation on why a medical service or Part D drug is not covered or if your coverage is restricted. Chapter 9 also provides information on asking us to change a decision, also called an appeal.
- We follow all Medicare guidelines regarding the use and adoption of new technology. New technology may include behavioral health procedures, medical procedures, and pharmaceuticals, for example. Adoption of new technology occurs within the timelines Medicare communicates in its coverage determination releases.

Section 1.5	We must support your right to make decisions about your care
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You have the right to know your treatment options and participate in decisions about your health care

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

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

- **To know about all of your choices.** You have the right to be told about all of the treatment options that are recommended for your condition, no matter what they cost or whether they are covered by our plan. It also includes being told about programs our plan offers to help members manage their medications and use drugs safely.
- **To know about the risks.** You have the right to be told about any risks involved in your care. You must be told in advance if any proposed medical care or treatment is part of a research experiment. You always have the choice to refuse any experimental treatments.
- **The right to say “no”.** You have the right to refuse any recommended treatment. This includes the right to leave a hospital or other medical facility, even if your doctor advises you not to leave. You also have the right to stop taking your medication. Of course, if you refuse treatment or stop taking medication, you accept full responsibility for what happens to your body as a result.

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

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

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

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

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

- **Get the form.** You can get an advance directive 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 also contact Customer Service to ask for the forms.
- **Fill it out and sign it.** Regardless of where you get this form, keep in mind that it is a legal document. You should consider having a lawyer help you prepare it.
- **Give copies to appropriate people.** You should give a copy of the form to your doctor and to the person you name on the form who can make decisions for you if you can't. You may want to give copies to close friends or family members. Keep a copy at home.

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

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

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

What if your instructions are not followed?

If you have signed an advance directive, and you believe that a doctor or hospital did not follow the instructions in it, you may file a complaint with your state's Quality Improvement Organization (QIO), State Department of Health or seek help from your State Health Insurance Assistance Program (SHIP). Contact information can be found in "Exhibit A" in the back of this document.

Section 1.6	You have the right to make complaints and to ask us to reconsider decisions we have made
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If you have any problems, concerns, or complaints and need to request coverage, or make an appeal, Chapter 9 of this document tells what you can do. Whatever you do – ask for a coverage decision, make an appeal, or make a complaint – **we are required to treat you fairly.**

Section 1.7	What can you do if you believe you are being treated unfairly or your rights are not being respected?
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If it is about discrimination, call the Office for Civil Rights

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

Is it about something else?

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

- You can **call Customer Service**.
- You can **call the SHIP**. For details, go to Chapter 2, Section 3 (contact information can also be found in "Exhibit A" in the back of this document).
- Or, **you can call Medicare** at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week (TTY 1-877-486-2048).

Section 1.8	How to get more information about your rights
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There are several places where you can get more information about your rights:

- You can **call Customer Service**.
- You can **call the SHIP**. For details, go to Chapter 2, Section 3 (contact information can also be found in "Exhibit A" in the back of this document).
- You can contact **Medicare**.
 - You can visit the Medicare website to read or download the publication "Medicare Rights &

Protections”. (The publication is available at: www.medicare.gov/Pubs/pdf/11534-Medicare-Rights-and-Protections.pdf.)

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

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

Things you need to do as a member of the plan are listed below. If you have any questions, please call Customer Service.

- **Get familiar with your covered services and the rules you must follow to get these covered services.** Use this Evidence of Coverage to learn what is covered for you and the rules you need to follow to get your covered services.
 - Chapters 3 and 4 give the details about your medical services.
 - Chapters 5 and 6 give the details about your Part D prescription drug coverage.
- **If you have any other health insurance coverage or prescription drug coverage in addition to our plan, you are required to tell us.** Chapter 1 tells you about coordinating these benefits.
- **Tell your doctor and other health care providers that you are enrolled in our plan.** Show your plan membership card whenever you get your medical care or Part D prescription drugs.
- **Help your doctors and other providers help you by giving them information, asking questions, and following through on your care.**
 - To help get the best care, tell your doctors and other health providers about your health problems. Follow the treatment plans and instructions that you and your doctors agree upon.
 - Make sure your doctors know all of the drugs you are taking, including over-the-counter drugs, vitamins, and supplements.
 - If you have any questions, be sure to ask and get an answer you can understand.
 - You have the responsibility to understand your health problems and help set treatment goals that you and your doctor agree to.
 - You have the responsibility to follow the treatment plans and instructions that you and your doctors agree upon.
- **Be considerate.** We expect all our members to respect the rights of other patients. We also expect you to act in a way that helps the smooth running of your doctor’s office, hospitals, and other offices.
- **Pay what you owe.** As a plan member, you are responsible for these payments:
 - You must pay your plan premiums.
 - You must continue to pay your Medicare Part B premium to remain a member of the plan.
 - For most of your medical services or drugs covered by the plan, you must pay your share of the cost when you get the service or drug.
 - If you are required to pay a late enrollment penalty, you must pay the penalty to keep your prescription drug coverage.

Chapter 8 Your rights and responsibilities

- If you are required to pay the extra amount for Part D because of your yearly income, you must continue to pay the extra amount directly to the government to remain a member of the plan.
- **If you move *within* our plan service area, we need to know** so we can keep your membership record up to date and know how to contact you.
- **If you move *outside* of our plan service area, you cannot remain a member of our plan.**
- If you move, it is also important to tell Social Security (or the Railroad Retirement Board).

CHAPTER 9:

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

SECTION 1 Introduction

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

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

- For some problems, you need to use the **process for coverage decisions and appeals**.
- For other problems, you need to use the **process for making complaints**; also called grievances.

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

The guide in Section 3 will help you identify the right process to use and what you should do.

Section 1.2 What about the legal terms?

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

- Uses simpler words in place of certain legal terms. For example, this chapter generally says, making a complaint rather than filing a grievance, coverage decision rather than organization determination, or coverage determination or at-risk determination, and independent review organization instead of Independent Review Entity.
- It also uses abbreviations as little as possible.

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

SECTION 2 Where to get more information and personalized assistance

We are always available to help you. Even if you have a complaint about our treatment of you, we are obligated to honor your right to complain. Therefore, you should always reach out to customer service for help. But in some situations, you may also want help or guidance from someone who is not connected with us. Below are two entities that can assist you.

State Health Insurance Assistance Program (SHIP)

Each state has a government program with trained counselors. The program is not connected with us or with any insurance company or health plan. The counselors at this program can help you understand which process you should use to handle a problem you are having. They can also answer your questions, give you more information, and offer guidance on what to do.

The services of SHIP counselors are free. You will find phone numbers and website URLs in “Exhibit A” in the back of this document.

Medicare

You can also contact Medicare to get help. To contact Medicare:

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

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

If you have a problem or concern, you only need to read the parts of this chapter that apply to your situation. The guide that follows will help.

Is your problem or concern about your benefits or coverage?

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

Yes.

Go on to the next section of this chapter, **Section 4, A guide to the basics of coverage decisions and appeals.**

No.

Skip ahead to **Section 10** at the end of this chapter: **How to make a complaint about quality of care, waiting times, customer service or other concerns.**

COVERAGE DECISIONS AND APPEALS

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

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

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

Asking for coverage decisions prior to receiving benefits

A coverage decision is a decision we make about your benefits and coverage or about the amount we will pay for your medical care. For example, if your plan network doctor refers you to a medical specialist not inside the network, this referral is considered a favorable coverage decision unless either your network doctor can show that you received a standard denial notice for this medical specialist, or the Evidence of Coverage makes it clear that the referred service is never covered under any condition. You or your doctor can also contact us and ask for

a coverage decision if your doctor is unsure whether we will cover a particular medical service or refuses to provide medical care you think that you need. In other words, if you want to know if we will cover a medical care before you receive it, you can ask us to make a coverage decision for you. In limited circumstances a request for a coverage decision will be dismissed, which means we won't review the request. Examples of when a request will be dismissed include if the request is incomplete, if someone makes the request on your behalf but isn't legally authorized to do so or if you ask for your request to be withdrawn. If we dismiss a request for a coverage decision, we will send a notice explaining why the request was dismissed and how to ask for a review of the dismissal.

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

Making an appeal

If we make a coverage decision, whether before or after a benefit is received, and you are not satisfied, you can **appeal** the decision. An appeal is a formal way of asking us to review and change a coverage decision we have made. Under certain circumstances, which we discuss later, you can request an expedited or **fast appeal** of a coverage decision. Your appeal is handled by different reviewers than those who made the original decision.

When you appeal a decision for the first time, this is called a Level 1 appeal. In this appeal, we review the coverage decision we made to check to see if we were properly following the rules. When we have completed the review, we give you our decision. In limited circumstances a request for a Level 1 appeal will be dismissed, which means we won't review the request. Examples of when a request will be dismissed include if the request is incomplete, if someone makes the request on your behalf but isn't legally authorized to do so, or if you ask for your request to be withdrawn. If we dismiss a request for a Level 1 appeal, we will send a notice explaining why the request was dismissed and how to ask for a review of the dismissal.

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

- You do not need to do anything to start a Level 2 appeal. Medicare rules require we automatically send your appeal for medical care to Level 2 if we do not fully agree with your Level 1 appeal.
- See **Section 5.4** of this chapter for more information about Level 2 appeals for medical care.
- Part D appeals are discussed further in Section 6 of this chapter.

If you are not satisfied with the decision at the Level 2 appeal, you may be able to continue through additional levels of appeal (Section 9 in this chapter explains the Level 3, 4, and 5 appeals processes).

Section 4.2	How to get help when you are asking for a coverage decision or making an appeal
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Here are resources if you decide to ask for any kind of coverage decision or appeal a decision:

- You **can call us at Customer Service**.
- You **can get free help** from your State Health Insurance Assistance Program.
- **Your doctor can make a request for you.** If your doctor helps with an appeal past Level 2, they will need to be appointed as your representative. Please call Customer Service and ask for the *Appointment of Representative* form. (The form is also available on Medicare's website at www.cms.gov/Medicare/CMS-

Chapter 9 What to do if you have a problem or complaint (coverage decisions, appeals, complaints)

Forms/CMS-Forms/downloads/cms1696.pdf or on our website at regence.com/medicare.)

- For medical care or Part B prescription drugs, your doctor can request a coverage decision or a Level 1 appeal on your behalf. If your appeal is denied at Level 1, it will be automatically forwarded to Level 2.
- For Part D prescription drugs, your doctor or other prescriber can request a coverage decision or a Level 1 appeal on your behalf. If your Level 1 appeal is denied your doctor or prescriber can request a Level 2 appeal.
- **You can ask someone to act on your behalf.** If you want to, you can name another person to act for you as your representative to ask for a coverage decision or make an appeal.
 - If you want a friend, relative, or other person to be your representative, call Customer Service and ask for the *Appointment of Representative* form. (The form is also available on Medicare's website at www.cms.gov/Medicare/CMS-Forms/CMS-Forms/downloads/cms1696.pdf or on our website at regence.com/medicare.) The form gives that person permission to act on your behalf. It must be signed by you and by the person who you would like to act on your behalf. You must give us a copy of the signed form.
 - While we can accept an appeal request without the form, we cannot begin or complete our review until we receive it. If we do not receive the form before our deadline for making a decision on your appeal, your appeal request will be dismissed. If this happens, we will send you a written notice explaining your right to ask the independent review organization to review our decision to dismiss your appeal.
- **You also have the right to hire a lawyer.** You may contact your own lawyer or get the name of a lawyer from your local bar association or other referral service. There are also groups that will give you free legal services if you qualify. However, **you are not required to hire a lawyer** to ask for any kind of coverage decision or appeal a decision.

Section 4.3 Which section of this chapter gives the details for your situation?

