2023 Evidence of Coverage

Providence Medicare Focus Medical (HMO)

This document is for members in: Clackamas, Columbia, Crook, Deschutes, Hood River, Jefferson, Lane, Marion, Multnomah, Polk, Washington, Wheeler, and Yamhill counties in Oregon and Clark County in Washington.

Thank you for choosing Providence Medicare Advantage Plans. We’re happy to have you as a member. This document is filled with helpful information about your plan’s coverage, benefits and resources on how you can get the most out of your health plan.

Questions? We’re here to help.
+ Visit us at ProvidenceHealthAssurance.com
+ Call us at 503-574-8000 (toll-free: 1-800-603-2340), 8 a.m. to 8 p.m. (Pacific Time), seven days a week
+ Using a hearing impaired TTY device? Call us toll-free at 711
January 1 – December 31, 2023

Evidence of Coverage:

Your Medicare Health Benefits and Services as a Member of Providence Medicare Focus Medical (HMO)

This document gives you the details about your Medicare health care coverage from January 1 – December 31, 2023. This is an important legal document. Please keep it in a safe place.

For questions about this document, please contact our Customer Service at 503-574-8000 or 1-800-603-2340. (TTY users should call 711.) Hours are 8 a.m. to 8 p.m. (Pacific Time), seven days a week.

This plan, Providence Medicare Focus Medical (HMO), is offered by Providence Health Assurance. (When this Evidence of Coverage says “we,” “us,” or “our,” it means Providence Health Assurance. When it says “plan” or “our plan,” it means Providence Medicare Focus Medical (HMO).)

This information is available in multiple formats, including audio CDs, large print, and braille.

Benefits, premium, deductible, and/or copayments/coinsurance may change on January 1, 2024.

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

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

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

H9047_2023EOC33_C
# 2023 Evidence of Coverage

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Getting started as a member
SECTION 1 Introduction

Section 1.1 You are enrolled in Providence Medicare Focus Medical (HMO), which is a Medicare HMO

You are covered by Medicare, and you have chosen to get your Medicare health care through our plan, Providence Medicare Focus Medical (HMO). We are required to cover all Part A and Part B services. However, cost sharing and provider access in this plan differ from Original Medicare.

Providence Medicare Focus Medical (HMO) is a Medicare Advantage HMO Plan (HMO stands for Health Maintenance Organization) approved by Medicare and run by a private company. Providence Medicare Focus Medical (HMO) does not include Part D prescription drug coverage.

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

Section 1.2 What is the Evidence of Coverage document about?

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

The words “coverage” and “covered services” refer to the medical care and services available to you as a member of Providence Medicare Focus Medical (HMO).

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

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

Section 1.3 Legal information about the Evidence of Coverage

This Evidence of Coverage is part of our contract with you about how Providence Medicare Focus Medical (HMO) covers your care. Other parts of this contract include your enrollment form and any notices you receive from us about changes to your coverage or conditions that affect your coverage. These notices are sometimes called “riders” or “amendments.”

The contract is in effect for months in which you are enrolled in Providence Medicare Focus Medical (HMO) between January 1, 2023, and December 31, 2023.
Each calendar year, Medicare allows us to make changes to the plans that we offer. This means we can change the costs and benefits of Providence Medicare Focus Medical (HMO) after December 31, 2023. We can also choose to stop offering the plan, or to offer it in a different service area, after December 31, 2023.

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

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

Section 2.1  Your eligibility requirements

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

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

Section 2.2  Here is the plan service area for Providence Medicare Focus Medical (HMO)

Providence Medicare Focus Medical (HMO) is available only to individuals who live in our plan service area. To remain a member of our plan, you must continue to reside in the plan service area. The service area is described below.

Our service area includes these counties in Oregon: Clackamas, Columbia, Crook, Deschutes, Hood River, Jefferson, Lane, Marion, Multnomah, Polk, Washington, Wheeler, and Yamhill and this county in Washington: Clark.

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

It is also important that you call Social Security if you move or change your mailing address. You can find phone numbers and contact information for Social Security in Chapter 2, Section 5.
Section 2.3  U.S. Citizen or Lawful Presence

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

SECTION 3  Your plan membership card – Use it to get all covered care

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

Do NOT use your red, white, and blue Medicare card for covered medical services while you are a member of this plan. If you use your Medicare card instead of your Providence Medicare Focus Medical (HMO) membership card, you may have to pay the full cost of medical services yourself. Keep your Medicare card in a safe place. You may be asked to show it if you need hospital services, hospice services, or participate in Medicare approved clinical research studies also called clinical trials.

If your plan membership card is damaged, lost, or stolen, call Customer Service right away and we will send you a new card.
SECTION 4  Your monthly costs for Providence Medicare Focus Medical (HMO)

Your costs may include the following:
- Plan Premium (Section 4.1)
- Monthly Medicare Part B Premium (Section 4.2)
- Optional Supplemental Benefit Premium (Section 4.3)

Medicare Part B premiums differ for people with different incomes. If you have questions about these premiums review your copy of Medicare & You 2023 handbook, the section called “2023 Medicare Costs.” If you need a copy you can download it from the Medicare website (www.medicare.gov). Or, you can order a printed copy by phone at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users call 1-877-486-2048.

Section 4.1  Plan premium

As a member of our plan, you pay a monthly plan premium. For 2023, the monthly premium for Providence Medicare Focus Medical (HMO) is $128.

Section 4.2  Monthly Medicare Part B Premium

Many members are required to pay other Medicare premiums

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

Section 4.3  Optional Supplemental Benefit Premium

If you signed up for extra benefits, also called “optional supplemental benefits,” then you pay an additional premium each month for these extra benefits. See Chapter 4, Section 2.2 for details.

If you elected Optional Supplemental Dental coverage, the premium pricing is as follows:

<table>
<thead>
<tr>
<th>Optional Supplemental Dental Plan</th>
<th>Monthly Premium</th>
</tr>
</thead>
<tbody>
<tr>
<td>Providence Dental Basic</td>
<td>$32.50</td>
</tr>
<tr>
<td>Providence Dental Enhanced</td>
<td>$45.10</td>
</tr>
</tbody>
</table>

Section 4.4  There are several ways you can pay your plan premium

There are four ways you can pay your plan premium.
Option 1: Paying by check

You can pay by check every month. We generate and mail you a monthly billing statement, which includes a payment coupon and return envelope. If you lose your payment coupon, please contact Customer Service to request a new one.

If you would like to mail your check, our payment address is:

Providence Health Assurance  
P.O. Box 4175  
Portland, OR 97208

Checks should be made payable to Providence Health Assurance, not to CMS or HHS. Please include your member ID number on your check.

Payments are due on the 1st of each month but are not considered late until the 15th of each month.

Option 2: Paying online or by telephone

You can pay online or by telephone every month. We accept payment via checking/savings account or credit/debit card (Visa or MasterCard only). You can make one-time or monthly reoccurring payments via your myProvidence account or the Providence website. Please visit myProvidence.com or Providence.org/premiumpay to get started. If you would like to pay by phone, Self Service is available at 844-791-1468, 24 hours a day, seven days a week. TTY users should call 711. Payments are due on the 1st of each month but are not considered late until the 15th of each month.

Option 3: Having your premium taken out of your monthly Social Security check

You can have the plan premium taken out of your monthly Social Security check. Contact Customer Service for more information on how to pay your plan premium this way. We will be happy to help you set this up.

Option 4: Having your premium taken out of your monthly Railroad Retirement Board check

You can have the plan premium taken out of your monthly Railroad Retirement Board check. We will be happy to help you set this up. Contact Customer Service for more information about how to pay this way. Please note that once SSA or RRB payment is in effect, you will not receive a monthly statement.

Changing the way you pay your premium. If you decide to change the way you pay your premium, it can take up to three months for your new payment method to take effect. While we are processing your request for a new payment method, you are responsible for making sure that
your plan premium is paid on time. To change your payment method, please contact Customer Service.

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

Your plan premium is due in our office by the 1st of each month. If we have not received your premium by the 15th of the month, we will send you a notice telling you that your plan membership will end if we do not receive your premium payment within 90 days.

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

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

If you think we have wrongfully ended your membership, you can make a complaint (also called a grievance); see Chapter 7 for how to file a complaint. If you had an emergency circumstance that was out of your control and it caused you to not be able to pay your plan premium within our grace period, you can make a complaint. For complaints, we will review our decision again. Chapter 7, Section 9 of this document tells how to make a complaint, or you can call us at 503-574-8000 or 1-800-603-2340 between 8 a.m. and 8 p.m. (Pacific Time), seven days a week. TTY users should call 711. You must make your request no later than 60 days after the date your membership ends.

<table>
<thead>
<tr>
<th>Section 4.5</th>
<th>Can we change your monthly plan premium during the year?</th>
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</thead>
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<tr>
<td><strong>No.</strong></td>
<td>We are not allowed to change the amount we charge for the plan’s monthly plan premium during the year. If the monthly plan premium changes for next year we will tell you in September and the change will take effect on January 1.</td>
</tr>
</tbody>
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SECTION 5 Keeping your plan membership record up to date

Your membership record has information from your enrollment form, including your address and telephone number. It shows your specific plan coverage, including your Primary Care Provider.

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

**Let us know about these changes:**

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

If any of this information changes, please let us know by calling Customer Service.

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

SECTION 6 How other insurance works with our plan

Other insurance

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

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

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

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

• If you have retiree coverage, Medicare pays first.
• If your group health plan coverage is based on your or a family member’s current employment, who pays first depends on your age, the number of people employed by
your employer, and whether you have Medicare based on age, disability, or End-Stage Renal Disease (ESRD):

- If you’re under 65 and disabled and you or your family member is still working, your group health plan pays first if the employer has 100 or more employees or at least one employer in a multiple employer plan that has more than 100 employees.
- If you’re over 65 and you or your spouse is still working, your group health plan pays first if the employer has 20 or more employees or at least one employer in a multiple employer plan that has more than 20 employees.

- If you have Medicare because of ESRD, your group health plan will pay first for the first 30 months after you become eligible for Medicare.

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

- No-fault insurance (including automobile insurance)
- Liability (including automobile insurance)
- Black lung benefits
- Workers’ compensation

Medicaid and TRICARE never pay first for Medicare-covered services. They only pay after Medicare, employer group health plans, and/or Medigap have paid.
CHAPTER 2:

*Important phone numbers and resources*
SECTION 1  Providence Medicare Focus Medical (HMO) contacts
(how to contact us, including how to reach Customer Service)

How to contact our plan’s Customer Service

For assistance with claims, billing or member card questions, please call or write to Providence Medicare Focus Medical (HMO) Customer Service. We will be happy to help you.

<table>
<thead>
<tr>
<th>Method</th>
<th>Customer Service – Contact Information</th>
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</thead>
<tbody>
<tr>
<td>CALL</td>
<td>503-574-8000 or 1-800-603-2340</td>
</tr>
<tr>
<td></td>
<td>Calls to this number are free. Hours are 8 a.m. to 8 p.m. (Pacific Time), seven days a week.</td>
</tr>
<tr>
<td></td>
<td>Customer Service also has free language interpreter services available for non-English speakers.</td>
</tr>
<tr>
<td>TTY</td>
<td>711</td>
</tr>
<tr>
<td></td>
<td>Calls to this number are free. Hours are 8 a.m. to 8 p.m. (Pacific Time), seven days a week.</td>
</tr>
<tr>
<td>FAX</td>
<td>503-574-8608</td>
</tr>
<tr>
<td>WRITE</td>
<td>Providence Health Assurance</td>
</tr>
<tr>
<td></td>
<td>Attn: Customer Service Team</td>
</tr>
<tr>
<td></td>
<td>P.O. Box 5548</td>
</tr>
<tr>
<td></td>
<td>Portland, OR 97228-5548</td>
</tr>
<tr>
<td>WEBSITE</td>
<td><a href="http://www.ProvidenceHealthAssurance.com">www.ProvidenceHealthAssurance.com</a></td>
</tr>
</tbody>
</table>

How to contact us when you are asking for a coverage decision about your medical care

A “coverage decision” is a decision we make about your benefits and coverage or about the amount we will pay for your medical services. For more information on asking for coverage decisions about your medical care, see Chapter 7 (What to do if you have a problem or complaint (coverage decisions, appeals, complaints)).

<table>
<thead>
<tr>
<th>Method</th>
<th>Coverage Decisions For Medical Care – Contact Information</th>
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</thead>
<tbody>
<tr>
<td>CALL</td>
<td>503-574-8000 or 1-800-603-2340</td>
</tr>
<tr>
<td></td>
<td>Calls to this number are free. Hours are 8 a.m. to 8 p.m. (Pacific Time), seven days a week.</td>
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<td></td>
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</table>
## Chapter 2 Important phone numbers and resources

<table>
<thead>
<tr>
<th>Method</th>
<th>Coverage Decisions For Medical Care – Contact Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>FAX</td>
<td>503-574-6464 or 1-800-989-7479</td>
</tr>
<tr>
<td>WRITE</td>
<td>Providence Health Assurance</td>
</tr>
<tr>
<td></td>
<td>Attn: Health Care Services</td>
</tr>
<tr>
<td></td>
<td>P.O. Box 4327</td>
</tr>
<tr>
<td></td>
<td>Portland, OR 97208-4327</td>
</tr>
<tr>
<td>WEBSITE</td>
<td><a href="http://www.ProvidenceHealthAssurance.com">www.ProvidenceHealthAssurance.com</a></td>
</tr>
</tbody>
</table>

### How to contact us when you are making an appeal or a complaint about your medical care

An appeal is a formal way of asking us to review and change a coverage decision we have made. For more information on making an appeal about your medical care, see Chapter 7 (*What to do if you have a problem or complaint (coverage decisions, appeals, complaints)*).

You can make a complaint about us or one of our network providers, including a complaint about the quality of your care. This type of complaint does not involve coverage or payment disputes. For more information on making a complaint about your medical care, see Chapter 7 (*What to do if you have a problem or complaint (coverage decisions, appeals, complaints)*).

<table>
<thead>
<tr>
<th>Method</th>
<th>Appeals for Medical Care – Contact Information</th>
</tr>
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<tbody>
<tr>
<td>CALL</td>
<td>503-574-8000 or 1-800-603-2340</td>
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<tr>
<td></td>
<td>Calls to this number are free. Hours are 8 a.m. to 8 p.m. (Pacific Time), seven days a week.</td>
</tr>
<tr>
<td>FAX</td>
<td>503-574-8757 or 1-800-396-4778</td>
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<tr>
<td>WRITE</td>
<td>Providence Health Assurance</td>
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<td></td>
<td>Attn: Appeals and Grievances</td>
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<td></td>
<td>P.O. Box 4158</td>
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<td></td>
<td>Portland, OR 97208-4158</td>
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<tr>
<td>MEDICARE WEBSITE</td>
<td>You can submit a complaint about Providence Medicare Focus Medical (HMO) directly to Medicare. To submit an online complaint to Medicare go to <a href="http://www.medicare.gov/MedicareComplaintForm/home.aspx">www.medicare.gov/MedicareComplaintForm/home.aspx</a>.</td>
</tr>
</tbody>
</table>
Where to send a request asking us to pay for our share of the cost for medical care you have received

If you have received a bill or paid for services (such as a provider bill) that you think we should pay for, you may need to ask us for reimbursement or to pay the provider bill. See Chapter 5 (Asking us to pay our share of a bill you have received for covered medical services).

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

<table>
<thead>
<tr>
<th>Method</th>
<th>Payment Requests – Contact Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>CALL</td>
<td>503-574-8000 or 1-800-603-2340</td>
</tr>
<tr>
<td></td>
<td>Calls to this number are free. Hours are 8 a.m. to 8 p.m. (Pacific Time), seven days a week.</td>
</tr>
<tr>
<td>TTY</td>
<td>711</td>
</tr>
<tr>
<td></td>
<td>Calls to this number are free. Hours are 8 a.m. to 8 p.m. (Pacific Time), seven days a week.</td>
</tr>
<tr>
<td>FAX</td>
<td>503-574-8627</td>
</tr>
<tr>
<td>WRITE</td>
<td>Providence Health Assurance</td>
</tr>
<tr>
<td></td>
<td>Attn: Claims</td>
</tr>
<tr>
<td></td>
<td>P.O. Box 3125</td>
</tr>
<tr>
<td></td>
<td>Portland, OR 97208-3125</td>
</tr>
<tr>
<td>WEBSITE</td>
<td><a href="http://www.ProvidenceHealthAssurance.com">www.ProvidenceHealthAssurance.com</a></td>
</tr>
</tbody>
</table>

SECTION 2 Medicare

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

The Federal agency in charge of Medicare is the Centers for Medicare & Medicaid Services (sometimes called “CMS”). This agency contracts with Medicare Advantage organizations including us.
### Chapter 2 Important phone numbers and resources

<table>
<thead>
<tr>
<th>Method</th>
<th>Medicare – Contact Information</th>
</tr>
</thead>
</table>
| **CALL** | 1-800-MEDICARE, or 1-800-633-4227  
Calls to this number are free.  
24 hours a day, 7 days a week. |
| **TTY**  | 1-877-486-2048  
This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.  
Calls to this number are free. |
| **WEBSITE** | [www.medicare.gov](http://www.medicare.gov)  
This is the official government website for Medicare. It gives you up-to-date information about Medicare and current Medicare issues. It also has information about hospitals, nursing homes, physicians, home health agencies, and dialysis facilities. It includes documents you can print directly from your computer. You can also find Medicare contacts in your state.  
The Medicare website also has detailed information about your Medicare eligibility and enrollment options with the following tools:  
- **Medicare Eligibility Tool**: Provides Medicare eligibility status information.  
- **Medicare Plan Finder**: Provides personalized information about available Medicare prescription drug plans, Medicare health plans, and Medigap (Medicare Supplement Insurance) policies in your area. These tools provide an estimate of what your out-of-pocket costs might be in different Medicare plans. You can also use the website to tell Medicare about any complaints you have about Providence Medicare Focus Medical (HMO):  
  - **Tell Medicare about your complaint**: You can submit a complaint about Providence Medicare Focus Medical (HMO) directly to Medicare. To submit a complaint to Medicare, go to [www.medicare.gov/MedicareComplaintForm/home.aspx](http://www.medicare.gov/MedicareComplaintForm/home.aspx). Medicare takes your complaints seriously and will use this information to help improve the quality of the Medicare program.  
If you don’t have a computer, your local library or senior center may be able to help you visit this website using its computer. Or, you can call Medicare and tell them what information you are looking for. They will find the information on the website and review the information with you. (You can call Medicare at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.) |
SECTION 3  State Health Insurance Assistance Program
(free help, information, and answers to your questions about Medicare)

The State Health Insurance Assistance Program (SHIP) is a government program with trained counselors in every state. Here is a list of the State Health Insurance Assistance Programs in each state we serve:

- In Oregon, the SHIP is called Senior Health Insurance Benefits Assistance (SHIBA).
- In Washington, the SHIP is called Statewide Health Insurance Benefits Advisors (also SHIBA).

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

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

METHOD TO ACCESS SHIP and OTHER RESOURCES:

- Visit [www.medicare.gov](http://www.medicare.gov)
- Click on “Talk to Someone” in the middle of the homepage
- You now have the following options
  - Option #1: You can have a live chat with a 1-800-MEDICARE representative
  - Option #2: You can select your STATE from the dropdown menu and click GO. This will take you to a page with phone numbers and resources specific to your state.

<table>
<thead>
<tr>
<th>Method</th>
<th>Senior Health Insurance Benefits Assistance (Oregon SHIP) – Contact Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>CALL</td>
<td>1-800-722-4134</td>
</tr>
<tr>
<td>TTY</td>
<td>711</td>
</tr>
<tr>
<td>WRITE</td>
<td>SHIBA</td>
</tr>
<tr>
<td></td>
<td>500 Summer St. NE, E-12</td>
</tr>
<tr>
<td></td>
<td>Salem, OR 97301</td>
</tr>
<tr>
<td></td>
<td>Email: <a href="mailto:SHIBA.oregon@dhsoha.state.or.us">SHIBA.oregon@dhsoha.state.or.us</a></td>
</tr>
<tr>
<td>WEBSITE</td>
<td><a href="http://www.shiba.oregon.gov">www.shiba.oregon.gov</a></td>
</tr>
</tbody>
</table>
## Section 4 Quality Improvement Organization

There is a designated Quality Improvement Organization for serving Medicare beneficiaries in each state. For Oregon and Washington, the Quality Improvement Organization is called KEPRO.

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

You should contact KEPRO in any of these situations:

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

<table>
<thead>
<tr>
<th>Method</th>
<th>KEPRO (Oregon and Washington’s Quality Improvement Organization) – Contact Information</th>
</tr>
</thead>
</table>
| CALL   | 813-280-8256 (local) or 1-888-305-6759 (toll-free)  
Local hours are 9 a.m. to 5 p.m. (Pacific Time), Monday through Friday, and 11 a.m. to 3 p.m. (Pacific Time) on weekends and holidays.  
A message can also be left at the toll-free number 24 hours a day, seven days a week. |
| TTY    | 711 |
SECTION 5  Social Security

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

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

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

SECTION 6  Medicaid

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

The programs offered through Medicaid help people with Medicare pay their Medicare costs, such as their Medicare premiums. These “Medicare Savings Programs” include:
• **Qualified Medicare Beneficiary (QMB):** Helps pay Medicare Part A and Part B premiums, and other cost sharing (like deductibles, coinsurance, and copayments). (Some people with QMB are also eligible for full Medicaid benefits (QMB+).)

