
2008 Welborn HMO Senior Advantage Plan EOC

EVIDENCE OF COVERAGE:

**Your Medicare Health Benefits and Services as a Member of
Welborn Health Plans
Welborn HMO Senior Advantage - PBP 002**

January 1 – December 31, 2008

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

Welborn Health Plans Member Services

For help or information, call Welborn Health Plans Member Services at or go to our Plan Web site at www.welbornhealthplans.com:

Local Phone Number (812) 426-6600

TTY Users may call via Indiana Relay 1-800-743-3333

Toll Free: 1-800-521-0265

FAX: (812) 773-0589

Calls to these numbers are free:

Phone: 1-800-521-0265

TTY: 1-800-743-3333

Hours of Operation:

Member Service Hours: 7 days a week, 8 a.m. – 8 p.m. (CST)

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1 Introduction

Contact Information

Telephone numbers and other information for reference

How to contact Member Services

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

CALL Call Welborn Health Plans at (812) 426-6600
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Toll Free: 1-800-521-0265
This number is also on the cover of this booklet for easy reference

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TTY TTY users may call via Indiana Relay 1-800-743-3333
This number requires special telephone equipment. It is also on the cover of this booklet for easy reference.

FAX FAX: (812) 773-0589

WRITE Welborn Health Plans
101 SE 3rd St
Evansville, IN 47708

VISIT WHP is located at 101 SE 3rd Street. This is the corner of 2nd Street and Locust in downtown Evansville (the old Permanent Federal Building). Please use the west side entrance (side nearest the river). Parking is available on the west side of the building.

WEBSITE www.welbornhealthplans.com

Contact Information for Grievances, Organizations Determinations, Coverage Determinations and Appeals

Part C Organization Determinations

CALL Call Welborn Health Plans at (812) 426-6600
TTY users may call: Indiana Relay 1-800-743-3333
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FAX FAX: (812) 773-0589

WRITE Welborn Health Plans
101 SE 3rd St
Evansville, IN 47708

For information about Part C organization determinations, see [section 8](#).

Part C Grievances

CALL Call Welborn Health Plans at (812) 426-6600
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FAX FAX: (812) 773-0589

WRITE Welborn Health Plans
101 SE 3rd St
Evansville, IN 47708

For information about Part C grievances, see [section 8](#).

Part C Appeals

CALL Call Welborn Health Plans at (812) 426-6600
TTY users may call: Indiana Relay 1-800-743-3333
Toll Free: 1-800-521-0265
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101 SE 3rd St
Evansville, IN 47708

For information about Part C appeals, see section 8.

Southwest Indiana Regional Council on Aging (SWIRCA) – a state program that gives free local health insurance counseling to people with Medicare

“SHIP” stands for **S**tate **H**ealth **I**nsurance Assistance **P**rogram. SWIRCA is a state program that gets money from the federal government to give free local health insurance counseling to people with Medicare. SWIRCA can explain your Medicare rights and protections, help you make complaints about care or treatment, and help straighten out problems with Medicare bills. SWIRCA has information about Medicare Advantage Plans, Medicare Prescription Drug Plans, Medicare Cost Plans and about Medigap (Medicare supplement insurance) policies. This includes information about whether to drop your Medigap policy while enrolled in a Medicare Advantage plan. This also includes special Medigap rights for people who have tried a Medicare Advantage Plan for the first time.

You may contact the local SHIP at SWIRCA, 16 W. Virginia Street, P.O. Box 3938, Evansville, Indiana 47737-3938, (812) 464-7800 or 800-253-2188. You may also find information on the Web site for the SHIP program at www.medicare.gov on the web. Under “Search Tools”, select “Helpful Phone Numbers and Websites”.

Health Care Excel a *Quality Improvement Organization*– a group of doctors and health professionals in your state that reviews medical care and handle certain types of complaints from patients with Medicare

“QIO” stands for **Q**uality **I**mprovement **O**rganization. The QIO is paid by the federal government to check on and help improve the care given to Medicare patients. There is a QIO in each state. QIOs have different names, depending on which state they are in. The doctors and other health experts in the QIO review certain types of complaints made by Medicare patients. These include complaints about quality of care and appeals filed by Medicare patients who think the coverage for their hospital, skilled nursing facility, home health agency, or comprehensive outpatient rehabilitation stay is ending too soon. See Section 7 and 8 for more information about complaints, appeals and grievances.

You may contact Health Care Excel at: Health Care Excel, 2901 Ohio Boulevard, P.O. Box 3713, Terre Haute, Indiana 47803, or by telephone at 1-800-288-1499.

How to contact the Medicare program

Medicare is health insurance for people age 65 or older, under age 65 with certain disabilities, and any age with permanent kidney failure (called End-Stage Renal Disease or ESRD) The Centers for Medicare & Medicaid Services (CMS) is the Federal agency in charge of the Medicare Program. CMS contracts with and regulates Medicare Plans (including our Plan). Here are ways to get help and information about Medicare from CMS:

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

Other organizations (including Social Security and Medicaid, a state government agency that handles health care programs for people with limited resources)

Medicaid helps with medical costs for some people with limited incomes and resources. Some people with Medicare are also eligible for Medicaid. Medicaid has programs that can help pay for your Medicare premiums and other costs, if you qualify. To find out more about Medicaid and its programs, contact the Southwestern Indiana Regional Council on Aging (SWIRCA) at 16 W. Virginia Street, P.O. Box 3938, Evansville, Indiana 47737-3938, or by telephone at (812)464-7800 or 1-800-253-2188, or on the Web site at: swirca.org.

Social Security

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

Railroad Retirement Board

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

Employer (or “Group”) Coverage

If you or your spouse get your benefits from your current or former employer or union, or from your spouse’s current or former employer or union, call your employer’s or union’s benefits administrator or

Member Services if you have any questions about your employer/union benefits, plan premiums, or the open enrollment season. Important Note: You (or your spouses') employer/union benefits may change, or you or your spouse may lose the benefits, if you or your spouse enrolls in Medicare Part D. Call your employer's or union's benefits administrator or Member Services to find out whether the benefits will change or be terminated if you or your spouse enrolls in Part D.

Welcome to Welborn Health Plans!

We are pleased that you've chosen Welborn HMO Senior Advantage Plan.

Welborn HMO Senior Advantage Plan is a Medicare Advantage Plan – Health Maintenance Organization (HMO) for people with Medicare.

Thank you for your membership in Welborn HMO Senior Advantage Plan; you are getting your health care through our Plan. Welborn HMO Senior Advantage Plan is not a "Medigap" Medicare Supplement Insurance policy.

Throughout the remainder of this Evidence of Coverage (EOC), we refer to the Welborn HMO Senior Advantage Plan as "Plan" or "Our Plan".

This Evidence of Coverage explains how to get your health care through our Plan.

This Evidence of Coverage, together with your enrollment form, riders, and amendments that we may send to you, is our contract with you. It explains your rights, benefits, and responsibilities as a member of our Plan. The information in this Evidence of Coverage is in effect for the time period from January 1, 2008 - December 31, 2008.

You will be getting your Medicare services as a member of our Plan.

This Evidence of Coverage will explain to you:

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

If you need this Evidence of Coverage in a different format (such as in large print), please call us so we can send you a copy.

Eligibility Requirements

To be a member of our Plan, you must live in our service area (Gibson, Knox, Perry, Pike, Posey, Spencer, Vanderburgh or Warrick counties in Southwestern Indiana) and be entitled to Medicare Part A and enrolled in Medicare Part B. If you currently pay a premium for Medicare Part A and Medicare

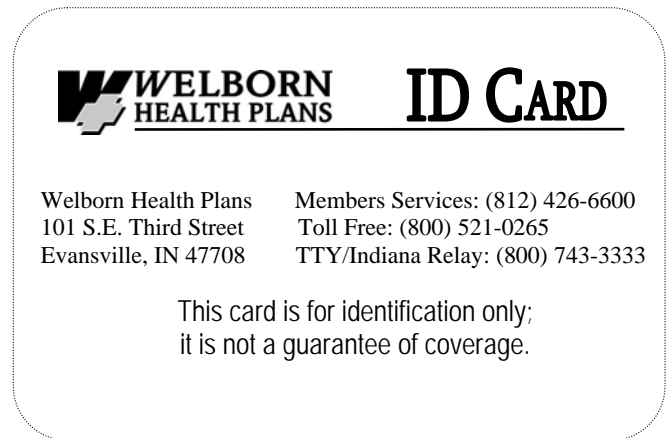
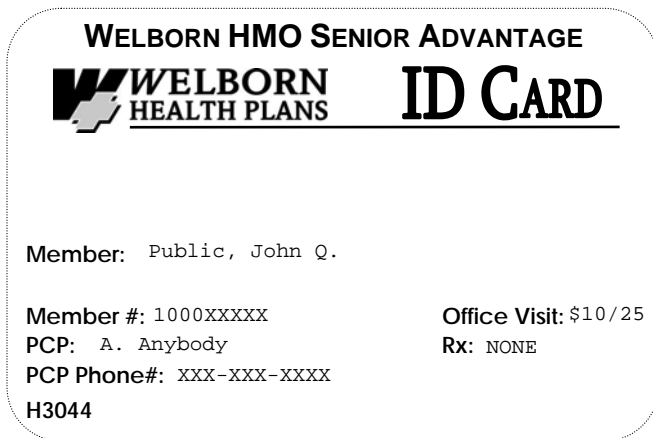
Part B, you must continue paying your premium in order to keep your Medicare Part A and/or Medicare Part B and remain a member of this plan.

Use your WHP plan membership card, not your red, white, and blue Medicare card

Now that you are a member of our Plan, you must use our membership card for services covered by this plan. While you are a member of our Plan and using our plan services, you *must* use your Welborn Health Plans Medicare plan membership card instead of your red, white, and blue Medicare card to get covered services and items. See [Section 3](#) for information on covered services. Keep your red, white, and blue Medicare card in a safe place in case you need it later. If you get covered services using your red, white, and blue Medicare card instead of using our membership card while you are a plan member, the Medicare program won't pay for these services and you may have to pay the full cost yourself.

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

Here is a sample card to show you what it looks like:



The Provider Directory gives you a list of plan providers

Except in emergencies, certain urgently needed services, and out of the area dialysis services, and out-of-network services pre-approved by WHP you are required to use plan providers in order for services to be covered.

Note: The 2008 Welborn Health Plans “Provider Directory” is enclosed. Every year as long as you are a member of our Plan, we will send you either a Provider Directory or an update to your Provider Directory, which gives you a list of our plan providers. If you don’t have the Provider Directory, you can get a copy from Member Services. Contact information is located in [Section 1](#) of this booklet. You may ask Member Services for more information about our plan providers, including their qualifications and experience.

Member services can give you the most up-to-date information about changes in our plan providers. And about which ones are accepting new patients.

How Do I keep my WHP membership records up-to-date?

We have a membership record about you as a plan member. Doctors, hospitals, and other plan providers use your membership record to know what services are covered for you. 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 Physician (PCP), and other information. Section 5 tells how we protect the privacy of your personal health information.

Please help us keep your membership record up to date by letting Member Services know right away if there are any changes to your name, address, or phone number, or if you go into a nursing home. Also, tell Member Services about any changes in health insurance coverage you have from other sources, such as from your employer, your spouse’s employer, workers’ compensation, Medicaid, or liability claims such as claims from an automobile accident. Call Member Services at the number on the cover of this booklet.

The geographic service area for the Welborn HMO Senior Advantage Plan.

The counties in our service area are: *Gibson, Knox, Perry, Pike, Posey, Spencer, Vanderburgh and Warrick counties in Southwestern Indiana.*

2 How You Get Care

Providers you can use to get services covered by our Plan.

While you are a member of our plan, you must use our plan providers to get your covered services except in limited circumstances such as an emergency.

- **What are “plan providers”?** “Providers” is the term we use for doctors, other health care professionals, hospitals, and other health care facilities that are licensed or certified by Medicare and by the state to provide health care services.

We call them “plan providers” when they participate in our plan. When we say that plan providers “participate in our Plan,” this means that we have arranged with them to coordinate or provide covered services to members in our plan.

Rules about using non-plan providers to get your covered services.

We list the providers that participate with our plan in our provider directory. These providers are called network providers. Except in limited cases such as emergency care, urgently needed care when our network is not available, or out of service area dialysis, you must obtain covered services from network providers for the services to be covered. If you get non-emergency care from non-network providers without prior authorization, you must pay the entire cost yourself.

