

## **Your Medicare Health Benefits and Services as a Member of Welborn Health Plans Cost Basic and Cost Plus**

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

### **Welborn Health Plans Member Services:**

For help or information, please call Member Services or go to our Plan website at [www.welbornhealthplans.com](http://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)

**This Plan is offered by Welborn Health Plans, referred throughout the EOC as “we”, “us” or “our.” Welborn Health Plans Cost Basic and Cost Plus is referred to as “Plan” or “our Plan.” Our organization contracts with the Federal government.**

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

## Important Information

### How Your Plan Will Change For 2009

This is the time of year when we like to thank you for your membership and let you know of new plan changes for the upcoming year. Beginning January 1, 2009, there will be some changes to our Plans.

You are enrolled in the Cost Basic or Cost Plus in 2008 and your plan costs are changing. All changes will be effective January 1, 2009.

This is just a brief summary of the changes in your plan for 2009. **Make sure to read the next few pages for answers to important questions you may be asking.** If you have any questions, call Member Services. Note: If you are receiving help from your state Medicaid agency such as a reduced co-payment, these reductions are not reflected in this packet. Please call your state at the number listed in Section 8 if you have questions.

	2008	2009
<b>Monthly Premium</b>		
<b>Cost Basic</b>	\$121	\$140
<b>Cost Plus</b>	\$144	\$160
		<p>If you are receiving a subsidy from your current or former employer or union to pay for some or all of your Plan premium. Please contact your employer or union's group benefit plan administrator for information about your Plan premium.</p> <p>If your employer stops subsidizing the plan, you have protected rights to remain in the plan or join another plan with Welborn Health Plans.</p>
<b>Benefit changes</b>	These plans are closed and benefits will remain the same. If you leave this plan, Medicare will not allow you to join it again.	

With this notice, you also received a 2009 Evidence of Coverage that will be effective January 1, 2009. Medicare has closed this plan to new members but will continue to cover current members. Please see Section 10 for more information about the benefits described in the table above.

## This is Your Annual Notice of Change

Why am I receiving this information?

We are sending this Annual Notice of Change (ANOC) so you can review the 2009 coverage offered through this plan. Since the Cost Basic and Cost Plus plans are a type of Medicare plan called Medicare Cost Plans, you may leave this plan at anytime and return to the Original Medicare plan. However, while you may leave our Plan at any time, you are generally limited to certain times of the year when you may join other Medicare plans. Each year from November 15 through December 31, you may make a change to your Medicare plan and Medicare prescription drug coverage, with your new plan beginning on January 1. Certain individuals, such as those with Medicaid, those who get extra help, or who move, can make changes at other times. **Please keep in mind this plan is closed to enrollment. If you leave our Plan you will not be able to re-enroll in the future. If you want to stay in our Plan, you don't need to do anything. You will still be a member of our Plan for the coming year.**

Note: If you are a member of an employer group, you may be required to belong to a specific plan in order to continue to get the additional benefits you may be receiving. Please check with your employer before switching to another health plan.

What if I don't have drug coverage that expects to pay, on average, at least as much as standard Medicare prescription drug coverage?

Our plan does not include Medicare prescription drug coverage. If you haven't had other prescription drug coverage that was creditable coverage (coverage that expects to pay, on average, at least as much as Medicare's standard prescription drug coverage), you may have to pay a late enrollment penalty when you sign up for Medicare prescription drug coverage. You will pay the penalty if you go without creditable coverage for a continuous period of 63 days or more. The longer you wait to enroll in a Medicare drug plan, the higher the penalty may be. If you have had creditable prescription drug coverage, your employer/union will notify you each year if it continues to be creditable coverage. If you received a notice this year that you no longer have creditable coverage, consider joining a Medicare health plan that offers prescription drug coverage. If you are a member of this plan and want to get Medicare prescription drug coverage, you may join a Medicare Prescription Drug Plan. If you are a member of this plan and want to get Medicare prescription drug coverage, you may join a Medicare Advantage plan with prescription drug coverage offered by our organization or buy a separate Medicare prescription drug plan from another organization. Our organization offers the following plans that include Medicare prescription drug coverage: WHP Silver Rx and WHP Platinum Rx. You can also contact Member Services for additional information. To find other plans available in your area, visit [www.medicare.gov](http://www.medicare.gov) and under "Search Tools" select "Compare Medicare Prescription Drug Plans." Or call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

If you join another Medicare Health Plan you will be disenrolled from our Plan when your enrollment in the new plan begins.

## 2009 Evidence of Coverage (EOC)

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Where can I get more information?

The Evidence of Coverage on the following pages has more information on our Plan's coverage, including information on how to make changes to your membership in Section 6.

Please call Member Services if you have any questions. You can also get information about the Medicare program and other Medicare plans available by visiting [www.medicare.gov](http://www.medicare.gov) or by calling 1-800-MEDICARE (1-800-633-4227) 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

**This is Your 2009 Evidence of Coverage (EOC)**

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Other enclosures:

Cover sheet.

Comparison to other plans offered by WHP.

## **1. Introduction**

Thank you for being a member of our Plan!

This is your Evidence of Coverage, which explains how to get your Medicare health care coverage through our Plan, an HMO; you are getting your health care through our Plan.

This Evidence of Coverage, together with your enrollment form, riders, and amendments that we send to you, is our contract with you. The Evidence of Coverage explains your rights, benefits, and responsibilities as a member of our Plan and is in effect from January 1, 2009 - December 31, 2009. There is more than one plan described in this EOC. Please refer to the cover sheet you received with this information to identify which plan you are enrolled in. Our plan's contract with the Centers for Medicare & Medicaid Services (CMS) is renewed annually, and availability of coverage beyond the end of the current contract year is not guaranteed.

This Evidence of Coverage will explain to you:

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

This Section of the EOC has important information about:

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

### **Eligibility Requirements**

To be a member of our Plan, you must live in our service area, be entitled to Medicare Part A, and enrolled in Medicare Part B or enrolled in Medicare Part B only and not have End Stage Renal Disease (ESRD), with limited exceptions, such as if you are already a member of our plan. If you currently pay a premium for Medicare Part A and/or Medicare Part B, you must continue paying your premium in order to keep your Medicare Part A and/or Medicare Part B and remain a member of this plan.

The geographic service area for our Plan.

The counties in our service area are listed below.

Gibson, Posey, Spencer, Warrick and Vanderburgh counties in Southwestern Indiana

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If you move outside of our service area, you cannot remain a member of our plan. For members living outside the service area now, any move may result in leaving our plan. Please call Member Services to find out if we have a plan in the new area.

### **How do I keep my membership record up to date?**

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

Please help us keep your membership record up to date by telling Member Services if there are changes to your name, address, or phone number, or if you go into a nursing home. Also, tell Member Services about any changes in other health insurance coverage you have, such as from your employer, your spouse's employer, workers' compensation, Medicaid, or liability claims such as claims from an automobile accident.

### **Materials that you will receive from our Plan**

#### **Plan membership card**

While you are a member of our Plan, you must use our membership card for services covered by this plan. While you are a member of our Plan you must continue to use your red, white, and blue Medicare card to get covered services, items. You will continue to receive benefits under Medicare and our plan.

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

#### **The Provider Directory gives you a list of network providers**

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

You must use network providers for services to be covered by us at plan cost-sharing levels, except in emergencies or for urgently needed care. See the benefits chart in Section 10 for more specific out-of-network coverage information.

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### Your monthly plan premium

As a member of our Plan, you pay:

- 1) Your monthly Medicare Part B premium. Most people will pay the standard premium amount, which is \$96.40 in 2009. (Your Part B premium is typically deducted from your Social Security payment.) (If you receive benefits from your state Medicaid program, all or part of your Part B premium may be paid for you.)

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

If your Yearly Income is*		In 2009, you pay*
File individual tax return	File joint tax return	
\$82,000 or below	\$164,000 or below	\$96.40
\$82,001-\$102,000	\$164,001-\$204,000	\$122.20
\$102,001-\$153,000	\$204,001-\$306,000	\$160.90
\$153,001-\$205,000	\$306,001-\$410,000	\$199.70
Above \$205,000	Above \$410,000	\$238.40

\*If you pay a Part B late-enrollment penalty, the premium amount is higher.

- 2) Your monthly Medicare Part A premium, if necessary (most people don't have to pay this premium).
- 3) Your monthly premium for our Plan. You can also pay a quarterly premium.

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

### Monthly Plan Premium Payment Options

There are two ways to pay your monthly plan premium. You can inform the plan of any changes in payment options by calling member services.

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

You may decide to pay your monthly plan premium directly to our Plan.

You can decide to pay your premium directly to our Plan with a check or money order. Your plan premium is due on the first of each month for coverage of that month and should be received in our offices by that date.

Instead of paying by check, you can have your monthly plan premium automatically withdrawn from your bank account. These automatic deductions will occur monthly on or around the 5<sup>th</sup>. For information on setting up the automatic deduction, please call Member Services.

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

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

**What is the Medicare Prescription Drug Plan late enrollment penalty?**

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

If you must pay a late enrollment penalty, your penalty is calculated when you first join a Medicare drug plan. To estimate your penalty, take 1% of the national base beneficiary premium for the year you join (in 2009, the national base beneficiary premium is \$30.36).” Multiply it by the number of full months you were eligible to join a Medicare drug plan but didn't, and then round that amount to the nearest ten cents. This is your estimated penalty amount, which is added each month to your Medicare drug plan's premium for as long as you are in that plan.

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

- You had creditable coverage (coverage that expects to pay, on average, at least as much as Medicare's standard prescription drug coverage)
- You had prescription drug coverage but you were not adequately informed that the coverage was not creditable (as good as Medicare's drug coverage)
- Any period of time that you didn't have creditable prescription drug coverage was less than 63 continuous days
- You lived in an area affected by Hurricane Katrina at the time of the hurricane (August 2005) AND you signed up for a Medicare prescription drug plan by December 31, 2006, AND you stay in a Medicare prescription drug plan
- You received or are receiving extra help AND you enroll in a Medicare prescription drug plan by December 31, 2008, AND you stay in a Medicare prescription drug plan

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

If your monthly plan premiums are late or you have not been paying your co-payments, we will tell you in writing that if you don't pay your monthly plan premium or co-payments by a certain date, which includes a grace period, we will end your membership in our Plan. Our plans grace period is 60 days. If we end your membership, you will have Original Medicare Plan coverage.

Should you decide later to re-enroll in our Plan, or to enroll in another plan offered by WHP, you will have to pay any late plan premiums or cost sharing that you didn't pay from your previous enrollment in our Plan.