• **Specified Low-Income Medicare Beneficiary (SLMB):** Helps pay Part B premiums. (Some people with SLMB are also eligible for full Medicaid benefits (SLMB+).)

• **Qualifying Individual (QI):** Helps pay Part B premiums.

• **Qualified Disabled & Working Individuals (QDWI):** Helps pay Part A premiums.

To find out more about Medicaid and its programs, contact Oregon Health Plan or Washington Apple Health.

<table>
<thead>
<tr>
<th>Method</th>
<th>Oregon Health Plan – Contact Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>CALL</td>
<td>1-800-273-0557</td>
</tr>
<tr>
<td></td>
<td>Hours are 8 a.m. to 5 p.m. (Pacific Time), Monday through Friday.</td>
</tr>
<tr>
<td>TTY</td>
<td>711</td>
</tr>
<tr>
<td>WRITE</td>
<td>Oregon Health Authority</td>
</tr>
<tr>
<td></td>
<td>500 Summer Street NE, E-20</td>
</tr>
<tr>
<td></td>
<td>Salem, OR 97301</td>
</tr>
<tr>
<td>WEBSITE</td>
<td><a href="http://www.oregon.gov/oha/healthplan">www.oregon.gov/oha/healthplan</a></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Method</th>
<th>Washington Apple Health – Contact Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>CALL</td>
<td>1-800-562-3022</td>
</tr>
<tr>
<td></td>
<td>Hours are 7 a.m. to 5 p.m. (Pacific Time), Monday through Friday, except state holidays.</td>
</tr>
<tr>
<td>TTY</td>
<td>711</td>
</tr>
<tr>
<td>WRITE</td>
<td>Washington Apple Health</td>
</tr>
<tr>
<td></td>
<td>P.O. Box 45531</td>
</tr>
<tr>
<td></td>
<td>Olympia, WA 98504</td>
</tr>
<tr>
<td></td>
<td>Email: <a href="mailto:askmedicaid@hca.wa.gov">askmedicaid@hca.wa.gov</a></td>
</tr>
</tbody>
</table>

**SECTION 7     How to contact the Railroad Retirement Board**

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

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

**SECTION 8**

**Do you have “group insurance” or other health insurance from an employer?**

If you (or your spouse) get benefits from your (or your spouse’s) employer or retiree group as part of this plan, you may call the employer/union benefits administrator or Customer Service if you have any questions. You can ask about your (or your spouse’s) employer or retiree health benefits, premiums, or the enrollment period. You may also call 1-800-MEDICARE (1-800-633-4227; TTY: 1-877-486-2048) with questions related to your Medicare coverage under this plan.
CHAPTER 3:
Using the plan for your medical services
SECTION 1  Things to know about getting your medical care as a member of our plan

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

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

Section 1.1  What are “network providers” and “covered services”?

- **“Providers”** are doctors and other health care professionals licensed by the state to provide medical services and care. The term “providers” also includes hospitals and other health care facilities.

- **“Network providers”** are the doctors and other health care professionals, medical groups, hospitals, and other health care facilities that have an agreement with us to accept our payment and your cost-sharing amount as payment in full. We have arranged for these providers to deliver covered services to members in our plan. The providers in our network bill us directly for care they give you. When you see a network provider, you pay only your share of the cost for their services.

- **“Covered services”** include all the medical care, health care services, supplies, and equipment that are covered by our plan.

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

As a Medicare health plan, Providence Medicare Focus Medical (HMO) must cover all services covered by Original Medicare and must follow Original Medicare’s coverage rules.

Providence Medicare Focus Medical (HMO) will generally cover your medical care as long as:

- **The care you receive is included in the plan’s Medical Benefits Chart** (this chart is in Chapter 4 of this document).

- **The care you receive is considered medically necessary.** “Medically necessary” means that the services, supplies, equipment, or drugs are needed for the prevention, diagnosis, or treatment of your medical condition and meet accepted standards of medical practice.

- **You have a network primary care provider (a PCP) who is providing and overseeing your care.** As a member of our plan, you must choose a network PCP (for more information about this, see Section 2.1 in this chapter).
  - In most situations, your network PCP must give you approval in advance before you can use other providers in the plan’s network, such as specialists, hospitals,
skilled nursing facilities, or home health care agencies. This is called giving you a “referral.” For more information about this, see Section 2.3 of this chapter.

- Referrals from your PCP are not required for emergency care or urgently needed services. There are also some other kinds of care you can get without having approval in advance from your PCP (for more information about this, see Section 2.2 of this chapter).

• You must receive your care from a network provider (for more information about this, see Section 2 in this chapter). In most cases, care you receive from an out-of-network provider (a provider who is not part of our plan’s network) will not be covered. This means that you will have to pay the provider in full for the services furnished. Here are three exceptions:
  - The plan covers emergency or urgently needed services that you get from an out-of-network provider. For more information about this, and to see what emergency or urgently needed services means, see Section 2 in this chapter.
  - If you need medical care that Medicare requires our plan to cover but there are no specialists in our network that provide this care, you can get this care from an out-of-network provider at the same cost sharing you normally pay in-network. Authorization should be obtained from the plan prior to seeking care. In this situation, you will pay the same as you would pay if you got the care from a network provider. For information about getting approval to see an out-of-network doctor, see Section 2.4 in this chapter.
  - The plan covers kidney dialysis services that you get at a Medicare-certified dialysis facility when you are temporarily outside the plan’s service area or when your provider for this service is temporarily unavailable or inaccessible. The cost sharing you pay the plan for dialysis can never exceed the cost sharing in Original Medicare. If you are outside the plan’s service area and obtain the dialysis from a provider that is outside the plan’s network, your cost sharing cannot exceed the cost sharing you pay in-network. However, if your usual in-network provider for dialysis is temporarily unavailable and you choose to obtain services inside the service area from a provider outside the plan’s network, the cost sharing for the dialysis may be higher.
SECTION 2  Use providers in the plan’s network to get your medical care

Section 2.1  You must choose a Primary Care Provider (PCP) to provide and oversee your medical care

What is a “PCP” and what does the PCP do for you?

What is a PCP?

When you enroll in Providence Medicare Focus Medical (HMO), you must choose an available plan provider to be your PCP. A PCP is a physician, nurse practitioner, or health care professional who meets state requirements and is trained to give you basic medical care. In addition to providing your routine or basic care, your PCP will coordinate the other covered services you receive as a plan member. For example, you usually need your PCP’s approval before you can see a specialist. (This is called getting a “referral” to a specialist.)

What types of providers may act as a PCP?

There are several types of providers who qualify as PCPs. Your PCP could be:

- An Internal Medicine Physician
- A Family Practice Physician
- A General Practice Physician
- A Geriatric Physician
- A Nurse Practitioner

What is the role of a PCP in your plan?

Usually, you will see your PCP first for your health care needs. There are only a few types of covered services you can get on your own, without contacting your PCP first. Please see Section 2.2 for these exceptions.

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

As previously mentioned, your PCP will provide most of your care. They will also help coordinate the rest of your covered services, such as x-rays, laboratory tests, therapies, specialist visits, hospital admissions, and follow-up care. “Coordinating” your services includes reaching out to other plan providers to discuss your care and progress. If you need certain types of covered services or supplies, your PCP must approve them in advance (e.g., by giving you a referral to see a specialist).

What is the role of the PCP in making decisions about or obtaining prior authorization (PA), if applicable?

In some cases, your PCP will also need to request prior authorization (prior approval) before you get some services. Since your PCP will provide and coordinate most of your health care services, you should confirm that their office has all of your past medical records.
How do you choose your PCP?

You may choose your PCP from the Provider Directory, which is available on our website at www.ProvidenceHealthAssurance.com/findaprovider. You may also call Customer Service for assistance selecting your PCP. Once you make your decision, you **must** notify Customer Service to ensure accurate claims processing and payment and to have your PCP’s name and office telephone number printed on your membership card.

It is important to keep other providers and facilities in mind when choosing your PCP. For example, if there is a particular specialist or hospital that you want to use, check to see if your prospective PCP makes referrals to that specialist or uses that hospital.

Changing your PCP

You may change your PCP for any reason, at any time. Also, it’s possible that your PCP might leave our plan’s network of providers and you would have to find a new PCP.

Please notify Customer Service if you want to change your PCP before your first appointment. Changes to your PCP will go into effect the first day of the month following the date of your request. Customer Service is more than happy to assist you, but please understand that if your PCP changes, all referrals to specialists made by your previous PCP will expire on the effective date of your new PCP.

Please note: If you are under the care of a specialist, your new PCP will need to coordinate and reissue any needed referrals. If there is a particular specialist or hospital that you want to use, check with your PCP first to make sure they refer to your desired specialist or facility.

### Section 2.2 What kinds of medical care can you get without a referral from your PCP?

You can get the services listed below without getting approval in advance from your PCP.

- Routine women’s health care, which includes breast exams, screening mammograms (x-rays of the breast), Pap tests, and pelvic exams as long as you get them from a network provider
- Flu shots, COVID-19 vaccinations, and pneumonia vaccinations
- Emergency services from network providers or from out-of-network providers
- Urgently needed services are covered services that are not emergency services, provided when the network providers are temporarily unavailable or inaccessible or when the enrollee is out of the service area. For example, you need immediate care during the weekend. Services must be immediately needed and medically necessary.
- Kidney dialysis services that you get at a Medicare-certified dialysis facility when you are temporarily outside the plan’s service area. (If possible, please call Customer Service before you leave the service area so we can help arrange for you to have maintenance dialysis while you are away.)
• Mental health and chemical dependency services. Please contact Customer Service for details.

• Routine eye exams and routine vision hardware. You can get your routine eye exam and hardware from any qualified provider that accepts Medicare. Please see the Medical Benefits Chart in Chapter 4 for details.

• Embedded routine preventive dental services. You are required to use a plan provider for these services. Please see the Medical Benefits Chart in Chapter 4 for details. Also, see Chapter 4, Section 2.2 for information about optional supplemental dental coverage.

• Routine hearing exam and hearing aids as long as you use a TruHearing provider. Please see the Medical Benefits Chart in Chapter 4 for details.

• Routine alternative care services. Please contact Customer Service for details.

### Section 2.3 How to get care from specialists and other network providers

A specialist is a doctor who provides health care services for a specific disease or part of the body. There are many kinds of specialists. Here are a few examples:

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

Health care services are only covered when they are medically necessary and when your PCP, along with Providence Health Assurance, provides or arranges these services for you. Please note that your PCP will provide most of your health care and, when medically appropriate, refer you to a Providence network specialist for continued care.

Services like elective surgical procedures, hospitalizations, and skilled nursing care must be approved by Providence Health Assurance before the date of service. Likewise, authorizations to see out-of-network providers must be approved by Providence Health Assurance before you receive care. Your PCP is responsible for getting Providence Health Assurance’s approval for the above. For more information, please contact Customer Service.

If there is a particular specialist or hospital that you want to use, check with your PCP first to make sure they refer to your desired specialist or facility.

To find out which services require prior authorization, please see Chapter 4, Section 2.1.

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

It is important that you know that we may make changes to the hospitals, doctors and specialists (providers) that are part of your plan during the year. If your doctor or specialist leaves your plan, you have certain rights and protections summarized below:
• Even though our network of providers may change during the year, Medicare requires that we furnish you with uninterrupted access to qualified doctors and specialists.
• We will make a good faith effort to provide you with at least 30 days’ notice that your provider is leaving our plan so that you have time to select a new provider.
• We will assist you in selecting a new qualified provider to continue managing your health care needs.
• If you are undergoing medical treatment you have the right to request, and we will work with you to ensure that the medically necessary treatment you are receiving is not interrupted.
• If our network does not have a qualified specialist for a plan-covered service, we must cover that service at in-network cost sharing. Please note that prior authorization rules may still apply in this situation.
• If you find out your doctor or specialist is leaving your plan, please contact us so we can assist you in finding a new provider to manage your care.
• If you believe we have not furnished you with a qualified provider to replace your previous provider or that your care is not being appropriately managed, you have the right to file a quality of care complaint to the QIO, a quality of care grievance to the plan, or both. Please see Chapter 7.

Section 2.4 How to get care from out-of-network providers

In general, care you receive from an out-of-network provider (a provider who is not part of our plan’s network) will not be covered. Here are five exceptions that will be paid at the in-network rate if received from an out-of-network provider:

• Emergency or urgently needed care when you are out of the service area of the plan or when in-area providers are temporarily unavailable. Please see Chapter 4, Section 2.1 for additional details on obtaining this care.
• Flu shots or pneumonia vaccinations.
• Kidney dialysis services that you get at a dialysis facility when you are temporarily outside the plan’s service area.
• Routine eye exam and routine eye wear. Please see Chapter 4, Section 2.1 for additional details on obtaining this care.
• If you need medical care that Medicare requires our plan to cover and the providers in our network cannot provide this care, you can get this care from an out-of-network provider. Authorization should be obtained from the plan prior to seeking care. Your provider is responsible for requesting authorization before providing you services. If authorization is received, you will pay the same as you would pay if you got the care from a network provider.
SECTION 3 How to get services when you have an emergency or urgent need for care or during a disaster

Section 3.1 Getting care if you have a medical emergency

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

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

If you have a medical emergency:

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

What is covered if you have a medical emergency?

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

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

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

If your emergency care is provided by out-of-network providers, we will try to arrange for network providers to take over your care as soon as your medical condition and the circumstances allow.

What if it wasn’t a medical emergency?

Sometimes it can be hard to know if you have a medical emergency. For example, you might go in for emergency care – thinking that your health is in serious danger – and the doctor may say that it wasn’t a medical emergency after all. If it turns out that it was not an emergency, as long as you reasonably thought your health was in serious danger, we will cover your care.
However, after the doctor has said that it was not an emergency, we will cover additional care only if you get the additional care in one of these two ways:

- You go to a network provider to get the additional care;
- or – The additional care you get is considered “urgently needed services” and you follow the rules for getting this urgent care (for more information about this, see Section 3.2 below).

### Section 3.2 Getting care when you have an urgent need for services

**What are “urgently needed services”?**

An urgently needed service is a non-emergency situation requiring immediate medical care but, given your circumstances, it is not possible or not reasonable to obtain these services from a network provider. The plan must cover urgently needed services provided out of network. Some examples of urgently needed services are i) a severe sore throat that occurs over the weekend or ii) an unforeseen flare-up of a known condition when you are temporarily outside the service area.

If you have an urgent medical situation, you may contact your primary care provider, call ProvRN at 503-574-6520 or 1-800-700-0481, and/or get services from an urgent care provider. Please see Chapter 4, Section 2 for cost-sharing information.

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

- Emergency care: Treatment needed immediately because any delay would mean risk of permanent damage to your health.
- Urgently needed services: Services you require within 12 hours in order to avoid the likely onset of an emergency medical condition.

See the Medical Benefits Chart in Chapter 4, Section 2 for more information on this coverage.

### Section 3.3 Getting care during a disaster

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

Please visit the following website: [www.ProvidenceHealthAssurance.com/disastercare](http://www.ProvidenceHealthAssurance.com/disastercare) for information on how to obtain needed care during a disaster.

If you cannot use a network provider during a disaster, your plan will allow you to obtain care from out-of-network providers at in-network cost sharing.
SECTION 4  What if you are billed directly for the full cost of your services?

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

If you have paid more than your plan cost sharing for covered services, or if you have received a bill for the full cost of covered medical services, go to Chapter 5 (Asking us to pay our share of a bill you have received for covered medical services) for information about what to do.

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

Providence Medicare Focus Medical (HMO) covers all medically necessary services as listed in the Medical Benefits Chart in Chapter 4 of this document. If you receive services not covered by our plan or services obtained out-of-network and were not authorized, you are responsible for paying the full cost of services.

For covered services that have a benefit limitation, you also pay the full cost of any services you get after you have used up your benefit for that type of covered service. Once a benefit limit has been reached for a particular service, any additional out-of-pocket costs for that service will not count toward your plan’s out-of-pocket maximum. You can call Customer Service when you want to know how much of your benefit limit you have already used.

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

Section 5.1  What is a “clinical research study”?

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

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

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

If you want to participate in any Medicare-approved clinical research study, you do not need to tell us or to get approval from us or your PCP. The providers that deliver your care as part of the clinical research study do not need to be part of our plan’s network of providers.

Although you do not need to get our plan’s permission to be in a clinical research study, we encourage you to notify us in advance when you choose to participate in Medicare-qualified clinical trials.

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

<table>
<thead>
<tr>
<th>Section 5.2</th>
<th>When you participate in a clinical research study, who pays for what?</th>
</tr>
</thead>
</table>

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

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

After Medicare has paid its share of the cost for these services, our plan will pay the difference between the cost sharing in Original Medicare and your in-network cost sharing as a member of our plan. This means you will pay the same amount for the services you receive as part of the study as you would if you received these services from our plan. However, you are required to submit documentation showing how much cost sharing you paid. Please see Chapter 5 for more information for submitting requests for payments.

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

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

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

**Do you want to know more?**

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

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

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

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

**Section 6.2 Receiving Care from a Religious Non-Medical Health Care Institution**

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

- “Non-exceptioned” medical care or treatment is any medical care or treatment that is *voluntary* and *not required* by any federal, state, or local law.
- “Excepted” medical treatment is medical care or treatment that you get that is *not* voluntary or *is required* under federal, state, or local law.
To be covered by our plan, the care you get from a religious non-medical health care institution must meet the following conditions:

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

There is no limit to the number of days covered by the plan for each hospital stay. For more information, please see the “Inpatient hospital care” row in the Medical Benefits Chart, which is located in Chapter 4, Section 2 of this document.

**SECTION 7  Rules for ownership of durable medical equipment**

<table>
<thead>
<tr>
<th>Section 7.1</th>
<th>Will you own the durable medical equipment after making a certain number of payments under our plan?</th>
</tr>
</thead>
</table>

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

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

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

If you did not acquire ownership of the DME item while in our plan, you will have to make 13 new consecutive payments after you switch to Original Medicare in order to own the item. The payments made while enrolled in your plan do not count.
Example 1: You made 12 or fewer consecutive payments for the item in Original Medicare and then joined our plan. The payments you made in Original Medicare do not count.

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

**Section 7.2 Rules for oxygen equipment, supplies, and maintenance**

**What oxygen benefits are you entitled to?**

If you qualify for Medicare oxygen equipment coverage, Providence Medicare Focus Medical (HMO) will cover:

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

If you leave Providence Medicare Focus Medical (HMO) or no longer medically require oxygen equipment, then the oxygen equipment must be returned.

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

Original Medicare requires an oxygen supplier to provide you services for five years. During the first 36 months you rent the equipment. The remaining 24 months the supplier provides the equipment and maintenance (you are still responsible for the copayment for oxygen). After five years you may choose to stay with the same company or go to another company. At this point, the five-year cycle begins again, even if you remain with the same company, requiring you to pay copayments for the first 36 months. If you join or leave our plan, the five-year cycle starts over.
CHAPTER 4: 
Medical Benefits Chart 
(what is covered and what you pay)
SECTION 1  Understanding your out-of-pocket costs for covered services

This chapter provides a Medical Benefits Chart that lists your covered services and shows how much you will pay for each covered service as a member of Providence Medicare Focus Medical (HMO). Later in this chapter, you can find information about medical services that are not covered. It also explains limits on certain services. Please contact Customer Service for information about exclusions or limitations that are not listed in this Evidence of Coverage.

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

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

- A “copayment” is the fixed amount you pay each time you receive certain medical services. You pay a copayment at the time you get the medical service. (The Medical Benefits Chart in Section 2 tells you more about your copayments.)

- “Coinsurance” is the percentage you pay of the total cost of certain medical services. You pay a coinsurance at the time you get the medical service. (The Medical Benefits Chart in Section 2 tells you more about your coinsurance.)

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

Section 1.2  What is the most you will pay for covered medical services?

Because you are enrolled in a Medicare Advantage Plan, there is a limit on the total amount you have to pay out-of-pocket each year for in-network medical services that are covered by our plan. This limit is called the maximum out-of-pocket (MOOP) amount for medical services. For calendar year 2023, this amount is $3,400.

The amounts you pay for copayments and coinsurance for in-network covered services count toward this maximum out-of-pocket amount. The amount you pay for your plan premium does not count toward your maximum out-of-pocket amount. In addition, amounts you pay for some services do not count toward your maximum out-of-pocket amount. These services are marked with a plus sign (+) in the Medical Benefits Chart. If you reach the maximum out-of-pocket amount of $3,400, you will not have to pay any out-of-pocket costs for the rest of the year for in-network covered services. However, you must continue to pay your plan premium and the Medicare Part B premium (unless your Part B premium is paid for you by Medicaid or another third party).
As a member of Providence Medicare Focus Medical (HMO), an important protection for you is that you only have to pay your cost-sharing amount when you get services covered by our plan. Providers may not add additional separate charges, called “balance billing.” This protection applies even if we pay the provider less than the provider charges for a service and even if there is a dispute and we don’t pay certain provider charges.

Here is how this protection works.

- If your cost sharing is a copayment (a set amount of dollars, for example, $15.00), then you pay only that amount for any covered services from a network provider.
- If your cost sharing is a coinsurance (a percentage of the total charges), then you never pay more than that percentage. However, your cost depends on which type of provider you see:
  - If you receive the covered services from a network provider, you pay the coinsurance percentage multiplied by the plan’s reimbursement rate (as determined in the contract between the provider and the plan).
  - If you receive the covered services from an out-of-network provider who participates with Medicare, you pay the coinsurance percentage multiplied by the Medicare payment rate for participating providers. (Remember, the plan covers services from out-of-network providers only in certain situations, such as when you get a referral or for emergencies or urgently needed services.)
  - If you receive the covered services from an out-of-network provider who does not participate with Medicare, you pay the coinsurance percentage multiplied by the Medicare payment rate for non-participating providers. (Remember, the plan covers services from out-of-network providers only in certain situations, such as when you get a referral, or for emergencies or urgently needed services.)