Choosing Your Primary Care Physician (PCP).

What is a “PCP”?

When you become a member of WHP, you must choose a plan provider to be your PCP. Your PCP is a Physician who meets state requirements and is trained to give you basic medical care. As we explain below, you will get your routine or basic care from your PCP. Your PCP will also coordinate the rest of the covered services you get as a member of our Plan. For example, in order for you to see a specialist, you usually need to get your PCP’s approval first (this is called getting a “referral” to a specialist).

Your PCP will provide most of your care and will help you arrange or coordinate the rest of the covered services you get as a member of our Plan. This includes:

- Your x-rays
- Laboratory tests
- Therapies
- Care from doctors who are specialists
- Hospital admissions, and
- Follow-up care

“Coordinating” your services includes checking or consulting with other plan providers about your care and how it is going. If you need certain types of covered services or supplies, you must get approval in advance from your PCP (such as giving you a referral to see a specialist). In some cases, your PCP will need to get prior authorization (prior approval) from us. Since your PCP will provide and coordinate your medical care, you should have all of your past medical records sent to your PCP’s office. Section 5 tells you how we will protect the privacy of your medical records and personal health information.

How do you choose a PCP?

You must choose a PCP from the participating providers listed in our Provider Directory. For assistance in selecting a PCP, please contact Member Services (call the number on the cover of this booklet). If there is a particular WHP specialist or hospital that you want to use, check first to be sure your PCP makes referrals to that specialist or uses that hospital. The name and office number of your PCP will be printed on your membership card.

How do you get care from your PCP?

You will usually see your PCP first for most of your routine health care needs. Your PCP will provide most of your care and will help arrange or coordinate the rest of the covered services you get as a plan member.

If you don’t want to pay the cost of the services you receive, there are only a few types of covered services you can get on your own, without contacting your PCP first.

You can self-refer to network physicians for the following services. If you use non-plan providers (not pre-approved by WHP) you will have to pay the entire cost yourself. If you use plan providers, or a provider pre-approved by WHP you will only have to pay the plan co-payments.

- Mammograms (x-rays of the breast). Mammograms are covered without a referral from your PCP *only* if you get it from a plan provider.
- Flu shots (as long as you get them from a plan provider).
- Emergency services, whether you get these services from plan providers or non-plan providers
- Urgently needed care that you get from non-plan providers when you are temporarily outside the plan’s service area.

WHP will still cover your emergency care or urgently needed care if you use non-plan providers without prior authorization from us and the care is a covered benefit under Original Medicare.

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

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

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

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

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

If the specialist wants you to come back for more care, check first to be sure that the referral (approval in advance) you got from your PCP and/or WHP for the first visit covers more visits to the specialist.

If there are specific specialists you want to use find out whether your PCP sends patients to these specialists. Each plan PCP has certain plan specialists they use for referrals. This means that the PCP you select may determine the specialists you may see. You may generally change your PCP at any time if you want to see a Plan specialist that your current PCP can’t refer you to. Later in this section, under “How can you switch to another PCP,” we tell you how to change your PCP. If there are specific hospitals you want to use, you must first find out whether your PCP uses / the doctors you will be seeing uses these hospitals.

How can you switch to another PCP?

You may change your PCP for any reason, at any time. To change your PCP, call Member Services.

When you call, be sure to tell Member Services if you are seeing specialists or getting other covered services that needed your PCP’s approval (such as home health services and durable medical equipment). Member Services will help make sure that you can continue with the specialty care and other services you have been getting when you change your PCP. They will also check to be sure the PCP you want to switch to is accepting new patients. Member Services will tell you when the change to your new PCP will take effect.

They will also send you a new membership card that shows the name and phone number of your new PCP.

What if your doctor or other provider leaves your plan?

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

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

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

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

You may get care when you are outside the service area. You will usually pay higher costs for the care because you will get your care from non-plan providers, but you won't pay extra if you are getting care for a medical emergency. If you have questions about your medical costs when you travel, please call Member Services.

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

What is a “medical emergency”?

A “medical emergency” is when you reasonably believe that your health is in serious danger – when every second counts. A medical emergency includes severe pain, a bad injury, a serious illness, or a medical condition that is quickly getting much worse.

What should you do if you have a medical emergency?

If you have a medical emergency:

- Get medical help as quickly as possible. Call 911 for help or go to the nearest emergency room, hospital, or urgent care center. **You do not need to get approval or a referral first from your PCP, WHP or other plan provider.**
- Make sure that we know about your emergency, because we need to be involved in following up on your emergency care. You or someone else should call to tell us about your emergency care as soon as possible, usually within 48 hours. Please call Member Services at 800-521-0265. TTY users may call Indiana Relay at 1-800-743-3333.

We will help manage and follow up on your emergency care

We will talk with the doctors who are giving you emergency care to help manage and follow up on your care. When the doctors who are giving you emergency care say that your condition is stable and the medical emergency is over, what happens next is called “post-stabilization care.” Your follow-up care (post-stabilization care) will be covered according to Medicare guidelines. In general, we will try to arrange for plan providers to take over your care as soon as your medical condition and the circumstances allow.

What is covered if you have a medical emergency?

- You may get covered emergency or urgent medical care whenever you need it, anywhere in the United States. Please refer to the Summary of Benefits for additional information.
- **Ambulance** services are covered in situations where other means of transportation in the United States would endanger your health.
- Worldwide coverage.

What if it wasn’t a medical emergency?

Sometimes it can be hard to know if you have a medical emergency. For example, you might go in for emergency care – thinking that your health is in serious danger – and the doctor may say that it wasn’t a medical emergency after all. If this happens, you are still covered for the care you got to determine what was wrong, (as long as you thought your health was in serious danger, as explained in “What is a ‘medical emergency’” above). However, please note that:

-
- If you get any extra care after the doctor says it wasn't a medical emergency, the Plan will pay its portion of the covered extra care **only if you get it from a plan provider**.
 - If you get any extra care from a *non-plan provider* after the doctor says it wasn't a medical emergency, the Plan will usually not cover the extra care. We will pay our portion of the covered additional care from a non-plan provider if you're out of our service area, as long as the additional care you get meets the definition of "urgently needed care" that is given below.

What is urgently needed care? (This is different from a medical emergency)

Urgently needed care refers to a non-emergency situation where you are inside the United States, you are temporarily absent from the Plan's authorized service area, you need medical attention right away for an unforeseen illness, injury, or condition, and it isn't reasonable given the situation, for you to obtain medical care through the Medicare Advantage Plan's participating provider network. **Note:** Under unusual and extraordinary circumstances, care may be considered urgently-needed when the member is in the service area but the provider network of the plan is temporarily unavailable or inaccessible.

What is the difference between a "medical emergency" and "urgently needed care"?

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

How to get urgently needed care?

If, while temporarily outside the Plan's service area, you require urgently needed care, then you may get this care from any provider. The plan is obligated to cover all urgently needed care at the cost-sharing levels that apply to care received within the Plan network.

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

Hospital care, skilled nursing facility care, and other services

How do you get hospital care?

If you need hospital care, we will cover these services for you. Covered services are listed in the Benefits Chart in [Section 3](#) under the heading "Inpatient Hospital Care".

Routine hospital stays must be arranged for you by your PCP or plan specialist and pre-certified (approved by WHP) prior to your admission. To verify the status of the pre-certification you may call Member Services. Phone numbers are on the cover of this booklet.

What is a “benefit period” for hospital care?

Our Plan uses benefit periods to determine your coverage for inpatient services during a hospital stay (generally, you are an inpatient of a hospital if you are admitted to the hospital and are receiving inpatient services in the hospital). A benefit period *begins* on the first day you are admitted as an inpatient at a Medicare-covered inpatient hospital or a skilled nursing facility (SNF). The benefit period *ends* when you haven't been an inpatient at any hospital or SNF for 60 days in a row. If you are admitted to the hospital after one benefit period has ended, then a new benefit period begins. There is no limit to the number of benefit periods you may have.

Please note that after your hospital day limits are used up, we will still pay for covered physician services and other covered medical services. These services are listed in the Benefits Chart in [Section 3](#) under the heading, “Inpatient services (when the hospital or SNF days are not or are no longer covered).”

Please also note that if you are getting hospital services out of plan and paying the cost for the hospital services, you will have to pay the cost for other services you get while you are in the hospital. As shown in the Benefits Chart in [Section 3](#), you must pay the inpatient hospital deductible for each benefit period.

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

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

What is skilled nursing facility care?

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

How do you get Skilled Nursing Facility care (SNF care)?

If you need skilled nursing facility care, we will cover these services for you. Covered services are listed in the Benefits Chart in [Section 3](#) under the heading “Skilled nursing facility care.” The purpose of this subsection is to tell you more about some rules that apply to your covered services. Services must be pre-approved by WHP.

Are Nursing Home stays that provide custodial care covered?

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

What are the benefit period limitations on SNF

Inpatient skilled nursing facility care is limited to 100 days per benefit period. A “**benefit period**” begins on the first day you are admitted as an inpatient at a Medicare covered hospital or SNF. The benefit period ends when you haven’t been an inpatient at any hospital or SNF for 60 days in a row. If you go to the hospital (or SNF) after one benefit period has ended, a new benefit period begins. There is no limit to the number of benefit periods you can have. If you have exhausted your 100 day benefit period and have not begun a new benefit period, certain services will still be covered. These services are listed in the Benefits Chart in [Section 3](#) under the heading, “Inpatient services (when the hospital or SNF days are no longer covered)”.

NOTE: If you are getting SNF services out of plan and have not received prior approval from WHP you will be responsible for paying the cost for the SNF services, you will also have to pay the costs for other services you get while you are in the SNF.

What are the situations when you may be able to get care in a Skilled Nursing Facility (SNF) that isn’t a plan provider?

Generally, you will get your skilled nursing facility care from plan SNFs. However, under certain conditions shown below, you may be able to pay in-network cost sharing for skilled nursing facility care from a SNF that isn’t a plan provider if the SNF accepts our Plan’s amounts for payment.

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

What happens if our Plan doesn’t authorize your care?

Except in cases of medical emergencies, you or your provider must obtain prior authorization for your SNF stay. Your PCP or Plan specialist should arrange for WHP to pre-certify (authorize) your care. However, it is ultimately the member’s responsibility to be sure SNF care is authorized. The member or their documented representative may call Member Services PRIOR to receiving the care for authorization details.

What happens if you join or Leave of our Plan during a Skilled Nursing facility (SNF) stay?

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

How do you get home health care?

Home health care is skilled nursing care and certain other health care services that you get in your home for the treatment of an illness or injury. Covered services are listed in the Benefits Chart in [Section 3](#) under the heading "Home health care." If you need home health care services, we will cover these services for you provided the Medicare coverage requirements are met.

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

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

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

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

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

What is hospice care?

"Hospice" is a special way of caring for people who are terminally ill and providing counseling for their families. Hospice care is physical care and counseling that is given by a team of people who are part of a Medicare-certified public agency or private company. Depending on the situation, this care may be given in the home, a hospice facility, a hospital, or a nursing home. Care from a hospice is meant to help patients who qualify for hospice care in the last months of life by giving comfort and relief from pain. The focus is on care, not cure.

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

As a member of our Plan, you may receive care from any Medicare-certified hospice. Your doctor can help you arrange hospice care. If you are interested in using hospice services, you can call Member Services to get a list of the Medicare-certified hospice providers in your area or you may call the Regional Home Health Intermediary at:

Phone: 1-727-773-9225
Fax: 1-727-771-7806
Hours: 9:00am-5:30pm

Toll free: 1-866-801-5301
E-mail: eileen.gannon@palmettogba.com
Web site: www.palmettogba.com

How is your hospice care paid for?

If you enroll in a Medicare-certified hospice program, the Original Medicare Plan (rather than our Plan) will pay the hospice provider for the services you receive. Your hospice doctor can be a plan provider or a non-plan provider. Even if you choose to enroll in a Medicare-certified hospice, you will still be a plan member and continue to get the rest of your care that is unrelated to your terminal condition through our Plan.

How to get more information on hospice care

Visit www.medicare.gov on the web. Under "Search Tools," "Find a Medicare Publication" to view or download the publication "Medicare Hospice Benefits." Or, call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

How to get an organ transplant if you need it

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

How can you participate in a clinical trial?