## **Important Information**

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

## **2. How You Get Care**

### **What are “providers”?**

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

### **What are “network providers”?**

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

### **What are “covered services”?**

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

### **What do you pay for “covered services”?**

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

### **Providers you can use to get services covered by our Plan**

For services to be covered by our Plan, you must use our network providers to get your covered services, except in limited cases such as emergency care or urgently needed care when our network is not available. We list the providers that participate with our Plan in our provider directory. Note: If you get original Medicare services from an out-of-network provider then you must pay the original Medicare cost-sharing amounts - except in an emergency or if the services were urgently needed. You can find the original Medicare cost-sharing amounts in the *Medicare & You* handbook or by calling 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048. If an out-of-network provider sends you a bill that you think we should pay, please contact Member Services. Generally, it is best to ask an out-of-network provider to bill the Original Medicare Plan first, and then to bill us for the remaining amount. We may require the out-of-network provider to bill the Original Medicare Plan. We will then pay any applicable Medicare coinsurance and deductibles minus your co-payments on your behalf. Note: If we do not cover services furnished by an out-of-network provider, the services will be covered by

Original Medicare if they are Medicare-covered services. In this case you would be responsible for Original Medicare cost-sharing amounts.

### **Choosing Your Primary Care Physician (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).

### **What types of providers may act as a PCP?**

If you have questions about PCP eligibility or how to locate a PCP, please contact our member services.

### **How do you choose/change a PCP if member desires or when PCP leaves plan?**

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.

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.

### **The role of a PCP in your plan.**

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

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

***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

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plan providers, or a provider pre-approved by WHP you will only have to pay the plan copayments.

- Routine women's health care, which include breast exams, mammograms (X-rays of the breast), Pap tests, and pelvic exams as long as you get them from a network provider
- Flu shots and pneumonia vaccinations as long as you get them from a network provider.
- Emergency services, whether you get these services from network providers or out-of-network providers
- Urgently needed care that you get from out-of-network providers when you are temporarily outside the Plan's service area or when you are in the service area but, because of unusual or extraordinary circumstances, the Network providers are temporarily unavailable or inaccessible.
- Dialysis (kidney) services that you get at a Medicare certified dialysis facility when you are temporarily outside the Plan's service area. If possible, please let us know before you leave the service area where you are going to be so we can help arrange for you to have maintenance dialysis while outside the service area.

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.

What is the role of the PCP in coordinating covered services?

“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 3 tells you how we will protect the privacy of your medical records and personal health information.

### Services Requiring Authorization:

- Out of Network Services, Specialists
- Plastic Surgery Referrals
- Infertility
- Elective Inpatient Admissions:
  - Acute Care Hospital, Rehabilitation Hospital, Mental Health/Chemical Dependency, and Skilled Nursing Facility
- Outpatient Surgical Procedures or other therapeutic procedures performed in Acute Care Facilities, Radiology Departments, Ambulatory or Day Surgery Centers with the following **exceptions**:
  - Breast Biopsy, Liver Biopsy, Prostate Biopsy, Lap Tubal Ligation, Lap Cholecystectomy, Vasectomy, TURBT, Bone Marrow Aspiration and Biopsy, T&A, D&C, Radiation Therapy, Chemotherapy, BTT, TURP, ESWL, Colonoscopy, Gastroscopy (EGD) – including dilation, Cystoscopy, Bronchoscopy, Ophthalmic laser procedures, Cataracts and Central Venous Access Procedures
- Outpatient Non-Office Diagnostic Procedures:
- Arteriogram (carotid, femoral, aortic, etc.), Arthrogram, and Carotid Dopplers (Carotid Ultrasounds)

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- 4D Obstetrical Ultrasounds
- First Screen Prenatal Testing (Under age 34)
- Sleep Studies
- Radiology Imaging Studies:
  - MRI/MRA/CAT Scans and PET Scans/SPECT Scans
- Mental Health/Chemical Dependency *Intensive Outpatient Services* (After patient has been evaluated.)
- Home Health & Hospice
- IV Therapy/Infusion Therapy (Home, Office or Outpatient Hospital)
- Physical Therapy/Occupational Therapy Speech Therapy
- Cardiac and Pulmonary Rehabilitation
- Durable Medical Equipment (DME), Prosthetics/Orthotics dispensed outside the Physician Office with the following **exceptions**:
  - Walkers/Crutches/Canes, TENS Unit, Commode Chairs (Medicare Only), Manual Breast Pump, Phototherapy, Overdoor Cervical Traction (E0860), Truss, Nebulizer (E0570), and Glucometers
- Specialty Pain Management Services (all related Procedures &/or Services, excluding Consults)
- Dialysis
- Transfers by Ambulance (Elective)
- Pharmacy:
  - Selected Drugs for Commercial members, Selected Drugs for Medicare members only, Finally Beat Smoking! Program Prescriptions, and BioTech Drugs (ie: Synvisc, Hyalgen, Remicade)
- Oral Surgery
- Finally Beat Smoking! Modalities:
  - Medications, Acupuncture and Hypnosis
- Tertiary Care
- Transplantation Services
- Botox Injection (Medically Necessary - Only NOTE: Cosmetic Uses are Not Covered)

### Pre-certification Turn Around Time Standards:

Elective – 2 day maximum, Urgent – same day

### Emergent Admission/Procedure:

No Pre-certification is required. Welborn Health Plans **must** be notified within 48 hours.

### Ordering DME After Hours:

Leave a voice mail message with the request at 812-426-6600, ext. 1344

### After Hours Care:

Should be directed by the PCP.

**A PCP can refer to any network provider and is not limited to a specific specialist, sub-network, or referral circles.**

### **What if your doctor or other provider leaves your plan?**

Sometimes a network 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. Member Services can assist you in finding and selecting another provider.

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

#### **What is a “medical emergency”?**

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

#### **If you have a medical emergency:**

- Get medical help as quickly as possible. Call 911 for help or go to the nearest emergency room, hospital, or urgent care center. You don't need to get approval or a referral first from your doctor or other network provider.
- As soon as possible, 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, usually within 48 hours by calling Member Services. Please call Member Services at 1-800-521-0265. TTY users may call Indiana Relay at 1-800-743-3333. We will help manage and follow up on your emergency care.
- As an added benefit under the WHP "Plus" Plan, you have coverage for emergencies and urgently needed care - anywhere in the world - with the protection of The WHP Foreign Travel Emergency Care benefit. You pay a \$250 calendar year deductible, 20% coinsurance for the remainder of covered charges, and any amount over the \$50,000 lifetime maximum benefit.
- As an added benefit under The WHP "Plus" Plan, you have coverage for ambulance services - anywhere in the world - with the protection of The WHP Foreign Travel Emergency Care benefit. You pay a \$250 calendar year deductible, 20% coinsurance for the remainder of covered charges, and any amount over the \$50,000 lifetime maximum benefit.

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 then you are still entitled to follow-up post stabilization care. Your follow-up post stabilization care will be covered according to Medicare guidelines. In general, if your emergency care is provided out of network we will try to arrange for network providers to take over your care as soon as your medical condition and the circumstances allow.

#### **What is covered if you have a medical emergency?**

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

detailed information.)

- The plan offers a supplemental benefit covering emergencies physician services outside of the country; please refer to Section 10 for more information.

### **What if it wasn't a medical emergency?**

Sometimes it can be hard to know if you have a medical emergency. For example, you might go in for emergency care – thinking that your health is in serious danger – and the doctor may say that it wasn't a medical emergency after all. If this happens, you are still covered for the care you got to determine what was wrong, as long as you thought your health was in serious danger, as explained in “What is a ‘medical emergency’” above. 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 additional care **only if you get it from a network provider**. We will pay our portion of the covered additional care from an out-of-network provider if you are out of our service area, as long as the additional care you get meets the definition of “urgently needed care” that is given below. If you get any extra care from an **out-of-network** provider after the doctor says it wasn't a medical emergency, you will normally have to pay the Original Medicare Plan cost-sharing.

### **What is urgently needed care?**

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

- Inside the United States
- Temporarily absent from the Plan's authorized service area
- In need of medical attention right away for an unforeseen illness, injury, or condition, ***and***
- It isn't reasonable given the situation for you to obtain medical care through the Plan's participating provider network.

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

### **What is the difference between a “medical emergency” and “urgently needed care”?**

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

### **How to get urgently needed care**

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

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

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

When you receive emergency or urgently needed health care services from a provider who is not part of our network, you are responsible for paying your plan cost sharing amount and you should tell the provider to bill our Plan for the balance of the payment they are due. However, if you have received a bill from the provider, please send that claim to Welborn Health Plans, 101 S.E. Third Street, Evansville, IN 47708, so we can pay the provider the amount they are owed.

If you have any questions about what to pay a provider or where to send a paper claim you may call Member Services.

### **What is your cost for services that are not covered by Medicare or our Plan**

You are responsible for paying for the full cost of care and services that aren't covered by the Original Medicare Plan or our Plan. Other sections of this EOC describe the services that are covered by our Plan and the rules that apply to getting your care as a plan member. You also have the right to seek care from any provider that is qualified to treat Medicare members. However, in that case it will be the original Medicare program that pays your claims and you will owe the Original Medicare Plan cost-sharing amounts.

If you have any question whether Medicare or our Plan will pay for a service, including inpatient hospital services, you have the right under law to have a written/binding advance coverage determination made for the service. Call our Plan and tell us you would like a decision if the service or item will be covered by our Plan.

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 Plan limits

You can call Member Services when you want to know how much of your benefit limit you have already used.

### **How can you participate in a clinical trial?**

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

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

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

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

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

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

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

Care in a Medicare-certified Religious Non-medical Health Care Institution (RNHCI) is covered by our Plan under certain conditions. Covered services in an RNHCI are limited to non-religious aspects of care. To be eligible for covered services in a RNHCI, you must have a medical condition that would allow you to receive inpatient hospital or skilled nursing facility care. You may get services furnished in the home, but only items and services ordinarily furnished by home health agencies that are not 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. Medicare Inpatient Hospital coverage limits apply (reference Benefits Chart).

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

### **Introduction to your rights and protections**

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

### **Your right to be treated with dignity, respect and fairness**

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

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

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

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

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

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

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

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

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

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

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

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

If you want to have an advance directive, you can get a form from your lawyer, from a social worker, or from some office supply stores. You can sometimes get advance directive forms from organizations that give people information about Medicare. 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.

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

Remember, it is your choice whether you want to fill out an advance directive (including whether you want to sign one if you are in the hospital). According to law, no one can deny you care or discriminate against you based on whether or not you have signed an advance directive. If you have signed an advance directive, and you believe that a doctor or hospital hasn't followed the instructions in it, you may file a complaint with the 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 312-886-2359 or TTY/TDD 1-312-353-5693.