- If you believe a provider has “balance billed” you, call Customer Service.

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

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

The Medical Benefits Chart on the following pages lists the services Providence Medicare Focus Medical (HMO) covers and what you pay out-of-pocket for each service. The services listed in the Medical Benefits Chart are covered only when the following coverage requirements are met:

- Your Medicare covered services must be provided according to the coverage guidelines established by Medicare.
• Your services (including medical care, services, supplies, equipment, and Part B prescription drugs) must be medically necessary. “Medically necessary” means that the services, supplies, or drugs are needed for the prevention, diagnosis, or treatment of your medical condition and meet accepted standards of medical practice.

• You receive your care from a network provider. In most cases, care you receive from an out-of-network provider will not be covered, unless it is emergent or urgent care or unless your plan or a network provider has given you a referral. This means that you will have to pay the provider in full for the services furnished.

• You have a primary care provider (a PCP) who is providing and overseeing your care. In most situations, your PCP must give you approval in advance before you can see other providers in the plan’s network. This is called giving you a “referral.”

• Some of the services listed in the Medical Benefits Chart are covered only if your doctor or other network provider gets approval in advance (sometimes called “prior authorization”) from us. Covered services that need approval in advance are marked in the Medical Benefits Chart by an asterisk. In addition, the following services not listed in the Benefits Chart require prior authorization:
  o Ambulance
    ▪ Non-emergency ambulance transportation services, such as transports from a hospital to a skilled nursing facility, require prior authorization. Most of the time, the ordering provider contacts us to get the prior authorization; however, you always have the right to request an authorization.
  o Dental services
    ▪ General anesthesia for dental services requires prior authorization. Most of the time, the ordering provider contacts us to get the prior authorization; however, you always have the right to request an authorization.
    ▪ Some oral surgery services, including services provided in an office setting, require prior authorization. Most of the time, the ordering provider contacts us to get the prior authorization; however, you always have the right to request an authorization.
  o Diabetes self-management training, diabetic services, and supplies
    ▪ Non-preferred test strips and glucometers, testing supplies over the Medicare-covered quantity limits, and diabetic shoes or inserts require prior authorization.
    ▪ You or the ordering provider should contact Providence Home Services at 1-800-762-1253 to request a prior authorization.
  o Durable medical equipment (DME) and related supplies
    ▪ Select durable medical equipment, including, but not limited to, the following categories, requires prior authorization:
      • Certain continuous glucose monitors (CGM)
      • Seat lift mechanisms
      • Power wheelchair and supplies
• Select nerve stimulators
• Skin substitutes
• Oral appliances
• Flexion/extension devices
• Wound therapy pumps
• Speech generating devices
• Purchase of CPAP post trial/rental period
  ▪ You or the ordering provider should contact Providence Home Services at 1-800-762-1253 to request a prior authorization.

  o Home health agency care
    ▪ Home health services require prior authorization. You or the ordering provider should contact Providence Home Services at 1-800-762-1253 to request a prior authorization.

  o Inpatient hospital care
    ▪ No matter the reason for admission, all inpatient hospital admissions, including maternity, require prior authorization. Most of the time, the inpatient facility or ordering provider contacts us to get the prior authorization; however, you always have the right to request an authorization.

  o Inpatient mental health care
    ▪ All inpatient mental health, chemical dependency, and opioid treatment services require prior authorization. Most of the time, the inpatient facility or ordering provider contacts us to get the prior authorization; however, you always have the right to request an authorization.

  o Inpatient stay: Covered services received in a hospital or SNF during a non-covered inpatient stay
    ▪ All services received during a non-covered inpatient stay require prior authorization. Most of the time, the inpatient facility or ordering provider contacts us to get the prior authorization; however, you always have the right to request an authorization.

  o Inpatient rehabilitation facility admissions
    ▪ All inpatient rehabilitation facility admissions require prior authorization. Most of the time, the inpatient facility or ordering provider contacts us to get the prior authorization; however, you always have the right to request an authorization.

  o Medicare Part B prescription drugs
    ▪ Certain Medicare Part B prescription drugs, such as chemotherapy drugs, require prior authorization. Most of the time, the ordering provider contacts us to get the prior authorization; however, you always have the right to request an authorization.
o Outpatient diagnostic tests and therapeutic services and supplies
  ▪ All high-tech radiology, such as MRI, MRA, SPECT, CTA, CT, PET, cardiac echocardiogram, and nuclear cardiology, requires prior authorization. Most of the time, the ordering provider contacts American Imaging Management (AIM) at 1-800-920-1250 to get the prior authorization; however, you always have the right to request an authorization.

o Outpatient hospital services
  ▪ Neuropsychological testing may require prior authorization. You or the ordering provider should contact us to inquire about prior authorization.
  ▪ Genetic testing, cytogenetic studies, and related counseling require prior authorization. Most of the time, the ordering provider contacts us to get the prior authorization; however, you always have the right to request an authorization.

o Outpatient mental health care
  ▪ Outpatient mental health services may require prior authorization. You or the ordering provider should contact us to inquire about prior authorization.

o Outpatient substance abuse services
  ▪ Outpatient chemical dependency services may require prior authorization. You or the ordering provider should contact us to inquire about prior authorization.

o Outpatient surgery, including services provided at hospital outpatient facilities and ambulatory surgical centers
  ▪ Select hip, knee, and shoulder procedures require prior authorization. Most of the time, the ordering provider contacts us to get the prior authorization; however, you always have the right to request an authorization.
  ▪ Miscellaneous cosmetic, reconstructive, nasal, oral, dental, and/or orthognathic procedures require prior authorization. Most of the time, the ordering provider contacts us to get the prior authorization; however, you always have the right to request an authorization.
  ▪ Organ, tissue, and bone marrow transplants, including pre-transplant evaluations and HLA typing, require prior authorization. Most of the time, the ordering provider contacts us to get the prior authorization; however, you always have the right to request an authorization.
  ▪ Uvulectomy, uvulopalatopharyngoplasty (UPPP), and laser-assisted uvulopalatoplasty (LAUP) require prior authorization. Most of the time, the ordering provider contacts us to get the prior authorization; however, you always have the right to request an authorization.
  ▪ Cervical, thoracic, and lumbar spinal surgeries require prior authorization. Most of the time, the ordering provider contacts us to get the prior authorization; however, you always have the right to request an authorization.
▪ Bariatric surgical procedures require prior authorization. Most of the time, the ordering provider contacts us to get the prior authorization; however, you always have the right to request an authorization.

▪ Procedures, surgeries, and treatments that may be considered experimental or investigational require prior authorization. Most of the time, the ordering provider contacts us to get the prior authorization; however, you always have the right to request an authorization.

▪ Services and procedures without specific CPT codes (unlisted services and procedures) require prior authorization. Most of the time, the ordering provider contacts us to get the prior authorization; however, you always have the right to request an authorization.

   ▪ Partial hospitalization services
      ▪ All partial hospitalization services require prior authorization. You or the ordering provider should contact us to get the prior authorization.

   ▪ Prosthetic devices and related supplies
      ▪ All prosthetic devices and some supplies require prior authorization.
      ▪ You or the ordering provider should contact Providence Home Services at 1-800-762-1253 to request a prior authorization.

   ▪ Screening for lung cancer with low dose computed tomography (LDCT)
      ▪ This screening includes a CT scan that requires prior authorization. Most of the time, the ordering provider contacts American Imaging Management (AIM) at 1-800-920-1250 to get the prior authorization; however, you always have the right to request an authorization.
      ▪ LDCT counseling does not require authorization.

   ▪ Skilled nursing facility (SNF) care
      ▪ All skilled nursing facility care requires prior authorization. Most of the time, the skilled nursing facility or ordering provider contacts us to get the prior authorization; however, you always have the right to request an authorization.

   ▪ Vision care – Medical vision hardware
      ▪ Medical vision hardware may require prior authorization. You or the ordering provider should contact us to inquire about prior authorization.

Other important things to know about our coverage:

▪ Like all Medicare health plans, we cover everything that Original Medicare covers. For some of these benefits, you pay more in our plan than you would in Original Medicare. For others, you pay less. (If you want to know more about the coverage and costs of Original Medicare, look in your Medicare & You 2023 handbook. View it online at www.medicare.gov or ask for a copy by calling 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.)
• For all preventive services that are covered at no cost under Original Medicare, we also cover the service at no cost to you. However, if you also are treated or monitored for an existing medical condition during the visit when you receive the preventive service, a copayment will apply for the care received for the existing medical condition.

• If Medicare adds coverage for any new services during 2023, either Medicare or our plan will cover those services.

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

Medical Benefits Chart

<table>
<thead>
<tr>
<th>Services that are covered for you</th>
<th>What you must pay when you get these services</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Abdominal aortic aneurysm screening</strong></td>
<td>A one-time screening ultrasound for people at risk. The plan only covers this screening if you have certain risk factors and if you get a referral for it from your physician, physician assistant, nurse practitioner, or clinical nurse specialist. Please note: If you are treated or monitored for an existing medical condition during the visit when you receive this preventive service, a copayment or coinsurance may apply for the care received for the existing medical condition.</td>
</tr>
</tbody>
</table>

**Acupuncture for chronic low back pain**

Covered services include:

Up to 12 visits in 90 days are covered for Medicare beneficiaries under the following circumstances:

For the purpose of this benefit, chronic low back pain is defined as:

- Lasting 12 weeks or longer;
- Nonspecific, in that it has no identifiable systemic cause (i.e., not associated with metastatic, inflammatory, infectious, etc. disease);
- Not associated with surgery; and
- Not associated with pregnancy.

An additional eight sessions will be covered for those patients demonstrating an improvement. No more than 20 acupuncture treatments may be administered annually. Treatment must be discontinued if the patient is not improving or is regressing.

$20 copayment for each Medicare-covered acupuncture visit.
<table>
<thead>
<tr>
<th>Services that are covered for you</th>
<th>What you must pay when you get these services</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Acupuncture for chronic low back pain (continued)</strong></td>
<td>Provider Requirements:</td>
</tr>
<tr>
<td></td>
<td>Physicians (as defined in 1861(r)(1) of the Social Security Act (the Act) may furnish acupuncture in accordance with applicable state requirements.</td>
</tr>
<tr>
<td></td>
<td>Physician assistants (PAs), nurse practitioners (NPs)/clinical nurse specialists (CNSs) (as identified in 1861(aa)(5) of the Act), and auxiliary personnel may furnish acupuncture if they meet all applicable state requirements and have:</td>
</tr>
<tr>
<td></td>
<td>- a masters or doctoral level degree in acupuncture or Oriental Medicine from a school accredited by the Accreditation Commission on Acupuncture and Oriental Medicine (ACAOM); and,</td>
</tr>
<tr>
<td></td>
<td>- a current, full, active, and unrestricted license to practice acupuncture in a State, Territory, or Commonwealth (i.e. Puerto Rico) of the United States, or District of Columbia.</td>
</tr>
<tr>
<td></td>
<td>Auxiliary personnel furnishing acupuncture must be under the appropriate level of supervision of a physician, PA, or NP/CNS required by our regulations at 42 CFR §§ 410.26 and 410.27.</td>
</tr>
<tr>
<td>Services that are covered for you</td>
<td>What you must pay when you get these services</td>
</tr>
<tr>
<td>----------------------------------</td>
<td>---------------------------------------------</td>
</tr>
<tr>
<td><strong>Acupuncture (non-Medicare-covered)</strong>&lt;sup&gt;+&lt;/sup&gt;</td>
<td>$20 copayment for each routine acupuncture visit.</td>
</tr>
<tr>
<td>Routine acupuncture services are covered when they are:</td>
<td>Plan covers up to $500 every year for routine chiropractic, acupuncture, and naturopathic services combined.</td>
</tr>
<tr>
<td>• Received from a qualified licensed acupuncturist who is practicing within the scope of their license</td>
<td>+ The cost-sharing amount for acupuncture services does not count toward your plan’s out-of-pocket maximum.</td>
</tr>
<tr>
<td>• Determined by your plan to be medically necessary</td>
<td></td>
</tr>
<tr>
<td>• Not listed as an exclusion</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Ambulance services*</th>
<th>$250 copayment per one-way Medicare-covered ground ambulance transport.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Covered ambulance services include fixed wing, rotary wing, and ground ambulance services, to the nearest appropriate facility that can provide care only if they are furnished to a member whose medical condition is such that other means of transportation could endanger the person’s health or if authorized by the plan.</td>
<td>$250 copayment per one-way Medicare-covered air ambulance transport.</td>
</tr>
<tr>
<td>Non-emergency transportation by ambulance is appropriate if it is documented that the member’s condition is such that other means of transportation could endanger the person’s health and that transportation by ambulance is medically required.</td>
<td>$50 copayment for ambulance services received through the 911 emergency medical response system when you receive treatment but do not ride in the ambulance.</td>
</tr>
<tr>
<td>*Prior authorization rules may apply for non-emergency transportation services, including from out-of-network to in-network facilities. See Section 2.1 of this chapter for details.</td>
<td>$50 copayment for an authorized one-way ambulance transport from an out-of-network to an in-network facility.</td>
</tr>
</tbody>
</table>
### Services that are covered for you

<table>
<thead>
<tr>
<th>Service</th>
<th>What you must pay when you get these services</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Annual routine physical exam</strong></td>
<td>There is no coinsurance, copayment, or deductible for an annual routine physical exam.</td>
</tr>
<tr>
<td>Our plan covers an annual routine physical exam in addition to the Medicare-covered annual wellness visit. This benefit allows you to see your provider without a specific medical complaint and includes a comprehensive physical exam once per calendar year.</td>
<td></td>
</tr>
<tr>
<td><strong>Please note:</strong> If you are treated or monitored for an existing medical condition during the visit when you receive this preventive service, a copayment or coinsurance may apply for the care received for the existing medical condition.</td>
<td></td>
</tr>
<tr>
<td><strong>Annual wellness visit</strong></td>
<td>There is no coinsurance, copayment, or deductible for the annual wellness visit.</td>
</tr>
<tr>
<td>If you’ve had Part B for longer than 12 months, you can get an annual wellness visit to develop or update a personalized prevention plan based on your current health and risk factors. This is covered once every 12 months.</td>
<td></td>
</tr>
<tr>
<td><strong>Note:</strong> Your first annual wellness visit can’t take place within 12 months of your “Welcome to Medicare” preventive visit. However, you don’t need to have had a “Welcome to Medicare” visit to be covered for annual wellness visits after you’ve had Part B for 12 months.</td>
<td></td>
</tr>
<tr>
<td><strong>Please note:</strong> If you are treated or monitored for an existing medical condition during the visit when you receive this preventive service, a copayment or coinsurance may apply for the care received for the existing medical condition.</td>
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</tr>
</tbody>
</table>
## Services that are covered for you

<table>
<thead>
<tr>
<th>Services that are covered for you</th>
<th>What you must pay when you get these services</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Bone mass measurement</strong></td>
<td>There is no coinsurance, copayment, or deductible for Medicare-covered bone mass measurement.</td>
</tr>
<tr>
<td>For qualified individuals (generally, this means people at risk of losing bone mass or at risk of osteoporosis), the following services are covered every 24 months or more frequently if medically necessary: procedures to identify bone mass, detect bone loss, or determine bone quality, including a physician’s interpretation of the results.</td>
<td><strong>Please note:</strong> If you are treated or monitored for an existing medical condition during the visit when you receive this preventive service, a copayment or coinsurance may apply for the care received for the existing medical condition.</td>
</tr>
</tbody>
</table>

**Please note:** If you are treated or monitored for an existing medical condition during the visit when you receive this preventive service, a copayment or coinsurance may apply for the care received for the existing medical condition.

## Breast cancer screening (mammograms)

Covered services include:

- One baseline mammogram between the ages of 35 and 39
- One screening mammogram every 12 months for women age 40 and older
- Clinical breast exams once every 24 months

**Please note:** If you are treated or monitored for an existing medical condition during the visit when you receive this preventive service, a copayment or coinsurance may apply for the care received for the existing medical condition.

There is no coinsurance, copayment, or deductible for covered screening mammograms.
<table>
<thead>
<tr>
<th>Services that are covered for you</th>
<th>What you must pay when you get these services</th>
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</thead>
<tbody>
<tr>
<td><strong>Cardiac rehabilitation services</strong>&lt;br&gt;Comprehensive programs of cardiac rehabilitation services that include exercise, education, and counseling are covered for members who meet certain conditions with a doctor’s order. The plan also covers intensive cardiac rehabilitation programs that are typically more rigorous or more intense than cardiac rehabilitation programs. Cardiac rehabilitation visits are limited to 36 sessions over a period of 36 weeks. If medically necessary, you may receive up to 36 additional sessions. Intensive cardiac rehabilitation visits are limited to 36 sessions over a period of 36 weeks. If medically necessary, you may receive up to 36 additional sessions.</td>
<td>There is no coinsurance, copayment, or deductible for each Medicare-covered cardiac rehabilitation visit. $20 copayment for each Medicare-covered intensive cardiac rehabilitation visit.</td>
</tr>
<tr>
<td><strong>Cardiovascular disease risk reduction visit (therapy for cardiovascular disease)</strong>&lt;br&gt;We cover one visit per year with your primary care doctor to help lower your risk for cardiovascular disease. During this visit, your doctor may discuss aspirin use (if appropriate), check your blood pressure, and give you tips to make sure you’re eating healthy.</td>
<td>There is no coinsurance, copayment, or deductible for the intensive behavioral therapy cardiovascular disease preventive benefit. There is no coinsurance, copayment, or deductible for the intensive behavioral therapy cardiovascular disease preventive benefit.</td>
</tr>
<tr>
<td><strong>Cardiovascular disease testing</strong>&lt;br&gt;Blood tests for the detection of cardiovascular disease (or abnormalities associated with an elevated risk of cardiovascular disease) once every 5 years (60 months).</td>
<td>There is no coinsurance, copayment, or deductible for cardiovascular disease testing that is covered once every 5 years.</td>
</tr>
<tr>
<td>Services that are covered for you</td>
<td>What you must pay when you get these services</td>
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</tr>
<tr>
<td><strong>Cervical and vaginal cancer screening</strong></td>
<td><strong>Please note:</strong> If you are treated or monitored for an existing medical condition during the visit when you receive this preventive service, a copayment or coinsurance may apply for the care received for the existing medical condition.</td>
</tr>
<tr>
<td>Covered services include:</td>
<td></td>
</tr>
<tr>
<td>• For all women: Pap tests and pelvic exams are covered once every 24 months</td>
<td>There is no coinsurance, copayment, or deductible for Medicare-covered preventive Pap and pelvic exams.</td>
</tr>
<tr>
<td>• If you are at high risk of cervical or vaginal cancer or you are of childbearing age and have had an abnormal Pap test within the past 3 years: one Pap test every 12 months</td>
<td></td>
</tr>
<tr>
<td><strong>Chiropractic services</strong></td>
<td></td>
</tr>
<tr>
<td>Covered services include:</td>
<td>$20 copayment for each Medicare-covered chiropractic visit.</td>
</tr>
<tr>
<td>• Manual manipulation of the spine to correct subluxation (when one or more of the bones of your spine move out of position) if you get this service from a chiropractor or other qualified provider.</td>
<td>$20 copayment for each routine chiropractic visit. Plan covers up to $500 every year for routine chiropractic, acupuncture, and naturopathic services combined.</td>
</tr>
<tr>
<td>Routine chiropractic services are covered when they are: +</td>
<td>+ The cost-sharing amount for routine chiropractic services does not count toward your plan’s out-of-pocket maximum.</td>
</tr>
<tr>
<td>• Received from a qualified licensed chiropractic physician who is practicing within the scope of their license</td>
<td></td>
</tr>
<tr>
<td>• Determined by your plan to be medically necessary</td>
<td></td>
</tr>
<tr>
<td>• Not listed as an exclusion</td>
<td></td>
</tr>
<tr>
<td><strong>Colorectal cancer screening</strong></td>
<td>There is no coinsurance, copayment, or deductible for a Medicare-covered colorectal cancer screening exam.</td>
</tr>
<tr>
<td>For people 50 and older, the following are covered:</td>
<td></td>
</tr>
<tr>
<td>• Flexible sigmoidoscopy (or screening barium enema as an alternative) every 48 months</td>
<td></td>
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<tr>
<td>One of the following every 12 months:</td>
<td></td>
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<tr>
<td>• Guaiac-based fecal occult blood test (gFOBT)</td>
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<tr>
<td>• Fecal immunochemical test (FIT)</td>
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</tbody>
</table>
### Colorectal cancer screening (continued)

DNA based colorectal screening every 3 years

For people at high risk of colorectal cancer, we cover:
- Screening colonoscopy (or screening barium enema as an alternative) every 24 months

For people not at high risk of colorectal cancer, we cover:
- Screening colonoscopy every 10 years (120 months), but not within 48 months of a screening sigmoidoscopy

**Please note:** If you are treated or monitored for an existing medical condition during the visit when you receive this preventive service, a copayment or coinsurance may apply for the care received for the existing medical condition.

### Dental services*

In general, preventive dental services (such as cleaning, routine dental exams, and dental x-rays) are not covered by Original Medicare. We cover:

**Medicare-covered dental services:**
- 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 for neoplastic disease, and other jaw or dental services that would be provided by a medical doctor.