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

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

There are certain requirements for Medicare coverage of clinical trials. If you participate as a patient in a clinical trial that meets Medicare requirements, the Original Medicare Plan (and not our Plan) pays the clinical trial doctors and other providers for the covered services you get that are related to the clinical trial. When you are in a clinical trial, you may stay enrolled in our Plan and continue to get the rest of your care that is unrelated to the clinical trial through our Plan.

You don't need to get a referral (approval in advance) from a plan provider to join a clinical trial, and the clinical trial providers don't need to be plan providers. However, please be sure to **tell us before you start participation in a clinical trial** so that we can keep track of your health care services. When you tell us about starting participation in a clinical trial, we can let you know what services you will get from clinical trial providers and the costs for those services. You can view or download the publication "Medicare and Clinical Trials" At www.medicare.gov on the Web. Under "Search Tools," select "Find a Medicare Publication." Or, call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

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

Care in a Medicare-certified Religious Non-medical Health Care Institution (RNHCI) is covered by our Plan under certain conditions. Covered services in a RNHCI are limited to non-religious aspects of care. To be eligible for covered services in a RNHCI, you must have a medical condition that would allow you to receive inpatient hospital care or extended care services, or care in a home health agency. You may get services when furnished in the home, but only items and services ordinarily furnished by home health agencies that are not RNHCI. In addition, you must sign a legal document that says you are conscientiously opposed to the acceptance of "non-excepted" medical treatment. ("Excepted" medical treatment is medical care or treatment that you receive involuntarily or that is required under federal, state or local law. "Non-excepted" medical treatment is any other medical care or treatment.) Your stay in the RNHCI is not covered by our plan unless you obtain authorization (approval) in advance from our Plan. If your stay in a RNHCI does not meet Medicare guidelines and is not pre-approved by WHP you will be responsible for 100% of the cost.

3 Covered Benefits

Covered Services

What are “covered services”?

This section describes the medical benefits and coverage you get as a member of our Plan. **“Covered services” means the medical care, services, supplies, and equipment that are covered by our Plan.** This section has a Benefits Chart that gives a list of your covered services and tells what you must pay for each covered service. Section 6 tells about **services that aren’t covered** (these are called “exclusions”).

Note: Section 6 also tells about limitations on certain services.

There are some conditions that apply in order to get covered services.

Some general requirements apply to all covered services.

The covered services listed in the Benefits Chart in this section are covered only when all requirements listed below are met:

- Services must be provided according to the Medicare coverage guidelines established by the Medicare Program.
- The medical care, services, supplies, and equipment that are listed as covered services must be medically necessary. Certain preventive care and screening tests are also covered.
- With few exceptions, covered services must be provided by plan providers, be approved in advance by plan providers, and some services may need to be authorized by our Plan. The exceptions are care for medical emergency, urgently needed services outside the service area, and renal (kidney) dialysis you get when you are outside the Plan’s service area.

Note: In addition, some covered services require “prior authorization” by the Plan in order to be covered. Some of the covered services listed in the Benefits Chart in this section are covered only if your doctor or other plan provider gets “prior authorization” (approval in advance) from our Plan. Covered services that need prior authorization (approval ahead of time) are marked in the Benefits Chart by an asterisk and/or footnote.

Benefits chart – your covered services

Welborn HMO Senior Advantage Plan PBP-002

What you must pay when you get these covered services within the WHP network

Services

Inpatient

Inpatient hospital care*

For more information about inpatient hospital care, see [Section 2](#).

Covered services include, but aren't limited to, the following:

- Semiprivate room (or a private room if medically necessary).
- Meals including special diets.
- Regular nursing services.
- Costs of special care units (such as intensive or coronary care units).
- Drugs and medications.
- Lab tests.
- X-rays and other radiology services.
- Necessary surgical and medical supplies.
- Use of appliances, such as wheelchairs.
- Operating and recovery room costs.
- Physical therapy, occupational therapy, and speech therapy.
- Under certain conditions, the following types of transplants are covered: corneal, kidney, pancreas, heart, liver, lung, heart/lung, bone marrow, stem cell, and intestinal/multivisceral. See Section 2 for more information about transplants.
- Blood - including storage and administration. Coverage of whole blood and packed red cells begins only with the fourth pint of blood that you need – you pay for the first 3 pints of un-replaced blood. All other components of blood are covered beginning with the first pint used.
- Physician Services.

Days 1-10: \$150 copay per day.

Days 11-90: \$0 copay per day.

Plan covers 90 days each benefit period.

Except in an emergency, your provider must obtain authorization from Welborn HMO Senior Advantage Plan.

**Welborn HMO Senior Advantage Plan
PBP-002**

What you must pay when you get these covered services within the WHP network

Benefits chart – your covered services

Services

Inpatient mental health care*

Covered services include mental health care services that require a hospital stay.

There is a 190-day lifetime limit for inpatient services in a psychiatric hospital.

The 190-day limit does not apply to Mental Health services provided in a psychiatric unit of a general hospital.

Days 1-10: \$150 copay per day.

Days 11-90: \$0 copay per day.

Medicare beneficiaries may receive only 190 days in a Psychiatric Hospital in a lifetime.

Except in an emergency, your provider must obtain authorization from Welborn HMO Senior Advantage Plan.

Skilled nursing facility care*

For more information about skilled nursing facility care, see [Section 2](#).

Requires a 3-day prior Medicare covered hospital stay.

Covered services include, but aren't limited to, the following:

- Semiprivate room (or a private room if medically necessary).
- Meals, including special diets.
- Regular nursing services.
- Physical therapy, occupational therapy, and speech therapy.
- Drugs (This includes substances that are naturally present in the body, such as blood clotting factors).
- Blood - including storage and administration. Coverage of whole blood and packed red cells begins only with the fourth pint of blood that you need - you pay for the first 3 pints of unreplaced blood. All other components of blood are covered beginning with the first pint used.
- Medical and surgical supplies.

Days 1-20: \$0 copay per day.

Days 21-100: \$50 copay per day.

3-day prior hospital stay required.

100 days each benefit period.

Prior authorization is required. Contact plan for details.

Benefits chart – your covered services

Services

- Laboratory tests.
- X-rays and other radiology services.
- Use of appliances such as wheelchairs.
- Physician services.

Inpatient services (when the hospital or SNF days aren't or are no longer covered) *

For more information about inpatient services, see [Section 2](#). Covered services include, but aren't limited to, the following:

- Physician services.
- Tests (like X-ray or lab tests).
- X-ray, radium, and isotope therapy including technician materials and services.
- Surgical dressings, splints, casts and other devices used to reduce fractures and dislocations.
- Prosthetic 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.

You are responsible for 100% of the inpatient facility fees once you have exhausted your benefit period coverage. See page 16 and Pg 17 in this document for more information on Benefit Periods.

Covered services will be paid at your regular benefit levels.

Authorization rules may apply. Contact plan for details.

Benefits chart – your covered services

Services

Home health care*

For more information about home health agency care, see [Section 2](#). Covered services include, but aren't limited to, the following:

- Part-time or intermittent skilled nursing and home health aide services.
- Physical therapy, occupational therapy, and speech therapy.
- Medical social services.
- Medical equipment and supplies.

\$0 copay for Medicare-covered home health visits.

Authorization rules may apply for services. Contact plan for details.

Hospice care

For more information about hospice services, see [Section 2](#). Covered services include, but aren't limited to, the following:

- Drugs for symptom control and pain relief, short-term respite care, and other services not otherwise covered by Medicare.
- Home care.

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

When you enroll in a Medicare-certified Hospice program, your hospice services are paid for by Medicare, not your Medicare Advantage plan (see [Section 2](#) for more information about hospice services).

Outpatient Services

Physician services, including doctor office visits*

Covered services include, but aren't limited to, the following:

- Office visits, including medical and surgical care in a physician's office or certified ambulatory surgical center.
- Consultation, diagnosis, and treatment by a specialist.

See "Routine Physical Exams" for more information.

\$10 copay for each primary care doctor visit for a Medicare-covered benefit.

\$25 copay for each specialist visit for Medicare-covered benefits.

Benefits chart – your covered services

Services

- Second opinion by another plan provider prior to surgery.
- Outpatient hospital services.
- Non-routine dental care (covered services are limited to surgery of the jaw or related structures, setting fractures of the jaw or facial bones, extraction of teeth to prepare the jaw for radiation treatments of neoplastic cancer disease, or services that would be covered when provided by a doctor).

Chiropractic services*

Covered services, include, but aren't limited, to the following:

- Manual manipulation of the spine to correct subluxation.

\$25 copay for Medicare-covered visits.

Authorization rules may apply.

Medicare-covered chiropractic visits are for manual manipulation of the spine to correct a displacement or misalignment of a joint or body part.

Podiatry services

Covered services include, but aren't limited to, the following:

- Treatment of injuries and diseases of the feet (such as hammer toe or heel spurs).
- Routine foot care for certain medical conditions affecting the lower limbs.

\$25 copay for each Medicare-covered visit.

Medicare-covered podiatry benefits are for medically necessary foot care.

Outpatient mental health care* (including

Partial Hospitalization Services) Covered services include, but are not limited to, the following: Mental health services provided by a doctor, clinical psychologist, clinical social worker, clinical nurse specialist, nurse practitioner, physician assistant, or other Medicare-qualified mental health care professional as allowed under applicable state laws. "Partial hospitalization" is a structured program of active treatment that is more intense than the care received in

\$25 copay for each Medicare-covered individual or group therapy visit.

Authorization rules may apply for services. Contact plan for details.

Benefits chart – your covered services

Welborn HMO Senior Advantage Plan PBP-002

What you must pay when you get these covered services within the WHP network

Services

your doctor's or therapist's office and is an alternative to inpatient hospitalization.

Outpatient substance abuse services*

\$25 copay for each Medicare-covered individual or group therapy visit.

Authorization rules may apply for services. Contact plan for details.

Outpatient surgery*

\$0 copay for each Medicare-covered visit to an ambulatory surgical center.

\$160 copay for each Medicare-covered outpatient hospital facility visit.

Authorization rules may apply. Contact plan for details.

Ambulance services

Covered services include ambulance services to an institution (like a hospital or SNF), from an institution to another institution, from an institution to your home, and services dispatched through 911, where other means of transportation could endanger your health.

\$75 copay for Medicare-covered ambulance benefits.

If you are admitted to the hospital, you pay \$0 for Medicare-covered ambulance benefits.

Emergency care

For more information, see [Section 2](#).

\$50 copay for each Medicare-covered emergency room visit.

If you are admitted to the hospital within 24-hours for the same condition, you pay \$0 for the emergency room visit.

Out-of-network
Worldwide coverage

Urgently needed care

For more information, see [Section 2](#).

\$50 copay for each Medicare-covered emergency room visit.

If you are admitted to the hospital within 24-hours for the same condition, you pay \$0 for the urgent care visit.

**Welborn HMO Senior Advantage Plan
PBP-002**

What you must pay when you get these covered services within the WHP network

Benefits chart – your covered services

Services

Outpatient rehabilitation services*

Covered services include, but aren't limited to, the following: physical therapy, occupational therapy, and speech and language therapy

\$25 copay for each Medicare-covered Occupational Therapy visit.

\$25 copay for each Medicare-covered Physical Therapy and/or Speech/Language Therapy visit.

Authorization rules may apply. Contact plan for details.

Durable medical equipment and related supplies * – such as wheelchairs, crutches, hospital bed, IV infusion pump, oxygen equipment, nebulizer, and walker. (See definition of “durable medical equipment” in [Section 11](#))

20% of the cost for Medicare-covered items.

Authorization rules may apply. Contact plan for details.

Prosthetic devices and related

supplies* – (other than dental) which replace a body part or function. These include colostomy bags and supplies directly related to colostomy care, pacemakers, braces, prosthetic shoes, artificial limbs, and breast prostheses (including a surgical brassiere after a mastectomy). Includes certain supplies related to prosthetic devices, and repair and/or replacement of prosthetic devices. Also includes some coverage following cataract removal or cataract surgery – see “Vision Care” below for more detail.

20% of the cost for Medicare-covered items.

Authorization rules may apply. Contact plan for details.

Diabetes self-monitoring, training and supplies*

– for all people who have diabetes (insulin and non-insulin users). Covered services include, but aren't limited to, the following:

- Blood glucose monitor, blood glucose test strips, lancet devices and lancets, and glucose control solutions for checking the accuracy of test strips and monitors.
- One pair per calendar year of therapeutic shoes

\$0 copay for Diabetes self-monitoring training.