There are four different situations that involve coverage decisions and appeals. Since each situation has different rules and deadlines, we give the details for each one in a separate section:

- **Section 5** of this chapter: Your medical care: How to ask for a coverage decision or make an appeal.
- **Section 6** of this chapter: Your Part D prescription drugs: How to ask for a coverage decision or make an appeal.
- **Section 7** of this chapter: How to ask us to cover a longer inpatient hospital stay if you think the doctor is discharging you too soon.
- **Section 8** of this chapter: How to ask us to keep covering certain medical services if you think your coverage is ending too soon (*Applies only to these services*: home health care, skilled nursing facility care, and Comprehensive Outpatient Rehabilitation Facility (CORF) services).

If you're not sure which section you should be using, please call Customer Service. You can also get help or information from government organizations such as your SHIP.

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

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

This section is about your benefits for medical care. These benefits are described in Chapter 4 of this document: *Medical Benefits Chart (what is covered and what you pay)*. In some cases, different rules apply to a request for a Part B prescription drug. In those cases, we will explain how the rules for Part B prescription drugs are different from the rules for medical items and services.

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

1. You are not getting certain medical care you want, and you believe that this is covered by our plan. **Ask for a coverage decision. Section 5.2.**
2. Our plan will not approve the medical care your doctor or other medical provider wants to give you, and you believe that this care is covered by the plan. **Ask for a coverage decision. Section 5.2.**
3. You have received medical care that you believe should be covered by the plan, but we have said we will not pay for this care. **Make an appeal. Section 5.3.**
4. You have received and paid for medical care that you believe should be covered by the plan, and you want to ask our plan to reimburse you for this care. **Send us the bill. Section 5.5.**
5. You are being told that coverage for certain medical care you have been getting that we previously approved will be reduced or stopped, and you believe that reducing or stopping this care could harm your health. **Make an appeal. Section 5.3.**

Note: If the coverage that will be stopped is for hospital care, home health care, skilled nursing facility care, or Comprehensive Outpatient Rehabilitation Facility (CORF) services, you need to read Sections 7 and 8 of this Chapter. Special rules apply to these types of care.

Section 5.2 Step-by-step: How to ask for a coverage decision

Legal Terms

When a coverage decision involves your medical care, it is called an **organization determination**.

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

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

A standard coverage decision is usually made within 14 calendar days or 72 hours for Part B drugs. A fast coverage decision is generally made within 72 hours, for medical services, or 24 hours for Part B drugs. In order to get a fast coverage decision, you must meet two requirements:

- You may *only ask* for coverage for medical items and/or services (not requests for payment for items and/or services already received).
- You can get a fast coverage decision *only* if using the standard deadlines could *cause serious harm to*

your health or hurt your ability to function.

- **If your doctor tells us that your health requires a fast coverage decision, we will automatically agree to give you a fast coverage decision.**
- **If you ask for a fast coverage decision on your own, without your doctor's support, we will decide whether your health requires that we give you a fast coverage decision.** If we do not approve a fast coverage decision, we will send you a letter that:
 - Explains that we will use the standard deadlines.
 - Explains if your doctor asks for the fast coverage decision, we will automatically give you a fast coverage decision.
 - Explains that you can file a fast complaint about our decision to give you a standard coverage decision instead of the fast coverage decision you requested.

Step 2: Ask our plan to make a coverage decision or fast coverage decision.

- Start by calling, writing, or faxing our plan to make your request for us to authorize or provide coverage for the medical care you want. You, your doctor, or your representative can do this. Chapter 2 has contact information.

Step 3: We consider your request for medical care coverage and give you our answer.

For standard coverage decisions we use the standard deadlines

This means we will give you an answer within 14 calendar days after we receive your request **for a medical item or service**. If your request is for a **Medicare Part B prescription drug**, we will give you an answer **within 72 hours** after we receive your request.

- **However**, if you ask for more time, or if we need more information that may benefit you, **we can take up to 14 more calendar days** if your request is for a medical item or service. If we take extra days, we will tell you in writing. We can't take extra time to make a decision if your request is for a Medicare Part B prescription drug.
- If you believe we should *not* take extra days, you can file a fast complaint. We will give you an answer to your complaint as soon as we make the decision. (The process for making a complaint is different from the process for coverage decisions and appeals. See Section 10 of this chapter for information on complaints.)

For fast coverage decisions we use an expedited timeframe

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

- **However**, if you ask for more time, or if we need more information that may benefit you, **we can take up to 14 more calendar days**. If we take extra days, we will tell you in writing. We can't take extra time to make a decision if your request is for a Medicare Part B prescription drug.
- If you believe we should *not* take extra days, you can file a fast complaint. (See Section 10 of this chapter for information on complaints.) We will call you as soon as we make the decision.
- **If our answer is no to part or all of what you requested**, we will send you a written statement that explains why we said no.

Step 4: If we say no to your request for coverage for medical care, you can appeal.

- If we say no, you have the right to ask us to reconsider this decision by making an appeal. This means asking again to get the medical care coverage you want. If you make an appeal, it means you are going on to Level 1 of the appeals process.

Section 5.3 Step-by-step: How to make a Level 1 appeal**Legal Terms**

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

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

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

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

- If you are appealing a decision we made about coverage for care that you have not yet received, you and/or your doctor will need to decide if you need a fast appeal. If your doctor tells us that your health requires a fast appeal, we will give you a fast appeal.
- The requirements for getting a fast appeal are the same as those for getting a fast coverage decision in Section 5.2 of this chapter.

Step 2: Ask our plan for an appeal or a fast appeal.

- **If you are asking for a standard appeal, submit your standard appeal in writing.** Chapter 2 has contact information.
- **If you are asking for a fast appeal, make your appeal in writing or call us.** Chapter 2 has contact information.
- **You must make your appeal request within 65 calendar days** from the date on the written notice we sent to tell you our answer on the coverage decision. If you miss this deadline and have a good reason for missing it, explain the reason your appeal is late when you make your appeal. We may give you more time to make your appeal. Examples of good cause may include a serious illness that prevented you from contacting us or if we provided you with incorrect or incomplete information about the deadline for requesting an appeal.
- **You can ask for a copy of the information regarding your medical decision. You and your doctor may add more information to support your appeal.**

Step 3: We consider your appeal and we give you our answer.

- When our plan is reviewing your appeal, we take a careful look at all of the information. We check to see if we were following all the rules when we said no to your request.
- We will gather more information if needed, possibly contacting you or your doctor.

Deadlines for a fast appeal

- For fast appeals, we must give you our answer **within 72 hours after we receive your appeal.** We

will give you our answer sooner if your health requires us to.

- However, if you ask for more time, or if we need more information that may benefit you, we **can take up to 14 more calendar days** if your request is for a medical item or service. If we take extra days, we will tell you in writing. We can't take extra time if your request is for a Medicare Part B prescription drug.
- If we do not give you an answer within 72 hours (or by the end of the extended time period if we took extra days), we are required to automatically send your request on to Level 2 of the appeals process, where it will be reviewed by an independent review organization. Section 5.4 explains the Level 2 appeal process.
- **If our answer is yes to part or all of what you requested**, we must authorize or provide the coverage we have agreed to provide within 72 hours after we receive your appeal.
- **If our answer is no to part or all of what you requested**, we will send you our decision in writing and automatically forward your appeal to the independent review organization for a Level 2 appeal. The independent review organization will notify you in writing when it receives your appeal.

Deadlines for a standard appeal

- For standard appeals, we must give you our answer **within 30 calendar days** after we receive your appeal. If your request is for a Medicare Part B prescription drug you have not yet received, we will give you our answer **within 7 calendar days** after we receive your appeal. We will give you our decision sooner if your health condition requires us to.
 - However, if you ask for more time, or if we need more information that may benefit you, we **can take up to 14 more calendar days** if your request is for a medical item or service. If we take extra days, we will tell you in writing. We can't take extra time to make a decision if your request is for a Medicare Part B prescription drug.
 - If you believe we should *not* take extra days, you can file a fast complaint. When you file a fast complaint, we will give you an answer to your complaint within 24 hours. (See Section 10 of this chapter for information on complaints.)
 - If we do not give you an answer by the deadline (or by the end of the extended time period), we will send your request to a Level 2 appeal, where an independent review organization will review the appeal. Section 5.4 explains the Level 2 appeal process.
- **If our answer is yes to part or all of what you requested**, we must authorize or provide the coverage within 30 calendar days if your request is for a medical item or service, or **within 7 calendar days** if your request is for a Medicare Part B prescription drug.
- If our plan says no to part or all of your appeal, we will automatically send your appeal to the independent review organization for a Level 2 appeal.

Section 5.4 Step-by-step: How a Level 2 appeal is done

Legal Term

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

The **independent review organization is an independent organization hired by Medicare**. It is not connected with us and is not a government agency. This organization decides whether the decision we made is correct or if it should be changed. Medicare oversees its work.

Step 1: The independent review organization reviews your appeal.

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

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

- For the fast appeal the review organization must give you an answer to your Level 2 appeal within 72 hours of when it receives your appeal.
- However, if your request is for a medical item or service and the independent review organization needs to gather more information that may benefit you, **it can take up to 14 more calendar days**. The independent review organization can't take extra time to make a decision if your request is for a Medicare Part B prescription drug.

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

- For the standard appeal if your request is for a medical item or service, the review organization must give you an answer to your Level 2 appeal **within 30 calendar days** of when it receives your appeal. If your request is for a Medicare Part B prescription drug, the review organization must give you an answer to your Level 2 appeal **within 7 calendar days** of when it receives your appeal.
- However, if your request is for a medical item or service and the independent review organization needs to gather more information that may benefit you, **it can take up to 14 more calendar days**. The independent review organization can't take extra time to make a decision if your request is for a Medicare Part B prescription drug.

Step 2: The independent review organization gives you their answer.

The independent review organization will tell you its decision in writing and explain the reasons for it.

- **If the review organization says yes to part or all of a request for a medical item or service**, we must authorize the medical care coverage within 72 hours or provide the service within 14 calendar days after we receive the decision from the review organization for standard requests. For expedited requests, we have 72 hours from the date we receive the decision from the review organization.
- **If the review organization says yes to part or all of a request for a Medicare Part B prescription drug**, we must authorize or provide the Part B prescription drug within **72 hours** after we receive the decision from the review organization for **standard requests**. For **expedited requests** we have **24 hours** from the date we receive the decision from the review organization.
- **If this organization says no to part or all of your appeal**, it means they agree with us that your request (or part of your request) for coverage for medical care should not be approved. (This is called **upholding the decision** or **turning down your appeal**). In this case, the independent review organization will send you a letter:

- Explaining its decision.
- Notifying you of the right to a Level 3 appeal if the dollar value of the medical care coverage meets a certain minimum. The written notice you get from the independent review organization will tell you the dollar amount you must meet to continue the appeals process.
- Telling you how to file a Level 3 appeal.

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

- There are three additional levels in the appeals process after Level 2 (for a total of five levels of appeal). If you want to go to a Level 3 appeal the details on how to do this are in the written notice you get after your Level 2 appeal.
- The Level 3 appeal is handled by an Administrative Law Judge or attorney adjudicator. Section 9 in this chapter explains the Level 3, 4, and 5 appeals processes.

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

Chapter 7 describes when you may need to ask for reimbursement or to pay a bill you have received from a provider. It also tells how to send us the paperwork that asks us for payment.

Asking for reimbursement is asking for a coverage decision from us

If you send us the paperwork asking for reimbursement, you are asking for a coverage decision. To make this decision, we will check to see if the medical care you paid for is a covered service. We will also check to see if you followed all the rules for using your coverage for medical care.

- **If we say yes to your request:** If the medical care is covered and you followed all the rules, we will send you the payment for the cost typically within 30 calendar days, but no later than 60 calendar days after we receive your request. If you haven't paid for the medical care, we will send the payment directly to the provider.
- **If we say no to your request:** If the medical care is *not* covered, or you did *not* follow all the rules, we will not send payment. Instead, we will send you a letter that says we will not pay for the medical care and the reasons why.