**Embedded routine preventive dental services:**
- Two dental exams per calendar year, including a maximum of one comprehensive evaluation per 36 months and one limited oral evaluation per 12 months, two cleanings (excluding periodontal cleanings) per calendar year, and two bitewing x-rays per calendar year or one bitewing x-ray and one diagnostic x-ray per calendar year.

<table>
<thead>
<tr>
<th>Services that are covered for you</th>
<th>What you must pay when you get these services</th>
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</thead>
<tbody>
<tr>
<td>Colorectal cancer screening (continued)</td>
<td>There is no coinsurance, copayment, or deductible for members eligible for each Medicare-covered screening barium enema.</td>
</tr>
<tr>
<td>Dental services*</td>
<td>$20 copayment for each Medicare-covered dental visit.</td>
</tr>
<tr>
<td></td>
<td>There is no coinsurance, copayment, or deductible for each embedded routine preventive dental visit.</td>
</tr>
<tr>
<td>Services that are covered for you</td>
<td>What you must pay when you get these services</td>
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<td>---------------------------------------------</td>
</tr>
<tr>
<td><em><em>Dental services</em> (continued)</em>*</td>
<td></td>
</tr>
<tr>
<td>This does not include services in connection with routine or periodontal care, treatment, filling, removal or replacement of teeth. Coverage for additional dental services can be purchased for an extra cost. Refer to Section 2.2 of this chapter for more information.</td>
<td></td>
</tr>
<tr>
<td>*This service may require prior authorization. See Section 2.1 of this chapter for details.</td>
<td></td>
</tr>
<tr>
<td><strong>Depression screening</strong></td>
<td></td>
</tr>
<tr>
<td>We cover one screening for depression per year. The screening must be done in a primary care setting that can provide follow-up treatment and/or referrals. Please note: If you are treated or monitored for an existing medical condition during the visit when you receive this preventive service, a copayment or coinsurance may apply for the care received for the existing medical condition.</td>
<td>There is no coinsurance, copayment, or deductible for an annual depression screening visit.</td>
</tr>
<tr>
<td><strong>Diabetes screening</strong></td>
<td></td>
</tr>
<tr>
<td>We cover this screening (includes fasting glucose tests) if you have any of the following risk factors: high blood pressure (hypertension), history of abnormal cholesterol and triglyceride levels (dyslipidemia), obesity, or a history of high blood sugar (glucose). Tests may also be covered if you meet other requirements, like being overweight and having a family history of diabetes. Based on the results of these tests, you may be eligible for up to two diabetes screenings every 12 months. Please note: If you are treated or monitored for an existing medical condition during the visit when you receive this preventive service, a copayment or coinsurance may apply for the care received for the existing medical condition.</td>
<td>There is no coinsurance, copayment, or deductible for the Medicare-covered diabetes screening tests.</td>
</tr>
</tbody>
</table>
Diabetes self-management training, diabetic services and supplies*

For all people who have diabetes (insulin and non-insulin users), covered services include:

- Supplies to monitor your blood glucose: Blood glucose monitor, blood glucose test strips, lancet devices and lancets, and glucose-control solutions for checking the accuracy of test strips and monitors.

  There is no coinsurance, copayment, or deductible for Medicare-covered diabetic monitoring supplies.

  Test strips and glucometers are limited to the plan’s preferred manufacturers. All diabetic supplies and/or devices should be provided and arranged through the retail pharmacy network or other network provider.

- For people with diabetes who have severe diabetic foot disease: One pair per calendar year of therapeutic custom-molded shoes (including inserts provided with such shoes) and two additional pairs of inserts, or one pair of depth shoes and three pairs of inserts (not including the non-customized removable inserts provided with such shoes). Coverage includes fitting.

  There is no coinsurance, copayment, or deductible for Medicare-covered therapeutic shoes or inserts.

  All Durable Medical Equipment (DME) must be provided and arranged through the retail pharmacy network, Providence Home Services, or other plan-authorized provider.

- Diabetes self-management training is covered under certain conditions.

Please note: If you are treated or monitored for an existing medical condition during the visit when you receive this preventive service, a copayment or coinsurance may apply for the care received for the existing medical condition.

*This service may require prior authorization. See Section 2.1 of this chapter for details.
### Services that are covered for you

<table>
<thead>
<tr>
<th>What you must pay when you get these services</th>
</tr>
</thead>
<tbody>
<tr>
<td>Durable medical equipment (DME) and related supplies*</td>
</tr>
</tbody>
</table>

(For a definition of “durable medical equipment,” see Chapter 10 as well as Chapter 3, Section 7 of this document.)

Covered items include, but are not limited to: wheelchairs, crutches, powered mattress systems, diabetic supplies, hospital beds ordered by a provider for use in the home, IV infusion pumps, speech generating devices, oxygen equipment, nebulizers, and walkers.

We cover all medically necessary DME covered by Original Medicare. If our supplier in your area does not carry a particular brand or manufacturer, you may ask them if they can special order it for you. The most recent list of suppliers is available on our website at www.ProvidenceHealthAssurance.com/findaprovider under “Medical Supplies.” Our DME supplier in your area is Providence Home Services. They can be reached at 1-800-762-1253.

*This service may require prior authorization. See Section 2.1 of this chapter for details.
### Emergency care

Emergency care refers to services that are:

- Furnished by a provider qualified to furnish emergency services, and
- Needed to evaluate or stabilize an emergency medical condition.

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

Cost sharing for necessary emergency services furnished out-of-network is the same as for such services furnished in-network.

You have worldwide emergency coverage. Please see the “Worldwide emergency/urgent care” section of this medical benefits chart for details.

<table>
<thead>
<tr>
<th>Services that are covered for you</th>
<th>What you must pay when you get these services</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Emergency care</strong></td>
<td>$70 copayment for each Medicare-covered emergency room visit.</td>
</tr>
<tr>
<td>Emergency care refers to services that are:</td>
<td>If you are admitted to the hospital within 24 hours of your emergency room visit, you do not have to pay the emergency room copayment.</td>
</tr>
<tr>
<td>• Furnished by a provider qualified to furnish emergency services, and</td>
<td>If you receive emergency care at an out-of-network hospital and need inpatient care after your emergency condition is stabilized, you must have your inpatient care at the out-of-network hospital authorized by the plan and your cost is the cost sharing you would pay at a network hospital.</td>
</tr>
<tr>
<td>• Needed to evaluate or stabilize an emergency medical condition.</td>
<td>See the “Inpatient hospital services” section of this medical benefits chart for inpatient cost-sharing information.</td>
</tr>
</tbody>
</table>
## Services that are covered for you

### What you must pay when you get these services

<table>
<thead>
<tr>
<th>Services that are covered for you</th>
<th>What you must pay when you get these services</th>
</tr>
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</table>

**Fitness benefit**

The Silver&Fit® Healthy Aging and Exercise program is offered to Providence Medicare Focus Medical (HMO) members. Take control of your health and feel your best with a variety of digital and in-person resources. As a Silver&Fit member, you get the following at low or no cost to you:

- **Workout Plans:** Answer a few online questions about your areas of interest to receive a customized workout plan, including instructions on how to get started and suggested digital workout videos.
- **Digital Workouts:** View on-demand videos through the website and mobile app’s digital workout library, including Silver&Fit Signature Series Classes®.
- **Fitness Center Membership:** Visit a local fitness center or YMCA that takes part in the program.* Aside from exercise equipment, many participating fitness centers offer low-impact classes focused on improving muscular strength and endurance, mobility, flexibility, range of motion, balance, agility, and coordination. You also have access to the Premium Fitness Network, which allows you to use additional fitness centers, studios, and unique spaces like swimming centers, rock climbing gyms, and rowing centers, with a buy-up price for each.
- **Home Fitness Kits:** Receive one Home Fitness Kit per calendar year from a variety of fitness categories.
- **Well-Being Club:** Set your preferences for well-being topics on the website to see resources tailored to your interests and healthy-habit goals, including articles, videos, live-streaming classes, and meetups.**
- **Silver&Fit Connected!™:** The Silver&Fit Connected! tool will help you track your physical activity.
- **Rewards:** Earn a hat and pins for reaching new activity milestones.

The Silver&Fit program has Something for Everyone®!

Ready to get started? If you have any questions, need help finding a participating fitness center, or want to enroll in the program, please visit the Silver&Fit website at [www.SilverandFit.com](http://www.SilverandFit.com), or call Customer Service at 1-888-354-4863. TTY users should call 711.

* There is no coinsurance, copayment, or deductible for the standard fitness benefit.

** The premium fitness benefit is available for an additional monthly cost.
<table>
<thead>
<tr>
<th>Services that are covered for you</th>
<th>What you must pay when you get these services</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Fitness benefit (continued)</strong></td>
<td></td>
</tr>
<tr>
<td>*Non-standard membership services that call for an added fee are not part of the Silver&amp;Fit program and will not be reimbursed. **ASH Fitness has no affiliations, interest, endorsements, or sponsorships with any of the organizations or clubs. Some clubs may require a fee to join. Such fees are not part of the Silver&amp;Fit programs and will not be reimbursed by ASH Fitness. The Silver&amp;Fit program is provided by American Specialty Health Fitness, Inc., a subsidiary of American Specialty Health Incorporated (ASH). Silver&amp;Fit, Silver&amp;Fit Signature Series Classes, Silver&amp;Fit Connected!, and Something for Everyone are trademarks of ASH. Limitations, member fees, and restrictions may apply. Participating facilities and fitness chains may vary by location and are subject to change. Kits and rewards are subject to change.</td>
<td></td>
</tr>
</tbody>
</table>

**Health and wellness education programs**

**Care Management**

Our Care Management Team offers empowering programs for a variety of health conditions, including Chronic Obstructive Pulmonary Disorder (COPD), rare disease management, Congestive Heart Failure (CHF), diabetes, asthma, cancer, pain management, End Stage Renal Disease (ESRD), and more. These programs give you the tools and resources necessary to live a healthy, balanced life. For more information, please call 503-574-7247 or 1-800-662-1121 (toll-free). TTY users should call 711.

**Nurse Hotline**

Dealing with a potentially urgent medical situation? ProvRN is available 24 hours a day, 7 days a week. Registered nurses will help you determine your next steps, from taking a pain reliever to visiting an urgent care location. Whether you’re calling about yourself or your child, our nurses can help. Simply call 503-574-6520 or 1-800-700-0481 to get started.

There is no coinsurance, copayment, or deductible for Care Management programs.

There is no coinsurance, copayment, or deductible for the nurse hotline.
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<tr>
<th>Services that are covered for you</th>
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<tbody>
<tr>
<td><strong>Health and wellness education programs (continued)</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Remote Access Technology</strong></td>
<td>There is no coinsurance, copayment, or deductible for non-Medicare-covered remote access technology services.</td>
</tr>
<tr>
<td>We provide access to in-network providers via</td>
<td></td>
</tr>
<tr>
<td>• Telephonic visits for medication and disease management services, like when you call ProvRN</td>
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</tr>
<tr>
<td>• Emails through an application, like when you send your care team a message in MyChart</td>
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</tr>
<tr>
<td>• A dedicated, web-based platform for same-day medical appointments, like when you visit Providence ExpressCare Virtual on a tablet, smartphone, or computer</td>
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</tr>
<tr>
<td><strong>Smoking Cessation</strong></td>
<td></td>
</tr>
<tr>
<td>We cover the “Quit for Life” telephonic program, including program supplies like nicotine replacement therapy. Ready for 12 months of support? Call 1-866-784-8454 to enroll.</td>
<td>There is no coinsurance, copayment, or deductible for “Quit for Life” smoking cessation program.</td>
</tr>
<tr>
<td><strong>Health Coaching</strong></td>
<td></td>
</tr>
<tr>
<td>Want to look and feel your best? How about establish a consistent lifestyle? We cover up to 12 telephonic health coaching sessions per calendar year. Work with certified health coaches to set goals and stay motivated throughout your health and wellness journey. Our coaches offer individualized support in a variety of areas, including, but not limited to, exercise, nutrition, stress, weight management, sleep, tobacco cessation, and diabetes prevention. For more information about this benefit or to enroll, call the Providence Health Coaching Team at 503-574-6000 or 1-888-819-8999. Hours are 7:00 a.m. to 6:00 p.m. (Pacific Time), Monday through Friday.</td>
<td>There is no coinsurance, copayment, or deductible for up to 12 telephonic health coaching visits.</td>
</tr>
<tr>
<td><strong>Health and Wellness Classes</strong></td>
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</tr>
<tr>
<td>We cover educational health and wellness classes on a variety of topics, including weight management, stress reduction, fall prevention, pain education, urinary incontinence-pelvic floor, osteoporosis, yoga, smoking cessation, progressive disorders, and nutrition. Classes offered virtually can be accessed through participating facilities. For more information, please call the Providence Resource Line at 503-216-7969 or 1-800-562-8964 (toll-free).</td>
<td>There is no coinsurance, copayment, or deductible for health and wellness classes.</td>
</tr>
<tr>
<td>Services that are covered for you</td>
<td>What you must pay when you get these services</td>
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<td>---------------------------------------------</td>
</tr>
<tr>
<td><strong>Hearing services</strong></td>
<td></td>
</tr>
<tr>
<td>Diagnostic hearing and balance evaluations performed by your provider to determine if you need medical treatment are covered as outpatient care when furnished by a physician, audiologist, or other qualified provider.</td>
<td>$20 copayment for Medicare-covered diagnostic hearing exams.</td>
</tr>
<tr>
<td><strong>Please note:</strong> A separate cost sharing may apply if additional services are provided.</td>
<td></td>
</tr>
<tr>
<td><strong>Routine hearing services</strong></td>
<td></td>
</tr>
<tr>
<td>You may also receive one routine hearing exam from a TruHearing provider per calendar year. You do not need a referral for this exam.</td>
<td>There is no coinsurance, copayment, or deductible for one routine hearing exam with a TruHearing provider.*</td>
</tr>
<tr>
<td><strong>Hearing Aids:</strong></td>
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</tr>
<tr>
<td>• Up to two TruHearing-branded hearing aids every year (one for each ear).</td>
<td>$399 copayment per Advanced hearing aid.*</td>
</tr>
<tr>
<td>This benefit is limited to TruHearing’s Advanced and Premium hearing aids, which come in a variety of styles and colors to customize your look and feel. Rechargeable options are also available for an additional $50 per aid. Please keep in mind that you must see a TruHearing provider to use this benefit. Ready to get started? Call 1-855-205-6201 to schedule an appointment. TTY users should call 711.</td>
<td>$699 copayment per Premium hearing aid.*</td>
</tr>
<tr>
<td></td>
<td>$50 additional fee per rechargeable hearing aid.</td>
</tr>
<tr>
<td>*Cost-sharing amounts for routine hearing exam and hearing aids do not count toward your plan's out-of-pocket maximum.</td>
<td></td>
</tr>
<tr>
<td>Services that are covered for you</td>
<td>What you must pay when you get these services</td>
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<td>---------------------------------------------</td>
</tr>
<tr>
<td><strong>Hearing services (continued)</strong></td>
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</tr>
<tr>
<td>Hearing aid purchase includes:</td>
<td></td>
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<tr>
<td>• One year of follow-up provider visits from the date of purchase</td>
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<tr>
<td>• 60-day trial period</td>
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<tr>
<td>• 3-year extended warranty</td>
<td></td>
</tr>
<tr>
<td>• 80 batteries per aid for non-rechargeable models</td>
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</tr>
<tr>
<td>Hearing aid benefit does not include or cover any of the following:</td>
<td></td>
</tr>
<tr>
<td>• Additional fee for rechargeable hearing aids</td>
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</tr>
<tr>
<td>• Ear molds</td>
<td></td>
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<tr>
<td>• Hearing aid accessories</td>
<td></td>
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<tr>
<td>• Additional provider visits</td>
<td></td>
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<tr>
<td>• Additional batteries for non-rechargeable hearing aids</td>
<td></td>
</tr>
<tr>
<td>• Any batteries for rechargeable hearing aids</td>
<td></td>
</tr>
<tr>
<td>• Any hearing aids aside from TruHearing’s Advanced and Premium aids</td>
<td></td>
</tr>
<tr>
<td>• Costs associated with loss and damage warranty claims</td>
<td></td>
</tr>
<tr>
<td>Costs associated with excluded items are the responsibility of the member and are not covered by the plan.</td>
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</tbody>
</table>

**HIV screening**

For people who ask for an HIV screening test or who are at increased risk for HIV infection, we cover:

- One screening exam every 12 months

For women who are pregnant, we cover:

- Up to three screening exams during a pregnancy

**Please note:** If you are treated or monitored for an existing medical condition during the visit when you receive this preventive service, a copayment or coinsurance may apply for the care received for the existing medical condition.

There is no coinsurance, copayment, or deductible for members eligible for Medicare-covered preventive HIV screening.
### Home health agency care*

Prior to receiving home health services, a doctor must certify that you need home health services and will order home health services to be provided by a home health agency. You must be homebound, which means leaving home is a major effort.

Covered services include, but are not limited to:
- Part-time or intermittent skilled nursing and home health aide services (To be covered under the home health care benefit, your skilled nursing and home health aide services combined must total fewer than 8 hours per day and 35 hours per week)
- Physical therapy, occupational therapy, and speech therapy
- Medical and social services
- Medical equipment and supplies

*This service may require prior authorization. See Section 2.1 of this chapter for details.

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<thead>
<tr>
<th>Services that are covered for you</th>
<th>What you must pay when you get these services</th>
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<tbody>
<tr>
<td><strong>Home health agency care</strong></td>
<td>There is no coinsurance, copayment, or deductible for each Medicare-covered home health visit. However, the applicable cost sharing listed elsewhere in this medical benefits chart will apply if the item is covered under a different benefit. For example, durable medical equipment not provided by a home health agency.</td>
</tr>
<tr>
<td>Prior to receiving home health services, a doctor must certify that you need home health services and will order home health services to be provided by a home health agency. You must be homebound, which means leaving home is a major effort. Covered services include, but are not limited to: Part-time or intermittent skilled nursing and home health aide services (To be covered under the home health care benefit, your skilled nursing and home health aide services combined must total fewer than 8 hours per day and 35 hours per week), Physical therapy, occupational therapy, and speech therapy, Medical and social services, Medical equipment and supplies.</td>
<td>All home health care and services must be provided by Providence Home Services or other plan-authorized provider.</td>
</tr>
</tbody>
</table>
## Home infusion therapy*

Home infusion therapy involves the intravenous or subcutaneous administration of drugs or biologicals to an individual at home. The components needed to perform home infusion include the drug (for example, antivirals, immune globulin), equipment (for example, a pump), and supplies (for example, tubing and catheters).

Covered services include, but are not limited to:

- Professional services, including nursing services, furnished in accordance with the plan of care
- Patient training and education not otherwise covered under the durable medical equipment benefit
- Remote monitoring
- Monitoring services for the provision of home infusion therapy and home infusion drugs furnished by a qualified home infusion therapy supplier

Non-preferred Part B drugs may be subject to Step Therapy. The most current list of Part B drugs subject to Step Therapy can be found on our website, [www.providencehealthplan.com/medicare/medicare-advantage-plans/members](http://www.providencehealthplan.com/medicare/medicare-advantage-plans/members).

**Please note:** A separate cost sharing may apply for professional fees.

*This service may require prior authorization. See Section 2.1 of this chapter for details.
### Hospice care

You are eligible for the hospice benefit when your doctor and the hospice medical director have given you a terminal prognosis certifying that you’re terminally ill and have 6 months or less to live if your illness runs its normal course. You may receive care from any Medicare-certified hospice program. Your plan is obligated to help you find Medicare-certified hospice programs in the plan’s service area, including those the MA organization owns, controls, or has a financial interest in. Your hospice doctor can be a network provider or an out-of-network provider.

Covered services include:

- Drugs for symptom control and pain relief
- Short-term respite care
- Home care

When you are admitted to a hospice, you have the right to remain in your plan; if you chose to remain in your plan, you must continue to pay plan premiums.

For hospice services and for services that are covered by Medicare Part A or B and are related to your terminal prognosis: Original Medicare (rather than our plan) will pay your hospice provider for your hospice services and any Part A and Part B services related to your terminal prognosis. While you are in the hospice program, your hospice provider will bill Original Medicare for the services that Original Medicare pays for. You will be billed Original Medicare cost sharing.

For services that are covered by Medicare Part A or B and are not related to your terminal prognosis:

If you need non-emergency, non-urgently needed services that are covered under Medicare Part A or B and that are not related to your terminal prognosis, your cost for these services depends on whether you use a provider in our plan’s network and follow plan rules (such as if there is a requirement to obtain prior authorization).

<table>
<thead>
<tr>
<th>Services that are covered for you</th>
<th>What you must pay when you get these services</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospice care</td>
<td>When you enroll in a Medicare-certified hospice program, your hospice services and your Part A and Part B services related to your terminal prognosis are paid for by Original Medicare, not Providence Medicare Focus Medical (HMO). You must get care from a Medicare-certified hospice provider. An additional cost sharing may apply for hospice consultation services provided during an inpatient hospital stay. A separate cost sharing may apply for drugs and respite care. Our plan covers hospice consultation services (one time only) for a terminally ill person who hasn’t elected the hospice benefit. There is no coinsurance, copayment, or deductible for hospice consultation services obtained in a primary care provider’s office. $20 copayment for hospice consultation services obtained in a specialist’s office.</td>
</tr>
<tr>
<td>Hospice care</td>
<td></td>
</tr>
</tbody>
</table>
### Immunizations

Covered Medicare Part B services include:

- Pneumonia vaccine
- Flu shots, once each flu season in the fall and winter, with additional flu shots if medically necessary
- Hepatitis B vaccine if you are at high or intermediate risk of getting Hepatitis B
- COVID-19 vaccine
- Other vaccines if you are at risk and they meet Medicare Part B coverage rules

**Please note:** If you are treated or monitored for an existing medical condition during the visit when you receive this preventive service, a copayment or coinsurance may apply for the care received for the existing medical condition.