### **Your right to get information about our Plan**

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

### **Your right to get information in other formats**

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

### **Your right to get information about our network providers**

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

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

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

### Your right to make complaints

You have the right to make a complaint if you have concerns or problems related to your coverage or care. See Section 4 and Section 5 for more information about complaints. If you make a complaint, we must treat you fairly (i.e. not retaliate against you) because you made a complaint. You have the right to get a summary of information about the appeals and grievances that members have filed against our Plan in the past. To get this information, call Member Services.

### How to get more information about your rights

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

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

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

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

- If you think you have been treated unfairly due to your race, color, national origin, disability, age, or religion, you can call the Office for Civil Rights at 1-800-368-1019 or TTY/TDD 1-800-537-7697, or call your local Office for Civil Rights.
- If you have any other kind of concern or problem related to your Medicare rights and protections described in this section, you can also get help from your SHIP.

Your responsibilities as a member of our Plan include:

- Getting familiar with your coverage and the rules you must follow to get care as a member. You can use this booklet to learn about your coverage, what you have to pay, and the rules you need to follow. Call Member Services if you have questions.
- Using all of your insurance coverage. If you have additional health insurance coverage besides our Plan, it is important that you use your other coverage in combination with your coverage as a member of our Plan to pay your health care expenses. This is called “coordination of benefits” because it involves coordinating all of the health benefits that are available to you.
- **You are required to tell our Plan if you have additional health insurance. Call Member Services.**
- Notifying out-of-network providers when seeking care (unless it is an emergency) that although you are enrolled in our Plan, the provider should bill original Medicare. You should present your plan enrollment card and your Medicare card.
- Giving your doctor and other providers the information they need to care for you, and following the treatment plans and instructions that you and your doctors agree upon. Be sure to ask your doctors and other providers if you have any questions and have them explain your treatment in a way you can understand.

- Acting in a way that supports the care given to other patients and helps the smooth running of your doctor's office, hospitals, and other offices.
- Paying your plan premiums and coinsurance or co-payment for your covered services. You must pay for services that aren't covered.
- Notifying us if you move. If you move within our service area, we need to keep your membership record up-to-date. If you move outside of our plan service area, you cannot remain a member of our plan, but we can let you know if we have a plan in that area.
- Letting us know if you have any questions, concerns, problems, or suggestions. If you do, please call Member Services.

## **4. How to File a Grievance**

### **What is a Grievance?**

A grievance is any complaint, other than one that involves a request for an initial determination or an appeal as described in Section 5 of this manual.

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

If we will not pay for or give you the Part C medical care or services you want, you believe that you are being released from the hospital or SNF too soon, or your HHA or CORF services are ending too soon, you must follow the rules outlined in Section 5.

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

- Problems with the service you receive from Member Services.
- If you feel that you are being encouraged to leave (disenroll from) the Plan.
- If you disagree with our decision not to give you a "fast" decision or a "fast" appeal. We discuss these fast decisions and appeals in Section 5.
- We don't give you a decision within the required time frame.
- We don't give you required notices.
- You believe our notices and other written materials are hard to understand.
- Problems with the quality of the medical care or services you receive, including quality of care during a hospital stay.
- Problems with how long you have to wait on the phone, in the waiting room, or in the exam room.
- Problems getting appointments when you need them, or waiting too long for them.
- Rude behavior by doctors, nurses, receptionists, or other staff.
- Cleanliness or condition of doctor's offices, clinics, or hospitals.

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

### **Who may file a grievance**

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

### **Filing a grievance with our Plan**

If you have a complaint, you or your representative may call the phone number for **Part C Grievances** (for complaints about Part C medical care or services) in Section 8. We will try to resolve your complaint over the phone. If you ask for a written response, file a written grievance, or your complaint is related to quality of care, we will respond in writing to you. **If we cannot resolve your complaint over the phone, we have a formal procedure to review your complaints. We call this filing a grievance.** Simply 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 document.

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

### **Fast Grievances**

In certain cases, you have the right to ask for a “fast grievance,” meaning we will answer your grievance within 24 hours. We discuss situations where you may request a fast grievance in Section 5.

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

You may complain about the quality of care received under Medicare, including care during a hospital stay. You may complain to us using the grievance process, to the Quality Improvement Organization (QIO), or both. If you file with the QIO, we must help the QIO resolve the complaint. See Section 8 for more information about the QIO and for the name and phone number of the QIO in your state.

## **5. Complaints and Appeals about your Part C Medical Care and Service(s)**

### **Introduction**

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

Other complaints that do not involve the types of requests or complaints discussed below in Part 1, Part 2, or Part 3 are considered **grievances**. You would file a grievance if you have any type of problem with us or one of our network providers that does not relate to coverage for Part C medical care or services. For more information about grievances, see Section 4.

As stated in Section 2, you may use out-of-network providers. However, if you use out-of-network providers for care that is not emergent or urgently needed care, you will usually have to pay Original Medicare cost-sharing amounts for your care. If you have a complaint about a bill when you receive care from an out-of-network provider, the appeals process in Section 5 will not apply (unless you were directed to go to that out-of-network provider by the Plan or one of the network providers). Instead, please refer to the notice of the service you receive from Original Medicare. It is called a Medicare Summary Notice (MSN). The MSN will provide information on how to appeal a decision made by Original Medicare.

If you have a complaint regarding a service provided by a hospital or skilled nursing facility that is not part of the Plan network, you will follow Original Medicare rules as provided in your 2009 *Medicare & You Handbook*. However, if you have a complaint involving a plan network hospital or skilled nursing facility (or you were directed to go to a non-plan network hospital or skilled nursing facility by the Plan or one of the network providers), you will follow the instructions contained in this section. This is true even if you received a Medicare Summary Notice (MSN) indicating that a claim was processed but not covered by Original Medicare. Furthermore, if you have a complaint regarding an emergency service or urgently needed care, or the cost-sharing for hospital or skilled nursing facility services, you will follow the instructions contained in this section. See Section 2 for guidance on what is emergency or urgently needed care.

### **Part 1. Requests for Part C medical care or services or payments.**

Please note that if you have complaints about optional supplemental benefits, you may also file an appeal.

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

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

### **PART 1. Requests for medical care or services or payment**

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

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

#### **Initial Determinations**

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

The following are examples of requests for initial determinations:

- You are not getting Part C medical care or services you want, and you believe that this care is covered by the Plan.
- We will not approve the medical treatment your doctor or other medical provider wants to give you, and you believe that this treatment is covered by the Plan.
- You are being told that a medical treatment or service you have been getting will be reduced or stopped, and you believe that this could harm your health.
- You have received Part C medical care or services that you believe should be covered by the Plan, but we have refused to pay for this care.

#### **Who may ask for an initial determination?**

You, your prescribing physician, or someone you name may ask us for an initial determination. The person you name would be your "appointed representative." You may name a relative, friend, advocate, doctor, or anyone else to act for you. Other persons may already be authorized under State law to act for you. If you want someone to act for you who is not already authorized under State law, then you and that person must sign and date a statement that gives the person legal permission to be your appointed representative. If you are requesting Part C medical care or services, this statement must be sent to us at the address or fax number listed under "**Part C Organization Determinations**" in Section 8. To learn how to name your appointed representative, you may call Member Services.

You also have the right to have a lawyer act for you. You may contact your own lawyer, or get the name of a lawyer from your local bar association or other referral service. There are also groups that will give you free legal services if you qualify.

### **Asking for a “standard” or “fast” initial determination**

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

### **Asking for a standard decision**

To ask for a standard decision for a Part C medical care or service you, your doctor, or your representative should call, fax, or write us at the numbers or address listed under **Part C Organization Determinations** (for appeals about Part C medical care or services) in Section 8.

### **Asking for a fast decision**

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

If you are requesting a Part C medical care or service that you have not yet received, you, your doctor, or your representative may ask us to give you a fast decision by calling, faxing, or writing us at the numbers or address listed under **Part C Organization Determinations** (for appeals about Part C medical care or services) in Section 8.

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

If you ask for a fast decision without support from a doctor, we will decide if your health requires a fast decision. If we decide that your medical condition does not meet the requirements for a fast decision, we will send you a letter informing you that if you get a doctor’s support for a fast review, we will automatically give you a fast decision. The letter will also tell you how to file a “fast grievance.” You have the right to file a fast grievance if you disagree with our decision to deny your request for a fast review (for more information about fast grievances, see Section 4). If we deny your request for a fast initial determination, we will give you a standard decision.

### **What happens when you request an initial determination?**

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

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

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

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

We have 14 days to make a decision after we receive your request. However, we can take up to 14 more days if you ask for additional time, or if we need more information (such as medical records) that may benefit you. If we take additional days, we will notify you in writing. If you believe that we should not take additional days, you can make a specific type of complaint called a “fast grievance”. For more information about fast grievances, see Section 4.

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

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

If you receive a “fast” decision, we will give you our decision about your requested medical care or services within 72 hours after we receive the request. However, we can take up to 14 more days if we find that some information is missing that may benefit you, or if you need more time to prepare for this review. If we take additional days, we will notify you in writing. If you believe that we should not take any extra days, you can file a fast grievance. We will call you as soon as we make the decision.

If we do not tell you about our decision within 72 hours (or by the end of any extended time period), you have the right to appeal. If we deny your request for a fast decision, you may file a "fast grievance." For more information about fast grievances, see Section 4.

### **What happens if we decide completely in your favor?**

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

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

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

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

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

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

### **What happens if we decide against you?**

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

### **Appeal Level 1: Appeal to the Plan**

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

### **Who may file your appeal of the initial determination?**

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

### **How soon must you file your appeal?**

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

### **How to file your appeal**

#### **1. Asking for a standard appeal**

To ask for a standard appeal about a Part C medical care or service a signed, written appeal request must be sent to the address listed under **Part C Appeals** (for appeals about medical care or services) in Section 8.

You may also ask for a standard appeal by calling us at the phone number shown under **Part C Appeals** (for appeals about Part C medical care or services) in Section 8.

#### **2. Asking for a fast appeal**

If you are appealing a decision we made about giving you a Part C medical care or service that you have not received yet, you and/or your doctor will need to decide if you need a fast appeal. The rules about asking for a fast appeal are the same as the rules about asking for a fast initial determination. You, your doctor, or your representative may ask us for a fast appeal by calling,

faxing, or writing us at the numbers or address listed under **Part C Appeals** (for appeals about Part C medical care or services) in Section 8.