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

To make this appeal, follow the process for appeals that we describe in Section 5.3. For appeals concerning reimbursement, please note:

- We must give you our answer within 60 calendar days after we receive your appeal. If you are asking us to pay you back for medical care you have already received and paid for, you are not allowed to ask for a fast appeal.
- If the independent review organization decides we should pay, we must send you or the provider the payment within 30 calendar days. If the answer to your appeal is yes at any stage of the appeals process after Level 2, we must send the payment you requested to you or to the provider within 60 calendar days.

SECTION 6 Your Part D prescription drugs: How to ask for a coverage decision or make an appeal

Section 6.1 This section tells you what to do if you have problems getting a Part D drug or you want us to pay you back for a Part D drug

Your benefits include coverage for many prescription drugs. To be covered, the drug must be used for a medically accepted indication. (See Chapter 5 for more information about a medically accepted indication.) For details about Part D drugs, rules, restrictions, and costs please see Chapters 5 and 6. **This section is about your Part D drugs only.** To keep things simple, we generally say drug in the rest of this section, instead of repeating *covered outpatient prescription drug* or *Part D drug* every time. We also use the term Drug List instead of *List of Covered Drugs* or *Formulary*.

- If you do not know if a drug is covered or if you meet the rules, you can ask us. Some drugs require that you get approval from us before we will cover it.
- If your pharmacy tells you that your prescription cannot be filled as written, the pharmacy will give you a written notice explaining how to contact us to ask for a coverage decision.

Part D coverage decisions and appeals

Legal Term
An initial coverage decision about your Part D drugs is called a coverage determination .

A coverage decision is a decision we make about your benefits and coverage or about the amount we will pay for your drugs. This section tells what you can do if you are in any of the following situations:

- Asking to cover a Part D drug that is not on the plan's *List of Covered Drugs*. **Ask for an exception. Section 6.2.**
- Asking to waive a restriction on the plan's coverage for a drug (such as limits on the amount of the drug you can get, prior authorization, or the requirement to try another drug first). **Ask for an exception. Section 6.2.**
- Asking to pay a lower cost sharing amount for a covered drug on a higher cost sharing tier. **Ask for an exception. Section 6.2.**
- Asking to get pre-approval for a drug. **Ask for a coverage decision. Section 6.4.**
- Pay for a prescription drug you already bought. **Ask us to pay you back. Section 6.4.**

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

This section tells you both how to ask for coverage decisions and how to request an appeal.

Section 6.2 What is an exception?

Legal Terms

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

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

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

If a drug is not covered in the way you would like it to be covered, you can ask us to make an **exception**. An exception is a type of coverage decision.

For us to consider your exception request, your doctor or other prescriber will need to explain the medical reasons why you need the exception approved. Here are three examples of exceptions that you or your doctor or other prescriber can ask us to make:

1. **Covering a Part D drug for you that is not on our Drug List.** If we agree to cover a drug not on the Drug List, you will need to pay the cost sharing amount that applies to drugs in Tier 4 – Non-Preferred Drugs. You cannot ask for an exception to the cost sharing amount we require you to pay for the drug.
2. **Removing a restriction for a covered drug.** Chapter 5 describes the extra rules or restrictions that apply to certain drugs on our Drug List. If we agree to make an exception and waive a restriction for you, you can ask for an exception to the cost sharing amount we require you to pay for the drug.
3. **Changing coverage of a drug to a lower cost sharing tier.** Every drug on our Drug List is in one of five cost sharing tiers. In general, the lower the cost sharing tier number, the less you will pay as your share of the cost of the drug.
 - If our Drug List contains alternative drug(s) for treating your medical condition that are in a lower cost sharing tier than your drug, you can ask us to cover your drug at the cost sharing amount that applies to the same or similar type alternative drug(s).
 - If the drug you're taking is a biological product you can ask us to cover your drug at a lower cost sharing amount. This would be the lowest tier that contains biological product alternatives of the same or similar type for treating your condition.
 - If the drug you're taking is a brand name drug you can ask us to cover your drug at the cost sharing amount that applies to the lowest tier that contains brand name alternatives of the same or similar type for treating your condition.
 - If the drug you're taking is a generic drug you can ask us to cover your drug at the cost sharing amount that applies to the lowest tier that contains either brand or generic alternatives of the same or similar type for treating your condition.
 - You cannot ask us to change the cost sharing tier for any drug in the Tier 5 – Specialty tier.
 - If we approve your tiering exception request and there is more than one lower cost sharing tier with alternative drugs you can't take, you will usually pay the lowest amount.

Section 6.3 Important things to know about asking for exceptions**Your doctor must tell us the medical reasons**

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

Typically, our Drug List includes more than one drug for treating a particular condition. These different possibilities are called **alternative** drugs. If an alternative drug would be just as effective as the drug you are requesting and would not cause more side effects or other health problems, we will generally *not* approve your request for an exception. If you ask us for a tiering exception, we will generally *not* approve your request for an exception unless all the alternative drugs in the lower cost sharing tier(s) won't work as well for you or are likely to cause an adverse reaction or other harm.

We can say yes or no to your request

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

Section 6.4 Step-by-step: How to ask for a coverage decision, including an exception**Legal Term**

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

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

Standard coverage decisions are made within **72 hours** after we receive your doctor's statement. **Fast coverage decisions** are made within **24 hours** after we receive your doctor's statement.

If your health requires it, ask us to give you a fast coverage decision. To get a fast coverage decision, you must meet two requirements:

- You must be asking for a drug you have not yet received. (You cannot ask for fast coverage decision to be paid back for a drug you have already bought.)
- Using the standard deadlines could cause serious harm to your health or hurt your ability to function.
- **If your doctor or other prescriber tells us that your health requires a fast coverage decision, we will automatically give you a fast coverage decision.**
- **If you ask for a fast coverage decision on your own, without your doctor or prescriber's support, we will decide whether your health requires that we give you a fast coverage decision.** If we do not approve a fast coverage decision, we will send you a letter that:
 - Explains that we will use the standard deadlines.
 - Explains if your doctor or other prescriber asks for the fast coverage decision, we will automatically give you a fast coverage decision.

- Tells you how you can file a fast complaint about our decision to give you a standard coverage decision instead of the fast coverage decision you requested. We will answer your complaint within 24 hours of receipt.

Step 2: Request a standard coverage decision or a fast coverage decision.

Start by calling, writing, or faxing our plan to make your request for us to authorize or provide coverage for the medical care you want. You can also access the coverage decision process through our website. We must accept any written request, including a request submitted on the *CMS Model Coverage Determination Request Form* or on our plan's form, which are available on our website regence.com/medicare. Chapter 2 has contact information. Please visit regence.com/medicare to electronically submit your request for a coverage decision. Sign in to the secure member portal and follow directions to access the coverage determination form. To assist us in processing your request, please be sure to include your name, contact information, and information identifying which denied claim is being appealed.

You, your doctor, (or other prescriber) or your representative can do this. You can also have a lawyer act on your behalf. Section 4 of this chapter tells how you can give written permission to someone else to act as your representative.

- **If you are requesting an exception, provide the supporting statement**, which is the medical reasons for the exception. Your doctor or other prescriber can fax or mail the statement to us. Or your doctor or other prescriber can tell us on the phone and follow up by faxing or mailing a written statement if necessary.

Step 3: We consider your request and give you our answer.***Deadlines for a fast coverage decision***

- We must generally give you our answer **within 24 hours** after we receive your request.
 - For exceptions, we will give you our answer within 24 hours after we receive your doctor's supporting statement. We will give you our answer sooner if your health requires us to.
 - If we do not meet this deadline, we are required to send your request on to Level 2 of the appeals process, where it will be reviewed by an independent review organization.
- **If our answer is yes to part or all of what you requested**, we must provide the coverage we have agreed to provide within 24 hours after we receive your request or doctor's statement supporting your request.
- **If our answer is no to part or all of what you requested**, we will send you a written statement that explains why we said no. We will also tell you how you can appeal.

Deadlines for a standard coverage decision about a drug you have not yet received

- We must generally give you our answer **within 72 hours** after we receive your request.
 - For exceptions, we will give you our answer within 72 hours after we receive your doctor's supporting statement. We will give you our answer sooner if your health requires us to.
 - If we do not meet this deadline, we are required to send your request on to Level 2 of the appeals process, where it will be reviewed by an independent review organization.
- **If our answer is yes to part or all of what you requested**, we must **provide the coverage** we have agreed to provide **within 72 hours** after we receive your request or doctor's statement supporting your request.

Chapter 9 What to do if you have a problem or complaint (coverage decisions, appeals, complaints)

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

Deadlines for a standard coverage decision about payment for a drug you have already bought

- We must give you our answer **within 14 calendar days** after we receive your request.
 - If we do not meet this deadline, we are required to send your request on to Level 2 of the appeals process, where it will be reviewed by an independent review organization.
- **If our answer is yes to part or all of what you requested**, we are also required to make payment to you within 14 calendar days after we receive your request.
- **If our answer is no to part or all of what you requested**, we will send you a written statement that explains why we said no. We will also tell you how you can appeal.

Step 4: If we say no to your coverage request, you can make an appeal.

- If we say no, you have the right to ask us to reconsider this decision by making an appeal. This means asking again to get the drug coverage you want. If you make an appeal, it means you are going on to Level 1 of the appeals process.

Section 6.5 Step-by-step: How to make a Level 1 appeal**Legal Terms**

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

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

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

A standard appeal is usually made within 7 calendar days. A fast appeal is generally made within 72 hours. If your health requires it, ask for a fast appeal.

- If you are appealing a decision we made about a drug you have not yet received, you and your doctor or other prescriber will need to decide if you need a fast appeal.
- The requirements for getting a fast appeal are the same as those for getting a fast coverage decision in Section 6.4 of this chapter.

Step 2: You, your representative, doctor or other prescriber must contact us and make your Level 1 appeal. If your health requires a quick response, you must ask for a **fast appeal**.

- **For standard appeals, submit a written request** or call us. Chapter 2 has contact information.
- **For fast appeals either submit your appeal in writing or call us at 1-800-541-8981.** Chapter 2 has contact information.
- **We must accept any written request**, including a request submitted on the *CMS Model Redetermination Request Form*, which is available on our website [regence.com/medicare](https://www.regence.com/medicare). Please be sure to include your name, contact information, and information regarding your claim to assist us in processing your request.
- **Visit our website at [regence.com/medicare](https://www.regence.com/medicare)** to electronically submit your request for an appeal. Sign

in to the secure member portal and follow directions to access the appeal form.

- **You must make your appeal request within 65 calendar days** from the date on the written notice we sent to tell you our answer on the coverage decision. If you miss this deadline and have a good reason for missing it, explain the reason your appeal is late when you make your appeal. We may give you more time to make your appeal. Examples of good cause may include a serious illness that prevented you from contacting us or if we provided you with incorrect or incomplete information about the deadline for requesting an appeal.
- **You can ask for a copy of the information in your appeal and add more information.** You and your doctor may add more information to support your appeal.

Step 3: We consider your appeal and we give you our answer.

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

Deadlines for a fast appeal

- For fast appeals, we must give you our answer **within 72 hours after we receive your appeal**. We will give you our answer sooner if your health requires us to.
 - If we do not give you an answer within 72 hours, we are required to send your request on to Level 2 of the appeals process, where it will be reviewed by an independent review organization. Section 6.6 explains the Level 2 appeal process.
- **If our answer is yes to part or all of what you requested**, we must provide the coverage we have agreed to provide within 72 hours after we receive your appeal.
- **If our answer is no to part or all of what you requested**, we will send you a written statement that explains why we said no and how you can appeal our decision.

Deadlines for a standard appeal for a drug you have not yet received

- For standard appeals, we must give you our answer **within 7 calendar days** after we receive your appeal. We will give you our decision sooner if you have not received the drug yet and your health condition requires us to do so.
 - If we do not give you a decision within 7 calendar days, we are required to send your request on to Level 2 of the appeals process, where it will be reviewed by an independent review organization. Section 6.6 explains the Level 2 appeal process.
- **If our answer is yes to part or all of what you requested**, we must provide the coverage as quickly as your health requires, but no later than **7 calendar days** after we receive your appeal.
- **If our answer is no to part or all of what you requested**, we will send you a written statement that explains why we said no and how you can appeal our decision.