\$0 copay for Nutrition Therapy for Diabetes.

20% of the cost for Diabetes supplies.

Authorization rules may apply. Contact plan for details.

**Welborn HMO Senior Advantage Plan
PBP-002**

What you must pay when you get these covered services within the WHP network

Benefits chart – your covered services

Services

for people with diabetes who have severe diabetic foot disease, including fitting of shoes or inserts.

Self-management training is covered under certain conditions. *For persons at risk of diabetes:* Fasting plasma glucose tests as required by your network physician.

Medical nutrition therapy* – for people with diabetes, renal (kidney) disease (but not on dialysis), and after a transplant when referred by your doctor.

\$0 copay for Nutrition Therapy

Authorization rules may apply. Contact plan for details.

Outpatient diagnostic tests and therapeutic services and supplies*

Covered services include, but are not limited to, the following:

- X-rays.
- Radiation therapy.
- Surgical supplies, such as dressings.
- Supplies, such as splints and casts.
- Laboratory tests.
- Blood - Coverage begins with the fourth pint of blood that you need – you pay for the first 3 pints of unreplaced blood.
- Coverage of storage and administration begins with the first pint of blood that you need.

20% of the cost for the following Medicare-covered services:

- Lab Services
- Diagnostic procedures and tests
- X-Ray Visits
- Diagnostic Radiology Services
- Therapeutic Radiology Services

Authorization rules may apply. Contact plan for details.

Preventive Care and Screening Tests

Bone mass measurements*

For qualified individuals (generally, this means people at risk of losing bone mass or at risk of osteoporosis), the following services are covered every 2 years or more frequently if medically necessary: procedures to identify bone mass, detect

\$50 copay for each Medicare-covered Bone Mass Measurement.

Benefits chart – your covered services

Services

bone loss, or determine bone quality, including a physician's interpretation of the results.

Colorectal screening*

For people 50 and older, the following are covered:

- Flexible sigmoidoscopy (or screening barium enema as an alternative) every 48 months.
- Fecal occult blood test, every 12 months.

For people at high risk of colorectal cancer, the following are covered:

- Screening colonoscopy (or screening barium enema as an alternative) every 24 months.

For people not at high risk of colorectal cancer, the following is covered:

- Screening colonoscopy every 10 years, but not within 48 months of a screening sigmoidoscopy.

\$0 copay for Medicare-covered Colorectal Screening Exams.

Immunizations*

Covered services include, but aren't limited to, the following:

- Pneumonia vaccine (as explained in [Section 2](#), you may get this service on your own, without a referral from your PCP (as long as you get the service from a plan provider).
- Flu shots, once a year in the fall or winter. As explained in [Section 2](#), you may get this service on your own, without a referral from your PCP (as long as you get the service from a plan provider).
- If you are at high or intermediate risk of getting Hepatitis B: Hepatitis B vaccine.
- Other vaccines if you are at risk.

In Network \$0 copay for the Pneumonia and Flu vaccines.

No referral necessary for Medicare-covered influenza and pneumonia vaccines.

\$0 copay for the Hepatitis B vaccine.

Authorization rules may apply. Contact plan for details.

Benefits chart – your covered services

Services

Mammography screening

(As explained in [Section 2](#), you may get this service on your own, without a referral from your PCP (as long as you get it from a plan provider):

Covered services include, but aren't limited to, the following:

- One baseline exam between the ages of 35 and 39.
- One screening every 12 months for women age 40 and older.

\$0 copay for Medicare-covered Screening Mammograms.

No referral necessary for Medicare-covered screenings.

Pap tests, pelvic exams, and clinical breast exam

As explained in [Section 2](#), you may get these routine women's health services on your own, without a referral from your PCP (as long as you get the services from a plan provider)

Covered services include, but aren't limited to, the following:

- For all women, Pap tests, pelvic exams, and clinical breast exams are covered once every 24 months.
- If you are at high risk of cervical cancer or have had an abnormal Pap test and are of childbearing age: one Pap test every 12 months.

\$0 copay for Medicare-covered Pap Smears and Pelvic Exams.

Prostate cancer screening exams

For men age 50 and older, the following are covered once every 12 months:

Covered services include, but are not limited to, the following:

- Digital rectal exam.
- Prostate Specific Antigen (PSA) test.

\$0 copay for Medicare-covered Prostate Cancer Screening exams.

Benefits chart – your covered services

Services

Cardiovascular disease testing*

Blood tests for the detection of cardiovascular disease (or abnormalities associated with an elevated risk of cardiovascular disease).

20% of the cost for the following Medicare-covered services:

- Lab Services
- Diagnostic procedures and tests

Authorization rules may apply

Physical exams

For members whose Medicare Part B coverage begins on or after January 1, 2005: A one-time physical exam within the first 6 months that you have Medicare Part B. Includes measurement of height, weight, blood pressure; an electrocardiogram; education, counseling and referral with respect to covered screening and preventive services. Doesn't include lab tests.

\$0 copay for routine exams.
Limited to 1 exam every year.

\$0 copay for Medicare-covered benefits.

Other Services

Dialysis (Kidney)*

Covered services include, but are not limited to, the following:

- Outpatient dialysis treatments (including dialysis treatments when temporarily out of the service area, as explained in [Sections 2 and 3](#)).
- Inpatient dialysis treatments (if you are admitted to a hospital for special care).
- Self-dialysis training (includes training for you and anyone helping you with your home dialysis treatments).
- Home dialysis equipment and supplies.
- Certain home support services (such as, when necessary, visits by trained dialysis workers to check on your home dialysis, to help in emergencies, and check your dialysis equipment and water supply).

\$0 copay for in and out-of-area dialysis.
\$0 copay for Nutrition Therapy for Renal Disease.

Benefits chart – your covered services

Services

Prescription Drugs*

That are covered under the Original Medicare Plan
(these drugs are covered for everyone with Medicare)

“Drugs” includes substances that are naturally present in the body, such as blood clotting factors. Covered drugs include, but are not limited to, the following:

- Drugs that usually aren’t self-administered by the patient and are injected while you are getting physician services.
- Drugs you take using durable medical equipment (such as nebulizers) that was authorized by WHP.
- Clotting factors you give yourself by injection if you have hemophilia.
- Immunosuppressive drugs, if you have had an organ transplant that was covered by Medicare.
- Injectable osteoporosis drugs, if you are homebound, have a bone fracture that a doctor certifies was related to post-menopausal osteoporosis, and cannot self-administer the drug.
- Antigens.
- Certain oral anti-cancer drugs and anti-nausea drugs.
- Certain drugs for home dialysis, including heparin, the antidote for heparin when medically necessary, topical anesthetics, Erythropoietin (Epogen®) or Epoetin alfa, and Darboetin Alfa . (Aranesp®).
- Intravenous Immune Globulin for the treatment of primary immune deficiency diseases in your home.

Most drugs not covered.

This plan does not offer prescription drug coverage.

You pay 100% for most prescription drugs.

Benefits chart – your covered services

Welborn HMO Senior Advantage Plan
PBP-002

What you must pay when you get these covered services within the WHP network

Services

Additional Benefits

Dental services*

Services by a dentist or oral surgeon are limited to surgery of the jaw or related structures, setting fractures of the jaw or facial bones, extraction of teeth to prepare the jaw for radiation treatments of neoplastic disease, or services that would be covered when provided by a doctor.

In general, you pay 100% for dental services.

\$0 copay for Medicare covered dental Benefits

Hearing services

Diagnostic hearing exams.

In general, you pay 100% for hearing aids.

\$25 copay for diagnostic hearing exams.

\$25 copay for up to 1 routine hearing test(s) every year.

\$50 limit for routine hearing tests every year.

Vision care

Covered services include, but are not limited to, the following:

- Outpatient physician services for eye care.
- For people who are at high risk of glaucoma, such as people with a family history of glaucoma, people with diabetes, and African-Americans who are age 50 and older: glaucoma screening once per year
- One pair of eyeglasses or contact lenses after each cataract surgery that includes insertion of an intraocular lens. Corrective lenses/frames (and replacements) needed after a cataract removal without a lens implant.

\$25 copay for one pair of eyeglasses or contact lenses after each cataract surgery.

\$25 copay for exams to diagnose and treat diseases and conditions of the eye.

\$25 copay for up to 1 routine eye exam(s) every year.

\$25 copay for up to 1 pair of glasses every two years.

\$25 copay for up to 1 pair of contacts every two years.

\$50 limit for eye exams every year.

Benefits chart – your covered services

Services

Health and wellness education programs

These are programs focused on clinical health conditions such as hypertension, cholesterol, asthma and special diets. Programs designed to enrich the health and lifestyles of members include weight management, smoking cessation, fitness, and stress management.

This plan covers health/wellness education benefits.

- Written health education materials, including Newsletters
- Smoking Cessation
- Nursing Hotline
- Other Wellness Benefits

Copays may apply for these benefits.

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

If you have any concerns or problems getting the services you believe are covered for you as a member, we want to help. Please call Member Services. You have the right to make a complaint if you have problems related to getting services or payment for services that you believe are covered as a member. See [Section 8](#) for information about making a complaint.

Can your benefits change during the year?

Generally your benefits will not change during the year. The Medicare Program doesn't allow us to decrease your benefits during the calendar year. The only time your benefits may decrease is at the beginning of the next calendar year. The Medicare Program must approve any decreases we make in your benefits. We will tell you in November if there are going to be any increases or decreases in your benefits for the next calendar year that begins on January 1.

At any time during the year, the Medicare Program can change its national coverage. Since we cover what the Original Medicare Plan covers, we would have to make any change that the Medicare Program makes. In those cases, you will have to pay the Original Medicare Plan out-of-pocket amounts for those services. We will let you know in advance if you will have to pay the Original Medicare Plan out-of-pocket costs for an increased benefit.

4 Your Costs for This Plan

Paying your monthly plan premium

As a member of our Plan you Pay:

- 1) Your monthly Medicare Part B premium of **\$96.40**
- 2) Your monthly Medicare Part A premium if necessary (most people don't pay this premium).
- 3) **\$0** Monthly premium for being a member of the WHP HMO Senior Advantage Plan.

WHP HMO Senior Advantage Plan has a zero \$0 monthly premium per person per month

Paying your share of the cost when you get covered services

What are “deductibles”, “co-payments,” and “coinsurance”?

- The **“deductible”** is the amount you must pay for the health care services *OR* drugs you receive before our Plan begins to pay its share of your covered services.
- A **“co-payment”** is a payment you make for your share of the cost of certain covered services you get. A co-payment is a set amount per service such as paying \$50 co-payment for emergency room services. You pay it when you get the service. The Benefits Chart in [Section 3](#) gives your co-payments for covered services.
- “Co-insurance” is a payment you make for your share of the cost of certain covered services you receive. Co-insurance is a percentage of the cost of the service such as paying 20% coinsurance for Prosthetic devices, x-rays and lab services. You pay your co-insurance when you get the service. The Benefits Chart in [Section 3](#) gives your co-insurance amounts for covered services.

What is the Maximum amount you will pay for covered services?

There is a limit to how much you have to pay out of pocket for your covered health care services each year. Once the total costs for your drugs, including your co-payments reaches \$5,000 then you won't have to continue paying these expenses for the remainder of the year. Please contact the Plan for details.

What is your cost for services that aren't covered under our Plan?

You are responsible to pay the full cost of care and services that aren't covered by our Plan. Other sections of this booklet describe the services that are covered under our Plan and the rules that apply to getting your care as a plan member.

If you have any question whether our plan will pay for a service, including inpatient hospital services, you have the right to have an organization determination made for the service. You may call Member Services and tell us you would like a decision on whether the service will be covered.

For covered services that have a benefit limitation, you pay the full cost of any services you get after you have used up your benefit for that type of covered service, unless your plan offers, as a covered supplemental benefit, coverage beyond the original Medicare limits. You can call Members Services when you want to know how much of your benefit limit you have already used.

Using all of your insurance coverage

If you have additional health insurance coverage besides our Plan, it is important that you use your other coverage in combination with your coverage as a member of our plan to pay your health care expenses. This is called “coordination of benefits” because it involves coordinating all of the health benefits that are available to you. Using all of the coverage you have helps keep the cost of health care more affordable for everyone.

You are required to tell our plan if you have additional health insurance?