Be sure to ask for a "fast" or "expedited" review. Remember, if your doctor provides a written or oral supporting statement explaining that you need the fast appeal, we will automatically give you a fast appeal. If you ask for a fast decision without support from a doctor, we will decide if your health requires a fast decision. If we decide that your medical condition does not meet the requirements for a fast decision, we will send you a letter informing you that if you get a doctor's support for a fast review, we will automatically give you a fast decision. The letter will also tell you how to file a "fast grievance." You have the right to file a fast grievance if you disagree with our decision to deny your request for a fast review (for more information about fast grievances, see Section 4). If we deny your request for a fast appeal, we will give you a standard appeal.

### **Getting information to support your appeal**

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

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

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

You also have the right to ask us for a copy of information regarding your appeal. You may call or write us at the phone number or address listed under **Part C Appeals** (for appeals about Part C medical care or services) in Section 8. We are allowed to charge a fee for copying and sending this information to you.

### **How soon must we decide on your appeal?**

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

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

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

After we receive your appeal, we have 30 days to decide, but will decide sooner if your health condition requires. However, if you ask for more time, or if we find that helpful information is missing, we can take up to 14 more days to make our decision. If we do

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not tell you our decision within 30 days (or by the end of the extended time period), your request will automatically go to Appeal Level 2.

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

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

### What happens if we decide completely in your favor?

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

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

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

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

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

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

### Appeal Level 2: Independent Review Entity (IRE)

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

### How to file your appeal

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

### How soon must the IRE decide?

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

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If the IRE decides completely in your favor:

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

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

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

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

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

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

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

### **Appeal Level 3: Administrative Law Judge (ALJ)**

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

#### How to file your appeal

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

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

#### How soon will the Judge make a decision?

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

If the Judge decides in your favor:

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

### **Appeal Level 4: Medicare Appeals Council (MAC)**

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

### How to file your appeal

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

### How soon will the Council make a decision?

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

### If the Council decides in your favor:

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

### Appeal Level 5: Federal Court

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

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

### How to file your appeal

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

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

### How soon will the Judge make a decision?

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

### If the Judge decides in your favor:

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

If the Judge decides against you:

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

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

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

- For a decision about Part C medical care or services, we must pay for, authorize, or provide the medical care or service you have asked for within 60 days of the date we receive the decision.

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

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

Information you should receive during your hospital stay

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

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

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

Review of your hospital discharge by the Quality Improvement Organization

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

### **What is the “Quality Improvement Organization”?**

“QIO” stands for Quality Improvement Organization. The QIO is a group of doctors and other health care experts paid by the federal government to check on and help improve the care given to Medicare patients. They are not part of the Plan or the hospital. The QIO in Indiana is **Health Care Excel, 2901 Ohio Boulevard, PO Box 3713, Terre Haute, IN 47803**. QIOs have different names, depending on which state they are in. The doctors and other health experts in the 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 the QIO to review 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 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, called the Detailed Notice of Discharge, giving the reasons why we believe that your discharge date is medically appropriate. Call Member Services or 1-800-MEDICARE (1-800-633-4227 - TTY users should call 1-877-486-2048) to get a sample notice or see it online at <http://www.cms.hhs.gov/BNI/>.
- The QIO will decide, within one day after receiving the medical information it needs, whether it is medically appropriate for you to be discharged on the date that has been set for you.

### **What happens if the QIO decides in your favor?**

We will continue to cover your hospital stay (except for any applicable co-payments or deductibles) for as long as it is medically necessary and you have not exceeded our Plan coverage limitations as described in Section 10.

### **What happens if the QIO agrees with the discharge?**

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

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

### **What happens if you appeal the QIO decision?**

The QIO has 14 days to decide whether to uphold its original decision or agree that you should continue to receive inpatient care. If the QIO agrees that your care should continue, we must pay for or reimburse you for any care you have received since the discharge date on the Important Message from Medicare, and provide you with inpatient care (except for any applicable co-payments or deductibles) for as long as it is medically necessary and you have not exceeded our Plan coverage limitations as described in Section 10.

If the QIO upholds its original decision, you may be able to appeal its decision to an Administrative Law Judge (ALJ). Please see Appeal Level 3 in Part 1 of this section for guidance on the ALJ appeal. If the ALJ upholds the decision, you may also be able to ask for a review by the Medicare Appeals Council (MAC) or a Federal court. If any of these decision makers agree that your stay should continue, we must pay for or reimburse you for any care you have received since the discharge date, and provide you with inpatient care (except for any applicable co-payments or deductibles) for as long as it is medically necessary and you have not exceeded our Plan coverage limitations as described in Section 10.

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

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

- If we decide, based on the fast appeal, that you need to stay in the hospital, we will continue to cover your hospital care (except for any applicable co-payments or deductibles) for as long as it is medically necessary and you have not exceeded our Plan coverage limitations as described in Section 10.
- If we decide that you should not have stayed in the hospital beyond your discharge date, we will not cover any hospital care you received after the discharge date.

If we uphold our original decision, we will forward our decision and case file to the Independent Review Entity (IRE) within 24 hours. Please see Appeal Level 2 in Part 1 of this section for guidance on the IRE appeal. If the IRE upholds our decision, you may also be able to ask for a review by an ALJ, MAC, or a Federal court. If any of these decision makers agree that your stay should continue, we must pay for or reimburse you for any care you have received since the discharge date on the notice you got from your provider, and provide you with any services you asked for (except for any applicable co-payments or deductibles) for as long as it is medically necessary and you have not exceeded our Plan coverage limitations as described in Section 10.

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

When you are a patient in a Skilled Nursing Facility (SNF), Home Health Agency (HHA), or Comprehensive Outpatient Rehabilitation Facility (CORF), you have the right to get all the SNF, HHA or CORF care covered by the Plan that is necessary to diagnose and treat your illness or

injury. The day we end coverage for your SNF, HHA or CORF services is based on when these services are no longer medically necessary. This part explains what to do if you believe that coverage for your services is ending too soon.

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

Your provider will give you written notice called the Notice of Medicare Non-Coverage at least 2 days before coverage for your services ends (call Member Services or 1-800-MEDICARE (1-800-633-4227) to get a sample notice or see it online at <http://www.cms.hhs.gov/BNI/>). You (or your representative) will be asked to sign and date this notice to show that you received it.

**Signing the notice does not mean that you agree that coverage for your services should end – only that you received and understood the notice.**

### **Getting 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 Quality Improvement Organization (the “QIO”) to do an independent review of whether it is medically appropriate to end coverage for your services.

### **How soon do you have to ask for QIO review?**

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

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

### **What will happen during the QIO’s review?**

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

**The QIO will make a decision within one full day after it receives 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 (except for any applicable co-payments or deductibles) for as long as it is medically necessary and you have not exceeded our Plan coverage limitations as described in Section 10.

### **What happens if 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 may still ask the QIO to review its first decision if you make the request within 60 days of receiving the QIO's first denial of your request.

### **What happens if you appeal the QIO decision?**

The QIO has 14 days to decide whether to uphold its original decision or agree that you should continue to receive services. If the QIO agrees that your services should continue, we must pay for or reimburse you for any care you have received since the termination date on the notice you got from your provider, and provide you with any services you asked for (except for any applicable co-payments or deductibles) for as long as it is medically necessary and you have not exceeded our Plan coverage limitations as described in Section 10.

If the QIO upholds its original decision, you may be able to appeal its decision to an Administrative Law Judge (ALJ). Please see Appeal Level 3 in Part 1 of this section for guidance on the ALJ appeal. If the ALJ upholds our decision, you may also be able to ask for a review by the Medicare Appeals Council (MAC) or a Federal Court. If either the MAC or Federal Court agrees that your stay should continue, we must pay for or reimburse you for any care you have received since the termination date on the notice you got from your provider, and provide you with any services you asked for (except for any applicable co-payments or deductibles) for as long as it is medically necessary and you have not exceeded our Plan coverage limitations as described in Section 10.

### **What if you do not ask 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 (except for any applicable co-payments or deductibles) for as long as it is medically necessary and you have not exceeded our Plan coverage limitations as described in Section 10.
- If we decide that you should not have continued getting services, we will not cover any services you received after the termination date.

If we uphold our original decision, we will forward our decision and case file to the Independent Review Entity (IRE) within 24 hours. Please see Appeal Level 2 in Part 1 of this section for guidance on the IRE appeal. If the IRE upholds our decision, you may also be able to ask for a review by an ALJ, MAC, or a Federal court. If any of these decision makers agree that your stay should continue, we must pay for or reimburse you for any care you have received since the discharge date on the notice you got from your provider, and provide you with any services you

asked for (except for any applicable co-payments or deductibles) for as long as it is medically necessary and you have not exceeded our Plan coverage limitations as described in Section 10.

## **6. Ending your Membership**

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

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

### **Voluntarily ending your membership**

You may end your membership in our Plan at any time during the year and go to the Original Medicare Plan. Your membership will end on the first of the month following your request to our Plan. To end your membership, you must make this request in writing to us. Contact us if you need more information on how to do this.

If you want to end your membership and join another Medicare health plan or prescription drug coverage, there are limited times when you may join such plans. The Medicare fall open enrollment period (also known as the “Annual Election Period”) occurs every year from November 15 through December 31. This is the key time to review your health care and drug coverage and change your Medicare health or prescription drug coverage for the following year. Any changes you make during this time will be effective January 1.

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

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<p>prescription drug coverage, you can switch to another Medicare Advantage plan that does not offer drug coverage or go to Original Medicare</p> <p>If you are in Original Medicare Plan and have a Medicare prescription drug plan, you can join a Medicare Advantage Plan that offers Medicare drug coverage</p> <p>If you are in an MA plan that offers Medicare drug coverage, you can leave and join Original Medicare Plan and a Medicare prescription drug plan</p>		
<p>Special Enrollment Periods for limited special exceptions, such as:</p> <ul style="list-style-type: none"> <li>• You have a change in residence</li> <li>• You have Medicaid</li> <li>• You are eligible for extra help with Medicare prescriptions</li> <li>• You live in an institution (such as a nursing home)</li> </ul>	<p>Determined by exception.</p>	<p>Generally, first day of next month after plan receives your enrollment request</p>

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

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

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If you see out-of-network providers to obtain medical services, the services are covered under Original Medicare. You will be responsible for the Original Medicare cost-sharing for such services, with the exception of emergent and urgently needed 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 our Plan because of your health, you should call 1-800-MEDICARE (1-800-633-4227), which is the national Medicare help line. TTY users should call 1-877-486-2048. You may call 24 hours a day, 7 days a week.