Deadlines for a standard appeal about payment for a drug you have already bought

- We must give you our answer **within 14 calendar days** after we receive your request.
 - If we do not meet this deadline, we are required to send your request on to Level 2 of the appeals process, where it will be reviewed by an independent review organization.

- If our answer is yes to part or all of what you requested, we are also required to make payment to you within **30 calendar days** after we receive your request.
- If our answer is no to part or all of what you requested, we will send you a written statement that explains why we said no. We will also tell you how you can appeal.

Step 4: If we say no to your appeal, you decide if you want to continue with the appeals process and make *another* appeal.

- If you decide to make another appeal, it means your appeal is going on to Level 2 of the appeals process.

Section 6.6 Step-by-step: How to make a Level 2 appeal

Legal Term

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

The **independent review organization is an independent organization hired by Medicare**. It is not connected with us and is not a government agency. This organization decides whether the decision we made is correct or if it should be changed. Medicare oversees its work.

Step 1: You (or your representative or your doctor or other prescriber) must contact the independent review organization and ask for a review of your case.

- If we say no to your Level 1 appeal, the written notice we send you will include **instructions on how to make a Level 2 appeal** with the independent review organization. These instructions will tell who can make this Level 2 appeal, what deadlines you must follow, and how to reach the review organization. If, however, we did not complete our review within the applicable timeframe, or make an unfavorable decision regarding **at-risk** determination under our drug management program, we will automatically forward your claim to the IRE.
- We will send the information about your appeal to this organization. This information is called your **case file**. **You have the right to ask us for a copy of your case file.**
- You have a right to give the independent review organization additional information to support your appeal.

Step 2: The independent review organization reviews your appeal.

Reviewers at the independent review organization will take a careful look at all of the information related to your appeal.

Deadlines for fast appeal

- If your health requires it, ask the independent review organization for a fast appeal.
- If the organization agrees to give you a fast appeal, the organization must give you an answer to your Level 2 appeal **within 72 hours** after it receives your appeal request.

Deadlines for standard appeal

- For standard appeals, the review organization must give you an answer to your Level 2 appeal **within**

7 calendar days after it receives your appeal if it is for a drug you have not yet received. If you are requesting that we pay you back for a drug you have already bought, the review organization must give you an answer to your Level 2 appeal **within 14 calendar days** after it receives your request.

Step 3: The independent review organization gives you their answer.

For fast appeals:

- **If the independent review organization says yes to part or all of what you requested**, we must provide the drug coverage that was approved by the review organization **within 24 hours** after we receive the decision from the review organization.

For standard appeals:

- **If the independent review organization says yes to part or all of your request for coverage**, we must **provide the drug coverage** that was approved by the review organization **within 72 hours** after we receive the decision from the review organization.
- **If the independent review organization says yes to part or all of your request to pay you back** for a drug you already bought, we are required to **send payment to you within 30 calendar days** after we receive the decision from the review organization.

What if the review organization says no to your appeal?

If this organization says no **to part or all of** your appeal, it means they agree with our decision not to approve your request (or part of your request). (This is called **upholding the decision**. It is also called **turning down your appeal**.) In this case, the independent review organization will send you a letter:

- Explaining its decision.
- Notifying you of the right to a Level 3 appeal if the dollar value of the drug coverage you are requesting meets a certain minimum. If the dollar value of the drug coverage you are requesting is too low, you cannot make another appeal and the decision at Level 2 is final.
- Telling you the dollar value that must be in dispute to continue with the appeals process.

Step 4: If your case meets the requirements, you choose whether you want to take your appeal further.

- There are three additional levels in the appeals process after Level 2 (for a total of five levels of appeal).
- If you want to go on to a Level 3 appeal the details on how to do this are in the written notice you get after your Level 2 appeal decision.
- The Level 3 appeal is handled by an Administrative Law Judge or attorney adjudicator. Section 9 in this chapter tells more about Levels 3, 4, and 5 of the appeals process.

SECTION 7 How to ask us to cover a longer inpatient hospital stay if you think you are being discharged too soon

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

During your covered hospital stay, your doctor and the hospital staff will be working with you to prepare for

the day when you will leave the hospital. They will help arrange for care you may need after you leave.

- The day you leave the hospital is called your **discharge date**.
- When your discharge date is decided, your doctor or the hospital staff will tell you.
- If you think you are being asked to leave the hospital too soon, you can ask for a longer hospital stay and your request will be considered.

Section 7.1	During your inpatient hospital stay, you will get a written notice from Medicare that tells about your rights
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Within two calendar days of being admitted to the hospital, you will be given a written notice called *An Important Message from Medicare about Your Rights*. Everyone with Medicare gets a copy of this notice. If you do not get the notice from someone at the hospital (for example, a caseworker or nurse), ask any hospital employee for it. If you need help, please call Customer Service or 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week (TTY 1-877-486-2048).

1. Read this notice carefully and ask questions if you don't understand it. It tells you:

- Your right to receive Medicare-covered services during and after your hospital stay, as ordered by your doctor. This includes the right to know what these services are, who will pay for them, and where you can get them.
- Your right to be involved in any decisions about your hospital stay.
- Where to report any concerns you have about the quality of your hospital care.
- Your right to **request an immediate review** of the decision to discharge you if you think you are being discharged from the hospital too soon. This is a formal, legal way to ask for a delay in your discharge date so that we will cover your hospital care for a longer time.

2. You will be asked to sign the written notice to show that you received it and understand your rights.

- You or someone who is acting on your behalf will be asked to sign the notice.
- Signing the notice shows *only* that you have received the information about your rights. The notice does not give your discharge date. Signing the notice **does not mean** you are agreeing on a discharge date.

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

- If you sign the notice more than two calendar days before your discharge date, you will get another copy before you are scheduled to be discharged.
- To look at a copy of this notice in advance, you can call Customer Service or 1-800 MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048. You can also see the notice online at www.cms.gov/Medicare/Medicare-General-Information/BNI/HospitalDischargeAppealNotices.

Section 7.2	Step-by-step: How to make a Level 1 appeal to change your hospital discharge date
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If you want to ask for your inpatient hospital services to be covered by us for a longer time, you will need to use the appeals process to make this request. Before you start, understand what you need to do and what the

deadlines are.

- **Follow the process.**
- **Meet the deadlines.**
- **Ask for help if you need it.** If you have questions or need help at any time, please call Customer Service. Or call your State Health Insurance Assistance Program, a government organization that provides personalized assistance.

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

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

Step 1: Contact the Quality Improvement Organization for your state and ask for an immediate review of your hospital discharge. You must act quickly.

How can you contact this organization?

- The written notice you received (*An Important Message from Medicare About Your Rights*) tells you how to reach this organization. Or find the name, address, and phone number of the Quality Improvement Organization for your state in Chapter 2 (contact information can also be found in “Exhibit A” in the back of this document).

Act quickly:

- To make your appeal, you must contact the Quality Improvement Organization *before* you leave the hospital and **no later than midnight the day of your discharge**.
 - **If you meet this deadline**, you may stay in the hospital *after* your discharge date *without paying for it* while you wait to get the decision from the Quality Improvement Organization.
 - **If you do *not* meet this deadline**, contact us. If you decide to stay in the hospital after your planned discharge date, *you may have to pay all of the costs* for hospital care you receive after your planned discharge date.
- Once you request an immediate review of your hospital discharge the Quality Improvement Organization will contact us. By noon of the day after we are contacted we will give you a **Detailed Notice of Discharge**. This notice gives your planned discharge date and explains in detail the reasons why your doctor, the hospital, and we think it is right (medically appropriate) for you to be discharged on that date.
- You can get a sample of the **Detailed Notice of Discharge** by calling Customer Service or 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. (TTY users should call 1-877-486-2048.) Or you can see a sample notice online at www.cms.gov/Medicare/Medicare-General-Information/BNI/HospitalDischargeAppealNotices.

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

- Health professionals at the Quality Improvement Organization (the *reviewers*) will ask you (or your representative) why you believe coverage for the services should continue. You don’t have to prepare anything in writing, but you may do so if you wish.

Chapter 9 What to do if you have a problem or complaint (coverage decisions, appeals, complaints)

- The reviewers will also look at your medical information, talk with your doctor, and review information that the hospital and we have given to them.
- By noon of the day after the reviewers told us of your appeal, you will get a written notice from us that gives your planned discharge date. This notice also explains in detail the reasons why your doctor, the hospital, and we think it is right (medically appropriate) for you to be discharged on that date.

Step 3: Within one full day after it has all the needed information, the Quality Improvement Organization will give you its answer to your appeal.***What happens if the answer is yes?***

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

What happens if the answer is no?

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

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

- If the Quality Improvement Organization has said *no* to your appeal, *and* you stay in the hospital after your planned discharge date, then you can make another appeal. Making another appeal means you are going on to Level 2 of the appeals process.

Section 7.3**Step-by-step: How to make a Level 2 appeal to change your hospital discharge date**

During a Level 2 appeal, you ask the Quality Improvement Organization to take another look at their decision on your first appeal. If the Quality Improvement Organization turns down your Level 2 appeal, you may have to pay the full cost for your stay after your planned discharge date.

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

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

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

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

Step 3: Within 14 calendar days of receipt of your request for a Level 2 appeal, the reviewers

will decide on your appeal and tell you their decision.

If the review organization says yes:

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

If the review organization says no:

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

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

- There are three additional levels in the appeals process after Level 2 (for a total of five levels of appeal). If you want to go to a Level 3 appeal, the details on how to do this are in the written notice you get after your Level 2 appeal decision.
- The Level 3 appeal is handled by an Administrative Law Judge or attorney adjudicator. Section 9 in this chapter tells more about Levels 3, 4, and 5 of the appeals process.

SECTION 8 How to ask us to keep covering certain medical services if you think your coverage is ending too soon

Section 8.1	<i>This section is only about three services:</i> Home health care, skilled nursing facility care, and Comprehensive Outpatient Rehabilitation Facility (CORF) services
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When you are getting covered **home health services, skilled nursing care, or rehabilitation care (Comprehensive Outpatient Rehabilitation Facility)**, you have the right to keep getting your services for that type of care for as long as the care is needed to diagnose and treat your illness or injury.

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

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

Section 8.2	We will tell you in advance when your coverage will be ending
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Legal Term

Notice of Medicare Non-Coverage. It tells you how you can request a fast-track appeal . Requesting a fast-track appeal is a formal, legal way to request a change to our coverage decision about when to stop your care.
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Chapter 9 What to do if you have a problem or complaint (coverage decisions, appeals, complaints)

1. **You receive a notice in writing** at least two calendar days before our plan is going to stop covering your care. The notice tells you:
 - The date when we will stop covering the care for you.
 - How to request a fast track appeal to request us to keep covering your care for a longer period of time.
2. **You, or someone who is acting on your behalf, will be asked to sign the written notice to show that you received it.** Signing the notice shows *only* that you have received the information about when your coverage will stop. **Signing it does not mean you agree** with the plan's decision to stop care.

Section 8.3 Step-by-step: How to make a Level 1 appeal to have our plan cover your care for a longer time

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

- **Follow the process.**
- **Meet the deadlines.**
- **Ask for help if you need it.** If you have questions or need help at any time, please call Customer Service. Or call your State Health Insurance Assistance Program, a government organization that provides personalized assistance.

During a Level 1 appeal, the Quality Improvement Organization reviews your appeal. It decides if the end date for your care is medically appropriate.

The **Quality Improvement Organization** is a group of doctors and other health care experts paid by the Federal government to check on and help improve the quality of care for people with Medicare. This includes reviewing plan decisions about when it's time to stop covering certain kinds of medical care. These experts are not part of our plan.

Step 1: Make your Level 1 appeal: contact the Quality Improvement Organization and ask for a fast-track appeal. You must act quickly.