You must tell us if you have any other coverage besides our plan, and let us know whenever there are any changes in your additional coverage. The types of additional coverage you might have include the following:

- Coverage that you have from an employer’s group health insurance for employees or retirees, either through yourself or your spouse.
- Coverage that you have under workers’ compensation because of a job-related illness or injury, or under the Federal Black Lung Program.
- Coverage you have for an accident where no-fault insurance or liability insurance is involved.
- Coverage you have through Medicaid.
- Coverage you have through the “TRICARE for Life” program (veteran’s benefits).
- Coverage you have for dental insurance.
- “Continuation coverage” that you have through COBRA (COBRA is a law that requires employers with 20 or more employees to let employees and their dependents keep their group health coverage for a time after they leave their group health plan under certain conditions).

What should you do if you have bills from non-plan providers that you think we should pay?

As explained in [Section 2](#), we cover certain health care services that you get from non-plan providers. These include care for a medical emergency, urgently needed care, and renal dialysis that you get when you are outside the service area for our plan, care that has been approved in advance by WHP, and services that we denied but that were overturned in an appeal. If a non-plan provider asks you to pay for covered services you get in these situations, please contact Welborn Health Plans at (812) 426-6600, FAX: (812) 773-0589 or write to us at: Welborn Health Plans, 101 SE 3rd St., Evansville, Indiana, 47708.

It is best to ask a non-plan provider to bill us first, but if you have already paid for the covered services we will pay you for our share of the cost. If you get a bill for the services you may send the bill to us for payment.

We will pay your doctor for our share of the bill and will let you know what, if anything, you must pay. You won't have to pay a non-plan provider any more than what they would have gotten from you if you had been covered under the Original Medicare Plan.

5 Your Rights and Responsibilities as a Member of our Plan

Introduction to your rights and protections

Since you have Medicare, you have certain rights to help protect you. In this Section, we explain your Medicare rights and protections as a member of our Plan and, we explain what you can do if you think you are being treated unfairly or your rights are not being respected. If you want to receive Medicare publications on your rights, you may call and request them at 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048. Or visit www.medicare.gov on the web to view or download the publication “Your Medicare Rights & protections.” Under “Search Tools,” select “find a Medicare Publication.” If you have any questions whether our Plan will pay for a service, including inpatient hospital services, and including services obtained from providers not affiliated with our plan, you have the right under law to have an advance coverage determination made for the service. Call us and tell us you would like a decision if the service or item will be covered.

Your right to be treated with dignity, respect and fairness

You have the right to be treated with dignity, respect, and fairness at all times. Our Plan must obey laws that protect you from discrimination or unfair treatment. We don't discriminate based on a person's race, disability, religion, sex, sexual orientation, health, ethnicity, creed, age or national origin. If you need help with communication, such as help from a language interpreter, please call Member Services in [Section 1](#). Member Services can also help if you need to file a complaint about access (such as wheel chair access). You may also call the Office for Rights at 1-800-368-1019 or TTY/TDD 1-800-537-7697, or call your local Office for Civil Rights in Chicago, IL at 1-312-886-2359 or TTY/TDD 1-312-353-5693.

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

There are federal and state laws that protect the privacy of your medical records and personal health information. We protect your personal health information under these laws. Any personal information that you give us when you enroll in this plan is protected. We will make sure that unauthorized people don't see or change your records. Generally, we must get written permission from you (or from someone you have given legal power to make decisions for you) before we can give your health information to anyone who isn't providing your care or paying for your care. There are exceptions allowed or required by law, such as release of health information to government agencies that are checking on quality of care.

The laws that protect your privacy give you rights related to getting information and controlling how your health information is used. We are required to provide you with a notice that tells about these rights and explains how we protect the privacy of your health information. For example, you have the right to look at your medical records, and to get a copy of your records (there may be a fee charged for making copies). You also have the right to ask us to make additions or corrections to your medical

records (if you ask us to do this, we will review your request and figure out whether the changes are appropriate). You have the right to know how your health information has been given out and used for non-routine purposes. If you have questions or concerns about privacy of your personal information and medical records, please call Member Services at the phone number in [Section 1](#) of this booklet.

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

As explained in this booklet, you will get most or all of your care from doctors and other health providers who are part of our Plan. You have the right to choose a plan provider (we will tell you which doctors are accepting new patients). You have the right to timely access to your providers and to see specialists when care from a specialist is needed. “Timely access” means that you can get appointments and services within a reasonable amount of time. [Section 2](#) explains how to use plan providers to get the care and services you need.

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

You have the right to get full information from your providers when you go for medical care, and the right to participate fully in decisions about your health care. Your providers must explain things in a way that you can understand. Your rights include knowing about all of the treatment choices that are recommended for your condition, no matter what they cost or whether they are covered by our Plan. You have the right to be told about any risks involved in your care. You must be told in advance if any proposed medical care or treatment is part of a research experiment, and be given the choice of refusing experimental treatments.

You have the right to receive a detailed explanation from us if you believe that a provider has denied care that you believe you are entitled to receive or care you believe you should continue to receive. In these cases, you must request an initial decision. “Initial decisions” / “Organizational Determination” are discussed in [Section 7](#) and [Section 8](#).

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

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

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

for yourself. You also have the right to give your doctors written instructions about how you want them to handle your medical care if you become unable to make decisions for yourself. The legal documents that you can use to give your directions in advance in these situations are called “**advance directives**.” There are different types of advance directives and different names for them. Documents called “**living will**” and “**power of attorney for health care**” are examples of advance directives.

If you want to have an advance directive, you can get a form from your lawyer, from a social worker, or from some office supply stores.

You can sometimes get advance directive forms from organizations that give people information about Medicare. [Section 1](#) of this booklet tells how to contact the local State Health Insurance Assistance Program (SHIP) by calling the Southwest Indiana Regional Council on Aging (SWIRCA), Area XVI Agency on Aging, in Evansville, IN at (812) 464-7800 or 800-253-2188. You can also find information on the website for the SHIP program at www.medicare.gov on the Web.

Regardless of where you get this form, keep in mind that it is a legal document. You should consider having a lawyer help you prepare it. It is important to sign this form and keep a copy at home. You should give a copy of the form to your doctor and to the person you name on the form as the one to make decisions for you if you can't. You may want to give copies to close friends or family members as well.

If you know ahead of time that you are going to be hospitalized, and you have signed an advance directive, take a copy with you to the hospital. If you are admitted to the hospital, they will ask you whether you have signed an advance directive form and whether you have it with you. If you have *not* signed an advance directive form, the hospital has forms available and will ask if you want to sign one.

Remember, it is *your choice* whether you want to fill out an advance directive (including whether you want to sign one if you are in the hospital). According to law, no one can deny you care or discriminate against you based on whether or not you have signed an advance directive. If you *have* signed an advance directive, and you believe that a doctor or hospital hasn't followed the instructions in it, you may file a complaint please call the Indiana Department of Health at 1-800-246-8909.

Member Services can also help if you need to file a complaint about access (such as wheel chair access). You can also call the Office for Civil Rights at 1-800-368-1019 or TTY/TDD 1-800-537-7697, or, call the Office for Civil Rights in Chicago, IL at 1-312-886-2359 or TTY/TDD 1-312-353-5693.

Your right to make complaints

You have the right to make a complaint if you have concerns or problems related to your coverage or care. A complaint can be called a grievance, an organization determination, or a coverage determination depending on the situation. See [Section 8](#) for more information about complaints.

If you make a complaint, we must treat you fairly (i.e., not retaliate against you) because you made a complaint. You have the right to get a summary of information about the appeals and grievances that members have filed against our Plan in the past. To get this information, call Member Services.

Your right to get information about our Plan, plan providers, health care coverage, and costs

This booklet tells you what medical services are covered for you as a plan member and what you have to pay.

If you need more information, please call Member Services at the number in [Section 1](#) of this booklet. You have the right to an explanation from us about any bills you may get for services not covered by our Plan. We must tell you in writing why we will not pay for or approve a service, and how you can file an appeal to ask us to change this decision. See [Section 7](#) and [Section 8](#) for more information about filing an appeal.

You also have the right to get information from us about our Plan. This includes information about our financial condition, about our plan health care providers and their qualifications, about information on your network pharmacies, and about how our Plan compares to other health plans. You have the right to find out from us how we pay our doctors. To get any of this information, call Member Services at the phone number in [Section 1](#) of this booklet. You have the right to have an advance coverage determination made for the service, even if you obtain this service from a provider not affiliated with our organization.

How to get more information about your rights

If you have questions or concerns about your rights and protections, please call Member Services at the number in [Section 1](#) of this booklet. You can also get free help and information from your SHIP (contact information for your SHIP in [Section 1](#) of this booklet). You can also visit www.medicare.gov on the web to view or download the publication “Your Medicare Rights & Protections.” Under “Search Tools,” select “Find a Medicare Publication.” Or, call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

If you need more information, please call Member Services at the number on the front of this booklet. Also, please refer to your EOC for additional information and Advance Directives and all other topics in this handbook.

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

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

- If you think you have been treated unfairly due to your race, color, national origin, disability, age, or religion, you can call the Office for Civil Rights at 1-800-368-1019 or TTY/TDD 1-800-537-7697, or call your local Office for Civil Rights in Chicago, IL at 1-312-886-2359 or TTY/TDD 1-312-353-5693.

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- If you have any other kind of concern or problem related to your Medicare rights and protections described in this section, you can also get help from your SHIP (contact information for your SHIP is in [Section 1](#) of this booklet).

Your responsibilities as a member of WHP

Your responsibilities include the following:

- Getting familiar with your coverage and the rules you must follow to get care as a member. You can use this booklet to learn about your coverage, what you have to pay, and the rules you need to follow. Please call Member Services if you have any questions.
- Letting us know if you have additional health insurance coverage.
- Notifying providers when seeking care (unless it is an emergency) that you are enrolled in WHP and you must present your plan enrollment card to the provider.
- Giving your doctor and other providers the information they need to care for you, and following the treatment plans and instructions that you and your doctors agree upon. Be sure to ask your doctors and other providers if you have any questions and have them explain your treatment in a way you can understand.
- Acting in a way that supports the care given to other patients and helps the smooth running of your doctor's office, hospitals, and other offices.
- Paying your plan premiums and your co-payments/coinsurance for your covered services. You must pay for services that aren't covered.
- Letting us know if you have any questions, concerns, problems, or suggestions. If you do, please call Member Services at the phone number on the cover of this booklet.

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

For concerns or problems related to your Medicare rights and protections, you may call our Member Services Department number listed in [Section 1](#). You can also get help from your State Health Insurance Assistance Program or SHIP. Contact information for the SHIP (SWIRCA in our area) is in [Section 1](#) of this booklet.

6 General Exclusions

Introduction

The purpose of this section is to tell you about medical care and services that aren't covered ("excluded") or are limited by our Plan. The list below tells about these exclusions and limitations. The list describes services and items that aren't covered under any conditions, and some services that are covered only under specific conditions. (The Benefits Chart in [Section 3](#) also explains about some restrictions or limitations that apply to certain services).

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

We won't pay for the exclusions that are listed in this section (or elsewhere in this booklet), and neither will the Original Medicare Plan, unless they are found upon appeal to be services, items that we should have paid or covered (appeals are discussed in [Section 7](#) and [Section 8](#)).

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

In addition to any exclusions or limitations described in the Benefits Chart in [Section 3](#), or anywhere else in this booklet, **the following items and services aren't covered except as indicated by our Plan:**

1. Services that aren't covered under the Original Medicare Plan.
2. Services that aren't reasonable and necessary according to the standards of the Original Medicare Plan unless these services are otherwise listed by our Plan as a covered service.
3. Experimental or investigational medical and surgical procedures, equipment and medications, unless covered by the Original Medicare Plan or unless, for certain services, the procedures are covered under an approved clinical trial. In 2008 CMS will continue to pay through original Medicare for clinical trial items and services covered under the September 2000 National Coverage Determination that are provided to MA plan members. Experimental procedures and items are those items and procedures determined by our Plan and the Original Medicare Plan to not be generally accepted by the medical community.
4. Surgical treatment of morbid obesity *unless* medically necessary and covered under the Original Medicare plan.
5. Private room in a hospital, *unless* medically necessary.
6. Private duty nurses.
7. Personal convenience items, such as a telephone or television in your room at a hospital or skilled nursing facility.
8. Nursing care on a full-time basis in your home.