### **Involuntarily ending your membership**

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

- If you do not stay continuously enrolled in Medicare A and B (***Part B -only grandfathered members*** need to stay continuously enrolled in Medicare Part B).
- If you move out of the service area or are away from the service area for more than 90 days you cannot remain a member of our Plan. And we must end your membership (“disenroll” you)”. If you plan to move or take a long trip, please call Member Services to find out if the place you are moving to or traveling to is in our Plan’s service area. If you have been a member of our plan continuously since before January 1999, when you lived outside our service area, you may continue your membership. However, if you move and your move is still outside our service area, will be disenrolled from our Plan, as stated above.
- If you behave in a way that is unruly, uncooperative, abusive, or disruptive, to the extent that you continued enrollment seriously impairs our ability to arrange or provide medical care for you or for others who are members of our Plan. We cannot make you leave our Plan for this reason unless we get permission first from Medicare.
- If you let someone else use your plan membership card to get medical care. If you are disenrolled for this reason, CMS may refer your case to the Inspector General for additional investigation.
- If you do not pay the basic plan premiums or cost-sharing, we will tell you in writing before you are required to leave our Plan.

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

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

## **7. Definitions of Important Words Used in the EOC**

**Appeal** – 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.

**Sections 10 and 11** explain 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

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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 5 tells what is meant by skilled care.) Generally, you are an inpatient of a hospital if you are receiving 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.

**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 11 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 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 8](#) for more information about grievances.

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**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 Centers for Medicare & Medicaid Services (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.

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**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 2](#). 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 9](#) 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.

### **Definitions of a few Part D Words Used in This Book**

**Medicare Advantage Plan with Prescription Drug Coverage** – A plan offered by a private company that contracts with Medicare to provide you with all your Medicare Part A and Part B benefits. In most cases, Medicare Advantage Plans also offer Medicare prescription drug coverage. A Medicare Advantage Plan can be an HMO, PPO, or a Private Fee-for-Service Plan.

**Medicare Health Plan – A Medicare Advantage Plan** (such as an HMO, PPO, or Private Fee-for-Service Plan) or other plan such as a Medicare Cost Plan. Everyone who has Medicare Part A and Part B is eligible to join any Medicare Health Plans that are offered in their area, except people with End-Stage Renal Disease (unless certain exceptions apply).

**Medigap Policy** -- Medicare supplement insurance policy sold by private insurance companies to fill “gaps” in the Original Medicare Plan. Medigap policies only work with the Original Medicare Plan.

**Member (member of our Plan)** – 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).

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

**Part D Drugs** – Drugs that Congress permitted Part D plans to offer as part of a standard Medicare prescription drug benefit. Your PDP may or may not offer all Part D drugs, see your formulary for a specific list of covered drugs. Certain categories of drugs, such as benzodiazepines and barbiturates, and over-the-counter drugs were specifically excluded by

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Congress from the standard prescription drug package (contact your part D provider for a listing of these drugs). These drugs are not considered Part D drugs.

**Late Enrollment Penalty** – An amount added to your monthly premium for Medicare drug coverage if you don't join a plan when you're first able. You pay this higher amount as long as you have Medicare. There are some exceptions. If you do not have creditable prescription drug coverage, you will have to pay a penalty in addition to your monthly plan premium.

## **8. Helpful Phone Numbers and Resources**

Contact Information for our Plan Member Services

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

- CALL** Call Welborn Health Plans at: 812-426-6600  
Toll Free: 1-800-521-0265  
(This number is also on the cover of this booklet for easy reference.)
- Member Service Hours: 7 days a week, 8 a.m. – 8 p.m. (CST)
- TTY/TDD** 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** 812-773-0589
- WRITE** Welborn Health Plans  
101 S.E. 3rd Street  
Evansville, IN 47708
- VISIT** WHP is located at 101 SE 3<sup>rd</sup> Street. This is the corner of 2<sup>nd</sup> 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](http://www.welbornhealthplans.com)

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

### **Part C Organization Determinations (about your Medicare Care and Services)**

- CALL** Call Welborn Health Plans at: 812-426-6600  
Toll Free: 1-800-521-0265  
(This number is also on the cover of this booklet for easy reference.)
- Member Service Hours: 7 days a week, 8 a.m. – 8 p.m. (CST)
- TTY/TDD** 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** 812-773-0589

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**WRITE** Welborn Health Plans  
101 S.E. 3rd Street  
Evansville, IN 47708

For information about Part C grievances, see Section 4.

### **Part C Grievances (about your Medical Care and Services)**

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

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

**TTY/TDD** 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** 812-773-0589

**WRITE** Welborn Health Plans  
101 S.E. 3rd Street  
Evansville, IN 47708

For information about Part C grievances, see Section 4.

### **Part C Appeals (about your Medical Care and Services)**

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

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

**TTY/TDD** 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** 812-773-0589

**WRITE** Welborn Health Plans  
101 S.E. 3rd Street

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Evansville, IN 47708

For information about Part C organization determinations, see Section 5.

### **Part D Coverage Determinations (about your Part D Prescription Drugs)**

*Call your plan provider*

### **Part D Grievances (about your Part D Prescription Drugs)**

*Call your plan provider*

### **Part D Appeals (about your Part D Prescription Drugs)**

*Call your plan provider*

### **Other important contacts**

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

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

“SHIP” stands for State Health Insurance Assistance Program. 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 1-800-253-2188.** You may also find information on the website for the SHIP program at [www.medicare.gov](http://www.medicare.gov) on the web. Under “Search Tools”, select “Helpful Phone Numbers and Websites”.

### **Health Care Excel a QIO or Quality Improvement Organization**

“QIO” stands for Quality Improvement Organization. The QIO is a group of doctors and health professionals in your state that reviews medical care and handles certain types of complaints from patients with Medicare, and is paid by the federal government to check on and help improve the care given to Medicare patients. There is a QIO in each state. QIOs have different

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names, depending on which state they are in. The doctors and other health experts in the QIO review certain types of complaints made by Medicare patients. These include complaints about quality of care and appeals filed by Medicare patients who think the coverage for their hospital, skilled nursing facility, home health agency, or comprehensive outpatient rehabilitation stay is ending too soon. See Sections 4 and 5 for more information about complaints, appeals and grievances.

You may contact 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 the Federal health insurance program for people 65 years of age or older, some people under age 65 with certain disabilities, and people with End-Stage Renal Disease (generally those with permanent kidney failure who need dialysis or a kidney transplant). Our organization contracts with the federal government.

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

### **Medicaid**

Medicaid is a state government program that helps with medical costs for some people with limited incomes and resources. Some people with Medicare are also eligible for Medicaid. Medicaid has programs that can help pay for your Medicare premiums and other costs, if you qualify. To find out more about Medicaid and its programs, contact Hoosier Healthwise at 1-800-889-9949 or <http://www.healthcareforhoosiers.com>; Care Select at 1-866-963-7383 or <http://www.indianacareselect.com>; HIP at 1-877-438-4479 or <http://www.HIP.in.gov> For guidance on contacting the state programs, contact 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 [www.swirca.org](http://www.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](http://www.ssa.gov) on the Web.

### **Hoosier Rx a State Pharmacy Assistance Program (SPAP)**

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Hoosier Rx is a state organization that provides limited-income and medically needy senior citizens and individuals with disabilities financial help for prescription drugs. You may contact Hoosier Rx at P.O. Box 6224, Indianapolis, IN 46206-6224 or by phone at **1-866-267-4679**. The website for Hoosier Rx is <http://www.in.gov/fssa/ompp/4248.htm>.

### **Railroad Retirement Board**

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

### **Employer (or “Group”) Coverage**

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

## **9. Legal Notices**

### **Notice about governing law**

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

### **Notice about nondiscrimination**

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

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

### **Your Monthly Premium for Our Plan**

Your monthly premium for our Plan is \$140 for the Basic and \$160 for the Plus.

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

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

### **How Much You Pay for Part C Medical Benefits**

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

What do you pay for covered services?

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

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

### **Benefits Chart**

The benefits chart on the following pages lists the services our Plan covers and what you pay for each service. The benefits chart lists information for more than one of our Plans. The name of the plan you are in is listed on the front page of this packet. If you aren't sure which plan you are in or if you have any questions, call Member 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.
- Some of the covered services listed in the Benefits Chart are covered only if your doctor or other network provider gets "prior authorization" (approval in advance) from our Plan. Covered services that need prior authorization are marked in the Benefits Chart by an asterisk.

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See Section 2 for information on requirements for using network providers and a list of benefits requiring prior authorization.

Benefits chart – your covered services	WHP Medicare Basic Plan What you must pay when you get these covered services	WHP Medicare PLUS Plan What you must pay when you get these covered services
<b>Services</b>		
<b>Inpatient</b>		
<p><b>Inpatient hospital care*</b> For more information about inpatient hospital care, see <a href="#">Section 2</a>. Covered services include, but aren't limited to, the following:</p> <ul style="list-style-type: none"> <li>• Semiprivate room (or a private room if medically necessary).</li> <li>• Meals including special diets.</li> <li>• Regular nursing services.</li> <li>• Costs of special care units (such as intensive or coronary care units).</li> <li>• Drugs and medications.</li> <li>• Lab tests.</li> <li>• X-rays and other radiology services.</li> <li>• Necessary surgical and medical supplies.</li> <li>• Use of appliances, such as wheelchairs.</li> <li>• Operating and recovery room costs.</li> <li>• Physical therapy, occupational therapy, and speech therapy.</li> <li>• Under certain conditions, the following types of transplants are covered: corneal, kidney, pancreas, heart, liver, lung, heart/lung,</li> </ul>	<p>For Medicare Covered Hospital Stays:  \$0 copay</p> <p>If you get inpatient care at a non-plan hospital after your emergency condition is stabilized, you may be responsible for all Medicare co-payments and deductible amounts.</p> <p>WHP covers up to 364 days each benefit period.</p> <p>Except in an emergency your doctor must tell the plan you are being admitted to the hospital.</p> <p>Authorization rules may apply.</p> <p>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.</p>	<p>For Medicare Covered Hospital Stays:  \$0 copay</p> <p>If you get inpatient care at a non-plan hospital after your emergency condition is stabilized, you may be responsible for all Medicare co-payments and deductible amounts.</p> <p>WHP covers Up to 364 days each benefit period.</p> <p>Except in an emergency your doctor must tell the plan you are being admitted to the hospital.</p> <p>Authorization rules may apply.</p> <p>Coverage of whole blood and packed red cells begins with the first pint of blood that you need.</p>