How can you contact this organization?

- The written notice you received (*Notice of Medicare Non-Coverage*) tells you how to reach this organization. Or find the name, address, and phone number of the Quality Improvement Organization for your state in Chapter 2 (contact information can also be found in "Exhibit A" in the back of this document).

Act quickly:

- You must contact the Quality Improvement Organization to start your appeal **by noon of the day before the effective date** on the Notice of Medicare Non-Coverage.
- If you miss the deadline, and you wish to file an appeal, you still have appeal rights. Contact your Quality Improvement Organization.

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

Legal Term
Detailed Explanation of Non-Coverage. Notice that provides details on reasons for ending coverage.

What happens during this review?

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

Step 3: Within one full day after they have all the information they need; the reviewers will tell you their decision.***What happens if the reviewers say yes?***

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

What happens if the reviewers say no?

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

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

- If reviewers say *no* to your Level 1 appeal – and you choose to continue getting care after your coverage for the care has ended – then you can make a Level 2 appeal.

Section 8.4	Step-by-step: How to make a Level 2 appeal to have our plan cover your care for a longer time
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During a Level 2 appeal, you ask the Quality Improvement Organization to take another look at the decision on your first appeal. If the Quality Improvement Organization turns down your Level 2 appeal, you may have to pay the full cost for your home health care, or skilled nursing facility care, or Comprehensive Outpatient Rehabilitation Facility (CORF) services *after* the date when we said your coverage would end.

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

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

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

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

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

What happens if the review organization says yes?

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

What happens if the review organization says no?

- It means they agree with the decision made to your Level 1 appeal .
- The notice you get will tell you in writing what you can do if you wish to continue with the review process. It will give you the details about how to go on to the next level of appeal, which is handled by an Administrative Law Judge or attorney adjudicator.

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

- There are three additional levels of appeal after Level 2, for a total of five levels of appeal. If you want to go on to a Level 3 appeal, the details on how to do this are in the written notice you get after your Level 2 appeal decision.
- The Level 3 appeal is handled by an Administrative Law Judge or attorney adjudicator. Section 9 in this chapter tells more about Levels 3, 4, and 5 of the appeals process.

SECTION 9 Taking your appeal to Level 3 and beyond

Section 9.1 Appeal Levels 3, 4 and 5 for Medical Service Requests

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

If the dollar value of the item or medical service you have appealed meets certain minimum levels, you may be able to go on to additional levels of appeal. If the dollar value is less than the minimum level, you cannot appeal any further. The written response you receive to your Level 2 appeal will explain how to make a Level 3 appeal.

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

Level 3 appeal An Administrative Law Judge or an attorney adjudicator who works for the Federal government will review your appeal and give you an answer.

- **If the Administrative Law Judge or attorney adjudicator says yes to your appeal, the appeals process *may or may not* be over.** Unlike a decision at a Level 2 appeal, we have the right to appeal a Level 3 decision that is favorable to you. If we decide to appeal, it will go to a Level 4 appeal.
 - If we decide *not* to appeal, we must authorize or provide you with the medical care within 60 calendar days after receiving the Administrative Law Judge's or attorney adjudicator's decision.
 - If we decide to appeal the decision, we will send you a copy of the Level 4 appeal request with

Chapter 9 What to do if you have a problem or complaint (coverage decisions, appeals, complaints)

any accompanying documents. We may wait for the Level 4 appeal decision before authorizing or providing the medical care in dispute.

- **If the Administrative Law Judge or attorney adjudicator says no to your appeal, the appeals process *may or may not* be over.**
 - If you decide to accept this decision that turns down your appeal, the appeals process is over.
 - If you do not want to accept the decision, you can continue to the next level of the review process. The notice you get will tell you what to do for a Level 4 appeal.

Level 4 appeal The **Medicare Appeals Council (Council)** will review your appeal and give you an answer. The Council is part of the Federal government.

- **If the answer is yes, or if the Council denies our request to review a favorable Level 3 appeal decision, the appeals process *may or may not* be over.** Unlike a decision at Level 2, we have the right to appeal a Level 4 decision that is favorable to you. We will decide whether to appeal this decision to Level 5.
 - If we decide *not* to appeal the decision, we must authorize or provide you with the medical care within 60 calendar days after receiving the Council's decision.
 - If we decide to appeal the decision, we will let you know in writing.
- **If the answer is no or if the Council denies the review request, the appeals process *may or may not* be over.**
 - If you decide to accept this decision that turns down your appeal, the appeals process is over.
 - If you do not want to accept the decision, you may be able to continue to the next level of the review process. If the Council says no to your appeal, the notice you get will tell you whether the rules allow you to go on to a Level 5 appeal and how to continue with a Level 5 appeal.

Level 5 appeal A judge at the **Federal District Court** will review your appeal.

- A judge will review all of the information and decide *yes* or *no* to your request. This is a final answer. There are no more appeal levels after the Federal District Court.

Section 9.2 Appeal Levels 3, 4 and 5 for Part D Drug Requests

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

If the value of the drug you have appealed meets a certain dollar amount, you may be able to go on to additional levels of appeal. If the dollar amount is less, you cannot appeal any further. The written response you receive to your Level 2 appeal will explain who to contact and what to do to ask for a Level 3 appeal.

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

Level 3 appeal An **Administrative Law Judge or an attorney adjudicator who works for the Federal government** will review your appeal and give you an answer.

- **If the answer is yes, the appeals process is over.** We must **authorize or provide the drug coverage** that was approved by the Administrative Law Judge or attorney adjudicator **within 72 hours (24 hours**

for expedited appeals) or make payment no later than 30 calendar days after we receive the decision.

- **If the answer is no, the appeals process *may* or *may not* be over.**
 - If you decide to accept this decision that turns down your appeal, the appeals process is over.
 - If you do not want to accept the decision, you can continue to the next level of the review process. The notice you get will tell you what to do for a Level 4 appeal.

Level 4 appeal The **Medicare Appeals Council** (Council) will review your appeal and give you an answer. The Council is part of the Federal government.

- **If the answer is yes, the appeals process is over.** We must **authorize or provide the drug coverage** that was approved by the Council **within 72 hours (24 hours for expedited appeals) or make payment no later than 30 calendar days** after we receive the decision.
- **If the answer is no, the appeals process *may* or *may not* be over.**
 - If you decide to accept this decision that turns down your appeal, the appeals process is over.
 - If you do not want to accept the decision, you may be able to continue to the next level of the review process. If the Council says no to your appeal or denies your request to review the appeal, the notice will tell you whether the rules allow you to go on to a Level 5 appeal. It will also tell you who to contact and what to do next if you choose to continue with your appeal.

Level 5 appeal A judge at the **Federal District Court** will review your appeal.

- A judge will review all of the information and decide *yes* or *no* to your request. This is a final answer. There are no more appeal levels after the Federal District Court.

MAKING COMPLAINTS

SECTION 10 How to make a complaint about quality of care, waiting times, customer service, or other concerns

Section 10.1 What kinds of problems are handled by the complaint process?

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

Complaint	Example
Quality of your medical care	<ul style="list-style-type: none"> • Are you unhappy with the quality of the care you have received (including care in the hospital)?
Respecting your privacy	<ul style="list-style-type: none"> • Did someone not respect your right to privacy or share confidential information?
Disrespect, poor customer service, or other negative behaviors	<ul style="list-style-type: none"> • Has someone been rude or disrespectful to you? • Are you unhappy with our Customer Service? • Do you feel you are being encouraged to leave the plan?

Chapter 9 What to do if you have a problem or complaint (coverage decisions, appeals, complaints)

Complaint	Example
Waiting times	<ul style="list-style-type: none"> • Are you having trouble getting an appointment, or waiting too long to get it? • Have you been kept waiting too long by doctors, pharmacists, or other health professionals? Or by our Customer Service or other staff at the plan? <ul style="list-style-type: none"> ○ Examples include waiting too long on the phone, in the waiting or exam room, or getting a prescription.
Cleanliness	<ul style="list-style-type: none"> • Are you unhappy with the cleanliness or condition of a clinic, hospital, or doctor's office?
Information you get from us	<ul style="list-style-type: none"> • Did we fail to give you a required notice? • Is our written information hard to understand?
Timeliness (These types of complaints are all related to the <i>timeliness</i> of our actions related to coverage decisions and appeals)	<p>If you have asked for a coverage decision or made an appeal, and you think that we are not responding quickly enough, you can make a complaint about our slowness. Here are examples:</p> <ul style="list-style-type: none"> • You asked us for a fast coverage decision or a fast appeal, and we have said no; you can make a complaint. • You believe we are not meeting the deadlines for coverage decisions or appeals; you can make a complaint. • You believe we are not meeting deadlines for covering or reimbursing you for certain medical items or services or drugs that were approved; you can make a complaint. • You believe we failed to meet required deadlines for forwarding your case to the independent review organization; you can make a complaint.

Section 10.2 How to make a complaint**Legal Terms**

- A **Complaint** is also called a **grievance**.
- **Making a complaint** is also called **filing a grievance**.
- **Using the process for complaints** is also called **using the process for filing a grievance**.
- A **fast complaint** is also called an **expedited grievance**.

Section 10.3 Step-by-step: Making a complaint**Step 1: Contact us promptly – either by phone or in writing.**

- **Usually, calling Customer Service is the first step.** If there is anything else you need to do, Customer Service will let you know.
- **If you do not wish to call (or you called and were not satisfied), you can put your complaint in writing and send it to us.** If you put your complaint in writing, we will respond to your complaint in writing.

- **We must notify you of our decision about your grievance within 30 calendar days after receiving your grievance or notify you prior to the 30-calendar day deadline that we are taking a 14-day extension.** We may take a 14-day extension upon your request or if we justify a need for additional information and documents, which would be in your best interest. We must promptly notify you in writing if the extension is going to be taken and explain the reason for the delay. You may also file an expedited grievance if we have denied your request to process a coverage decision, organization decision, or appeal under the expedited time frame. An expedited grievance may also be requested if you disagree with our decision to grant a 14-day extension. We must notify you of our decision about your expedited grievance within 24 hours after receiving your grievance.
- The **deadline** for making a complaint is 60 calendar days from the time you had the problem you want to complain about.

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

- **If possible, we will answer you right away.** If you call us with a complaint, we may be able to give you an answer on the same phone call.
- **Most complaints are answered within 30 calendar days.** If we need more information and the delay is in your best interest or if you ask for more time, we can take up to 14 more calendar days (44 calendar days total) to answer your complaint. If we decide to take extra days, we will tell you in writing.
- **If you are making a complaint because we denied your request for a fast coverage decision or a fast appeal, we will automatically give you a fast complaint.** If you have a fast complaint, it means we will give you **an answer within 24 hours.**
- **If we do not agree** with some or all of your complaint or don't take responsibility for the problem you are complaining about, we will include our reasons in our response to you.

Section 10.4 You can also make complaints about quality of care to the Quality Improvement Organization

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

- **You can make your complaint directly to the Quality Improvement Organization.** The Quality Improvement Organization is a group of practicing doctors and other health care experts paid by the Federal government to check and improve the care given to Medicare patients. Chapter 2 has contact information (contact information can also be found in "Exhibit A" in the back of this document).

Or

- **You can make your complaint to both the Quality Improvement Organization and us at the same time.**

Section 10.5 You can also tell Medicare about your complaint

You can submit a complaint about us directly to Medicare. To submit a complaint to Medicare, go to www.medicare.gov/MedicareComplaintForm/home.aspx. You may also call 1-800-MEDICARE (1-800-633-4227). TTY/TDD users can call 1-877-486-2048.

CHAPTER 10:

Ending your membership in the plan

SECTION 1 Introduction to ending your membership in our plan

Ending your membership in Regence MedAdvantage + Rx Classic 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. Sections 2 and 3 provide information on ending your membership voluntarily.
- There are also limited situations where we are required to end your membership. Section 5 tells you about situations when we must end your membership.