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9. Custodial care unless it is provided in conjunction with skilled nursing care and/or skilled rehabilitation services. "Custodial care" includes care that helps people with activities of daily living, like walking, getting in and out of bed, bathing, dressing, eating and using the bathroom, preparation of special diets, and supervision of medication that is usually self-administered.
 10. Homemaker services.
 11. Charges imposed by immediate relatives or members of your household.
 12. Meals delivered to your home.
 13. Elective or voluntary enhancement procedures, services, supplies and medications including but not limited to: Weight loss, hair growth, sexual performance, athletic performance, cosmetic purposes, anti-aging and mental performance unless medically necessary.
 14. Cosmetic surgery or procedures, unless needed because of accidental injury or to improve the function of a malformed part of the body. All stages of reconstruction are covered for a breast after a mastectomy, as well as the unaffected breast, to produce a symmetrical appearance.
 15. Routine dental care (such as cleanings, fillings, or dentures) or other dental services. However, non-routine dental services received at a hospital may be covered.
 16. Chiropractic care is generally not covered under the plan, (with the exception of manual manipulation of the spine, as outlined in [Section 3](#)) and is limited according to Medicare guidelines.
 17. Routine foot care is generally not covered under the plan and is limited according to Medicare guidelines.
 18. Orthopedic shoes, unless they are part of a leg brace and are included in the cost of the leg brace. There is an exception: Orthopedic or therapeutic shoes are covered for people with diabetic foot disease.
 19. Supportive devices for the feet. There is an exception: Orthopedic or therapeutic shoes are covered for people with diabetic foot disease.
 20. Hearing aids.
 21. Radial keratotomy, LASIK surgery, vision therapy and other low vision aids and services. Unless specifically detailed in the summary of benefits.
 22. Self-administered prescription medication for the treatment of sexual dysfunction, including erectile dysfunction, impotence, and anorgasm or hyporgasm.
 23. Reversal of sterilization procedures, sex change operations, and non-prescription contraceptive supplies and devices.
 24. Acupuncture.
 25. Naturopath services.

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26. Services provided to veterans in Veteran's Affairs (VA) facilities. However, in the case of emergency services received at a VA hospital, if the VA cost sharing is more than the cost sharing required under our Plan, we will reimburse veterans for the difference. Members are still responsible for our Plan cost-sharing amount.
27. Any of the services listed above that aren't covered will remain not covered even if received at an emergency facility. For example, non-authorized, routine conditions that do not appear to a reasonable person to be based on a medical emergency are not covered if received at an emergency facility.

7 How to File a Grievance

What is a Grievance?

A grievance is any complaint, other than one that involves a request for an organization determination, or an appeal, as described in [Section 7](#) or [Section 8](#) of this manual because grievances do not involve problems related to approving or paying for care, problems about having to leave the hospital too soon, and problems about having Skilled Nursing Facility (SNF), Home Health Agency (HHA), or comprehensive Outpatient Rehabilitation Facility (CORF) services ending too soon.

If we will not give you the services you want, you believe that you are being released from the hospital or SNF too soon, or you HHA or CORF services are ending too soon, you must follow the rules outline in [Section 7 and/or 8](#).

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

- Problems with the quality of the medical care you receive, including quality of care during a hospital stay.
- If you feel that you are being encouraged to leave (disenroll from) the Plan.
- Problems with the service you receive from Member Services.
- Problems with how long you have to wait on the phone, in the waiting room, or in the exam room.
- Problems getting appointments when you need them, or waiting too long for them.
- Rude behavior by doctors, nurses, receptionists, or other staff.
- Cleanliness or condition of doctor's offices, clinics, or hospitals.
- If you disagree with our decision not to give you a "fast" decision or "fast" appeal. We discuss these fast decisions and appeals in more detail in [Section 7](#) OR [Section 8](#).
- You believe our notices and other written materials are difficult to understand.
- We don't give you a decision within the required time frame (on time).
- We don't forward your case to the independent review entity if we do not give you a decision on time.
- We don't give you required notices.

If you have one of these types of problems and want to make a complaint, it is called "filing a grievance." In certain cases, you have the right to ask for a "fast grievance," meaning we will answer your grievance within 24 hours. We discuss these fast grievances in more detail in [Section 9 and/or Section 10](#).

Filing a grievance with our Plan

If you have a complaint, please call the phone number for **Part C Grievances** in [Section 1](#) of this booklet. We will try to resolve your complaint over the phone. If you ask for a written response, we will respond in writing to you. **If we cannot resolve your complaint over the phone, we have a formal procedure to review your complaints. We call this the written grievance procedure. Just**

complete a Grievance form or write us a letter and sign it. Then mail the grievance to WHP at the address shown on the cover of this booklet. We must address your grievance as quickly as your case requires based on your health status, but no later than 30 days after receiving your complaint. We may extend the time frame by up to 14 days if you ask for the extension, or if we justify a need for additional information and the delay is in your best interest.

For Quality of Care problems, you may also complain to the QIO

You may complain about the quality of care received under Medicare, including care during a hospital stay. You may complain to us using the grievance process, to an independent review entity called the Quality Improvement Organization QIO, or both. If you file with the QIO, we must help the QIO resolve the complaint. See Section 1 for more information about the QIO.

How to file a quality of care complaint with the QIO

You must write to the QIO to file a quality of care complaint. You may file your complaint with the QIO at any time. See p.5 for more information about how to file a quality of care complaint with the QIO.

8 What to Do if you have Complaints about Your Part C Medical Services and Benefits

Introduction

This section gives the rules for making complaints about Part C services and payments in different types of situations. Federal law guarantees your right to make complaints if you have concerns or problems with your medical care as a plan member. If you make a complaint, we must be fair in how we handle it. You cannot be disenrolled or penalized in any way if you make a complaint.

Please refer to Original Medicare in your 2008 Medicare & You Handbook for additional guidance on your appeal rights under Original Medicare. If you do not have a Medicare & You Handbook, please call 1-800 Medicare to get a copy.

How to make complaints in different situations

This section tells you how to make a complaint about services or payment disputes in each of the following situations:

Part 1. Complaints about what benefit or service we will approve or what we will pay for.

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

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

If you want to make a complaint about any situation not listed above, you may file a **grievance**. For more information about grievances, see **Section 7**.

PART 1. Complaints about what benefit or service the Plan will approve or what the Plan will pay for

What are “complaints about your services or payment for your care?”

- If you are not getting the care you want, and you believe that this care is covered by the plan.
- If we will not approve the medical treatment your doctor or other medical provider wants to give you, and you believe that this treatment is covered by the plan.
- If you are being told that a treatment or service you have been getting will be reduced or stopped, and you believe that this could harm your health.
- If you have received care that you believe should be covered by the plan, but we have refused to pay for this care because we say it is not medically necessary or is not a plan benefit.

What is an organization determination?

An organization determination is our **initial decision** about whether we will provide the medical care or service you request, or pay for a service you have received.

If our initial decision is to deny your request, you may **appeal** the decision by going to Appeal Level 1 (see below). You may also appeal if we fail to make a timely initial decision on your request.

When we make an “organization determination” we are giving our interpretation of how the benefits and services that are covered for members of the plan apply to your specific situation. This booklet and any amendments you may receive describe the benefits and services covered by the plan, including any limits on these services. This booklet also lists services that are “not covered” by the plan.

Who may ask for an “organization determination” about your medical care or payment?

Your doctor or other medical provider may ask us whether we will approve the treatment. You may also ask us for an initial decision, or you can name (appoint) someone to do it for you. This person you name would be your representative. You can name a relative, friend, advocate, doctor, or someone else to act for you. Other persons may already be authorized under state law to act for you. If you want someone to act for you, then you and the person you want to act for you must sign and date a statement that gives this person legal permission to be your representative. This statement must be sent to us at the address listed under **Part C Organization Determinations** in **Section 1** of this booklet. Please call us at the phone number listed under **Part C Organization Determinations** for more information. You also have the right to have a lawyer act for you. You can get your own lawyer, or find a lawyer from your local bar association or other referral service. There are also groups that will give you free legal services if you qualify. You may want to call The Legal Aid Society of Evansville at (812) 435-5173.

Do you have a request for medical care that needs to be decided more quickly than the standard time frame?

A decision about whether we will pay for or approve medical care can be a “standard decision” that is made within the standard time frame (typically within 14 days), or it can be a “fast decision” that is made more quickly (typically within 72 hours). A fast decision is also called an “expedited organization determination.” You may ask for a fast decision **only** if you or any doctor believe that waiting for a standard decision could seriously harm your health or your ability to function.

Asking for a standard decision

To ask for a standard decision about providing medical care or payment for care, you or your representative should mail or deliver a request in writing to the address listed under **Part C Organization Determinations** in **Section 1** of this booklet.

Asking for a fast decision

You, any doctor, or your representative can ask us to give a “fast” decision (rather than a “standard” decision) about medical care by calling us. Or, you can send or fax us a written request to the fax number or address listed under **Part C Organization Determinations** in [Section 1](#) of this booklet. You may contact Member Services 7 days a week from 8am to 8pm. WHP is located at 101 SE 3rd Street. This is the corner of 2nd Street and Locust in downtown Evansville (the old Permanent Federal Building). Please use the west side entrance (side nearest the river). Parking is available on the west side of the building. Be sure to ask for a “fast” or “72-hour” review.

If **any** doctor asks for a fast decision for you, or supports you in asking for one, and the doctor indicates that waiting for a standard decision could seriously harm your health or your ability to function, we will give you a fast decision.

If you ask for a fast decision without support from a doctor, we will decide if your health requires a fast decision. If we decide that you don’t need a fast decision, we will send you a letter informing you that if you get a doctor’s support for a “fast” decision, we will automatically give you a fast decision. The letter will also tell you how to file a “grievance” if you disagree with our decision to deny your request for a fast review. It will also tell you about your right to ask for a “fast grievance.” If we deny your request for a fast decision, we will give you a standard decision. For more information about grievances, see [Section 7](#).

What happens next when you request an initial decision?

1. For a decision about payment for care you already received.

We have 30 days to make a decision after we have received your request. However, if we need more information, we can take up to 30 more days. You will be told in writing if we extend the timeframe for making a decision. If we do not approve your request for payment, we must tell you why, and tell you how you can appeal this decision. If you have not received an answer from us within 60 days of your request, you can **appeal** this decision. (An appeal is also called a “reconsideration.”)

2. For a standard decision about medical care.

We have 14 days to make a decision after receiving your request. However, we can take up to 14 more days if you ask for additional time, or if we need more information (such as medical records) that may benefit you. If we take additional days, we will notify you in writing. If you believe that we should not take additional days, you can make a specific type of complaint called a “fast grievance”. If we do not approve your request, we must explain why in writing, and tell you of your right to appeal our decision. If you have not received an answer from us within 14 days of your request (or by the end of any extended time period), you have the right to appeal.

3. For a fast initial decision about medical care.

If you receive a “fast” decision, we will give you our decision about your requested medical care within 72 hours after you or your doctor ask for it – sooner if your health requires. However, we can take up to 14 more days if we find that some information is missing which may benefit you, or if you need

more time to prepare for this review. If you believe that we should not take any extra days, you can file a fast grievance.

We will call you as soon as we make the decision. If we deny any part of your request, we will send you a letter that explains the decision within 3 days of calling you. If we do not decide within 72 hours (or by the end of any extended time period), you have the right to appeal. If we deny your request for a fast decision, you may file a fast grievance.

Appeal Level 1: If we deny any part of your request for a service or payment of a service, you may ask us to reconsider our decision. This is called an “appeal” or a “request for reconsideration.”

Please call us if you need help in filing your appeal. We give the request to different people than those who made the organization determination. This helps ensure that we will give your request a fresh look.

If your appeal concerns a decision we made about a service you asked for, then you and/or your doctor will first need to decide whether you need a “fast” appeal. The procedures for deciding on a “standard” or a “fast” appeal are the same as those described for a “standard” or “fast” initial decision.

Getting information to support your appeal

If we need your help in gathering this information, we will contact you. You have the right to obtain and include additional information as part of your appeal. For example, you may already have documents related to the issue, or you may want to get your doctor’s records or your doctor’s opinion to support your request. You may need to give the doctor a written request to get information.

You can give us additional information to support your appeal by calling, faxing, or writing to the numbers or address listed under **Part C Appeals** in [Section 1](#) of this booklet. You can also deliver additional information in person to the address listed under **Part C Appeals** in [Section 1](#) of this booklet. You also have the right to ask us for a copy of the information we have regarding your appeal. You can call or write us at the numbers or address listed under **Part C Appeals** in [Section 1](#) of this booklet.