There is no coinsurance, copayment, or deductible for the pneumonia, influenza, Hepatitis B, and COVID-19 vaccines.

There is no coinsurance, copayment, or deductible for all other Medicare-covered Part B immunizations.

You must go to a Medicare provider for your flu and/or pneumonia shot.

You can get most immunizations at your local pharmacy.
### Inpatient hospital care*

Includes inpatient acute, inpatient rehabilitation, long-term care hospitals and other types of inpatient hospital services. Inpatient hospital care starts the day you are formally admitted to the hospital with a doctor’s order. The day before you are discharged is your last inpatient day.

Except in an emergency, your provider must tell us that you are going to be admitted to the hospital.

Covered services include, but are not limited to:

- Semi-private room (or a private room if medically necessary)
- Meals, including special diets
- Regular nursing services
- Costs of special care units (such as intensive care or coronary care units)
- Drugs and medications
- Lab tests
- X-rays and other radiology services
- Necessary surgical and medical supplies
- Use of appliances, such as wheelchairs
- Operating and recovery room costs
- Physical, occupational, and speech language therapy
- Inpatient substance abuse services
- Under certain conditions, the following types of transplants are covered: corneal, kidney, kidney-pancreatic, heart, liver, lung, heart/lung, bone marrow, stem cell, and intestinal/multivisceral. If you need a transplant, we will arrange to have your case reviewed by a Medicare-approved transplant center that will decide whether you are a candidate for a transplant.

<table>
<thead>
<tr>
<th>Services that are covered for you</th>
<th>What you must pay when you get these services</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inpatient hospital care*</td>
<td>For days 1-5, you pay a $250 copayment each day for each Medicare-covered inpatient hospital stay. For day 6 and beyond, there is no coinsurance, copayment, or deductible for each Medicare-covered inpatient hospital stay.</td>
</tr>
<tr>
<td></td>
<td>For inpatient hospital care, the cost sharing described above applies each time you are admitted to the hospital. Cost sharing is charged for each inpatient stay. A transfer to a separate facility type is considered a new admission. For each inpatient hospital stay, you are covered for unlimited days as long as the stay is covered in accordance with plan rules. Medicare hospital benefit periods do not apply.</td>
</tr>
<tr>
<td>Services that are covered for you</td>
<td>What you must pay when you get these services</td>
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<td>----------------------------------</td>
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</tbody>
</table>
| **Inpatient hospital care** (continued)  
Transplant providers may be local or outside of the service area. If our in-network transplant services are outside the community pattern of care, you may choose to go locally as long as the local transplant providers are willing to accept the Original Medicare rate. If Providence Medicare Focus Medical (HMO) provides transplant services at a location outside the pattern of care for transplants in your community and you choose to obtain transplants at this distant location, we will arrange or pay for appropriate lodging and transportation costs for you and a companion. Travel expenses are subject to prior authorization and eligibility of the recipient. The total maximum reimbursement allowed for transplant travel is $5,000. Food and lodging expenses are limited to up to $150 per day and apply to the $5,000 maximum.  
• Blood - including storage and administration. Coverage of whole blood and packed red cells begins with the first pint of blood that you need. All other components of blood are also covered beginning with the first pint used.  
• Physician services  
**Note:** To be an inpatient, your provider must write an order to admit you formally as an inpatient of the hospital. Even if you stay in the hospital overnight, you might still be considered an “outpatient.” If you are not sure if you are an inpatient or an outpatient, you should ask the hospital staff.  
You can also find more information in a Medicare fact sheet called “Are You a Hospital Inpatient or Outpatient? If You Have Medicare – Ask!” This fact sheet is available on the Web at https://www.medicare.gov/sites/default/files/2021-10/11435-Inpatient-or-Outpatient.pdf or by calling 1-800-MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048. You can call these numbers for free, 24 hours a day, 7 days a week.  
*This service may require prior authorization. See Section 2.1 of this chapter for details.  

Please note: If you receive take-home supplies or any items unrelated to the condition you are being treated for, you may be responsible for the costs.  
If you get authorized inpatient care at an out-of-network hospital after your emergency condition is stabilized, your cost is the cost sharing you would pay at a network hospital.
### Inpatient services in a psychiatric hospital*

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

You get up to 190 days of Medicare-covered inpatient psychiatric hospital care in a lifetime. Please keep in mind that the number of covered lifetime hospitalization days never resets. For example, if Medicare previously paid for you to stay in an inpatient psychiatric hospital for 100 days, then your plan will only pay for up to 90 days of a future stay. The 190-day limit does not apply to inpatient mental health services provided in a psychiatric unit of a general hospital.

Except in an emergency, your provider must tell us that you are going to be admitted to the hospital.

Mental health services are managed by Providence Health Assurance. Providence Health Assurance must be contacted for authorizations.

*This service may require prior authorization. See Section 2.1 of this chapter for details.

<table>
<thead>
<tr>
<th>Services that are covered for you</th>
<th>What you must pay when you get these services</th>
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</thead>
<tbody>
<tr>
<td><strong>Inpatient services in a psychiatric hospital</strong></td>
<td>For days 1-7, you pay a $200 copayment each day for each Medicare-covered inpatient psychiatric hospital stay.</td>
</tr>
<tr>
<td>Covered services include mental health care services that require a hospital stay.</td>
<td>For days 8-90, there is no coinsurance, copayment, or deductible for each Medicare-covered inpatient psychiatric hospital stay.</td>
</tr>
<tr>
<td>You get up to 190 days of Medicare-covered inpatient psychiatric hospital care in a lifetime. Please keep in mind that the number of covered lifetime hospitalization days never resets. For example, if Medicare previously paid for you to stay in an inpatient psychiatric hospital for 100 days, then your plan will only pay for up to 90 days of a future stay. The 190-day limit does not apply to inpatient mental health services provided in a psychiatric unit of a general hospital.</td>
<td>For inpatient mental health care, the cost sharing described above applies each time you are admitted to the hospital. Cost sharing is charged for each inpatient stay. A transfer to a separate facility type is considered a new admission. Medicare hospital benefit periods do not apply.</td>
</tr>
<tr>
<td>Except in an emergency, your provider must tell us that you are going to be admitted to the hospital.</td>
<td></td>
</tr>
<tr>
<td>Services that are covered for you</td>
<td>What you must pay when you get these services</td>
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<td>-------------------------------------------------------------------------------------------------</td>
<td>---------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td><strong>Inpatient stay: Covered services received in a hospital or SNF during a non-covered inpatient stay</strong>*</td>
<td>The services and supplies listed to the left will continue to be covered at the cost sharing described in their respective sections of this medical benefits chart. For example, physical therapy will be covered at the cost-sharing amount under “Outpatient rehabilitation services.”</td>
</tr>
<tr>
<td>If you have exhausted your inpatient benefits or if the inpatient stay is not reasonable and necessary, we will not cover your inpatient stay. However, in some cases, we will cover certain services you receive while you are in the hospital or the skilled nursing facility (SNF). Covered services include, but are not limited to:</td>
<td></td>
</tr>
<tr>
<td>• Physician services</td>
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<tr>
<td>• Diagnostic tests (like lab tests)</td>
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<tr>
<td>• X-ray, radium, and isotope therapy including technician materials and services</td>
<td></td>
</tr>
<tr>
<td>• Surgical dressings</td>
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<tr>
<td>• Splints, casts and other devices used to reduce fractures and dislocations</td>
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<tr>
<td>• Prosthetics and orthotics devices (other than dental) that replace all or part of an internal body organ (including contiguous tissue), or all or part of the function of a permanently inoperative or malfunctioning internal body organ, including replacement or repairs of such devices</td>
<td></td>
</tr>
<tr>
<td>• 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</td>
<td></td>
</tr>
<tr>
<td>• Physical therapy, speech therapy, and occupational therapy</td>
<td></td>
</tr>
<tr>
<td><strong>This service may require prior authorization. See Section 2.1 of this chapter for details.</strong></td>
<td></td>
</tr>
</tbody>
</table>
# Meal delivery program (for post-discharge only)

We cover up to 28 meals over a 14-day period. This benefit can be used immediately following your discharge from an Inpatient Acute Hospital, Inpatient Psychiatric Hospital, or SNF (if the preceding event is a qualified inpatient hospital stay). All meals will be delivered directly to your home, and you may be eligible to receive meals to help you manage or recover from your specific health conditions or injuries.

**Benefit guidelines:**
- First meal delivery may take up to three business days after ordered
- Observation stays do not qualify for this meal benefit
- Meals must be ordered through our meal delivery vendor, Mom’s Meals
- Some restrictions and limitations may apply

For general program information, please visit [www.ProvidenceHealthAssurance.com/momsmeals](http://www.ProvidenceHealthAssurance.com/momsmeals). No action is required on your part to initiate this benefit as Mom’s Meals will contact eligible members directly. If you decline this benefit but later change your mind, please call Customer Service at 503-574-8000 or 1-800-603-2340. TTY users should call 711.

<table>
<thead>
<tr>
<th>Services that are covered for you</th>
<th>What you must pay when you get these services</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Meal delivery program</strong></td>
<td>There is no coinsurance, copayment, or deductible for non-Medicare-covered meal delivery program. Coverage is limited to two meals per day for 14 days (28 meals total) following each inpatient hospitalization.</td>
</tr>
<tr>
<td>(for post-discharge only)</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Services that are covered for you</td>
<td>What you must pay when you get these services</td>
</tr>
<tr>
<td>---------------------------------</td>
<td>-----------------------------------------------</td>
</tr>
<tr>
<td><strong>Medical nutrition therapy</strong></td>
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</tr>
<tr>
<td>This benefit is for people with diabetes, renal (kidney) disease (but not on dialysis), or after a kidney transplant when ordered by your doctor. We cover 3 hours of one-on-one counseling services during your first year that you receive medical nutrition therapy services under Medicare (this includes our plan, any other Medicare Advantage plan, or Original Medicare), and 2 hours each year after that. If your condition, treatment, or diagnosis changes, you may be able to receive more hours of treatment with a physician’s order. A physician must prescribe these services and renew their order yearly if your treatment is needed into the next calendar year. We cover medical nutrition therapy prescribed by a physician regardless of your condition or diagnosis. <strong>Please note:</strong> If you are treated or monitored for an existing medical condition during the visit when you receive this preventive service, a copayment or coinsurance may apply for the care received for the existing medical condition. There is no coinsurance, copayment, or deductible for members eligible for Medicare-covered medical nutrition therapy services.</td>
<td>There is no coinsurance, copayment, or deductible for members eligible for Medicare-covered medical nutrition therapy services.</td>
</tr>
<tr>
<td><strong>Medicare Diabetes Prevention Program (MDPP)</strong></td>
<td></td>
</tr>
<tr>
<td>MDPP services will be covered for eligible Medicare beneficiaries under all Medicare health plans. MDPP is a structured health behavior change intervention that provides practical training in long-term dietary change, increased physical activity, and problem-solving strategies for overcoming challenges to sustaining weight loss and a healthy lifestyle.</td>
<td>There is no coinsurance, copayment, or deductible for the MDPP benefit.</td>
</tr>
</tbody>
</table>
## Services that are covered for you

### Medicare Part B prescription drugs*

These drugs are covered under Part B of Original Medicare. Members of our plan receive coverage for these drugs through our plan. Covered drugs include:

- Drugs that usually aren’t self-administered by the patient and are injected or infused while you are getting physician, hospital outpatient, or ambulatory surgical center services
- Drugs you take using durable medical equipment (such as nebulizers) that were authorized by the plan
- Clotting factors you give yourself by injection if you have hemophilia
- Immunosuppressive Drugs, if you were enrolled in Medicare Part A at the time of the organ transplant
- Injectable osteoporosis drugs, if you are homebound, have a bone fracture that a doctor certifies was related to post-menopausal osteoporosis, and cannot self-administer the drug
- Antigens
- Certain oral anti-cancer drugs and anti-nausea drugs

### What you must pay when you get these services

20% of the total cost for Medicare-covered Part B chemotherapy and radiation drugs and other Part B drugs. A separate cost sharing may apply for the administration of Medicare-covered Part B prescription drugs. Medicare Part B prescription drugs may be subject to step therapy.
### Services that are covered for you

<table>
<thead>
<tr>
<th>Medicare Part B prescription drugs* (continued)</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Certain drugs for home dialysis, including heparin, the antidote for heparin when medically necessary, topical anesthetics, and erythropoiesis-stimulating agents (such as Epogen®, Procrit®, Epoetin Alfa, Aranesp®, or Darbepoetin Alfa)</td>
</tr>
<tr>
<td>- Intravenous Immune Globulin for the home treatment of primary immune deficiency diseases</td>
</tr>
</tbody>
</table>

The following link will take you to a list of Part B Drugs that may be subject to Step Therapy: [www.providencehealthplan.com/medicare/medicare-advantage-plans/members](http://www.providencehealthplan.com/medicare/medicare-advantage-plans/members) then click on “Pharmacy and Formulary Information.”

We also cover some vaccines under our Part B prescription drug benefit.

*This service may require prior authorization. See Section 2.1 of this chapter for details.

### Naturopathic services+

Routine naturopathic services are covered when they are:

- Received from a qualified licensed naturopathic physician who is practicing within the scope of their license
- Determined by your plan to be medically necessary
- Not listed as an exclusion

<table>
<thead>
<tr>
<th>What you must pay when you get these services</th>
</tr>
</thead>
<tbody>
<tr>
<td>$20 copayment for each naturopathic visit.</td>
</tr>
<tr>
<td>Plan covers up to $500 every year for routine chiropractic, acupuncture, and naturopathic services combined.</td>
</tr>
</tbody>
</table>

*The cost-sharing amount for naturopathic services does not count toward your plan’s out-of-pocket maximum.*
### Services that are covered for you

<table>
<thead>
<tr>
<th>Services that are covered for you</th>
<th>What you must pay when you get these services</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Obesity screening and therapy to promote sustained weight loss</strong></td>
<td></td>
</tr>
</tbody>
</table>
| If you have a body mass index of 30 or more, we cover intensive counseling to help you lose weight. This counseling is covered if you get it in a primary care setting, where it can be coordinated with your comprehensive prevention plan. Talk to your primary care doctor or practitioner to find out more.  
Please note: If you are treated or monitored for an existing medical condition during the visit when you receive this preventive service, a copayment or coinsurance may apply for the care received for the existing medical condition. | There is no coinsurance, copayment, or deductible for preventive obesity screening and therapy. |
| **Opioid treatment program services**                                                          |                                               |
| Members of our plan with opioid use disorder (OUD) can receive coverage of services to treat OUD through an Opioid Treatment Program (OTP) which includes the following services:  
- U.S. Food and Drug Administration (FDA)-approved opioid agonist and antagonist medication-assisted treatment (MAT) medications.  
- Dispensing and administration of MAT medications (if applicable)  
- Substance use counseling  
- Individual and group therapy  
- Toxicology testing  
- Intake activities  
- Periodic assessments  
Please note: A separate cost sharing may apply if additional services are provided.  
*This service may require prior authorization. See Section 2.1 of this chapter for details. | There is no coinsurance, copayment, or deductible for Medicare-covered opioid treatment program services. |
## Outpatient diagnostic tests and therapeutic services and supplies*

Covered services include, but are not limited to:

<table>
<thead>
<tr>
<th>Services</th>
<th>What you must pay when you get these services</th>
</tr>
</thead>
<tbody>
<tr>
<td>X-rays</td>
<td>There is no coinsurance, copayment, or deductible for Medicare-covered x-rays.</td>
</tr>
<tr>
<td>Radiation (radium and isotope) therapy</td>
<td>15% of the total cost for Medicare-covered therapeutic radiology services and supplies.</td>
</tr>
<tr>
<td>Special imaging procedures, such as MRI, CT, and PET scans. All special imaging procedures need to be coordinated by your ordering provider through American Imaging Management (AIM).</td>
<td>15% of the total cost for Medicare-covered special imaging procedures and special diagnostic tests.</td>
</tr>
<tr>
<td>Special diagnostic tests, such as ultrasounds and Holter monitoring</td>
<td></td>
</tr>
</tbody>
</table>
### Services that are covered for you

<table>
<thead>
<tr>
<th>Outpatient diagnostic tests and therapeutic services and supplies* (continued)</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Surgical supplies, such as dressings</td>
</tr>
<tr>
<td>• Splints, casts, and other devices used to reduce fractures and dislocations</td>
</tr>
<tr>
<td>• Laboratory tests</td>
</tr>
<tr>
<td>• Blood - including storage and administration. Coverage of whole blood and packed red cells begins with the first pint of blood that you need. All other components of blood are also covered beginning with the first pint used.</td>
</tr>
<tr>
<td>• Other outpatient diagnostic tests and procedures</td>
</tr>
</tbody>
</table>

### What you must pay when you get these services

- 20% of the total cost for Medicare-covered dressings and supplies, splints, casts, and other devices used to reduce fractures and dislocations. These must be provided by Providence Home Services or other network provider.

- There is no coinsurance, copayment, or deductible for Medicare-covered lab services and blood services.

- 20% of the total cost for other Medicare-covered diagnostic tests and procedures.

**Please note:** A separate cost sharing may apply if you receive any services aside from the Medicare-covered lab, blood, or other diagnostic tests and procedures described above.

*This service may require prior authorization. See Section 2.1 of this chapter for details.
### Outpatient hospital observation*

Observation services are hospital outpatient services given to determine if you need to be admitted as an inpatient or can be discharged.

For outpatient hospital observation services to be covered, they must meet the Medicare criteria and be considered reasonable and necessary. Observation services are covered only when provided by the order of a physician or another individual authorized by state licensure law and hospital staff bylaws to admit patients to the hospital or order outpatient tests.

**Note:** Unless the provider has written an order to admit you as an inpatient to the hospital, you are an outpatient and pay the cost-sharing amounts for outpatient hospital services. Even if you stay in the hospital overnight, you might still be considered an “outpatient.” If you are not sure if you are an outpatient, you should ask the hospital staff.

You can also find more information in a Medicare fact sheet called “Are You a Hospital Inpatient or Outpatient? If You Have Medicare – Ask!” This fact sheet is available on the Web at [https://www.medicare.gov/sites/default/files/2021-10/11435-Inpatient-or-Outpatient.pdf](https://www.medicare.gov/sites/default/files/2021-10/11435-Inpatient-or-Outpatient.pdf) or by calling 1-800-MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048. You can call these numbers for free, 24 hours a day, 7 days a week.

*This service may require prior authorization. See Section 2.1 of this chapter for details.

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<tr>
<th>Services that are covered for you</th>
<th>What you must pay when you get these services</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Outpatient hospital observation</strong></td>
<td>$70 copayment for Medicare-covered observation services.</td>
</tr>
</tbody>
</table>
## Services that are covered for you

<table>
<thead>
<tr>
<th>Outpatient hospital services*</th>
</tr>
</thead>
<tbody>
<tr>
<td>We cover medically-necessary services you get in the outpatient department of a hospital for diagnosis or treatment of an illness or injury. Covered services include, but are not limited to:</td>
</tr>
<tr>
<td>- Services in an emergency department or outpatient clinic, such as observation services or outpatient surgery</td>
</tr>
<tr>
<td><strong>Please note:</strong> A separate cost sharing may apply for professional fees.</td>
</tr>
<tr>
<td>- Laboratory and diagnostic tests billed by the hospital</td>
</tr>
<tr>
<td>- Mental health care, including care in a partial-hospitalization program, if a doctor certifies that inpatient treatment would be required without it</td>
</tr>
<tr>
<td>- X-rays and other radiology services billed by the hospital</td>
</tr>
</tbody>
</table>

## What you must pay when you get these services

| - $70 copayment for each Medicare-covered emergency room visit. |
| - $70 copayment for Medicare-covered observation services. |
| - $250 copayment for each Medicare-covered outpatient hospital surgical service. |
| - There is no facility fee for outpatient clinic visits. |
| - There is no coinsurance, copayment, or deductible for Medicare-covered lab services and blood services. |
| - 20% of the total cost for other Medicare-covered diagnostic tests and procedures. |
| - There is no coinsurance, copayment, or deductible for Medicare-covered partial hospitalization program services. |
| - There is no coinsurance, copayment, or deductible for Medicare-covered x-rays. |
| - 15% of the total cost for Medicare-covered radiology services. |
| - 15% of the total cost for Medicare-covered special imaging procedures and special diagnostic tests. |
### Services that are covered for you

<table>
<thead>
<tr>
<th>What you must pay when you get these services</th>
</tr>
</thead>
<tbody>
<tr>
<td>Outpatient hospital services* (continued)</td>
</tr>
<tr>
<td>• Medical supplies such as splints and casts</td>
</tr>
<tr>
<td>• Certain drugs and biologicals that you can’t give yourself</td>
</tr>
</tbody>
</table>

**Note:** Unless the provider has written an order to admit you as an inpatient to the hospital, you are an outpatient and pay the cost-sharing amounts for outpatient hospital services. Even if you stay in the hospital overnight, you might still be considered an “outpatient.” If you are not sure if you are an outpatient, you should ask the hospital staff.

You can also find more information in a Medicare fact sheet called “Are You a Hospital Inpatient or Outpatient? If You Have Medicare – Ask!” This fact sheet is available on the Web at [https://www.medicare.gov/sites/default/files/2021-10/11435-Inpatient-or-Outpatient.pdf](https://www.medicare.gov/sites/default/files/2021-10/11435-Inpatient-or-Outpatient.pdf) or by calling 1-800-MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048. You can call these numbers for free, 24 hours a day, 7 days a week.