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Benefits chart – your covered services	WHP Medicare Basic Plan What you must pay when you get these covered services	WHP Medicare PLUS Plan What you must pay when you get these covered services
<b>Services</b>		
<p>bone marrow, stem cell, and intestinal/multivisceral. See <a href="#">Section 2</a> for more information about transplants.</p> <ul style="list-style-type: none"> <li>• Blood - including storage and administration.</li> <li>• All other components of blood are covered beginning with the first pint used.</li> <li>• Physician Services.</li> </ul>		
<p><b>Inpatient mental health care*</b> Covered services include mental health care services that require a hospital stay.</p> <p>There is a 190-day lifetime limit for inpatient services in a psychiatric hospital.</p> <p>The 190-day limit does not apply to Mental Health services provided in a psychiatric unit of a general hospital.</p>	<p>For Medicare Covered Stays:</p> <p>190-day limit in a Psychiatric Hospital. For hospital stays: Days 1-10: \$0 daily copay Days 11-90: \$0 daily copay</p> <p>Except in an emergency, your doctor must tell the plan that you are going to be admitted to the hospital.</p> <p>Authorization rules may apply.</p>	<p>For Medicare Covered Stays:</p> <p>190-day limit in a Psychiatric Hospital. For hospital stays: Days 1-10: \$0 daily copay Days 11-90: \$0 daily copay</p> <p>Except in an emergency, your doctor must tell the plan that you are going to be admitted to the hospital.</p> <p>Authorization rules may apply.</p>
<p><b>Skilled nursing facility care*</b> For more information about skilled nursing facility care, see <a href="#">Section 2</a>. Requires a 3-day prior Medicare covered hospital stay.</p> <p>Covered services include, but aren't limited to, the following:</p> <ul style="list-style-type: none"> <li>• Semiprivate room (or a private room if medically necessary).</li> <li>• Meals, including special</li> </ul>	<p>For Medicare Covered Stays:</p> <p>\$0 copay</p> <p>In a Medicare-certified skilled nursing facility we will cover up to 100 days for each benefit period.</p> <p>A "benefit period" starts the day you go into a hospital or SNF.</p>	<p>For Medicare Covered Stays:</p> <p>\$0 copay</p> <p>In a Medicare-certified skilled nursing facility we will cover up to 100 days for each benefit period.</p> <p>A "benefit period" starts the day you go into a hospital or SNF. It</p>

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Benefits chart – your covered services	WHP Medicare Basic Plan What you must pay when you get these covered services	WHP Medicare PLUS Plan What you must pay when you get these covered services
<b>Services</b>		
<ul style="list-style-type: none"> <li>diets.</li> <li>• Regular nursing services.</li> <li>• Physical therapy, occupational therapy, and speech therapy.</li> <li>• Drugs (This includes substances that are naturally present in the body, such as blood clotting factors).</li> <li>• 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.</li> <li>• Medical and surgical supplies.</li> <li>• Laboratory tests.</li> <li>• X-rays and other radiology services.</li> <li>• Use of appliances such as wheelchairs.</li> <li>• Physician services.</li> </ul>	<p>It ends when you go for 60 days in a row without hospital or skilled nursing care.</p> <p>There is no limit to the number of benefit periods you can have.</p> <p>Authorization rules may apply.</p>	<p>ends when you go for 60 days in a row without hospital or skilled nursing care.</p> <p>There is no limit to the number of benefit periods you can have.</p> <p>Authorization rules may apply.</p>
<p><b>Inpatient services (when the hospital or SNF days aren't or are no longer covered) *</b></p> <p>For more information about inpatient services, see <a href="#">Section 2</a>. Covered services include, but aren't limited to, the following:</p> <ul style="list-style-type: none"> <li>• Physician services.</li> </ul>	<p>Part B Medicare approved Services preformed by network providers are covered by WHP as detailed in the "Out Patient" section of this Summary of Benefits.</p> <p>Authorization rules may apply.</p>	<p>Part B Medicare approved Services preformed by network providers are covered as detailed in the "Out Patient" section of this Summary of Benefits.</p> <p>Authorization rules may apply.</p>

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Benefits chart – your covered services	WHP Medicare Basic Plan What you must pay when you get these covered services	WHP Medicare PLUS Plan What you must pay when you get these covered services
<b>Services</b>		
<ul style="list-style-type: none"> <li>• Tests (like X-ray or lab tests).</li> <li>• X-ray, radium, and isotope therapy including technician materials and services.</li> <li>• Surgical dressings, splints, casts and other devices used to reduce fractures and dislocations.</li> <li>• Prosthetic devices (other than dental) that replace all or part of an internal body organ (including contiguous tissue), or all or part of the function of a permanently inoperative or malfunctioning internal body organ, including replacement or repairs of such devices.</li> <li>• 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.</li> <li>• Physical therapy, speech therapy, and occupational therapy.</li> </ul>	<p>General (includes medically necessary intermittent skilled nursing care, home health aide services, and rehabilitation services, etc.)</p>	<p>General (includes medically necessary intermittent skilled nursing care, home health aide services, and rehabilitation services, etc.)</p>
<p><b>Home health agency care*</b> For more information about home health care, see <a href="#">Section 2</a> . Covered services include, but aren't limited to, the following:</p> <ul style="list-style-type: none"> <li>• Part-time or intermittent</li> </ul>	<p>General (includes medically necessary intermittent skilled nursing care, home health aide services, and rehabilitation services, etc.)</p>	<p>General (includes medically necessary intermittent skilled nursing care, home health aide services, and rehabilitation services, etc.)</p>

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Benefits chart – your covered services	WHP Medicare Basic Plan What you must pay when you get these covered services	WHP Medicare PLUS Plan What you must pay when you get these covered services
<b>Services</b>		
<p>skilled nursing and home health aide services.</p> <ul style="list-style-type: none"> <li>Physical therapy, occupational therapy, and speech therapy.</li> <li>Medical social services.</li> <li>Medical equipment and supplies.</li> </ul>	<p>Authorization rules may apply.</p> <p>\$0 copay for Medicare-covered home health visits.</p>	<p>Authorization rules may apply.</p> <p>\$0 copay for Medicare-covered home health visits.</p>
<b>Hospice care</b>		
<p>For more information about hospice services, see <a href="#">Section 2</a>. Covered services include, but aren't limited to, the following:</p> <ul style="list-style-type: none"> <li>Drugs for symptom control and pain relief, short-term respite care, and other services not otherwise covered by Medicare.</li> <li>Home care.</li> </ul> <p>Our plan covers hospice consultation services (one time only) for a terminally ill person who hasn't elected the hospice benefit.</p>	<p>When you enroll in a Medicare-certified Hospice, your hospice services are paid by Medicare (see <a href="#">Section 2</a> for more information about hospice services).</p> <p>You must get care from a Medicare-certified hospice.</p>	<p>When you enroll in a Medicare-certified Hospice, your hospice services are paid by Medicare (see <a href="#">Section 2</a> for more information about hospice services).</p> <p>You must get care from a Medicare-certified hospice.</p>
<b>Outpatient Services</b>		
<p><b>Physician services, including doctor office visits*</b></p> <p>Covered services include, but aren't limited to, the following:</p> <ul style="list-style-type: none"> <li>Office visits, including medical and surgical care in a physician's office or certified ambulatory surgical center.</li> <li>Consultation, diagnosis, and treatment by a specialist.</li> <li>Second opinion by another</li> </ul>	<p>\$0 copay for each primary care doctor visit for Medicare-covered benefits.</p> <p>Authorization rules may apply.</p>	<p>\$0 copay for each primary care doctor visit for Medicare-covered benefits.</p> <p>Authorization rules may apply.</p>

## 2009 Evidence of Coverage (EOC)

Benefits chart – your covered services	WHP Medicare Basic Plan What you must pay when you get these covered services	WHP Medicare PLUS Plan What you must pay when you get these covered services
<b>Services</b>		
<p>plan provider prior to surgery.</p> <ul style="list-style-type: none"> <li>• Outpatient hospital services.</li> <li>• 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).</li> </ul>		
<p><b>Chiropractic services</b> Covered services, include, but aren't limited, to the following: Manual manipulation of the spine to correct subluxation.</p>	\$0 copay for Medicare-covered visits.	\$0 copay for Medicare-covered visits.
<p><b>Podiatry services</b> Covered services include, but aren't limited to, the following:</p> <ul style="list-style-type: none"> <li>• Treatment of injuries and diseases of the feet (such as hammer toe or heel spurs).</li> <li>• Routine foot care for certain medical conditions affecting the lower limbs.</li> </ul>	\$0 copay for Medicare-covered visits.	\$0 copay for Medicare-covered visits.
<p><b>Outpatient mental health care*</b> (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</p>	<p>\$20 copay for each Medicare-covered individual or group therapy visit.</p> <p>Authorization rules may apply.</p>	<p>\$20 copay for each Medicare-covered individual or group therapy visit.</p> <p>Authorization rules may apply.</p>

## 2009 Evidence of Coverage (EOC)

Benefits chart – your covered services	WHP Medicare Basic Plan What you must pay when you get these covered services	WHP Medicare PLUS Plan What you must pay when you get these covered services
<b>Services</b>		
Medicare-qualified mental health care professional as allowed under applicable state laws. “Partial hospitalization” is a structured program of active treatment that is more intense than the care received in your doctor’s or therapist’s office and is an alternative to inpatient hospitalization.		
<b>Outpatient substance abuse services*</b>	\$20 copay for each Medicare-covered individual or group therapy visit.  Authorization rules may apply.	\$20 copay for each Medicare-covered individual or group therapy visit.  Authorization rules may apply.
<b>Outpatient surgery*</b>	\$0 copay for each Medicare-covered ambulatory surgical center visit.  \$0 copay for each Medicare-covered outpatient hospital facility visit.  Authorization rules may apply.	\$0 copay for each Medicare-covered ambulatory surgical center visit.  \$0 copay for each Medicare-covered outpatient hospital facility visit.  Authorization rules may apply.
<b>Ambulance services</b> 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.	\$0 copay for Medicare-covered ambulance benefits.	\$0 copay for Medicare-covered ambulance benefits.