If you are leaving our plan, our plan must continue to provide your medical care and prescription drugs and you will continue to pay your cost share until your membership ends.

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

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

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

- **The Annual Enrollment Period** is from **October 15 to December 7**.
- **Choose to keep your current coverage or make changes to your coverage for the upcoming year.** If you decide to change to a new plan, you can choose any of the following types of plans:
 - Another Medicare health plan, with or without prescription drug coverage.
 - Original Medicare *with* a separate Medicare prescription drug plan.
 - --or-- Original Medicare *without* a separate Medicare prescription drug plan.
 - If you choose this option, Medicare may enroll you in a drug plan, unless you have opted out of automatic enrollment.

Note: If you disenroll from Medicare prescription drug coverage and go without creditable prescription drug coverage for 63 or more days in a row, you may have to pay a Part D late enrollment penalty if you join a Medicare drug plan later.

- **Your membership will end in our plan** when your new plan's coverage begins on January 1.

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

You have the opportunity to make *one* change to your health coverage during the **Medicare Advantage Open Enrollment Period**.

- **The annual Medicare Advantage Open Enrollment Period** is from January 1 to March 31 and also for new Medicare beneficiaries who are enrolled in an MA plan, from the month of entitlement to Part A and Part B until the last day of the 3rd month of entitlement.
- **During the annual Medicare Advantage Open Enrollment Period** you can:

- Switch to another Medicare Advantage Plan with or without prescription drug coverage.
- Disenroll from our plan and obtain coverage through Original Medicare. If you choose to switch to Original Medicare during this period, you can also join a separate Medicare prescription drug plan at that time.
- **Your membership will end** on the first day of the month after you enroll in a different Medicare Advantage plan or we get your request to switch to Original Medicare. If you also choose to enroll in a Medicare prescription drug plan, your membership in the drug plan will begin the first day of the month after the drug plan gets your enrollment request.

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

- **You may be eligible to end your membership during a Special Enrollment Period** if any of the following situations apply to you. These are just examples; for the full list you can contact the plan, call Medicare, or visit the Medicare website (www.medicare.gov):
 - Usually, when you have moved
 - If you have Medicaid
 - If you are eligible for “Extra Help” with paying for your Medicare prescriptions
 - If we violate our contract with you
 - If you are getting care in an institution, such as a nursing home or long-term care (LTC) hospital
- Note:** If you’re in a drug management program, you may not be able to change plans. Chapter 5, Section 10 tells you more about drug management programs.
- **The enrollment time periods vary** depending on your situation.
- **To find out if you are eligible for a Special Enrollment Period**, please call Medicare at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users call 1-877-486-2048. If you are eligible to end your membership because of a special situation, you can choose to change both your Medicare health coverage and prescription drug coverage. You can choose:
 - Another Medicare health plan with or without prescription drug coverage.
 - Original Medicare *with* a separate Medicare prescription drug plan.
 - --or-- Original Medicare *without* a separate Medicare prescription drug plan.

Note: If you disenroll from Medicare prescription drug coverage and go without creditable prescription drug coverage for 63 days or more in a row, you may have to pay a Part D late enrollment penalty if you join a Medicare drug plan later.

- **Your membership will usually end** on the first day of the month after your request to change your plan is received.
- **If you receive “Extra Help” from Medicare to pay for your prescription drugs:** If you switch to Original Medicare and do not enroll in a separate Medicare prescription drug plan, Medicare may enroll you in a drug plan, unless you have opted out of automatic enrollment.

Section 2.4 Where can you get more information about when you can end your membership?

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

- **Call Customer Service.**
- Find the information in the *Medicare & You 2025* handbook.
- Contact **Medicare** at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. (TTY 1-877-486-2048).

SECTION 3 How do you end your membership in our plan?

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

If you would like to switch from our plan to:	This is what you should do:
<ul style="list-style-type: none">• Another Medicare health plan.	<ul style="list-style-type: none">• Enroll in the new Medicare health plan.• You will automatically be disenrolled from our plan when your new plan's coverage begins.
<ul style="list-style-type: none">• Original Medicare <i>with</i> a separate Medicare prescription drug plan.	<ul style="list-style-type: none">• Enroll in the new Medicare prescription drug plan.• You will automatically be disenrolled from our plan when your new plan's coverage begins.
<ul style="list-style-type: none">• Original Medicare <i>without</i> a separate Medicare prescription drug plan.	<ul style="list-style-type: none">• Send us a written request to disenroll. Contact Customer Service if you need more information on how to do this.• You can also contact Medicare, at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week, and ask to be disenrolled. TTY users should call 1-877-486-2048.• You will be disenrolled from our plan when your coverage in Original Medicare begins.

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

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

- **Continue to use our network providers to receive medical care.**
- **Continue to use our network pharmacies or mail order to get your prescriptions filled.**
- **If you are hospitalized on the day that your membership ends, your hospital stay will be covered by our plan until you are discharged** (even if you are discharged after your new health coverage begins).

SECTION 5 Regence MedAdvantage + Rx Classic must end your membership in the plan in certain situations

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

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

- If you no longer have Medicare Part A and Part B.
- If you move out of our service area.
- If you are away from our service area for more than twelve months.
 - If you move or take a long trip, call Customer Service to find out if the place you are moving or traveling to is in our plan's area.
- If you become incarcerated (go to prison).
- If you are no longer a United States citizen or lawfully present in the United States.
- If you lie or withhold information about other insurance you have that provides prescription drug coverage.
- If you intentionally give us incorrect information when you are enrolling in our plan and that information affects your eligibility for our plan. (We cannot make you leave our plan for this reason unless we get permission from Medicare first.)
- If you continuously behave in a way that is disruptive and makes it difficult for us to provide medical care for you and other members of our plan. (We cannot make you leave our plan for this reason unless we get permission from Medicare first.)
- If you let someone else use your membership card to get medical care. (We cannot make you leave our plan for this reason unless we get permission from Medicare first.)
 - If we end your membership because of this reason, Medicare may have your case investigated by the Inspector General.
- If you do not pay the plan premiums for three calendar months.
 - We must notify you in writing that you have three calendar months to pay the plan premium before we end your membership.
- If you are required to pay the extra Part D amount because of your income and you do not pay it, Medicare will disenroll you from our plan and you will lose prescription drug coverage.

Where can you get more information?

If you have questions or would like more information on when we can end your membership call Customer Service.

Section 5.2 We <u>cannot</u> ask you to leave our plan for any health-related reason
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We are not allowed to ask you to leave our plan for any health-related reason.

What should you do if this happens?

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

Section 5.3	You have the right to make a complaint if we end your membership in our plan
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If we end your membership in our plan, we must tell you our reasons in writing for ending your membership. We must also explain how you can file a grievance or make a complaint about our decision to end your membership.

CHAPTER 11:

Legal notices

SECTION 1 Notice about governing law

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

SECTION 2 Notice about nondiscrimination

We don't discriminate based on race, ethnicity, national origin, color, religion, sex, gender, age, sexual orientation, mental or physical disability, health status, claims experience, medical history, genetic information, evidence of insurability, or geographic location within the service area. All organizations that provide Medicare Advantage Plans, like our plan, must obey Federal laws against discrimination, including Title VI of the Civil Rights Act of 1964, the Rehabilitation Act of 1973, the Age Discrimination Act of 1975, the Americans with Disabilities Act, Section 1557 of the Affordable Care Act, all other laws that apply to organizations that get Federal funding, and any other laws and rules that apply for any other reason.

If you want more information or have concerns about discrimination or unfair treatment, please call the Department of Health and Human Services' **Office for Civil Rights** at 1-800-368-1019 (TTY 1-800-537-7697) or your local Office for Civil Rights. You can also review information from the Department of Health and Human Services' Office for Civil Rights at <https://www.hhs.gov/ocr/index.html>.

If you have a disability and need help with access to care, please call us at Customer Service. If you have a complaint, such as a problem with wheelchair access, Customer Service can help.

SECTION 3 Notice about Medicare Secondary Payer subrogation rights

We have the right and responsibility to collect for covered Medicare services for which Medicare is not the primary payer. According to CMS regulations at 42 CFR sections 422.108 and 423.462, Regence MedAdvantage + Rx Classic, as a Medicare Advantage Organization, will exercise the same rights of recovery that the Secretary exercises under CMS regulations in subparts B through D of part 411 of 42 CFR and the rules established in this section supersede any State laws.

SECTION 4 Events beyond our control

If there are events beyond Regence BlueCross BlueShield of Utah's control that affect its ability and/or its providers ability to perform or provide services to you, Regence BlueCross BlueShield of Utah's failure to perform its duties shall be excused and Regence BlueCross BlueShield of Utah shall not be liable to the extent it takes commercially reasonable steps to address any service delays. Such events may include natural disasters, epidemic or pandemic, terrorism, riots, insurrection, war, or any other cause which is beyond the reasonable control of Regence BlueCross BlueShield of Utah. Upon the occurrence of such an event, Regence BlueCross BlueShield of Utah will take commercially reasonable efforts to notify you of the steps it is taking to address service delivery interruptions or delays caused by the event. Such steps may include allowing you to obtain services from out of network providers.

SECTION 5 Liability of Member in the event of nonpayment

Unless otherwise required by law, you are responsible for any applicable coinsurance and copayments when covered services are provided by a plan provider.

You are responsible for any services for which there is a fee if the benefit is not included in the Schedule of Benefits. In the event Regence BlueCross BlueShield of Utah, fails to pay a contracting or non-contracting provider for covered services, you are not liable to the provider for any sums owed by Regence BlueCross BlueShield of Utah.

However, if you enter into a private contract with a non-contracting medical provider, neither Regence BlueCross BlueShield of Utah nor Medicare will pay for those services.

SECTION 6 Third Party Liability and Subrogation

If you are injured through the actions of a third party and are entitled to recovery from the third party or as a result of your injury for medical expenses, you are obligated to reimburse our plan for the reasonable value of the medical services received as a result of your injury.

If automobile medical, no-fault or liability insurance is available to you, then benefits under that plan must be used before there is coverage by Regence BlueCross BlueShield of Utah. Regence BlueCross BlueShield of Utah will pay only after the other coverage has been exhausted.

Payment of funds may be made directly between insurance and other providers of benefits. If benefits are provided in the form of service rather than cash payments, the reasonable cash value of each service rendered should be deemed both an allowable expense and a benefit paid.

In the case of injuries caused by an act or omission of a third party, and complications incident to that act, Regence BlueCross BlueShield of Utah will arrange for the provision of covered services and other benefits. You must notify Regence BlueCross BlueShield of Utah when there is a possibility that a third party may be liable for the injuries. Regence BlueCross BlueShield of Utah will have a first-party lien against any such accident-related settlement, even if the settlement does not specifically include payment for medical costs. Upon settlement, Regence BlueCross BlueShield of Utah will be reimbursed at the prevailing rates for the cost of services and benefits provided as a result of the injury. In the event the third party does not satisfy Regence BlueCross BlueShield of Utah lien by direct payment, you agree to reimburse Regence BlueCross BlueShield of Utah any amounts it has paid in connection with treatment of the injury or any complications, but not to exceed the amount of the recovery.

If you incur health care expenses for treatment of the illness or injury after receiving a recovery, we will exclude benefits for otherwise covered expenses until the total amount of health care expenses incurred after the recovery exceeds the net recovery amount.

You must agree to cooperate in protecting the interests of Regence BlueCross BlueShield of Utah under this provision and to execute and deliver to Regence BlueCross BlueShield of Utah, or its nominee, any and all assignments or other documents that may be necessary or proper to fully and completely carry out and protect the rights of Regence BlueCross BlueShield of Utah or its nominee.