*This service may require prior authorization. See Section 2.1 of this chapter for details.

### Outpatient mental health care*

**Covered services include:**

Mental health services provided by a state-licensed psychiatrist or doctor, clinical psychologist, clinical social worker, clinical nurse specialist, nurse practitioner, physician assistant, or other Medicare-qualified mental health care professional as allowed under applicable state laws.

Mental health services are managed by Providence Health Assurance. Providence Health Assurance must be contacted for authorizations.

*This service may require prior authorization. See Section 2.1 of this chapter for details.

$20 copayment for each Medicare-covered individual or group therapy visit.

There is no coinsurance, copayment, or deductible for Medicare-covered partial hospitalization program services.
<table>
<thead>
<tr>
<th>Services that are covered for you</th>
<th>What you must pay when you get these services</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Outpatient rehabilitation services</strong>*</td>
<td></td>
</tr>
<tr>
<td>Covered services include: physical therapy, occupational therapy, and speech language therapy.</td>
<td>$20 copayment for each Medicare-covered occupational therapy visit.</td>
</tr>
<tr>
<td>Outpatient rehabilitation services are provided in various outpatient settings, such as hospital outpatient departments, independent therapist offices, and Comprehensive Outpatient Rehabilitation Facilities (CORFs).</td>
<td>$20 copayment for each Medicare-covered physical therapy visit and speech and language therapy visit.</td>
</tr>
<tr>
<td>*Prior authorization is not required for initial rehab services; however, subsequent visits may require authorization.</td>
<td></td>
</tr>
</tbody>
</table>

<p>| Outpatient substance abuse services*** |  |
| Covered levels of care for substance abuse include: |  |
| • Partial hospitalization/day treatment | There is no coinsurance, copayment, or deductible for Medicare-covered partial hospitalization program services. |
| • Intensive outpatient treatment | $20 copayment for each Medicare-covered intensive outpatient therapy visit. |</p>
<table>
<thead>
<tr>
<th>Services that are covered for you</th>
<th>What you must pay when you get these services</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Outpatient substance abuse services</strong> <em>(continued)</em></td>
<td></td>
</tr>
<tr>
<td>• Outpatient treatment</td>
<td>$20 copayment for each Medicare-covered individual or group therapy visit.</td>
</tr>
<tr>
<td>Covered services include:</td>
<td></td>
</tr>
<tr>
<td>• Diagnostic assessment, evaluations, and treatment planning</td>
<td></td>
</tr>
<tr>
<td>• Treatment and/or procedures</td>
<td></td>
</tr>
<tr>
<td>• Medication management and other associated treatments</td>
<td></td>
</tr>
<tr>
<td>• Individual, family, and group therapy</td>
<td></td>
</tr>
<tr>
<td>• Provider-based case management services</td>
<td></td>
</tr>
<tr>
<td>• Crisis intervention</td>
<td></td>
</tr>
<tr>
<td><strong>Please note:</strong> All substance abuse services must be received on an outpatient basis in a hospital, alternate facility, or provider’s office. Additionally, these services must be provided by, or under the direction of, a properly qualified behavioral health practitioner. Mental health services are managed by Providence Health Assurance. Providence Health Assurance must be contacted for authorizations. *This service may require prior authorization. See Section 2.1 of this chapter for details.</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Outpatient surgery, including services provided at hospital outpatient facilities and ambulatory surgical centers</strong></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Note:</strong> If you are having surgery in a hospital facility, you should check with your provider about whether you will be an inpatient or outpatient. Unless the provider writes an order to admit you as an inpatient to the hospital, you are an outpatient and pay the cost-sharing amounts for outpatient surgery. Even if you stay in the hospital overnight, you might still be considered an “outpatient.” <strong>Please note:</strong> A separate cost sharing may apply for professional fees. *This service may require prior authorization. See Section 2.1 of this chapter for details.</td>
<td>$200 copayment for each Medicare-covered ambulatory surgical center visit.</td>
</tr>
<tr>
<td>$250 copayment for each Medicare-covered outpatient hospital surgical service.</td>
<td></td>
</tr>
<tr>
<td>$70 copayment for Medicare-covered observation services.</td>
<td></td>
</tr>
<tr>
<td>There is no facility fee for outpatient clinic visits.</td>
<td></td>
</tr>
</tbody>
</table>
### Services that are covered for you

<table>
<thead>
<tr>
<th>Over-the-counter (OTC) items</th>
<th>What you must pay when you get these services</th>
</tr>
</thead>
<tbody>
<tr>
<td>We give you a pre-loaded debit card with an allowance of $75 every three months to pay for over-the-counter (OTC) health and wellness items. Your allowance rolls over every three months and expires after 11:59 p.m. on December 31 of each year. You can purchase eligible OTC health items from participating retail pharmacies in your area. Or, for a contactless experience, you can order from the Medline catalog via phone, web, or mail. Please note that catalog items are available for home delivery only. Also, items may not be purchased through any other suppliers or channels than those described above. For a list of approved items and retail pharmacies, please visit athome.medline.com/providence or mybenefitscenter.com. For assistance with orders or website help, please call Medline Customer Service at 1-833-569-2329. For assistance with balance inquiries, please call Card Services at 1-888-682-2400. For all other questions or concerns, please call Providence Health Assurance at 503-574-8000 or 1-800-603-2340. TTY users should call 711. There is no coinsurance, copayment, or deductible for over-the-counter items. You have an allowance of $75 every three months. Over-the-counter items can only be purchased from the Medline catalog or approved retailers.</td>
<td></td>
</tr>
</tbody>
</table>

### Partial hospitalization services*

“Partial hospitalization” is a structured program of active psychiatric treatment provided as a hospital outpatient service or by a community mental health center, that is more intense than the care received in your doctor’s or therapist’s office and is an alternative to inpatient hospitalization. Mental health services are managed by Providence Health Assurance. Providence Health Assurance must be contacted for authorizations. *This service may require prior authorization. See Section 2.1 of this chapter for details.
### Services that are covered for you

**Personal Emergency Response System (PERS)**

A Personal Emergency Response System (PERS) gives you 24/7 access to help in the event of an emergency. Simply press the button on your device to speak with a trained operator who will coordinate emergency dispatch to your location.

Covered services include:
- Shipping and fulfillment of the mobile device and base unit
- GPS technology to identify your location during an emergency
- Automatic fall detection technology

**Please note:** Remote video monitoring is not covered.

For Member Services or to sign up, please call Connect America at 1-877-909-4882.

There is no coinsurance, copayment, or deductible for PERS services.

### What you must pay when you get these services

**Physician/Practitioner services, including doctor’s office visits**

Covered services include:

- Medically-necessary medical care or surgery services furnished in a physician’s office, certified ambulatory surgical center, hospital outpatient department, or any other location

  There is no coinsurance, copayment, or deductible for each Medicare-covered primary care provider visit.

- Consultation, diagnosis, and treatment by a specialist

  $20 copayment for each Medicare-covered specialist visit.

- Basic hearing and balance exams performed by your PCP or specialist, if your doctor orders it to see if you need medical treatment

  For hearing and balance exam cost sharing, please see the “Hearing services” section of this medical benefits chart.
### Services that are covered for you

**Physician/Practitioner services, including doctor’s office visits (continued)**

<table>
<thead>
<tr>
<th>Services</th>
<th>What you must pay when you get these services</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Certain telehealth services, including: primary and specialty care,</td>
<td>For each Medicare-covered telehealth service, you will pay the applicable primary care provider or specialist visit cost sharing described above.</td>
</tr>
<tr>
<td>mental health care, opioid and substance abuse treatment, supervised</td>
<td></td>
</tr>
<tr>
<td>exercise, occupational and physical therapy, speech language</td>
<td></td>
</tr>
<tr>
<td>pathology services, kidney disease education, diabetes self-management,</td>
<td></td>
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<tr>
<td>and consultation and follow-up visits for a hospital stay, surgery,</td>
<td></td>
</tr>
<tr>
<td>or emergency department visit.</td>
<td></td>
</tr>
<tr>
<td>o You have the option of getting these services through an in-person</td>
<td></td>
</tr>
<tr>
<td>visit or by telehealth. If you choose to get one of these services by</td>
<td></td>
</tr>
<tr>
<td>telehealth, you must use a network provider who offers the service by</td>
<td></td>
</tr>
<tr>
<td>telehealth.</td>
<td></td>
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<tr>
<td>o Services will be provided via interactive audio and video</td>
<td></td>
</tr>
<tr>
<td>communication when deemed clinically appropriate by the network</td>
<td></td>
</tr>
<tr>
<td>provider rendering the service.</td>
<td></td>
</tr>
<tr>
<td>• Some telehealth services including consultation, diagnosis, and</td>
<td></td>
</tr>
<tr>
<td>treatment by a physician or practitioner, for patients in certain</td>
<td></td>
</tr>
<tr>
<td>rural areas or other places approved by Medicare</td>
<td></td>
</tr>
<tr>
<td>• Telehealth services for monthly end-stage renal disease-related</td>
<td></td>
</tr>
<tr>
<td>visits for home dialysis members in a hospital-based or critical access</td>
<td></td>
</tr>
<tr>
<td>hospital-based renal dialysis center, renal dialysis facility, or the</td>
<td></td>
</tr>
<tr>
<td>member’s home</td>
<td></td>
</tr>
<tr>
<td>• Telehealth services to diagnose, evaluate, or treat symptoms of a</td>
<td></td>
</tr>
<tr>
<td>stroke, regardless of your location</td>
<td></td>
</tr>
<tr>
<td>• Telehealth services for members with a substance use disorder or</td>
<td></td>
</tr>
<tr>
<td>co-occurring mental health disorder, regardless of their location</td>
<td></td>
</tr>
<tr>
<td>• Telehealth services for diagnosis, evaluation, and treatment of</td>
<td></td>
</tr>
<tr>
<td>mental health disorders if:</td>
<td></td>
</tr>
<tr>
<td>o You have an in-person visit within 6 months prior to your first</td>
<td></td>
</tr>
<tr>
<td>telehealth visit</td>
<td></td>
</tr>
<tr>
<td>o You have an in-person visit every 12 months while receiving these</td>
<td></td>
</tr>
<tr>
<td>telehealth services</td>
<td></td>
</tr>
<tr>
<td>o Exceptions can be made to the above for certain circumstances</td>
<td></td>
</tr>
<tr>
<td>Services that are covered for you</td>
<td>What you must pay when you get these services</td>
</tr>
<tr>
<td>-------------------------------------------------------------------------------------------------</td>
<td>-------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td><strong>Physician/Practitioner services, including doctor’s office visits (continued)</strong></td>
<td></td>
</tr>
<tr>
<td>• Telehealth services for mental health visits provided by Rural Health Clinics and Federally</td>
<td>There is no coinsurance, copayment, or deductible for non-Medicare-covered remote access technology services. This benefit covers only the provider’s service fee, not any applicable clinic or facility fees.</td>
</tr>
<tr>
<td>Qualified Health Centers</td>
<td>Multiple cost-sharing amounts may apply depending on the services provided.</td>
</tr>
<tr>
<td>• Virtual check-ins (for example, by phone or video call) with your doctor for 5-10 minutes if:</td>
<td></td>
</tr>
<tr>
<td>o You’re not a new patient <strong>and</strong></td>
<td></td>
</tr>
<tr>
<td>o The check-in isn’t related to an office visit in the past 7 days <strong>and</strong></td>
<td></td>
</tr>
<tr>
<td>o The check-in doesn’t lead to an office visit within 24 hours or the soonest available</td>
<td></td>
</tr>
<tr>
<td>appointment</td>
<td></td>
</tr>
<tr>
<td>• Evaluation of video and/or images you send to your doctor, and interpretation and follow-up</td>
<td></td>
</tr>
<tr>
<td>by your doctor within 24 hours if:</td>
<td></td>
</tr>
<tr>
<td>o You’re not a new patient <strong>and</strong></td>
<td></td>
</tr>
<tr>
<td>o The evaluation isn’t related to an office visit in the past 7 days <strong>and</strong></td>
<td></td>
</tr>
<tr>
<td>o The evaluation doesn’t lead to an office visit within 24 hours or the soonest available</td>
<td></td>
</tr>
<tr>
<td>appointment</td>
<td></td>
</tr>
<tr>
<td>• Consultation your doctor has with other doctors by phone, internet, or electronic health</td>
<td></td>
</tr>
<tr>
<td>record</td>
<td></td>
</tr>
<tr>
<td>• Second opinion by another network provider prior to surgery</td>
<td></td>
</tr>
<tr>
<td>• Non-routine dental care (covered services are limited to surgery of the jaw or related</td>
<td></td>
</tr>
<tr>
<td>structures, setting fractures of the jaw or facial bones, extraction of teeth to prepare the</td>
<td></td>
</tr>
<tr>
<td>jaw for radiation treatments of neoplastic cancer disease, or services that would be covered</td>
<td></td>
</tr>
<tr>
<td>when provided by a physician)</td>
<td></td>
</tr>
<tr>
<td>• Non-Medicare-covered remote access technology: We provide access to in-network providers via</td>
<td></td>
</tr>
<tr>
<td>o Telephonic visits for medication and disease management services, like when you call ProvRN</td>
<td></td>
</tr>
<tr>
<td>o Emails through an application, like when you send your care team a message in MyChart</td>
<td></td>
</tr>
<tr>
<td>o A dedicated, web-based platform for same-day medical appointments, like when you visit</td>
<td></td>
</tr>
<tr>
<td>Providence ExpressCare Virtual on a tablet, smartphone, or computer</td>
<td></td>
</tr>
<tr>
<td>There is no coinsurance, copayment, or deductible for non-Medicare-covered remote access</td>
<td></td>
</tr>
<tr>
<td>technology services. This benefit covers only the provider’s service fee, not any applicable</td>
<td></td>
</tr>
<tr>
<td>clinic or facility fees.</td>
<td></td>
</tr>
<tr>
<td>Multiple cost-sharing amounts may apply depending on the services provided.</td>
<td></td>
</tr>
</tbody>
</table>
## Services that are covered for you

<table>
<thead>
<tr>
<th>PODIATRY SERVICES</th>
<th>WHAT YOU MUST PAY WHEN YOU GET THESE SERVICES</th>
</tr>
</thead>
<tbody>
<tr>
<td>Covered services include:</td>
<td></td>
</tr>
<tr>
<td>• Diagnosis and the medical or surgical treatment of injuries and diseases of the feet (such as hammer toe or heel spurs)</td>
<td>$20 copayment for each Medicare-covered podiatry visit.</td>
</tr>
<tr>
<td>• Routine foot care for members with certain medical conditions affecting the lower limbs</td>
<td>Please refer to “Outpatient surgery, including services provided at hospital outpatient facilities and ambulatory surgical centers” for services provided in an outpatient setting.</td>
</tr>
<tr>
<td><strong>Please note:</strong> A separate cost sharing may apply if additional services are provided and/or if covered podiatry services are provided at a hospital outpatient facility or ambulatory surgical center.</td>
<td></td>
</tr>
</tbody>
</table>

### Prostate cancer screening exams

For men age 50 and older, covered services include the following - once every 12 months:

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

**Please note:** If you are treated or monitored for an existing medical condition during the visit when you receive this preventive service, a copayment or coinsurance may apply for the care received for the existing medical condition.

There is no coinsurance, copayment, or deductible for a Medicare-covered annual PSA test or digital rectal exam.

### Prosthetic devices and related supplies*

Devices (other than dental) that replace all or part of a body part or function. These include, but are not limited to: colostomy bags and supplies directly related to colostomy care, pacemakers, braces, prosthetic shoes, artificial limbs, and breast prostheses (including a surgical brassiere after a mastectomy). Includes certain supplies related to prosthetic devices, and repair and/or replacement of prosthetic devices. Also includes some coverage following cataract removal or cataract surgery – see “Vision Care” later in this section for more detail.

*This service may require prior authorization. See Section 2.1 of this chapter for details.

20% of the total cost for Medicare-covered prosthetic devices and related supplies.

All prosthetic devices and related supplies must be provided by Providence Home Services or other network provider.
<table>
<thead>
<tr>
<th>Services that are covered for you</th>
<th>What you must pay when you get these services</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Pulmonary rehabilitation services</strong>&lt;br&gt;Comprehensive programs of pulmonary rehabilitation are covered for members who have moderate to very severe chronic obstructive pulmonary disease (COPD) and an order for pulmonary rehabilitation from the doctor treating the chronic respiratory disease.&lt;br&gt;Pulmonary rehabilitation visits are limited to 36 sessions over a period of 36 weeks. If medically necessary, you may receive up to 36 additional sessions.</td>
<td>$20 copayment for each Medicare-covered pulmonary rehabilitation service.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Screening and counseling to reduce alcohol misuse</th>
<th>There is no coinsurance, copayment, or deductible for each Medicare-covered screening and counseling to reduce alcohol misuse preventive benefit.</th>
</tr>
</thead>
<tbody>
<tr>
<td>We cover one alcohol misuse screening for adults with Medicare (including pregnant women) who misuse alcohol, but aren’t alcohol dependent.&lt;br&gt; If you screen positive for alcohol misuse, you can get up to 4 brief face-to-face counseling sessions per year (if you’re competent and alert during counseling) provided by a qualified primary care doctor or practitioner in a primary care setting.&lt;br&gt;&lt;strong&gt;Please note:&lt;/strong&gt; If you are treated or monitored for an existing medical condition during the visit when you receive this preventive service, a copayment or coinsurance may apply for the care received for the existing medical condition.</td>
<td></td>
</tr>
<tr>
<td>Services that are covered for you</td>
<td>What you must pay when you get these services</td>
</tr>
<tr>
<td>----------------------------------</td>
<td>---------------------------------------------</td>
</tr>
<tr>
<td><strong>Screening for lung cancer with low dose computed tomography (LDCT)</strong>*</td>
<td>There is no coinsurance, copayment, or deductible for the Medicare-covered counseling and shared decision making visit or for LDCT.</td>
</tr>
</tbody>
</table>

For qualified individuals, a LDCT is covered every 12 months.

**Eligible members are:** people aged 50 – 77 years who have no signs or symptoms of lung cancer, but who have a history of tobacco smoking of at least 20 pack-years and who currently smoke or have quit smoking within the last 15 years, who receive a written order for LDCT during a lung cancer screening counseling and shared decision making visit that meets the Medicare criteria for such visits and be furnished by a physician or qualified non-physician practitioner.

For **LDCT lung cancer screenings after the initial LDCT screening:** the members must receive a written order for LDCT lung cancer screening, which may be furnished during any appropriate visit with a physician or qualified non-physician practitioner. If a physician or qualified non-physician practitioner elects to provide a lung cancer screening counseling and shared decision making visit for subsequent lung cancer screenings with LDCT, the visit must meet the Medicare criteria for such visits.

LDCT needs to be coordinated by your ordering provider through American Imaging Management (AIM).

*This service may require prior authorization. See Section 2.1 of this chapter for details.
<table>
<thead>
<tr>
<th>Services that are covered for you</th>
<th>What you must pay when you get these services</th>
</tr>
</thead>
</table>
| **Screening for sexually transmitted infections (STIs) and counseling to prevent STIs**

We cover sexually transmitted infection (STI) screenings for chlamydia, gonorrhea, syphilis, and Hepatitis B. These screenings are covered for pregnant women and for certain people who are at increased risk for an STI when the tests are ordered by a primary care provider. We cover these tests once every 12 months or at certain times during pregnancy.

We also cover up to two individual 20 to 30 minute, face-to-face high-intensity behavioral counseling sessions each year for sexually active adults at increased risk for STIs. We will only cover these counseling sessions as a preventive service if they are provided by a primary care provider and take place in a primary care setting, such as a doctor’s office.

**Please note:** If you are treated or monitored for an existing medical condition during the visit when you receive this preventive service, a copayment or coinsurance may apply for the care received for the existing medical condition.

There is no coinsurance, copayment, or deductible for the Medicare-covered screening for STIs and counseling for STIs preventive benefit.
<table>
<thead>
<tr>
<th>Services that are covered for you</th>
<th>What you must pay when you get these services</th>
</tr>
</thead>
<tbody>
<tr>
<td>Services to treat kidney disease*</td>
<td></td>
</tr>
<tr>
<td>Covered services include:</td>
<td></td>
</tr>
<tr>
<td>• Kidney disease education services to teach kidney care and help members make informed decisions about their care. For members with stage IV chronic kidney disease when referred by their doctor, we cover up to six sessions of kidney disease education services per lifetime</td>
<td>There is no coinsurance, copayment, or deductible for each Medicare-covered kidney disease education service.</td>
</tr>
<tr>
<td>• Outpatient dialysis treatments (including dialysis treatments when temporarily out of the service area, as explained in Chapter 3, or when your provider for this service is temporarily unavailable or inaccessible)</td>
<td>20% of the total cost for Medicare-covered renal dialysis treatment.</td>
</tr>
<tr>
<td>• Inpatient dialysis treatments (if you are admitted as an inpatient to a hospital for special care)</td>
<td>There is no additional charge for dialysis treatments received during a Medicare-covered inpatient hospital stay. Please refer to the “Inpatient hospital care” section of this medical benefits chart for inpatient hospital stay cost-sharing amounts.</td>
</tr>
<tr>
<td>• Self-dialysis training (includes training for you and anyone helping you with your home dialysis treatments)</td>
<td>20% of the total cost for each Medicare-covered self-dialysis training.</td>
</tr>
<tr>
<td>• Home dialysis equipment and supplies</td>
<td>20% of the total cost for Medicare-covered home dialysis equipment and supplies.</td>
</tr>
<tr>
<td>• Certain home support services (such as, when necessary, visits by trained dialysis workers to check on your home dialysis, to help in emergencies, and check your dialysis equipment and water supply)</td>
<td>There is no coinsurance, copayment, or deductible for each Medicare-covered home health visit.</td>
</tr>
<tr>
<td>Services that are covered for you</td>
<td>What you must pay when you get these services</td>
</tr>
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<td>----------------------------------</td>
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</tbody>
</table>

**Services to treat kidney disease** (continued)

Certain drugs for dialysis are covered under your Medicare Part B drug benefit. For information about coverage for Part B Drugs, please go to the section, “Medicare Part B prescription drugs.”