## 2009 Evidence of Coverage (EOC)

Benefits chart – your covered services	WHP Medicare Basic Plan What you must pay when you get these covered services	WHP Medicare PLUS Plan What you must pay when you get these covered services
<b>Services</b>		
<b>Emergency care</b>		
For more information, see <a href="#">Section 2</a> .	\$50 for Medicare-covered emergency room visits.  If you get inpatient care at a non-plan hospital after your emergency condition is stabilized, your cost will be the Medicare deductibles and copayments Not the \$0 cost sharing you would pay at a plan hospital.  If you are admitted to the hospital within 72-hour(s) for the same condition, you pay \$0 for the emergency room visit.  NOT covered outside the U.S. except under limited circumstances.	\$50 for Medicare-covered emergency room visits.  If you get inpatient care at a non-plan hospital after your emergency condition is stabilized, your cost will be the Medicare deductibles and copayments Not the \$0 cost sharing you would pay at a plan hospital.  If you are admitted to the hospital within 72-hour(s) for the same condition, you pay \$0 for the emergency room visit.  World wide coverage.
<b>Urgently needed care</b>		
For more information, see <a href="#">Section 2</a> .	\$0 copay for Medicare-covered urgent-care visits.  NOT covered outside the U.S. except under limited circumstances.	\$0 copay for Medicare-covered urgent-care visits.  World wide coverage.
<b>Outpatient rehabilitation services*</b>		
Covered services include, but aren't limited to, the following: physical therapy, occupational therapy, and speech and language therapy.	\$0 copay for Medicare-covered Occupational Therapy visits.  \$0 copay for Medicare-covered Physical and/or Speech/Language Therapy visits.  Authorization rules may apply.	\$0 copay for Medicare-covered Occupational Therapy visits.  \$0 copay for Medicare-covered Physical and/or Speech/Language Therapy visits.  Authorization rules may apply.

## 2009 Evidence of Coverage (EOC)

Benefits chart – your covered services	WHP Medicare Basic Plan What you must pay when you get these covered services	WHP Medicare PLUS Plan What you must pay when you get these covered services
<b>Services</b>		
<p><b>Durable medical equipment and related supplies</b> *– such as wheelchairs, crutches, hospital bed, IV infusion pump, oxygen equipment, nebulizer, and walker. (See definition of “durable medical equipment” in <a href="#">Section 13</a>)</p>	<p>\$0 copay for Medicare-covered items.</p> <p>Authorization rules may apply.</p>	<p>\$0 copay for Medicare-covered items.</p> <p>Authorization rules may apply.</p>
<p><b>Prosthetic devices and related supplies*</b> – (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.</p>	<p>\$0 copay for Medicare-covered items.</p> <p>Authorization rules may apply.</p>	<p>\$0 copay for Medicare-covered items.</p> <p>Authorization rules may apply.</p>
<p><b>Diabetes self-monitoring, training and supplies*</b> – for all people who have diabetes (insulin and non-insulin users). Covered services include, but aren’t limited to, the following:</p> <ul style="list-style-type: none"> <li>• Blood glucose monitor, blood glucose test strips, lancet devices and lancets, and glucose control solutions for checking the accuracy of test strips and monitors.</li> <li>• One pair per calendar year of therapeutic shoes for people with diabetes who have</li> </ul>	<p>\$0 copay for Medicare-covered items.</p> <p>Authorization rules may apply.</p>	<p>\$0 copay for Medicare-covered items.</p> <p>Authorization rules may apply.</p>

## 2009 Evidence of Coverage (EOC)

Benefits chart – your covered services	WHP Medicare Basic Plan What you must pay when you get these covered services	WHP Medicare PLUS Plan What you must pay when you get these covered services
<b>Services</b>		
<p>severe diabetic foot disease, including fitting of shoes or inserts.</p> <p>Self-management training is covered under certain conditions. <i>For persons at risk of diabetes:</i> Fasting plasma glucose tests as required by your network physician.</p>	<p>\$0 copay for Diabetes self-monitoring training.</p>	<p>\$0 copay for Diabetes self-monitoring training.</p>
<p><b>Medical nutrition therapy*</b> – for people with diabetes, renal (kidney) disease (but not on dialysis), and after a transplant when referred by your doctor.</p>	<p>\$0 copay for Nutrition Therapy for Diabetes.</p> <p>Authorization rules may apply.</p>	<p>\$0 copay for Nutrition Therapy for Diabetes.</p> <p>Authorization rules may apply.</p>
<p><b>Outpatient diagnostic tests and therapeutic services and supplies*</b> Covered services include, but are not limited to, the following:</p> <ul style="list-style-type: none"> <li>• X-rays.</li> <li>• Radiation therapy.</li> <li>• Surgical supplies, such as dressings.</li> <li>• Supplies, such as splints and casts.</li> <li>• Laboratory tests.</li> <li>• Blood - Coverage begins with the fourth pint of blood that you need – you pay for the first 3 pints of unreplaced blood.</li> <li>• Coverage of storage and administration begins with the first pint of blood that you need.</li> </ul>	<p>\$0 copay for Medicare-covered:</p> <ul style="list-style-type: none"> <li>- diagnostic procedures and tests</li> <li>- X-rays</li> <li>- therapeutic radiology services</li> </ul> <p>Authorization rules may apply.</p> <p>Blood - Coverage begins with the fourth pint of blood that you need – you pay for the first 3 pints of unreplaced blood.</p>	<p>\$0 copay for Medicare-covered:</p> <ul style="list-style-type: none"> <li>- diagnostic procedures and tests</li> <li>- X-rays</li> <li>- diagnostic radiology services (not including X-rays)</li> <li>-therapeutic radiology services</li> </ul> <p>Authorization rules may apply.</p> <p>Blood - Coverage begins with the first pint of blood that you need.</p>

## 2009 Evidence of Coverage (EOC)

Benefits chart – your covered services	WHP Medicare Basic Plan What you must pay when you get these covered services	WHP Medicare PLUS Plan What you must pay when you get these covered services
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### Services

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

\$0 Copay

Authorization rules may apply.

\$0 Copay

Authorization rules may apply.

#### **Colorectal screening\***

For people 50 and older, the following are covered:

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

\$0 copay for Medicare-covered colorectal screenings.

Authorization rules may apply.

\$0 copay for Medicare-covered colorectal screenings.

Authorization rules may apply.

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.

## 2009 Evidence of Coverage (EOC)

Benefits chart – your covered services	WHP Medicare Basic Plan What you must pay when you get these covered services	WHP Medicare PLUS Plan What you must pay when you get these covered services
<b>Services</b>		
<p><b>Immunizations*</b></p> <p>Covered services include, but aren't limited to, the following:</p> <ul style="list-style-type: none"> <li>• Pneumonia vaccine (as explained in <a href="#">Section 2</a>, you can get this service on your own, without a referral from your PCP (as long as you get the service from a plan provider).</li> <li>• Flu shots, once a year in the fall or winter. As explained in <a href="#">Section 2</a>, you can get this service on your own, without a referral from your PCP (as long as you get the service from a plan provider).</li> <li>• If you are at high or intermediate risk of getting Hepatitis B: Hepatitis B vaccine.</li> <li>• Other vaccines if you are at risk.</li> </ul>	<p>\$0 copay for Flu and Pneumonia vaccines.</p> <p>\$0 copay for Hepatitis B vaccine.</p> <p>No referral needed for Flu and pneumonia vaccines.</p> <p>Authorization rules may apply.</p>	<p>\$0 copay for Flu and Pneumonia vaccines.</p> <p>\$0 copay for Hepatitis B vaccine.</p> <p>No referral needed for Flu and pneumonia vaccines.</p> <p>Authorization rules may apply.</p>
<p><b>Mammography screening</b></p> <p>(As explained in <a href="#">Section 2</a>, you can get this service on your own, without a referral from your PCP (as long as you get it from a plan provider):</p> <p>Covered services include, but aren't limited to, the following:</p> <ul style="list-style-type: none"> <li>• One baseline exam between the ages of 35 and 39.</li> <li>• One screening every 12 months for women age 40 and older.</li> </ul>	<p>\$0 copay for Medicare-covered screening mammograms.</p>	<p>\$0 copay for Medicare-covered screening mammograms.</p>

## 2009 Evidence of Coverage (EOC)

Benefits chart – your covered services	WHP Medicare Basic Plan What you must pay when you get these covered services	WHP Medicare PLUS Plan What you must pay when you get these covered services
<b>Services</b>		
<p><b>Pap smears, pelvic exams, and clinical breast exam</b> (As explained in <a href="#">Section 2</a>, you can 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:</p> <ul style="list-style-type: none"> <li>• For all women, Pap tests, pelvic exams, and clinical breast exams are covered once every 24 months.</li> <li>• 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.</li> </ul>	<p>\$0 copay for pap smears and pelvic exams.</p> <p>Covered once every 2 years.</p> <p>Covered once a year for women with Medicare at high risk.</p>	<p>\$0 copay for pap smears and pelvic exams.</p> <p>Up to 1 additional pap smear(s) every two years.</p>
<p><b>Prostate cancer screening exams</b> For men age 50 and older, the following are covered once every 12 months: Covered services include, but are not limited to, the following:</p> <ul style="list-style-type: none"> <li>• Digital rectal exam.</li> <li>• Prostate Specific Antigen (PSA) test.</li> </ul>	<p>\$0 copay for Medicare-covered prostate cancer screening.</p>	<p>\$0 copay for Medicare-covered prostate cancer screening.</p>
<p><b>Cardiovascular disease testing</b> Blood tests for the detection of cardiovascular disease (or abnormalities associated with an elevated risk of cardiovascular</p>	<p>\$0 copay for Medicare-covered Cardiovascular disease screening.</p>	<p>\$0 copay for Medicare-covered Cardiovascular disease screening.</p>

## 2009 Evidence of Coverage (EOC)

Benefits chart – your covered services	WHP Medicare Basic Plan What you must pay when you get these covered services	WHP Medicare PLUS Plan What you must pay when you get these covered services
<b>Services</b>		
disease).	Authorization rules may apply.	Authorization rules may apply.
<b>Physical exams</b>		
A routine physical exam for members limited to one per year. Includes measurement of height, weight, body mass index and blood pressure; end-of-life planning; education, counseling and referral with respect to covered screening and preventive services.	20% coinsurance for one exam within the first 12 months of your new Medicare Part B coverage.  When you get Medicare Part B, you can get a one time physical exam within the first 12 months of your new Part B coverage. The coverage does not include lab tests.	\$0 copay for routine exams.  Limited to 1 exam(s) every year.
<b>Other Services</b>		
<b>Renal Dialysis (Kidney)*</b>		
Covered services include, but are not limited to, the following:	\$0 copay for in and out-of-area dialysis.	\$0 copay for in and out-of-area dialysis.
<ul style="list-style-type: none"> <li>• Outpatient dialysis treatments (including dialysis treatments when temporarily out of the service area, as explained in <a href="#">Sections 2 and 3</a>).</li> <li>• Inpatient dialysis treatments (if you are admitted to a hospital for special care).</li> <li>• Self-dialysis training (includes training for you and others for the person helping you with your home dialysis treatments).</li> <li>• Home dialysis equipment and supplies.</li> </ul>	<p>Authorization rules may apply.</p> <p>Out-of-area Renal Dialysis services do not require authorization.</p>	<p>Authorization rules may apply.</p> <p>Out-of-area Renal Dialysis services do not require authorization.</p>
Certain home support services (such as, when necessary, visits by trained		

## 2009 Evidence of Coverage (EOC)

Benefits chart – your covered services	WHP Medicare Basic Plan What you must pay when you get these covered services	WHP Medicare PLUS Plan What you must pay when you get these covered services
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### Services

dialysis workers to check on your home dialysis, to help in emergencies, and check your dialysis equipment and water supply).