SECTION 7 Relationship to the Blue Cross and Blue Shield Association

You hereby expressly acknowledge your understanding that this Evidence of Coverage is a contract solely between you and Regence BlueCross BlueShield of Utah. Regence BlueCross BlueShield of Utah is an independent corporation operating under a license from the Blue Cross and Blue Shield Association (the “Association”), an association of independent Blue Cross and Blue Shield Plans, permitting Regence BlueCross BlueShield of Utah to use the Blue Cross and Blue Shield Service Marks in Utah. Regence BlueCross BlueShield of Utah is not contracting as an agent of the Association.

You further acknowledge and agree that you have not entered into this Plan based upon representations by any person other than Regence BlueCross BlueShield of Utah and that no person, entity, or organization other than Regence BlueCross BlueShield of Utah shall be held accountable or liable to you for any of Regence BlueCross BlueShield of Utah’s obligations to you created under this Evidence of Coverage. This paragraph shall not create any additional obligations whatsoever on the part of Regence BlueCross BlueShield of Utah other than those obligations created under other provisions of this Evidence of Coverage.

CHAPTER 12:

Definitions of important words

Allowed Amount – The amount that is considered the reasonable reimbursement amount that a provider will receive for their services. This amount is determined by either Medicare or the plan itself. If a provider is contracted as a network provider with the plan, they have agreed to accept the allowed amount as full reimbursement for all covered services.

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

Annual Enrollment Period – The time period of October 15 until December 7 of each year when members can change their health or drug plans or switch to Original Medicare.

Appeal – An appeal is something you do if you disagree with our decision to deny a request for coverage of health care services or prescription drugs or payment for services or drugs you already received. You may also make an appeal if you disagree with our decision to stop services that you are receiving. For example, you may ask for an appeal if we don't pay for a drug, item, or service you think you should be able to receive. If you or your physician feel the standard timeframe for an appeal could seriously jeopardize your life, health, or your ability to regain maximum function, you may request a "fast appeal". Chapter 9 explains appeals, including the process and timelines.

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

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

Biological Product – A prescription drug that is made from natural and living sources like animal cells, plant cells, bacteria, or yeast. Biological products are more complex than other drugs and cannot be copied exactly, so alternative forms are called biosimilars. (See also "**Original Biological Product**" and "**Biosimilar**").

Biosimilar – A biological product that is very similar, but not identical, to the original biological product. Biosimilars are as safe and effective as the original biological product. Some biosimilars substituted for the original biological product at the pharmacy without needing a new prescription (See "**Interchangeable Biosimilar**").

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

Catastrophic Coverage Stage – The stage in the Part D Drug Benefit that begins when you (or other qualified parties on your behalf) have spent \$2,000 for Part D covered drugs during the covered year. During this payment stage, you pay nothing for your covered Part D drugs.

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

Chronic-Care Special Needs Plan – C-SNPs are SNPs that restrict enrollment to MA eligible individuals

who have one or more severe or disabling chronic conditions, as defined under 42 CFR 422.2, including restricting enrollment based on the multiple commonly co-morbid and clinically linked condition groupings specified in 42 CFR 422.4(a)(1)(iv).

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

Combined Maximum Out-of-Pocket Amount – This is the most you will pay in a year for all Part A and Part B services from both network (preferred) providers and out-of-network (non-preferred) providers.

Complaint – The formal name for making a complaint is **filing a grievance**. The complaint process is used *only* for certain types of problems. This includes problems related to quality of care, waiting times, and the customer service you receive. It also includes complaints if your plan does not follow the time periods in the appeal process.

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

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

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

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

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

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

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

Custodial Care – Custodial care is personal care provided in a nursing home, hospice, or other facility setting when you do not need skilled medical care or skilled nursing care. Custodial care provided by people who do

not have professional skills or training, includes help with activities of daily living like bathing, dressing, eating, getting in or out of a bed or chair, moving around, and using the bathroom. It may also include the kind of health-related care that most people do themselves, like using eye drops. Medicare doesn't pay for custodial care.

Customer Service – A department within our plan responsible for answering your questions about your membership, benefits, grievances, and appeals.

Daily cost sharing rate – A daily cost sharing rate may apply when your doctor prescribes less than a full month's supply of certain drugs for you and you are required to pay a copayment. A daily cost sharing rate is the copayment divided by the number of days in a month's supply. Here is an example: If your copayment for a one-month supply of a drug is \$30, and a one-month's supply in your plan is 30 days, then your daily cost sharing rate is \$1 per day.

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

Diagnostic Procedures and Tests – The purpose of a diagnostic procedure or test is to confirm the presence (or absence) of disease in symptomatic individuals as a basis for treatment decisions or confirm a positive screening result.

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

Dispensing Fee – A fee charged each time a covered drug is dispensed to pay for the cost of filling a prescription, such as the pharmacist's time to prepare and package the prescription.

Dual Eligible Special Needs Plans (D-SNP) – D-SNPs enroll individuals who are entitled to both Medicare (Title XVIII of the Social Security Act) and medical assistance from a state plan under Medicaid (Title XIX). States cover some Medicare costs, depending on the state and the individual's eligibility.

Durable Medical Equipment (DME) – Certain medical equipment that is ordered by your doctor for medical reasons. Examples include walkers, wheelchairs, crutches, powered mattress systems, diabetic supplies, IV infusion pumps, speech generating devices, oxygen equipment, nebulizers, or hospital beds ordered by a provider for use in the home.

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

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

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

Exception – A type of coverage decision that, if approved, allows you to get a drug that is not on our formulary (a formulary exception), or get a non-preferred drug at a lower cost sharing level (a tiering exception). You may also request an exception if our plan requires you to try another drug before receiving the drug you are requesting, if our plan requires a prior authorization for a drug and you want us to waive the criteria restriction, or if our plan limits the quantity or dosage of the drug you are requesting (a formulary exception).

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

Generic Drug – A prescription drug that is approved by the Food and Drug Administration (FDA) as having the same active ingredient(s) as the brand name drug. Generally, a generic drug works the same as a brand name drug and usually costs less.

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

Health Maintenance Organization (HMO) plans – In most HMOs, you can only go to doctors, other health care providers, or hospitals in the plan’s network, except in an urgent or emergency situation. You may also need to get a referral from your primary care doctor for tests or to see other doctors or specialists.

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

Hospice – A benefit that provides special treatment for a member who has been medically certified as terminally ill, meaning having a life expectancy of 6 months or less. We, your plan, must provide you with a list of hospices in your geographic area. If you elect hospice and continue to pay premiums, you are still a member of our plan. You can still obtain all medically necessary services as well as the supplemental benefits we offer.

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

Hospital-Owned Clinics – Some clinics where you see providers may be owned by a hospital. When you receive services at these clinics you may have higher out-of-pocket costs because hospital-owned clinics may bill you for both the provider you see, and for the use of the facility the provider is in.

Income Related Monthly Adjustment Amount (IRMAA) – If your modified adjusted gross income as reported on your IRS tax return from 2 years ago is above a certain amount, you’ll pay the standard premium amount and an Income Related Monthly Adjustment Amount, also known as IRMAA. IRMAA is an extra charge added to your premium. Less than 5% of people with Medicare are affected, so most people will not pay a higher premium.

Initial Coverage Stage – This is the stage before your out-of-pocket costs for the year have reached the out-of-pocket threshold amount.

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

In-Network Maximum Out-of-Pocket Amount – The most you will pay for covered Part A and Part B services received from network (preferred) providers. After you have reached this limit, you will not have to pay anything when you get covered services from network providers for the rest of the contract year. However, until you reach your combined out-of-pocket amount, you must continue to pay your share of the costs when you seek care from an out-of-network (non-preferred) provider.

Institutional Special Needs Plan (SNP) – A plan that enrolls eligible individuals who continuously reside or are expected to continuously reside for 90 days or longer in a long-term care (LTC) facility. These facilities may include a skilled nursing facility (SNF), nursing facility (NF), (SNF/NF), an Intermediate Care Facility

for Individuals with Intellectual Disabilities (ICF/IID), an inpatient psychiatric facility, and/or facilities approved by CMS that furnishes similar long-term, health care services that are covered under Medicare Part A, Medicare Part B, or Medicaid; and whose residents have similar needs and health care status to the other named facility types. An institutional Special Needs Plan must have a contractual arrangement with (or own and operate) the specific LTC facility(ies).

Institutional Equivalent Special Needs Plan (SNP) – A plan that enrolls eligible individuals living in the community but requiring an institutional level of care based on the State assessment. The assessment must be performed using the same respective State level of care assessment tool and administered by an entity other than the organization offering the plan. This type of Special Needs Plan may restrict enrollment to individuals that reside in a contracted assisted living facility (ALF) if necessary to ensure uniform delivery of specialized care.

Interchangeable Biosimilar – A biosimilar that may be used as a substitute for an original biosimilar product at the pharmacy without needing a new prescription because it meets additional requirements related to the potential for automatic substitution. Automatic substitution at the pharmacy is subject to state law.

List of Covered Drugs (Formulary or Drug List) – A list of prescription drugs covered by the plan.

Low Income Subsidy (LIS) – See “Extra Help.”

Manufacturer Discount Program – A program under which drug manufacturers pay a portion of the plan’s full cost for covered Part D brand name drugs and biologics. Discounts are based on agreements between the Federal government and drug manufacturers.

Medicaid (or Medical Assistance) – A joint Federal and state program that helps with medical costs for some people with low incomes and limited resources. State Medicaid programs vary, but most health care costs are covered if you qualify for both Medicare and Medicaid.

Medically Accepted Indication – A use of a drug that is either approved by the Food and Drug Administration or supported by certain references, such as the American Hospital Formulary Service Drug Information and the Micromedex DRUGDEX Information system.

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

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

Medicare Advantage Open Enrollment Period – The time period from January 1 to March 31 when members in a Medicare Advantage plan can cancel their plan enrollment and switch to another Medicare Advantage plan or obtain coverage through Original Medicare. If you choose to switch to Original Medicare during this period, you can also join a separate Medicare prescription drug plan at that time. The Medicare Advantage Open Enrollment Period is also available for a 3-month period after an individual is first eligible for Medicare.

Medicare Advantage (MA) Plan – Sometimes called Medicare Part C. A plan offered by a private company that contracts with Medicare to provide you with all your Medicare Part A and Part B benefits. A Medicare Advantage Plan can be i)an HMO, ii)a PPO, iii)a Private Fee-for-Service (PFFS) plan, or iv)a Medicare Medical Savings Account (MSA) plan. Besides choosing from these types of plans, a Medicare Advantage HMO or PPO plan can also be a Special Needs Plan (SNP). In most cases, Medicare Advantage Plans also offer Medicare Part D (prescription drug coverage). These plans are called **Medicare Advantage Plans with**

Prescription Drug Coverage.

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

Medicare-Covered Services – Services covered by Medicare Part A and Part B. All Medicare health plans must cover all of the services that are covered by Medicare Part A and B. The term Medicare-Covered Services does not include the extra benefits, such as vision, dental, or hearing, that a Medicare Advantage plan may offer.

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

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

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

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

Network Pharmacy – A pharmacy that contracts with our plan where members of our plan can get their prescription drug benefits. In most cases, your prescriptions are covered only if they are filled at one of our network pharmacies.

Network Provider – Provider is the general term 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. **Network providers** have an agreement with our plan to accept our payment as payment in full, and in some cases to coordinate as well as provide covered services to members of our plan. Network providers are also called plan providers.

Observation Care – Specific, clinically appropriate services, which include ongoing short-term treatment, assessment, and reassessment before a decision can be made whether patients will require further treatment as an inpatient or is able to be discharged from the hospital.

Organization Determination – A decision our plan makes about whether items or services are covered or how much you have to pay for covered items or services. Organization determinations are called coverage decisions in this document.

Original Biological Product – A biological product that has been approved by the Food and Drug Administration (FDA) and serves as the comparison for manufacturers making a biosimilar version. It is also called a reference product.