*Some services may require prior authorization. See Section 2.1 of this chapter for details.

**Skilled nursing facility (SNF) care**

(For a definition of “skilled nursing facility care,” see Chapter 10 of this document. Skilled nursing facilities are sometimes called “SNFs.”)

Your plan covers up to 100 days each benefit period. No prior hospital stay is required.

Covered services include, but are not limited to:

- Semiprivate room (or a private room if medically necessary)
- Meals, including special diets
- Skilled nursing services
- Physical therapy, occupational therapy, and speech therapy
- Drugs administered to you as part of your plan of care (This includes substances that are naturally present in the body, such as blood clotting factors.)
- Blood - including storage and administration. Coverage of whole blood and packed red cells begins with the first pint of blood that you need. All other components of blood are also covered beginning with the first pint used.
- Medical and surgical supplies ordinarily provided by SNFs
- Laboratory tests ordinarily provided by SNFs
- X-rays and other radiology services ordinarily provided by SNFs
- Use of appliances such as wheelchairs ordinarily provided by SNFs
- Physician/Practitioner services

There is no coinsurance, copayment, or deductible for days 1-20 of a benefit period for Medicare-covered SNF care.

$150 copayment each day for days 21-100 of a benefit period for Medicare-covered SNF care.

The benefit period begins the day you go into a SNF and ends when you haven’t received any skilled care in that SNF for 60 days in a row. If you go into a SNF after one benefit period has ended, a new benefit period will begin. There is no limit to the number of benefit periods.

All SNF stays, regardless of condition, will apply towards the benefit period. Your SNF benefits are based on the calendar date. If you are admitted into the facility in 2023 and are not discharged until 2024, your copayment amount per day may be different.
<table>
<thead>
<tr>
<th>Services that are covered for you</th>
<th>What you must pay when you get these services</th>
</tr>
</thead>
<tbody>
<tr>
<td><em><em>Skilled nursing facility (SNF) care</em> (continued)</em>*</td>
<td></td>
</tr>
<tr>
<td>Generally, you will get your SNF care from network facilities. However, under certain conditions listed below, you may be able to pay in-network cost sharing for a facility that isn’t a network provider, if the facility accepts our plan’s amounts for payment.</td>
<td></td>
</tr>
<tr>
<td>• A nursing home or continuing care retirement community where you were living right before you went to the hospital (as long as it provides skilled nursing facility care)</td>
<td></td>
</tr>
<tr>
<td>• A SNF where your spouse is living at the time you leave the hospital</td>
<td></td>
</tr>
<tr>
<td>*This service may require prior authorization. See Section 2.1 of this chapter for details.</td>
<td></td>
</tr>
</tbody>
</table>

### Smoking and tobacco use cessation (counseling to stop smoking or tobacco use)

If you use tobacco, but do not have signs or symptoms of tobacco-related disease: We cover two counseling quit attempts within a 12-month period as a preventive service with no cost to you. Each counseling attempt includes up to four face-to-face visits.

If you use tobacco and have been diagnosed with a tobacco-related disease or are taking medicine that may be affected by tobacco: We cover cessation counseling services. We cover two counseling quit attempts within a 12-month period, however, you will pay the applicable cost sharing. Each counseling attempt includes up to four face-to-face visits.

**Please note:** If you are treated or monitored for an existing medical condition during the visit when you receive this preventive service, a copayment or coinsurance may apply for the care received for the existing medical condition.

There is no coinsurance, copayment, or deductible for the Medicare-covered smoking and tobacco use cessation preventive benefit.

See the “Health and wellness education programs” section of this medical benefits chart for additional smoking cessation benefits.
## Supervised Exercise Therapy (SET)

SET is covered for members who have symptomatic peripheral artery disease (PAD) and a referral for PAD from the physician responsible for PAD treatment.

Up to 36 sessions over a 12-week period are covered if the SET program requirements are met.

The SET program must:

- Consist of sessions lasting 30-60 minutes, comprising a therapeutic exercise-training program for PAD in patients with claudication
- Be conducted in a hospital outpatient setting or a physician’s office
- Be delivered by qualified auxiliary personnel necessary to ensure benefits exceed harms, and who are trained in exercise therapy for PAD
- Be under the direct supervision of a physician, physician assistant, or nurse practitioner/clinical nurse specialist who must be trained in both basic and advanced life support techniques

SET may be covered beyond 36 sessions over 12 weeks for an additional 36 sessions over an extended period of time if deemed medically necessary by a health care provider.

<table>
<thead>
<tr>
<th>Services that are covered for you</th>
<th>What you must pay when you get these services</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Supervised Exercise Therapy (SET)</strong></td>
<td>$20 copayment for each Medicare-covered SET service.</td>
</tr>
</tbody>
</table>
## Urgently needed services

Urgently needed services are provided to treat a non-emergency, unforeseen medical illness, injury, or condition that requires immediate medical care but, given your circumstances, it is not possible, or it is unreasonable, to obtain services from network providers. Examples of urgently needed services that the plan must cover out of network are i) you need immediate care during the weekend, or ii) you are temporarily outside the service area of the plan. Services must be immediately needed and medically necessary. If it is unreasonable given your circumstances to immediately obtain the medical care from a network provider, then your plan will cover the urgently needed services from a provider out-of-network.

You have worldwide urgent care coverage. Please see the “Worldwide emergency/urgent care” section of this medical benefits chart for details.

<table>
<thead>
<tr>
<th>Services that are covered for you</th>
<th>What you must pay when you get these services</th>
</tr>
</thead>
<tbody>
<tr>
<td>Urgently needed services</td>
<td>$50 copayment for each Medicare-covered urgent care visit.</td>
</tr>
<tr>
<td></td>
<td>If you are admitted to the hospital within 24 hours of your urgent care visit, you do not have to pay the urgent care visit copayment.</td>
</tr>
<tr>
<td></td>
<td>If you receive urgently needed care at an out-of-network hospital and require inpatient care once your condition has stabilized, you must get that inpatient care authorized by the plan. If authorized, your cost will be the same as if you received the inpatient care from an in-network hospital.</td>
</tr>
<tr>
<td></td>
<td>See the “Inpatient hospital services” section of this medical benefits chart for inpatient cost-sharing information.</td>
</tr>
<tr>
<td>Services that are covered for you</td>
<td>What you must pay when you get these services</td>
</tr>
<tr>
<td>----------------------------------</td>
<td>---------------------------------------------</td>
</tr>
<tr>
<td><strong>Vision care</strong></td>
<td></td>
</tr>
<tr>
<td>Covered services include:</td>
<td></td>
</tr>
<tr>
<td>• Outpatient physician services for the diagnosis and treatment of diseases and injuries of the eye, including treatment for age-related macular degeneration. Original Medicare doesn’t cover routine eye exams (eye refractions) for eyeglasses/contacts</td>
<td>$20 copayment for each Medicare-covered exam to diagnose and treat diseases and conditions of the eye. <strong>Please note:</strong> A separate cost sharing may apply if additional services are provided, such as drugs administered during your visit.</td>
</tr>
<tr>
<td>• ☀️ For people who are at high risk of glaucoma, we will cover one glaucoma screening each year. People at high risk of glaucoma include: people with a family history of glaucoma, people with diabetes, African-Americans who are age 50 and older and Hispanic Americans who are 65 or older.</td>
<td>There is no coinsurance, copayment, or deductible for an annual Medicare-covered preventive glaucoma screening. $20 copayment for one Medicare-covered diabetic retinopathy screening exam per calendar year.</td>
</tr>
<tr>
<td>• For people with diabetes, screening for diabetic retinopathy is covered once per year</td>
<td></td>
</tr>
<tr>
<td><strong>Vision hardware</strong></td>
<td></td>
</tr>
<tr>
<td>• Post-cataract: Your plan covers one pair of eyeglasses or contact lenses after each cataract surgery that includes insertion of an intraocular lens. (If you have two separate cataract operations, you cannot reserve the benefit after the first surgery and purchase two eyeglasses after the second surgery.)</td>
<td>There is no coinsurance, copayment, or deductible for one pair of Medicare-covered eyeglasses or contact lenses after each cataract surgery.</td>
</tr>
<tr>
<td>• Medical vision hardware*: Medical vision hardware is included under the “Prosthetic devices and related supplies” section of this medical benefits chart.</td>
<td>20% of the total cost for Medicare-covered prosthetic devices and related supplies.</td>
</tr>
</tbody>
</table>

*This service may require prior authorization. See Section 2.1 of this chapter for details.
### Vision care (routine non-Medicare-covered)

Covered services include:

- **Routine eye exam:**
  
  Our plan covers one refractive routine eye exam per calendar year. The purpose of this exam is to check your vision to determine if corrective eyewear or updated eyeglass or contact lens prescriptions are needed. A refraction is the part of an office visit that determines your eyeglass prescription. Both services are included under the routine eye exam benefit.

  This benefit excludes examinations for conditions such as conjunctivitis, dry eye, glaucoma or cataracts. These services are not part of a refractive routine exam as defined under this benefit and would be covered under your Part B medical benefits. Please refer to the “Vision care” row above for details regarding medical vision benefits.

- **Routine vision hardware:**
  
  Your plan includes routine eyeglasses or contact lenses every calendar year.

  The cost sharing for a routine eye exam or routine vision hardware does not count toward your plan’s out-of-pocket maximum.

<table>
<thead>
<tr>
<th>Services that are covered for you</th>
<th>What you must pay when you get these services</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Vision care (routine non-Medicare-covered)</strong></td>
<td>You have an allowance of up to $75 per calendar year for a routine eye exam, including refraction. This means we will pay up to $75 for routine vision services each year. Any amount billed by the provider above the allowance will be your responsibility. You are not limited to a network provider, which means you can see any qualified provider for a routine eye exam. Please note that the allowance described above is the same for all providers. You have an allowance of up to $250 per calendar year for a combination of routine prescription contacts, routine prescription lenses, routine vision frames, and/or upgrades, such as tinting. This means we will pay up to $250 per calendar year for routine vision hardware. Routine prescription contact lens fitting services are included under the routine vision hardware benefit. Any amount billed by the provider above the allowance will be your responsibility. You are not limited to a network provider.</td>
</tr>
<tr>
<td><strong>Routine eye exam:</strong></td>
<td>- You have an allowance of up to $75 per calendar year for a routine eye exam, including refraction. This means we will pay up to $75 for routine vision services each year. Any amount billed by the provider above the allowance will be your responsibility.</td>
</tr>
<tr>
<td><strong>Routine vision hardware:</strong></td>
<td>- You have an allowance of up to $250 per calendar year for a combination of routine prescription contacts, routine prescription lenses, routine vision frames, and/or upgrades, such as tinting. This means we will pay up to $250 per calendar year for routine vision hardware. Routine prescription contact lens fitting services are included under the routine vision hardware benefit. Any amount billed by the provider above the allowance will be your responsibility. You are not limited to a network provider.</td>
</tr>
<tr>
<td>Services that are covered for you</td>
<td>What you must pay when you get these services</td>
</tr>
<tr>
<td>----------------------------------</td>
<td>-----------------------------------------------</td>
</tr>
<tr>
<td>Vision care (routine non-Medicare-covered) (continued)</td>
<td>You can get your routine vision hardware from any qualified provider. Please note that the allowance described above is the same for all providers. Please ask your provider to bill us for the services using the Claims address on the back of your member ID card. You may also request reimbursement from us.</td>
</tr>
</tbody>
</table>

**“Welcome to Medicare” preventive visit**

The plan covers the one-time “Welcome to Medicare” preventive visit. The visit includes a review of your health, as well as education and counseling about the preventive services you need (including certain screenings and shots), and referrals for other care if needed.

**Important:** We cover the “Welcome to Medicare” preventive visit only within the first 12 months you have Medicare Part B. When you make your appointment, let your doctor’s office know you would like to schedule your “Welcome to Medicare” preventive visit.

**Please note:** If you are treated or monitored for an existing medical condition during the visit when you receive the preventive service, a copayment or coinsurance may apply for the care received for the existing medical condition.

There is no coinsurance, copayment, or deductible for the “Welcome to Medicare” preventive visit.

**Wig benefit**

We cover one synthetic wig every calendar year if you are experiencing hair loss from chemotherapy only. You may purchase your wig from any wig supplier.

**Please note:** You will need to pay the wig supplier directly and submit the paid receipt to us for reimbursement. Please see Chapter 5, Section 2 of this document for more information about asking us to pay you back for covered services.

20% of the total cost for one synthetic wig.
**Chapter 4 Medical Benefits Chart (what is covered and what you pay)**

<table>
<thead>
<tr>
<th>Services that are covered for you</th>
<th>What you must pay when you get these services</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Worldwide emergency/urgent care</strong></td>
<td><strong>$70 copayment for each emergency room visit.</strong></td>
</tr>
<tr>
<td>Your plan covers emergency/urgent care services worldwide. This is defined as emergency, urgent, and post-stabilization care received outside of the United States. The term “outside of the United States” means anywhere other than the 50 states, the District of Columbia, Puerto Rico, the U.S. Virgin Islands, Guam, American Samoa, and the Northern Mariana Islands. Cruise ships are considered outside of the United States. Coverage is limited to services that would be classified as emergency, urgently needed, or post-stabilization care had they been provided in the United States. One-way ambulance transport to an emergency or urgent care facility is covered in situations where getting to the facility in any other way could endanger your health. Transport must occur within 24 hours of when you receive the emergency or urgent treatment. All other transports received outside of the United States and its territories will be reviewed for medical necessity. Evacuation and repatriation services are not covered. Foreign fees, including, but not limited to, currency conversion or transaction fees, are not covered.</td>
<td><strong>$50 copayment for each urgent care visit.</strong> If you are admitted to the hospital within 24 hours of your emergency room or urgent care visit, you do not have to pay the applicable copayment listed above. See the “Inpatient hospital services” section of this medical benefits chart for inpatient cost-sharing information. See the “Ambulance services” section of this medical benefits chart for ambulance cost-sharing information. For services related to post stabilization, see the section of this medical benefits chart related to the services supplied. There is a calendar year limit of $50,000 for all associated emergency/urgent care received outside of the United States and its territories.</td>
</tr>
</tbody>
</table>

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**Section 2.2 Extra “optional supplemental” benefits you can buy**

Our plan offers some extra benefits that are not covered by Original Medicare and not included in your benefits package. These extra benefits are called “Optional Supplemental Benefits.” If you want these optional supplemental benefits, you must sign up for them and you may have to pay an additional premium for them. The optional supplemental benefits described in this section are subject to the same appeals process as any other benefits.
Providence Medicare Focus Medical (HMO) offers two Optional Supplemental Dental plans. The copays, deductibles, and monthly premium amounts for these plans are listed below. Please keep in mind that electing one of these Optional Supplemental Dental plans will not modify the dental services previously described in the Medical Benefits Chart in Section 2.1 of this chapter.

If you are currently a member of Providence Medicare Advantage Plans, you may change or elect your Optional Supplemental Dental Plan during the Annual Enrollment Period (AEP) or within the first 60 days following January 1st.

If you are brand new to Providence Medicare Advantage Plans, you will have an additional 60 days from your original effective date of coverage to elect an Optional Supplemental Dental Plan. If we do not receive your request to enroll within the time frame described above, you will need to wait until the next AEP or the following January to elect an Optional Supplemental Dental Plan.

Please contact Customer Service for an Optional Supplemental Dental Plan Application. If you are enrolling during AEP, your effective date will be January 1st. If you are enrolling any time outside of AEP, your effective date will be the first day of the month following the date we receive your application to enroll in an Optional Supplemental Dental Plan.

You can choose to discontinue your Optional Supplemental Dental Plan at any time. Your change in coverage will be effective the first day of the month following the date we receive your written request to disenroll from your Optional Supplemental Dental Plan.
Optional Supplemental Dental Coverage – Providence Dental Basic

Monthly premium: $32.50  
Annual maximum benefit: $1,000  
Provider network [1]: Any dentist*

<table>
<thead>
<tr>
<th>Services that are covered for you</th>
<th>What you must pay when you get these services</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>In-Network</td>
</tr>
<tr>
<td>• Annual deductible [2]</td>
<td>$50 deductible</td>
</tr>
<tr>
<td>• Office copayment</td>
<td>$0 office copayment</td>
</tr>
</tbody>
</table>

### Diagnostic and preventive dental care

<table>
<thead>
<tr>
<th>Services that are covered for you</th>
<th>What you must pay when you get these services</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>In-Network</td>
</tr>
<tr>
<td>• Oral examinations [3]</td>
<td>0% of the total cost</td>
</tr>
<tr>
<td>• Bitewing or Periapical x-rays [4]</td>
<td></td>
</tr>
<tr>
<td>• Panoramic x-rays [5]</td>
<td></td>
</tr>
<tr>
<td>• Teeth cleanings (basic routine cleaning) [6]</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Services that are covered for you</th>
<th>What you must pay when you get these services</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>In-Network</td>
</tr>
<tr>
<td>• Sealants</td>
<td>Not covered</td>
</tr>
<tr>
<td>• Topical fluoride</td>
<td></td>
</tr>
</tbody>
</table>

### Basic dental care

<table>
<thead>
<tr>
<th>Services that are covered for you</th>
<th>What you must pay when you get these services</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>In-Network</td>
</tr>
<tr>
<td>• Fillings (silver)</td>
<td>50% of the total cost</td>
</tr>
<tr>
<td>• Fillings (composite) [7]</td>
<td></td>
</tr>
</tbody>
</table>

### Major restorative care

<table>
<thead>
<tr>
<th>Services that are covered for you</th>
<th>What you must pay when you get these services</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>In-Network</td>
</tr>
<tr>
<td>• Crowns and bridges [8]</td>
<td>50% of the total cost</td>
</tr>
<tr>
<td>• Dentures [9]</td>
<td></td>
</tr>
<tr>
<td>• Simple extractions</td>
<td></td>
</tr>
<tr>
<td>• Endodontics (root canals)</td>
<td>Not covered</td>
</tr>
<tr>
<td>• Periodontics (also called scaling, treatment of gum disease, or a deep cleaning)</td>
<td></td>
</tr>
</tbody>
</table>
Important note: Out-of-network dentists may charge more than the amount allowed by Providence Medicare Advantage Plans. After you pay the annual deductible, Providence Medicare Advantage Plans will pay either the participating dentist’s negotiated fee or our share of the maximum allowable charge for covered dental procedures and services. Covered frequencies cannot be duplicated between the “Diagnostic and preventive dental care” services listed on the previous page and the “Embedded routine preventive dental services” described in the Medical Benefits Chart in Section 2.1 of this chapter. Please keep in mind that you may incur a higher cost share when going out-of-network if the dentist you see charges more than the allowed amount by Providence Medicare Advantage Plans. If this happens, you may receive a bill for the difference between the charged amount and the allowed amount paid by the plan.

[1] Seeking care from an in-network dentist will reduce your out-of-pocket costs. Please note that services provided by a Medicare-excluded or Medicare-opt-out provider will not be covered.

[2] Deductibles are waived for Diagnostic and preventive dental care (Class I)

[3] Oral examinations - limited to two per calendar year. Please note that you may receive two periodic oral evaluations or one periodic oral evaluation and one problem-focused oral evaluation per calendar year.