### Prescription Drugs\*

Drugs covered under the Original Medicare Plan (these drugs are covered for everyone with Medicare Part B)

There is no benefit limit on the drugs covered under Original Medicare (part B)

There is no benefit limit on the drugs covered under Original Medicare (part B)

Authorization rules may apply.

Authorization rules may apply.

“Drugs” includes substances that are naturally present in the body, such as blood clotting factorstopical anesthetics, Erythropoietin (Epogen®) or Epoetin alfa, and Darboetin Alfa. Covered drugs include, but are not limited to, the following:

In general, you pay 100% for Part D out-patient prescription drugs.

In general, you pay 100% for Part D out-patient prescription drugs.

- Drugs that usually aren’t self-administered by the patient and are injected while 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-

## 2009 Evidence of Coverage (EOC)

Benefits chart – your covered services	WHP Medicare Basic Plan What you must pay when you get these covered services	WHP Medicare PLUS Plan What you must pay when you get these covered services
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### Services

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, (Aranesp®).
- Intravenous Immune Globulin for the treatment of primary immune deficiency diseases in your home.

### Drugs That are covered under the Medicare Prescription Drug Benefit (Part D).

In general, you pay 100% for Part D outpatient prescription drugs.

In general, you pay 100% for Part D outpatient prescription drugs.

These plans do not cover Part D Drugs.

### Additional Benefits

#### Dental services\*

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

\$0 copay for Medicare-covered dental benefits.

Authorization rules may apply.

In general, preventive dental benefits (such as cleaning) not covered.

\$0 copay for Medicare-covered dental benefits.

Authorization rules may apply.

In general, preventive dental benefits (such as cleaning) not covered.

## 2009 Evidence of Coverage (EOC)

Benefits chart – your covered services	WHP Medicare Basic Plan What you must pay when you get these covered services	WHP Medicare PLUS Plan What you must pay when you get these covered services
<b>Services</b>		
<b>Hearing services</b>		
Diagnostic hearing exams.	\$0 copay for diagnostic hearing exams.	\$0 copay for diagnostic hearing exams.
	Routine hearing exams and hearing aids not covered.	- up to 1 routine hearing test(s) every year.  Hearing aids not covered.
<b>Vision care</b>		
Covered services include, but are not limited to, the following:	\$0 Copay- Annual glaucoma screenings covered for people at risk.	\$0 Copay- Annual glaucoma screenings covered for people at risk.
<ul style="list-style-type: none"> <li>• Outpatient physician services for eye care.</li> </ul>	\$0 copay for diagnosis and treatment of diseases and conditions of the eye.	\$0 copay for diagnosis and treatment of diseases and conditions of the eye.
<ul style="list-style-type: none"> <li>• 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</li> </ul>	\$0 copay for one pair of eyeglasses or contact lenses after each cataract surgery.	\$0 copay for one pair of eyeglasses or contact lenses after each cataract surgery.
<ul style="list-style-type: none"> <li>• 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.</li> </ul>	Routine eye exams and glasses not covered.	\$10 copay for up to 1 routine eye exam(s) every year  \$20 copay for up to 1 pair(s) of lenses every year  \$20 copay for up to 1 frame(s) every two years
<b>Health and wellness education programs</b>		
These are programs focused on clinical health conditions. Programs designed to enrich the health and lifestyles of members.	This plan covers health/wellness education benefits.	This plan covers health/wellness education benefits.
	Authorization rules may apply.	Authorization rules may apply.
	Written health education materials, including Newsletters.	Written health education materials, including Newsletters.

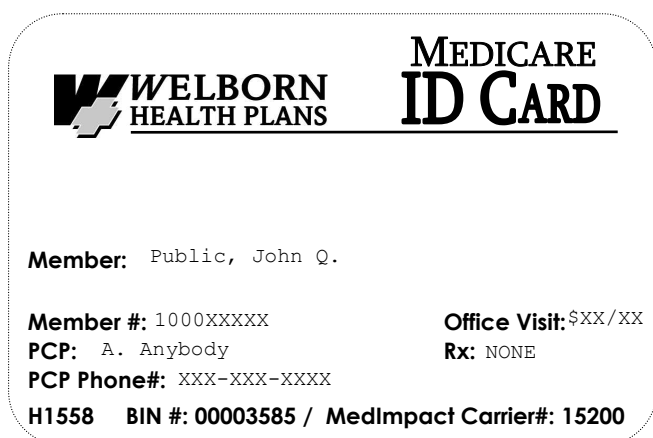
### Getting care using our Plan's traveler benefit

You may get care when you are outside the service area. You may need to pay higher cost sharing for routine care from non-network providers, but you won't pay extra in a medical emergency or if your care is urgently needed. If you have questions about your medical costs when you travel, please call Member Services.

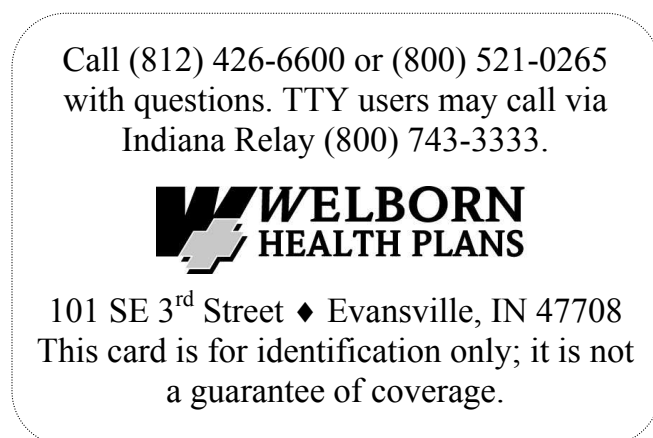
- As an added benefit under the WHP "Plus" Plan, you have coverage for emergencies and urgently needed care - anywhere in the world - with the protection of The WHP Foreign Travel Emergency Care benefit. You pay a \$250 calendar year deductible, 20% coinsurance for the remainder of covered charges, and any amount over the \$50,000 lifetime maximum benefit.
- As an added benefit under The WHP "Plus" Plan, you have coverage for ambulance services - anywhere in the world - with the protection of The WHP Foreign Travel Emergency Care benefit. You pay a \$250 calendar year deductible, 20% coinsurance for the remainder of covered charges, and any amount over the \$50,000 lifetime maximum benefit.

### Sample plan membership card

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



Front



Back

### General Exclusions

The purpose of this part of Section 10 is to tell you about medical care and services, items, and/or drugs that aren't covered ("are excluded") or are limited by our Plan. The list below tells about these exclusions and limitations. The list describes services and items, that aren't covered under any conditions. (The Benefits Chart earlier also explains about some restrictions or limitations that apply to certain services).

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

We won't pay for the exclusions that are listed in this section (or elsewhere in this EOC), and neither will the Original Medicare Plan, unless they are found upon appeal to be services/items that we should have paid or covered (appeals are discussed in Section 5).

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

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

1. Services that aren't reasonable and necessary, according to the standards of the Original Medicare Plan, unless these services are otherwise listed by our Plan as a covered service.
2. Experimental or investigational medical and surgical procedures, equipment and medications, unless covered by the Original Medicare Plan or unless, for certain services, the procedures are covered under an approved clinical trial. The Centers for Medicare and Medicaid Services (CMS) will continue to pay through Original Medicare for clinical trial items and services covered under the September 2000 National Coverage Determination that are provided to plan members. Experimental procedures and items are those items and procedures determined by our Plan and the Original Medicare Plan to not be generally accepted by the medical community.
3. Surgical treatment of morbid obesity unless medically necessary and covered under the Original Medicare plan.
4. Private room in a hospital, unless medically necessary.
5. Private duty nurses.
6. Personal convenience items, such as a telephone or television in your room at a hospital or skilled nursing facility.
7. Nursing care on a full-time basis in your home.
8. Custodial care unless it is provided in conjunction with covered skilled nursing care and/or skilled rehabilitation services. This includes care that helps people with activities of daily living like walking, getting in and out of bed, bathing, dressing, eating and using the bathroom, preparation of special diets, and supervision of medication that is usually self-administered.
9. Homemaker services.
10. Charges imposed by immediate relatives or members of your household.
11. Meals delivered to your home.

## 2009 Evidence of Coverage (EOC)

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12. Elective or voluntary enhancement procedures, services, supplies and medications including but not limited to: Weight loss, hair growth, sexual performance, athletic performance, cosmetic purposes, anti-aging and mental performance unless medically necessary.
13. Cosmetic surgery or procedures, unless needed because of accidental injury or to improve the function of a malformed part of the body. All stages of reconstruction are covered for a breast after a mastectomy, as well as for the unaffected breast to produce a symmetrical appearance.
14. Routine dental care (such as cleanings, fillings, or dentures) or other dental services. However, non-routine dental services received at a hospital may be covered.
15. Chiropractic care is generally not covered under the Plan, (with the exception of manual manipulation of the spine,) and is limited according to Medicare guidelines.
16. Routine foot care is generally not covered under the Plan and is limited according to Medicare guidelines.
17. Orthopedic shoes unless they are part of a leg brace and are included in the cost of the brace. Exception: Therapeutic shoes are covered for people with diabetic foot disease.
18. Supportive devices for the feet. Exception: Orthopedic or therapeutic shoes are covered for people with diabetic foot disease.
19. Hearing aids and routine hearing examinations.
20. Eyeglasses (except after cataract surgery), routine eye examinations, radial keratotomy, LASIK surgery, vision therapy and other low vision aids and services.
21. Self-administered prescription medication for the treatment of sexual dysfunction, including erectile dysfunction, impotence, and anorgasmy or hyporgasmy.
22. Reversal of sterilization procedures, sex change operations, and non-prescription contraceptive supplies and devices.
23. Acupuncture.
24. Naturopath services.
25. Prescription drugs are not covered by this plan.
26. Services provided to veterans in Veterans Affairs (VA) facilities. However, in the case of emergency services received at a VA hospital, if the VA cost-sharing is more than the cost-sharing required under our Plan, we will reimburse veterans for the difference. Members are still responsible for our Plan cost-sharing amount.
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.

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