How do you file your appeal of the organization determination?

The rules about who may file an appeal are the same as the rules about who may ask for an organization determination / initial decision. Follow the instructions under “Who may ask for an ‘organization determination’ about medical care or payment?” However, providers who do not have a contract with the plan must sign a “waiver of payment” statement that says that they will not ask you to pay for the medical service under review, regardless of the outcome of the appeal.

How soon must you file your appeal?

You must file your appeal within 60 days after we notify you of our decision. We can give you more time if you have a good reason for missing the deadline. To file your appeal, you can call or write us at the phone number or address listed under **Part C Appeals** in [Section 1](#) of this booklet.

What if you want a “fast” appeal?

The rules about asking for a “fast” appeal are the same as the rules about asking for a “fast” initial decision.

How soon must we decide on your appeal?

1. For a decision about payment for care you already received.

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

2. For a standard decision about medical care.

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

3. For a fast decision about medical care.

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

What happens next if we rule completely in your favor?

1. For a decision about payment for care you already received.

We must pay within 60 days of the day we received your appeal.

2. For a standard decision about medical care.

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

3. For a fast decision about medical care.

We must authorize or provide your requested care within 72 hours of receiving your appeal – or sooner, if your health requires it. If we extended the time needed to decide your appeal, we will authorize or provide your medical care immediately.

Appeal Level 2: If on your Level 1 appeal, we do not rule completely in your favor, your appeal will automatically be reviewed by an independent review entity

If we do not rule completely in your favor, your appeal is automatically sent to Appeal Level 2 where an independent review entity that has a contract with CMS (**C**enters for **M**edicare & **M**edicaid **S**ervices), the government agency that runs the Medicare program, and is not part of the plan, will review your appeal. We will tell you in writing that your appeal has been sent to this organization for review. How quickly we must forward your appeal depends on the type of appeal:

1. For a decision about payment for care you already received.

We must forward your appeal to the independent review entity within 60 days from the date we received your Level 1 appeal.

2. For a standard decision about medical care.

We must forward your appeal to the independent review entity as quickly as your health requires, but no later than 30 days after we received your Level 1 appeal.

3. For a fast decision about medical care.

We must forward your appeal to the independent review entity within 24 hours of our decision.

We will send the independent review entity a copy of your case file. You also have the right to get a copy of your case file from us by calling or writing us at the phone number or address listed under **Part C Appeals** in [Section 1](#) of this booklet.

How soon must the independent review entity decide?

1. For an appeal about payment for care, the independent review entity has 60 days to make a decision.
2. For a standard appeal about medical care, the independent review entity has 30 days to make a decision. However, it can take up to 14 more days if more information is needed and the extension will benefit you.
3. For a fast appeal about medical care, the independent review entity has 72 hours to make a decision. However, it can take up to 14 more days if more information is needed and the extension will benefit you.

If the independent review entity decides completely in your favor:

The independent review entity will tell you in writing about its decision.

1. For an appeal about payment for care,

We must pay within 30 days after receiving the decision.

2. For a standard appeal about medical care,

We must authorize the care you requested within 72 hours after receiving the decision, or provide the care no later than 14 days after receiving the decision.

We must authorize or provide the care no later than 14 days after receiving the decision. If it is not appropriate to provide the service within 14 calendar days, e.g., because of your medical condition or you are outside of the service area, we must authorize the services within 72 hours from the date we receive notice that the independent review entity reversed the determination.

3. For a fast appeal about medical care,

We must provide the care you requested within 72 hours after receiving the decision.

Appeal Level 3: If the entity that reviews your case in Appeal Level 2 and does not rule completely in your favor, you may ask for a review by an Administrative Law Judge

You must ask for a review by an Administrative Law Judge (ALJ) in writing within 60 days after the date you were notified of the decision made at Appeal Level 2. They may extend the deadline for good cause. You must send your written request to the ALJ Field Office that is listed in the decision you received from the independent review entity. The Administrative Law Judge will not review the appeal if the dollar value of the medical care does not meet the minimum requirement included in the independent review entity's decision. If the dollar value is less than the minimum requirement, you may not appeal any further. During this review, you may present evidence, review the record, and be represented by a lawyer.

How soon will the Judge make a decision?

The Administrative Law Judge will hear your case, weigh all of the evidence up to this point, and decide as soon as possible.

If the Judge decides in your favor

We must pay for, authorize or provide the service you have asked for within 60 days from the date we receive notice of the decision. However, we have the right to appeal this decision by asking for a review by the Medicare Appeals Council (Appeal Level 4).

Appeal Level 4: If the Judge does not rule completely in your favor, you may ask for a review by the Medicare Appeals Council

The Medicare Appeals Council does not review every case it receives. If they decide not to review your case, then either you or we may ask for a review by a Federal Court Judge (Appeal Level 5).

The Medicare Appeals Council will send a notice informing you of any action it has taken on your request. The notice will tell you how to request a review by a Federal Court Judge.

How soon will the Council make a decision?

If the Medicare Appeals Council reviews your case, they will decide as soon as possible.

If the Council decides in your favor

We must pay for, authorize, or provide the medical care you requested within 60 days from the date we receive the decision. However, we have the right to ask a Federal Court Judge to review the case (Appeal Level 5), as long as the dollar value of the care you asked for meets the minimum requirement.

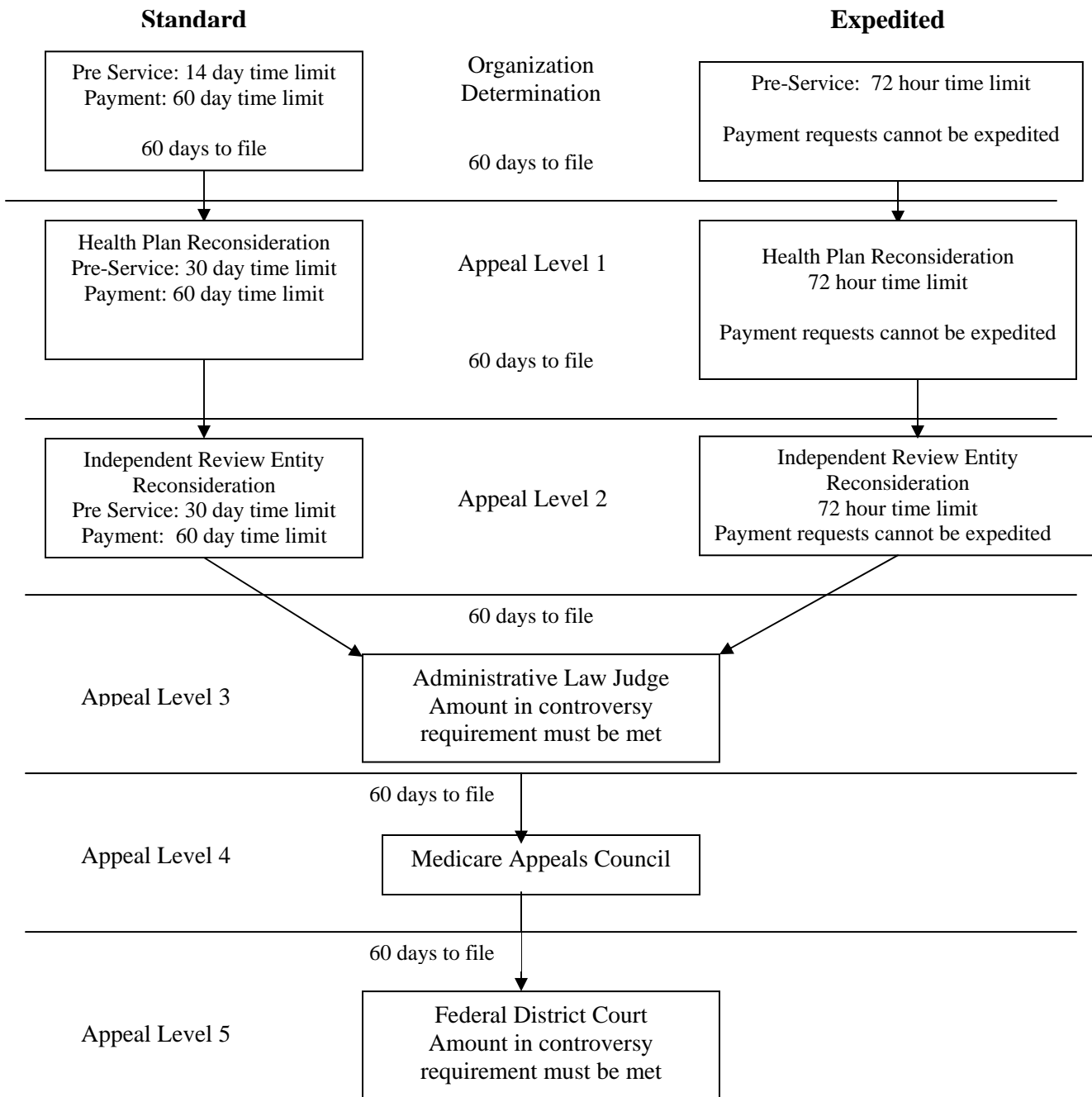
Appeal Level 5: If the Medicare Appeal Council does not rule completely in your favor, you may ask for a review by a Federal Court

You can file an appeal in Federal court if you receive a decision from the Medicare Appeals Council (MAC) that is not completely favorable to you or the MAC decided not to review your case. The letter you get from the MAC will tell you how to ask for this review. The Federal Court Judge will first decide whether to review your case. Your appeal will not be reviewed by a Federal Court if the dollar value of the care you asked for does not meet the minimum requirement included in the MAC's decision.

How soon will the Judge make a decision?

The Federal judiciary controls the timing of any decision. The Judge's decision is final.

Complaint process for what benefit or service the Plan will approve or what the Plan will pay for:



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

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

Information you should receive during your hospital stay

Within two days of admission as an inpatient, someone at the hospital must give you a notice called the Important Message from Medicare (call the plan Member Services phone number listed in [Section 1](#) or 1-800 MEDICARE (1-800-633-4227) to get a sample notice or see it online at <http://www.cms.hhs.gov/BNI/>). This notice explains:

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

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

Review of your hospital discharge by the Quality Improvement Organization

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

What is the “Quality Improvement Organization”?

“QIO” stands for **Q**uality **I**mprovement **O**rganization. In Indiana, the QIO is called Health Care Excel. The QIO is a group of doctors and other health care experts paid by the federal government to check on and help improve the care given to Medicare patients. They are not part of the Plan or the hospital. There is one QIO in each state. QIOs have different names, depending on which state they are in. Indiana’s is Health Care Excel. The doctors and other health experts in Health Care Excel

review certain types of complaints made by Medicare patients. These include complaints from Medicare patients who think their hospital stay is ending too soon.

Getting QIO review of your hospital discharge

You must quickly contact the QIO. The Important Message from Medicare gives the name and telephone number of the QIO and tells you what you must do. You can contact Health Care Excel at 2901 Ohio Boulevard, P.O. Box 3713, Terre Haute, Indiana 47803, or by telephone at 800-288-1499.

- You must ask the QIO for a **“fast review”** of your discharge. This “fast review” is also called an “immediate review.”
- You must request a review from the QIO no later than the day you are scheduled to be discharged from the hospital. **If you meet this deadline, you may stay in the hospital after your discharge date without paying for it while you wait to get the decision from the QIO.**
- The QIO will look at your medical information provided to the QIO by us and the hospital.
- During this process, you will get a notice giving our reasons why we believe that your discharge date is medically appropriate.
- The QIO will decide, within one day after receiving the medical information it needs, whether it is medically appropriate for you to be discharged on the date that has been set for you.

What happens if the QIO decides in your favor?

We will continue to cover your hospital stay for as long as it is medically necessary (except for any applicable co-payments or deductibles).

What happens if the QIO agrees with the discharge?

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

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

What happens if you appeal the QIO decision?

The QIO has 14 days to decide whether to uphold its original decision or agree that you should continue to receive inpatient care. If the QIO agrees that your care should continue, we must pay for or reimburse you for any care you have received since the discharge date on the Important Message from Medicare, and provide you with inpatient care as long as it is medically necessary (except for any applicable co-payments or deductibles).