Original Medicare (Traditional Medicare or Fee-for-Service Medicare) – Original Medicare is offered by the government, and not a private health plan such as Medicare Advantage Plans and prescription drug plans. Under Original Medicare, Medicare services are covered by paying doctors, hospitals, and other health care providers payment amounts established by Congress. You can see any doctor, hospital, or other health care

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

Out-of-Network Pharmacy – A pharmacy that does not have a contract with our plan to coordinate or provide covered drugs to members of our plan. Most drugs you get from out-of-network pharmacies are not covered by our plan unless certain conditions apply.

Out-of-Network Provider or Out-of-Network Facility – A provider or facility that does not have a contract with our plan 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.

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

Out-of-Pocket Threshold – The maximum amount you pay out of pocket for Part D drugs.

Part C – see Medicare Advantage (MA) Plan.

Part D – The voluntary Medicare Prescription Drug Benefit Program.

Part D Drugs – Drugs that can be covered under Part D. We may or may not offer all Part D drugs. Certain categories of drugs have been excluded as covered Part D drugs by Congress. Certain categories of Part D drugs must be covered by every plan.

Part D Late Enrollment Penalty – An amount added to your monthly premium for Medicare drug coverage if you go without creditable coverage (coverage that is expected to pay, on average, at least as much as standard Medicare prescription drug coverage) for a continuous period of 63 days or more after you are first eligible to join a Part D plan.

Preferred Cost Sharing – Preferred cost sharing means lower cost sharing for certain covered Part D drugs at certain network pharmacies.

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

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

Primary Care Provider (PCP) – The doctor or other provider you see first for most health problems. In many Medicare health plans, you must see your primary care provider before you see any other health care provider.

Prior Authorization – Approval in advance to get services or certain drugs. Some in-network medical services are covered only if your doctor or other network provider gets prior authorization from our plan. You do not need prior authorization to obtain out-of-network services. However, you may want to check with the plan before obtaining services from out-of-network providers to confirm that the service is covered by your plan and what your cost sharing responsibility is. Covered services that need prior authorization are marked in the

Benefits Chart in Chapter 4. Covered drugs that need prior authorization are marked in the formulary and our criteria are posted on our website.

Prosthetics and Orthotics – Medical devices including, but are not limited to, arm, back and neck braces; artificial limbs; artificial eyes; and devices needed to replace an internal body part or function, including ostomy supplies and enteral and parenteral nutrition therapy.

Quality Improvement Organization (QIO) – A group of practicing doctors and other health care experts paid by the Federal government to check and improve the care given to Medicare patients.

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

“Real-Time Benefit Tool” – A portal or computer application in which enrollees can look up complete, accurate, timely, clinically appropriate, enrollee-specific formulary and benefit information. This includes cost sharing amounts, alternative formulary medications that may be used for the same health condition as a given drug, and coverage restrictions (Prior Authorization, Step Therapy, Quantity Limits) that apply to alternative medications.

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

Screening Tests – The primary purpose of screening tests is to detect early disease or risk factors for disease in large numbers of apparently healthy individuals.

Service Area – A geographic area where you must live to join a particular health plan. For plans that limit which doctors and hospitals you may use, it’s also generally the area where you can get routine (non-emergency) services. The plan must disenroll you if you permanently move out of the plan’s service area.

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

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

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

Standard Cost Sharing – Standard cost sharing is cost sharing other than preferred cost sharing offered at a network pharmacy.

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

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

Urgently Needed Services – A plan-covered service requiring immediate medical attention that is not an

Chapter 12 Definitions of important words

emergency is an urgently needed service if either you are temporarily outside the service area of the plan, or it is unreasonable given your time, place, and circumstances to obtain this service from network providers with whom the plan contracts. Examples of urgently needed services are unforeseen medical illnesses and injuries, or unexpected flare-ups of existing conditions. However, medically necessary routine provider visits, such as annual checkups, are not considered urgently needed even if you are outside the service area of the plan or the plan network is temporarily unavailable.

Exhibit A – Utah State Agency Contact Information

This section provides the contact information for the state agencies referenced in Chapter 2 and in other locations within this Evidence of Coverage. If you have trouble finding the information you are looking for, please contact Customer Service at the phone on the back cover of this document.

Agency	Contact Information
State Health Insurance Assistance Program (SHIP)	Senior Health Insurance Information Program (SHIIP) Utah DHS Aging and Adult Services 288 North 1460 West Salt Lake City, UT 84116 1-800-541-7735 agingservices@utah.gov https://daas.utah.gov/seniors/
Quality Improvement Organization (QIO)	KEPRO 5201 West Kennedy Blvd. Suite 900 Tampa, FL 33609 1-888-317-0891 TTY: 711 Fax: 1-844-878-7921 QIOCommunications@kepro.com https://www.keproqio.com/
State Medicaid Office	Utah Department of Health and Human Services Division Integrated Healthcare PO Box 143106 Salt Lake City, UT 84114-3106 1-866-435-7414 MedicaidOps@utah.gov https://medicaid.utah.gov
AIDS Drug Assistance Program (ADAP)	Utah Ryan White Part B Program Utah Department of Health and Human Services Office of Communicable Diseases P.O. Box 142104 Salt Lake City, UT 84114-2104 1-801-538-6191 Fax: 1-801-538-9913 epi@utah.gov https://ptc.health.utah.gov/treatment/ryan-white/

NONDISCRIMINATION NOTICE

Regence complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Regence does not exclude people or treat them less favorably because of race, color, national origin, age, disability, or sex.

Regence:

Provides people with disabilities reasonable modifications and free appropriate auxiliary aids and services to communicate effectively with us, such as:

- Qualified sign language interpreters
- Written information in other formats (large print, audio, accessible electronic formats, other formats).

Provides free language assistance services to people whose primary language is not English, which may include:

- Qualified interpreters
- Information written in other languages.

If you need reasonable modifications, appropriate auxiliary aids and services, or language assistance services, contact the Civil Rights Coordinator.

If you believe that Regence has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, the Civil Rights Coordinator is available to help you.

Customer Service

Civil Rights Coordinator
PO Box 1106
Lewiston, ID 83501-1106
Phone: 1-888-344-6347, (TTY: 711)
Fax: 1-888-309-8784
Email: CS@regence.com

Medicare Customer Service

Phone: 1-800-541-8981 (TTY: 711)
Email: medicareappeals@regence.com

VSP Customer Service

Phone: 1-844-299-3041
TTY: 1-800-428-4833

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at
<http://www.hhs.gov/ocr/office/file/index.html>.

Language assistance

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-888-344-6347 (TTY: 711).

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-888-344-6347 (TTY: 711)。

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-888-344-6347 (TTY: 711).

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-888-344-6347 (TTY: 711) 번으로 전화해 주십시오.

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-888-344-6347 (TTY: 711).

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-888-344-6347 (телетайп: 711).

ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-888-344-6347 (ATS : 711)

注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1-888-344-6347 (TTY:711) まで、お電話にてご連絡ください。

Díí baa akó nínízin: Díí saad bee yáníłti'go **Diné Bizaad**, saad bee áká'ánída'áwo'déé', t'áá jiik'eh, éí ná hóló, koji' hódíilnih 1-888-344-6347 (TTY: 711.)

FAKATOKANGA'I: Kapau 'oku ke Lea-Fakatonga, ko e kau tokoni fakatonu lea 'oku nau fai atu ha tokoni ta'etotongi, pea te ke lava 'o ma'u ia. ha'o telefonimai mai ki he fika 1-888-344-6347 (TTY: 711)

OBAVJEŠTENJE: Ako govorite srpsko-hrvatski, usluge jezičke pomoći dostupne su vam besplatno. Nazovite 1-888-344-6347 (TTY- Telefon za osobe sa oštećenim govorom ili sluhom: 711)

ប្រយ័ត្ន: បើសិនជាអ្នកនិយាយ ភាសាខ្មែរ, សេវាជំនួយផ្នែកភាសា ដោយមិនគិតល្អល គឺអាចមានសំរាប់បំរើអ្នក។ ចូរ ទូរស័ព្ទ 1-888-344-6347 (TTY: 711)។

ਧਿਆਨ ਦਿਓ: ਜੇ ਤੁਸੀਂ ਪੰਜਾਬੀ ਬੋਲਦੇ ਹੋ, ਤਾਂ ਭਾਸ਼ਾ ਵਿੱਚ ਸਹਾਇਤਾ ਸੇਵਾ ਤੁਹਾਡੇ ਲਈ ਮੁਫਤ ਉਪਲਬਧ ਹੈ। 1-888-344-6347 (TTY: 711) 'ਤੇ ਕਾਲ ਕਰੋ।

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlose Sprachdienstleistungen zur Verfügung. Rufnummer: 1-888-344-6347 (TTY: 711)

ማስታወሻ:- የሚናገሩት ቋንቋ አማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ሊያግዝዎት ተዘጋጅተዋል፤ የሚከተለው ቁጥር ይደውሉ 1-888-344-6347 (መስማት ለተሳናቸው:- 711)::

УВАГА! Якщо ви розмовляєте українською мовою, ви можете звернутися до безкоштовної служби мовної підтримки. Телефонуйте за номером 1-888-344-6347 (телетайп: 711)

ध्यान दिनुहोस्: तपाईंले नेपाली बोल्नुहुन्छ भने तपाईंको निम्ति भाषा सहायता सेवाहरू निःशुल्क रूपमा उपलब्ध छ । फोन गर्नुहोस् 1-888-344-6347 (टिटिवाइ: 711)

ATENȚIE: Dacă vorbiți limba română, vă stau la dispoziție servicii de asistență lingvistică, gratuit. Sunați la 1-888-344-6347 (TTY: 711)

MAANDO: To a waawi [Adamawa], e woodi ballooji-ma to ekkitaaki wolde caahu. Noddu 1-888-344-6347 (TTY: 711)

โปรดทราบ: ถ้าคุณพูดภาษาไทย คุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โทร 1-888-344-6347 (TTY: 711)

ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັຽຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທ 1-888-344-6347 (TTY: 711)

Afaan dubbattan Oroomiffaa tiif, tajaajila gargaarsa afaanii tola ni jira. 1-888-344-6347 (TTY: 711) tiin bilbilaa.

توجه: اگر به زبان فارسی صحبت می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با 1-888-344-6347 (TTY: 711) تماس بگیرید.

ملحوظة: إذا كنت تتحدث فاذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-888-344-6347 (رقم هاتف الصم والبكم 711 TTY)

Regence MedAdvantage + Rx Classic Customer Service

Method	Customer Service – Contact Information
CALL	<p>1-800-541-8981</p> <p>Calls to this number are free. Our telephone hours are 8 a.m. to 8 p.m., Monday through Friday. From October 1 through March 31, our telephone hours are 8 a.m. to 8 p.m., seven days a week. Live online chat assistance is also available from 8 a.m. to 5 p.m. PT, Monday through Friday. To access online chat, sign in at regence.com/medicare, select Contact us and click on Chat Now to connect with us.</p> <p>Customer Service also has free language interpreter services available for non-English speakers.</p>
TTY	<p>711</p> <p>Calls to this number are free. Our telephone hours are 8 a.m. to 8 p.m., Monday through Friday. From October 1 through March 31, our telephone hours are 8 a.m. to 8 p.m., seven days a week. Live online chat assistance is also available from 8 a.m. to 5 p.m. PT, Monday through Friday. To access online chat, sign in at regence.com/medicare, select Contact us and click on Chat Now to connect with us.</p>
FAX	<p>1-888-335-2985</p>
WRITE	<p>Regence BlueCross BlueShield of Utah P.O. Box 1827 Medford, OR 97501</p> <p>Live chat assistance and secure email is available through the member portal. Sign in at regence.com/medicare, select Contact us and click on Chat Now to connect with us. Live chat is available from 8 a.m. to 5 p.m. PT, Monday through Friday. Emails will receive a response within one business day.</p>
WEBSITE	<p>regence.com/medicare</p>

State Health Insurance Assistance Program (SHIP)

SHIP is a state program that gets money from the Federal government to give free local health insurance counseling to people with Medicare. Contact information can be found in “Exhibit A” at the end of this document.

PRA Disclosure Statement According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1051. If you have comments or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.