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

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

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

If you ask us for a fast appeal of your discharge and you stay in the hospital past your discharge date, you may have to pay for the hospital care you receive past your discharge date. Whether you have to pay or not depends on the decision we make.

- If we decide, based on the fast appeal, that you need to stay in the hospital, we will continue to cover your hospital care for as long as it is medically necessary (except for any applicable co-payments or deductibles).
- If we decide that you should not have stayed in the hospital beyond your discharge date, we will not cover any hospital care you received after the discharge date.

If we uphold our original decision, we will forward our decision and case file to the independent review entity within 24 hours. Please see Appeal Level 2 in Part 1 of this section for guidance on the Independent Review Entity (IRE) appeal. If the IRE upholds our decision, you may also be able to ask for a review by an ALJ, MAC, or a Federal court. If any of these decision makers (Independent Review Entity, Administrative Law Judge, Medicare Appeal Council, Federal Court) agree that your stay should continue, we must pay for or reimburse you for any care you have received since the discharge date on the notice you got from your provider, and provide you with any services you asked for as long as they are medically necessary (except for any applicable co-payments or deductibles).

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

When you are a patient in a **S**killed **N**ursing **F**acility (SNF), **H**ome **H**ealth **A**gency (HHA), or **C**omprehensive **O**utpatient **R**ehabilitation **F**acility (CORF), you have the right to get all the SNF, HHA or CORF care covered by the Plan that is necessary to diagnose and treat your illness or injury. The day we end coverage for your SNF, HHA or CORF services is based on when these services are no longer medically necessary. This part explains what to do if you believe that coverage for your services is ending too soon.

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

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

Getting QIO review of our decision to end coverage

You have the right to appeal our decision to end coverage for your services. As explained in the notice you get from your provider, you may ask the **Q**uality **I**mprovement **O**rganization (the “QIO”) to do an independent review of whether it is medically appropriate to end coverage for your services.

How soon do you have to ask for QIO review?

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

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

What will happen during the QIO’s review?

The QIO will ask why you believe coverage for the services should continue. You don’t have to prepare anything in writing, but you may do so if you wish. The QIO will also look at your medical information, talk to your doctor, and review information that we have given to the QIO. During this process, you will get a notice called the Detailed Explanation of Non-Coverage giving the reasons why we believe coverage for your services should end (call the plan Member Services phone number in [Section 1](#) or 1-800 Medicare to get a sample notice or see it online at <http://www.cms.hhs.gov/BNI/>).

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

What happens if the QIO decides in your favor?

We will continue to cover your SNF, HHA or CORF services for as long as medically necessary (except for any applicable co-payments or deductibles).

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

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

What happens if you appeal the QIO decision?

The QIO has 14 days to decide whether to uphold its original decision or agree that you should continue to receive services. If the QIO agrees that your services should continue, we must pay for or reimburse you for any care you have received since the termination date on the notice you got from your provider, and provide you with any services you asked for as long as they are medically necessary (except for any applicable co-payments or deductibles).

If the QIO upholds its original decision, you may be able to appeal its decision to the Administrative Law Judge (ALJ). Please see Appeal Level 3 in Part 1 of this section for guidance on the ALJ appeal. If the ALJ upholds our decision, you may also be able to ask for a review by the Medicare Appeals Council or a Federal Court. If either the Medicare Appeal Council or Federal Court agrees that your stay should continue, we must pay for or reimburse you for any care you have received since the termination date on the notice you got from your provider, and provide you with any services you asked for as long as they are medically necessary (except for any applicable co-payments or deductibles).

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

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

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

- If we decide, based on the fast appeal, that coverage for your services should continue, we will continue to cover your SNF, HHA, or CORF services for as long as medically necessary.
- If we decide that you should not have continued getting services, we will not cover any services you received after the termination date.

If we uphold our original decision, we will forward our decision and case file to the independent review entity within 24 hours. Please see Appeal Level 2 in Part 1 of this section for guidance on the Independent Review Entity (IRE) appeal. If the IRE upholds our decision, you may also be able to ask for a review by an ALJ, MAC or a Federal Court. If any of these decision makers (Independent Review Entity, Administrative Law Judge, Medicare Appeal Council, Federal Court) agree that your stay should continue, we must pay for or reimburse you for any care you have received since the discharge date on the notice you got from your provider, and provide you with any services you asked for as long as they are medically necessary (except for any applicable co-payments or deductibles).

9 Ending your Membership

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

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

Voluntarily ending your membership

In general, there are only certain times during the year when you may voluntarily end your membership in our Plan.

Every year, from November 15 through December 31, during the Annual Coordinated Election Period (AEP), anyone with Medicare may switch from one way of getting Medicare to another for the following year. Your change will take effect on January 1.

There may be other limited times during which you may make changes. For more information about these times and the options available to you, please refer to the “Medicare & You” handbook you receive each fall. You may also call 1-800-MEDICARE (1-800-633-4227), or visit www.medicare.gov to learn more about your options.

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

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

If you must get services from plan providers and doctors or other medical providers who are not plan providers before your membership in our Plan ends, neither we nor the Medicare program will pay for these services, with just a few exceptions. The exceptions are urgently needed care, care for a medical emergency, out-of-area renal (kidney) dialysis services, and care that has been approved by us. There is another possible exception, if you happen to be hospitalized on the day your membership ends. If this happens to you, call Member Services to find out if your hospital care will be covered by our Plan. If you have any questions about leaving our Plan, please call us at Member Services.

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

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

Involuntarily ending your membership

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

- **If you move out of the service area or are away from the service area for more than 6 months (180 days) in a row.** If you plan to move or take a long trip, please call Member Services to find out if the place you are moving to or traveling to is in our Plan's service area. If you move permanently out of our geographic service area, or if you are away from our service area for more than six months in a row, you cannot remain a member of WHP. In these situations, if you do not leave on your own, we must end your membership ("disenroll" you). (See [Section 1](#) for information about the plan's service area).
- If you do *not* stay continuously enrolled in Medicare A and B.
- If you give us information on your enrollment request that you know is false or deliberately misleading, and it affects whether or not you can enroll in our Plan.
- If you behave in a way that is disruptive, to the extent that your continued enrollment seriously impairs our ability to arrange or provide medical care for you or for others who are members of our Plan. We cannot make you leave our Plan for this reason unless we get permission first from Medicare.
- If you let someone else use your plan membership card to get medical care. If you are disenrolled for this reason, CMS may refer your case to the Inspector General for additional investigation.

You have the right to make a complaint if we end your membership in our Plan

If we end your membership in our Plan we will tell you our reasons in writing and explain how you can file a complaint against us if you want to.

10 Legal Notices

Notice about governing law

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

Notice about non-discrimination

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

11 Definitions of Some Words Used in This Book

Appeal – A type of complaint you make when you want us to reconsider and change a decision we have made about what services are covered for you or what we will pay for a service. Section 8 explains about appeals, including the process involved in making an appeal.

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

You are an inpatient in a SNF only if your care in the SNF meets certain skilled level of care standards. Specifically, in order to have been an inpatient while in a SNF, you must need daily skilled nursing or skilled rehabilitation care, or both. (Section 2 tells what is meant by skilled care.)

Generally, you are an inpatient of a hospital if you are getting inpatient services in the hospital (the type of care you actually receive in the hospital doesn't determine whether you are considered to be an inpatient in the hospital).

Centers for Medicare & Medicaid Services (CMS) – The Federal agency that runs the Medicare program. Section 1 tells how you can contact CMS.

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

Coverage Determination - The plan has made a coverage determination when it makes a decision about the benefits you can receive under the Plan, and the amount that you must pay for those benefits.

Covered services – The general term we use in this booklet to mean all of the health care services and supplies that are covered by our Plan. Covered services are listed in the Benefits Chart in Section 3.

Creditable Coverage – Coverage that is at least as good as the standard Medicare prescription drug coverage.

Disenroll or disenrollment – The process of ending your membership. Disenrollment can be voluntary (your own choice) or involuntary (not your own choice). [Section 9](#) tells about disenrollment.

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

Emergency care – Covered services that are 1) furnished by a provider qualified to furnish emergency services; and 2) needed to evaluate or stabilize an emergency medical condition. [Section 2](#) tells about emergency services.

Evidence of coverage and disclosure information – This document along with your enrollment form which explains your covered services, defines our obligations, and explains your rights and responsibilities as a member of our Plan.

Grievance – A type of complaint you make about us or one of our plan providers, including a complaint concerning the quality of your care. This type of complaint doesn't involve payment or coverage disputes. See [Section 7](#) for more information about grievances.

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

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

Medicare – The federal health insurance program for people 65 years of age or older, some people under age 65 with certain disabilities, and people with permanent kidney failure who need dialysis or a kidney transplant).

Medicare Advantage Organization – A public or private organization licensed by the State as a risk-bearing entity that is under contract with the **C**enters for **M**edicare & **M**edicaid **S**ervices (CMS) to provide covered services. Medicare Advantage Organizations can offer one or more Medicare Advantage Plans. Our Plan is a Medicare Advantage Organization.

Medicare Advantage Plan – A benefit package offered by a Medicare Advantage Organization that offers a specific set of health benefits at the same premium and level of cost-sharing to all people with Medicare who live in the service area covered by the Plan. A Medicare Advantage Organization may offer more than one plan in the same service area. Our Plan is a Medicare Advantage Plan.

Medicare Cost Plan – Cost plan means 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. Welborn Health Plans Medicare Basic and Plus Plans are Cost Plans.

Medicare Managed Care Plan – Means a Medicare Advantage HMO, Medicare Cost Plan, or Medicare Advantage PPO. Welborn Health Plans Medicare Basic and Plus Plans are Medicare Managed Care Plans.

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

“Medigap” (Medicare supplement insurance) policy – Medicare Supplement Insurance sold by private insurance companies to fill “gaps” in the Original Medicare Plan coverage. Medigap policies only work with the Original Medicare Plan.

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

Member services – A department within our Plan responsible for answering your questions about your membership, benefits, grievances, and appeals. See Section 1 for information about how to contact Member Services.

Non-plan provider or non-plan facility – A provider or facility that we have not arranged with to coordinate or provide covered services to members of our Plan. Non-plan providers are providers that are not employed, owned, or operated by our Plan and are not under contract to deliver covered services to you.

As explained in this booklet, most services you get from non-plan providers are not covered by our Plan. If the services you get are Medicare covered services and WHP has NOT pre-approved them you will be responsible for all co-payments and deductibles under Original Medicare. If you get a non-Medicare covered service not pre-approved by WHP you will be responsible for 100% of the cost up to the Medicare limiting charge.

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

Original Medicare – Some people call it “traditional Medicare” or “fee-for-service” Medicare. The Original Medicare Plan is the way many people get their health care. It is the national pay-per-visit program that lets you go to any doctor, hospital, or other health care provider who 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.

Plan provider – **“Provider”** is the general term we use for doctors, other health care professionals, hospitals, and other health care facilities that are licensed or certified by Medicare and by the State to provide health care services. We call them **“plan providers”** when they have an agreement with our Plan to accept our payment as payment in full, and in some cases to coordinate as well as provide

covered services to members of our Plan. Our Plan pays plan providers based on the agreements it has with the providers.

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

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

Prior authorization – Approval in advance to get services. Some in-network services are covered only if your doctor or other plan provider gets “prior authorization” from our Plan. Covered services that need prior authorization are marked in the Benefits Chart in Section 3 Prior authorization is not required for out-of-network services. You do not need prior authorization to obtain out-of-network services. However, you may want to check with your plan before obtaining services out-of-network to confirm that the service is covered by your plan and what your cost share responsibility is. If your plan offers Part D drugs, certain drugs may require prior authorization. Check with your plan.

Quality Improvement Organization (QIO) – Groups of practicing doctors and other health care experts who are paid by the federal government to check and improve the care given to Medicare patients. They must review your complaints about the quality of care given by doctors in inpatient hospitals, hospital outpatient departments, hospital emergency rooms, skilled nursing facilities, home health agencies, Private fee-for-service plans and ambulatory surgical centers. See Section 1 for information about how to contact the QIO in your state and Section 8 for information about making complaints to the QIO.

Rehabilitation services – These services include physical therapy, cardiac rehabilitation, speech and language therapy, and occupational therapy that are provided under the direction of a plan provider.

Service area – Section 1 tells about our Plan’s service area. “Service area” is the geographic area approved by the Centers for Medicare & Medicaid Services (CMS) within which an eligible individual may enroll in a Medicare Health Plan.

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

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