[4] Bitewing or Periapical x-rays – limited to two per calendar year

[5] Full Mouth and Panoramic x-ray – limited to once every 60 months

[6] Teeth Cleanings/Prophylaxis (basic routine cleaning and polishing teeth) – limited to two per calendar year

[7] Fillings (composite) – see “Class II: Basic Care Services” below

[8] Crowns and bridges – $100 annual limit per tooth

[9] Denture partials and completes – $250 lifetime maximum

Class I: Diagnostic and Preventive Care Services

1. A total of two examinations per calendar year, including a maximum of one comprehensive evaluation per 36 months and one limited oral evaluation per 12 months
2. Two prophylaxis (cleaning, scaling, and polishing teeth) per calendar year
3. Two bitewing x-rays per calendar year
4. Two periapical x-rays per calendar year
5. One diagnostic x-ray (full mouth or panoramic) per 60 months
6. Emergency palliative treatment as long as no other services, aside from an exam and x-rays, are performed on the date of treatment

Class II: Basic Care Services

1. Simple extraction of teeth
2. Amalgam and composite fillings excluding posterior composites (anterior restorations of mesiolingual, distolingual, mesiobuccal, and distobuccal surfaces considered single surface restorations), per tooth, per surface every 24 months
3. Pin retention of fillings (multiple pins on the same tooth are considered one pin)
4. Antibiotic injections administered by a dentist

Class III. Major Restorative Care

1. Crown buildup procedure for non-vital teeth
2. Recementing bridges, inlays, onlays, and crowns at least 12 months after insertion and every 12 months per tooth thereafter  
3. One repair of dentures or fixed bridgework per 24 months  
4. Restoration services, limited to:  
   a. Cast metal, resin-based, gold, or porcelain/ceramic inlays, onlays, and crowns for teeth with extensive caries or fractures that are unable to be restored with an amalgam or composite filling  
   b. Replacement of existing inlay, onlay, or crown at least seven years after the restoration was initially placed or last replaced  
   c. Post and core, in addition to crown. Please note that the teeth being restored must have been treated with a root canal and have a good prognosis.  
   d. Stainless steel crowns  
5. Prosthetic services, limited to:  
   a. Initial placement of removable dentures or fixed bridges  
   b. Replacement of removable dentures or fixed bridges that cannot be repaired at least seven years after the last placement date  
   c. Addition of teeth to existing partial denture  
   d. One relining or rebasing of existing removable dentures at least 24 months after the last placement date (unless an immediate prosthesis replacing three or more teeth is needed) and every 24 months thereafter  
6. Two teledentistry, synchronous (D9995), or asynchronous (D9996) appointments per calendar year (when available)  

Class IV. Orthodontics: Not covered  

Benefit Exclusions*  
1. Services that are covered under worker’s compensation or employer’s liability laws  
2. Services that are not necessary for your dental health  
3. Reconstructive, plastic, cosmetic, elective, or aesthetic dentistry  
4. Oral surgery that requires the setting of fractures and dislocations  
5. Services with respect to malignancies, cysts, or neoplasms; hereditary, congenital, or mandibular prognathism; or development malformations where such services should not be performed in a dental office  
6. Dispensing of drugs  
7. Hospitalization for any dental procedure  
8. Implant removal or the replacement of dentures, bridges, inlays, onlays, or crowns that can be repaired or restored to normal function  
9. Diagnosis or treatment of Temporomandibular Disorder (TMD) and/or occlusal disharmony  
10. Elective surgery, including, but not limited to, extraction of non-pathologic, asymptomatic impacted teeth  
11. Services not listed as covered  
12. Implants and related services; replacement of lost, stolen, or damaged prosthetic or orthodontic appliances; athletic mouth guards; precision or semi-precision attachments; denture duplication; periodontal splinting of teeth
Chapter 4 Medical Benefits Chart (what is covered and what you pay)

13. Services for increasing vertical dimension, replacing tooth structure lost by attrition, and correcting developmental malformations and/or congenital conditions

14. Procedures, that in the opinion of the plan, are experimental or investigative in nature because they do not meet professionally recognized standards of dental practice and/or have not been shown to be consistently effective for the diagnosis or treatment of your condition

15. Treatment of cleft palate, malignancies, or neoplasms

*Please note that these exclusions are specific to Optional Supplemental Dental coverage. Some of these exclusions may be covered under your dental services benefit, which is described in the Medical Benefits Chart in Section 2.1 of this chapter. Please contact Customer Service to find out if any of these would be covered.
Optional Supplemental Dental Coverage – Providence Dental Enhanced

Monthly premium: $45.10
Annual maximum benefit: $1,500
Provider network [1]: Any dentist*

<table>
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<tr>
<th>Services that are covered for you</th>
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</tr>
</thead>
<tbody>
<tr>
<td></td>
<td><strong>In-Network</strong></td>
</tr>
<tr>
<td>- Annual deductible [2]</td>
<td>$50 deductible</td>
</tr>
<tr>
<td>- Office copayment</td>
<td>$0 office copayment</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Diagnostic and preventive dental care</th>
<th>In-Network</th>
<th>Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Oral examinations [3]</td>
<td>0% of the total cost</td>
<td>20% of the total cost</td>
</tr>
<tr>
<td>- Bitewing or Periapical x-rays [4]</td>
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<table>
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<tr>
<th>Basic dental care</th>
<th>In-Network</th>
<th>Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Fillings (silver)</td>
<td>50% of the total cost</td>
<td>60% of the total cost</td>
</tr>
<tr>
<td>- Fillings (composite) [7]</td>
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</table>

<table>
<thead>
<tr>
<th>Major restorative care</th>
<th>In-Network</th>
<th>Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Crowns and bridges [8]</td>
<td>50% of the total cost</td>
<td>60% of the total cost</td>
</tr>
<tr>
<td>- Dentures [9]</td>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>In-Network</th>
<th>Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Extractions, erupted tooth</td>
<td>50% of the total cost</td>
<td>60% of the total cost</td>
</tr>
<tr>
<td>- Oral surgery – certain minor surgery</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Endodontics (root canals)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Periodontics (also called scaling, treatment of gum disease, or a deep cleaning)</td>
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*Important note: Out-of-network dentists may charge more than the amount allowed by Providence Medicare Advantage Plans. After you pay the annual deductible, Providence Medicare Advantage Plans will pay either the participating dentist’s negotiated fee or our share of the maximum allowable charge for covered dental procedures and services. Covered frequencies cannot be duplicated between the “Diagnostic and preventive dental care” services listed on the previous page and the “Embedded routine preventive dental services” described in the Medical Benefits Chart in Section 2.1 of this chapter. Please keep in mind that you may incur a higher cost share when going out-of-network if the dentist you see charges more than the allowed amount by Providence Medicare Advantage Plans. If this happens, you may receive a bill for the difference between the charged amount and the allowed amount paid by the plan.

[1] Seeking care from an in-network dentist will reduce your out-of-pocket costs. Please note that services provided by a Medicare-excluded or Medicare-opt-out provider will not be covered.
[2] Deductibles are waived for Diagnostic and preventive dental care (Class I)
[3] Oral examinations - limited to two per calendar year. Please note that you may receive two periodic oral evaluations or one periodic oral evaluation and one problem-focused oral evaluation per calendar year.
[4] Bitewing or Periapical x-rays – limited to two per calendar year
[5] Full Mouth and Panoramic x-ray – limited to once every 60 months
[6] Teeth Cleanings/Prophylaxis (basic routine cleaning and polishing teeth) – limited to two per calendar year
[7] Fillings (composite) – see “Class II: Basic Care Services” below
[8] Crowns and bridges – $500 annual limit
[9] Denture partials and completes – $250 lifetime maximum

Class I: Diagnostic and Preventive Care Services
1. A total of two examinations per calendar year, including a maximum of one comprehensive evaluation per 36 months and one limited oral evaluation per 12 months
2. Two prophylaxis (cleaning, scaling, and polishing teeth) per calendar year
3. Two bitewing x-rays per calendar year
4. Two periapical x-rays per calendar year
5. One diagnostic x-ray (full mouth or panoramic) per 60 months
6. Emergency palliative treatment as long as no other services, aside from an exam and x-rays, are performed on the date of treatment

Class II: Basic Care Services
1. Simple extraction of teeth
2. Amalgam and composite fillings excluding posterior composites (anterior restorations of mesiolingual, distolingual, mesiobuccal, and distobuccal surfaces considered single surface restorations), per tooth, per surface every 24 months
3. Pin retention of fillings (multiple pins on the same tooth are considered one pin)
4. Antibiotic injections administered by a dentist

Class III: Major Restorative Care
1. Crown buildup procedure for non-vital teeth
2. Recementing bridges, inlays, onlays, and crowns at least 12 months after insertion and every 12 months per tooth thereafter
3. One repair of dentures or fixed bridgework per 24 months
4. One study model per 3 years
5. General anesthesia and analgesia, including intravenous sedation, in conjunction with covered oral surgery or periodontal surgery
6. Restoration services, limited to:
   a. Cast metal, resin-based, gold, or porcelain/ceramic inlays, onlays, and crowns for teeth with extensive caries or fractures that are unable to be restored with an amalgam or composite filling
   b. Replacement of existing inlay, onlay, or crown at least seven years after the restoration was initially placed or last replaced
   c. Post and core, in addition to crown. Please note that the teeth being restored must have been treated with a root canal and have a good prognosis.
   d. Stainless steel crowns
7. Prosthetic services, limited to:
   a. Initial placement of removable dentures or fixed bridges
   b. Replacement of removable dentures or fixed bridges that cannot be repaired at least seven years after the last placement date
   c. Addition of teeth to existing partial denture
   d. One relining or rebasing of existing removable dentures at least 24 months after the last placement date (unless an immediate prosthesis replacing three or more teeth is needed) and every 24 months thereafter
8. Two teledentistry, synchronous (D9995), or asynchronous (D9996) appointments per calendar year (when available)
9. Oral surgery, including postoperative care for:
   a. Removal of teeth, including impacted teeth
   b. Extraction of tooth root
   c. One coronectomy (intentional partial tooth removal) per lifetime
   d. Alveolecory, alveoplasty, and frenectomy
   e. Excision of periocoronal gingiva, exostosis, or hyper plastic tissue, and excision of oral tissue for biopsy
   f. Tooth transplantation, re-implantation, and/or stabilization
   g. Excision of a tumor or cyst and incision and drainage of an abscess or cyst
10. Endodontic treatment of disease of the tooth, pulp, root, and related tissue, limited to:
    a. Pre-existing limitations not allowed by CMS
    b. Pulpotomy
    c. Apicoectomy
    d. One retrograde filling per root per lifetime
11. Periodontic services, limited to:
    a. Two periodontal maintenance visits per calendar year, following surgery (D4341 is not considered surgery)
    b. One scaling and root planing (D4341 or D4342) per quadrant per 24 months, starting at age 21
c. One full-mouth scaling per two years, when gingival inflammation is present

d. Occlusal adjustment performed with covered surgery

e. Gingivectomy

f. Osseous surgery including flap entry and closure

g. One pedicle or free soft tissue graft per site per lifetime

h. One appliance (night guard) per 5 years within 6 months of osseous surgery

i. One full mouth debridement per lifetime

Class IV. Orthodontics: Not covered

Benefit Exclusions*

1. Services that are covered under worker’s compensation or employer’s liability laws

2. Services that are not necessary for your dental health

3. Reconstructive, plastic, cosmetic, elective, or aesthetic dentistry

4. Oral surgery that requires the setting of fractures and dislocations

5. Services with respect to malignancies, cysts, or neoplasms; hereditary, congenital, or mandibular prognathism; or development malformations where such services should not be performed in a dental office

6. Dispensing of drugs

7. Hospitalization for any dental procedure

8. Implant removal or the replacement of dentures, bridges, inlays, onlays, or crowns that can be repaired or restored to normal function

9. Diagnosis or treatment of Temporomandibular Disorder (TMD) and/or occlusal disharmony

10. Elective surgery, including, but not limited to, extraction of non-pathologic, asymptomatic impacted teeth

11. Services not listed as covered

12. Implants and related services; replacement of lost, stolen, or damaged prosthetic or orthodontic appliances; athletic mouth guards; precision or semi-precision attachments; denture duplication; periodontal splinting of teeth

13. Services for increasing vertical dimension, replacing tooth structure lost by attrition, and correcting developmental malformations and/or congenital conditions

14. Procedures, that in the opinion of the plan, are experimental or investigative in nature because they do not meet professionally recognized standards of dental practice and/or have not been shown to be consistently effective for the diagnosis or treatment of your condition

15. Treatment of cleft palate, malignancies, or neoplasms

*Please note that these exclusions are specific to Optional Supplemental Dental coverage. Some of these exclusions may be covered under your dental services benefit, which is described in the Medical Benefits Chart in Section 2.1 of this chapter. Please contact Customer Service to find out if any of these would be covered.
SECTION 3  What services are not covered by the plan?

Section 3.1  Services we do not cover (exclusions)

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

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

If you get services that are excluded (not covered), you must pay for them yourself except under the specific conditions listed below. Even if you receive the excluded services at an emergency facility, the excluded services are still not covered and our plan will not pay for them. The only exception is if the service is appealed and decided upon appeal to be a medical service that we should have paid for or covered because of your specific situation. (For information about appealing a decision we have made to not cover a medical service, go to Chapter 9, Section 5.3 in this document.)

<table>
<thead>
<tr>
<th>Services not covered by Medicare</th>
<th>Not covered under any condition</th>
<th>Covered only under specific conditions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acupuncture</td>
<td></td>
<td>Available for people with chronic low back pain under certain circumstances.</td>
</tr>
<tr>
<td>All costs associated with surrogate parenting</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>Ambulance claims where transport is refused (no treatment)</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>Appliances, equipment, and supplies primarily used for comfort or convenience, including, but not limited to, air conditioners, humidifiers, and incontinence pads</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>Autopsies and services related to autopsies</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>Charges for missed appointments or completion of claim forms</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>Services not covered by Medicare</td>
<td>Not covered under any condition</td>
<td>Covered only under specific conditions</td>
</tr>
<tr>
<td>-------------------------------------------------------------------------------------------------</td>
<td>----------------------------------</td>
<td>----------------------------------------</td>
</tr>
<tr>
<td>Conception by artificial means, such as in vitro fertilization, zygote intra-fallopian transfers, and gamete intra-fallopian transfers (GIFT)</td>
<td>✔</td>
<td></td>
</tr>
<tr>
<td>Cosmetic surgery or procedures</td>
<td></td>
<td>• Covered in cases of an accidental injury or for improvement of the functioning of a malformed body member. • Covered for all stages of reconstruction for a breast after a mastectomy, as well as for the unaffected breast to produce a symmetrical appearance.</td>
</tr>
<tr>
<td>Custodial care</td>
<td>✔</td>
<td></td>
</tr>
<tr>
<td>Custodial care is personal care that does not require the continuing attention of trained medical or paramedical personnel, such as care that helps you with activities of daily living, such as bathing or dressing.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Direct-to-consumer testing (also known as self-testing, at-home testing, or over-the-counter testing) sold directly to individuals via the Internet, television, print advertisements, or other marketing materials</td>
<td>✔</td>
<td></td>
</tr>
<tr>
<td>Elective or voluntary enhancement procedures or services</td>
<td>✔</td>
<td></td>
</tr>
<tr>
<td>Services not covered by Medicare</td>
<td>Not covered under any condition</td>
<td>Covered only under specific conditions</td>
</tr>
<tr>
<td>-------------------------------------------------------------------------------------------------</td>
<td>----------------------------------</td>
<td>----------------------------------------</td>
</tr>
<tr>
<td>Experimental medical and surgical procedures, equipment, and medications</td>
<td></td>
<td>May be covered by Original Medicare under a Medicare-approved clinical research study or by our plan. (See Chapter 3, Section 5 for more information on clinical research studies.)</td>
</tr>
<tr>
<td>Experimental procedures and items are those items and procedures determined by Original Medicare to not be generally accepted by the medical community.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fees charged for care by your immediate relatives or members of your household</td>
<td>✔</td>
<td></td>
</tr>
<tr>
<td>Full-time nursing care in your home</td>
<td>✔</td>
<td></td>
</tr>
<tr>
<td>Guest meals in a hospital or skilled nursing facility</td>
<td>✔</td>
<td></td>
</tr>
<tr>
<td>Hearing aids and provider visits to service hearing aids (except as specifically described in the Covered Benefits), ear molds, hearing aid accessories, warranty claim fees, and hearing aid batteries (beyond the 80 free batteries per non-rechargeable aid purchased)</td>
<td>✔</td>
<td></td>
</tr>
<tr>
<td>Home-delivered meals</td>
<td></td>
<td>Covered after a qualifying inpatient hospitalization.</td>
</tr>
<tr>
<td>Homemaker services including basic household assistance, such as light housekeeping or light meal preparation.</td>
<td>✔</td>
<td></td>
</tr>
<tr>
<td>Lens extras for cataract hardware (i.e., tints, anti-reflective coating, progressives, oversize lenses, etc.), unless medically necessary</td>
<td></td>
<td>✔</td>
</tr>
<tr>
<td>Medicare Part B prescription drugs for travel outside the U.S. and its territories</td>
<td>✔</td>
<td></td>
</tr>
<tr>
<td>Non-emergency transportation</td>
<td></td>
<td>Prior Authorization is required.</td>
</tr>
</tbody>
</table>
### Services not covered by Medicare

<table>
<thead>
<tr>
<th>Services</th>
<th>Not covered under any condition</th>
<th>Covered only under specific conditions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Non-routine dental care</td>
<td></td>
<td>Dental care required to treat illness or injury may be covered as inpatient or outpatient care.</td>
</tr>
<tr>
<td>Orthopedic shoes or supportive devices for the feet</td>
<td></td>
<td>Shoes that are part of a leg brace and are included in the cost of the brace. Orthopedic or therapeutic shoes for people with diabetic foot disease.</td>
</tr>
<tr>
<td>Personal items in your room at a hospital or a skilled nursing facility, such as a telephone or a television</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>Private duty nurses</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>Private room in a hospital</td>
<td></td>
<td>Covered only when medically necessary.</td>
</tr>
<tr>
<td>Psychological enrichment or self-help programs for mentally-healthy individuals</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>Radial keratotomy, LASIK surgery, and other low vision aids</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>Reports, evaluations, or routine physical exams primarily for insurance, licensing, employment, or other third-party and non-preventive purposes</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>Reversal of sterilization procedures and/or non-prescription contraceptive supplies</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>Routine dental care, such as fillings or dentures</td>
<td>✓</td>
<td></td>
</tr>
</tbody>
</table>

This exclusion applies unless you've purchased the Optional Supplemental Dental benefit. For more information, see Section 2.2 of this chapter.
<table>
<thead>
<tr>
<th>Services not covered by Medicare</th>
<th>Not covered under any condition</th>
<th>Covered only under specific conditions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Routine foot care</td>
<td></td>
<td>Some limited coverage provided according to Medicare guidelines (e.g., if you have diabetes).</td>
</tr>
<tr>
<td>Services considered not reasonable and necessary, according to Original Medicare standards</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>Services not covered by Medicare</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>Services provided in Veterans Affairs (VA) facilities</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>Services related to intrauterine devices (IUD), including insertion of the device and the device itself</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>Services, such as drug claims, are not covered if they are ordered, prescribed, or provided by you for your own benefit, by a person who resides in your home, or by a member of your family. In this context, a “member of your family” is a person who could possibly inherit from you under any state's intestate succession law as well as any in-law, step relative, foster parent, or domestic partner of yours or of any such person.</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>Subnormal vision aids, aniseikonic lenses, or plain (non-prescription) glasses, sunglasses, and other low vision aids and services</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>Treatment or counseling in the absence of illness, including marriage counseling</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>Wig</td>
<td></td>
<td>Synthetic wigs are only covered for members experiencing hair loss due to chemotherapy. Natural- or human-hair wigs are not covered.</td>
</tr>
</tbody>
</table>
CHAPTER 5:

Asking us to pay our share of a bill you have received for covered medical services
SECTION 1 Situations in which you should ask us to pay our share of the cost of your covered medical services

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

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

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

1. **When you’ve received emergency or urgently needed medical care from a provider who is not in our plan’s network**

   You can receive emergency or urgently needed services from any provider, whether or not the provider is a part of our network. In these cases,
   - You are only responsible for paying your share of the cost for emergency or urgently needed services. Emergency providers are legally required to provide emergency care. If you accidentally pay the entire amount yourself at the time you receive the care, ask us to pay you back for our share of the cost. Send us the bill, along with documentation of any payments you have made.
   - You may get a bill from the provider asking for payment that you think you do not owe. Send us this bill, along with documentation of any payments you have already made.
     - If the provider is owed anything, we will pay the provider directly.
     - If you have already paid more than your share of the cost of the service, we will determine how much you owed and pay you back for our share of the cost.

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

   Network providers should always bill the plan directly and ask you only for your share of the cost. But sometimes they make mistakes and ask you to pay more than your share.
   - You only have to pay your cost-sharing amount when you get covered services. We do not allow providers to add additional separate charges, called “balance billing.” This protection (that you never pay more than your cost-sharing amount) applies even if we
Chapter 5 Asking us to pay our share of a bill you have received for covered medical services

pay the provider less than the provider charges for a service and even if there is a dispute and we don’t pay certain provider charges.

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

3. If you are retroactively enrolled in our plan

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

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

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

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

You may request us to pay you back by sending us a request in writing. If you send a request in writing, send your bill and documentation of any payment you have made. It’s a good idea to make a copy of your bill and receipts for your records. You must submit your claim to us within 12 months of the date you received the service, or item.

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

- You don’t have to use the form, but it will help us process the information faster.
- Either download a copy of the form from our website (www.ProvidenceHealthAssurance.com/MemberForms) or call Customer Service and ask for the form.
- For Medical, Behavioral Health claims, please include the following: provider name, address, and phone number; Tax ID; date of service; diagnosis; item description and procedure code if available; any medical records related to the service; and amount charged and paid.
- Foreign Claims: For services out of the country, please explain where services were rendered (Office, ER, Urgent care, Hospital, Clinic, Pharmacy) and explain the nature of injury or illness.
Chapter 5 Asking us to pay our share of a bill you have received for covered medical services

Mail your request for payment together with any bills or paid receipts to us at this address:

Providence Health Assurance  
Attn: Claims  
P.O. Box 3125  
Portland, OR 97208-3125

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

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

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

- If we decide that the medical care is covered and you followed all the rules, we will pay for our share of the cost. If you have already paid for the service, we will mail your reimbursement of our share of the cost to you. If you have not paid for the service yet, we will mail the payment directly to the provider.

- If we decide that the medical care is not covered, or you did not follow all the rules, we will not pay for our share of the cost. We will send you a letter explaining the reasons why we are not sending the payment and your rights to appeal that decision.

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

If you think we have made a mistake in turning down your request for payment or the amount we are paying, you can make an appeal. If you make an appeal, it means you are asking us to change the decision we made when we turned down your request for payment. The appeals process is a formal process with detailed procedures and important deadlines. For the details on how to make this appeal, go to Chapter 7 of this document.
CHAPTER 6:
Your rights and responsibilities
SECTION 1 Our plan must honor your rights and cultural sensitivities as a member of the plan

Section 1.1 We must provide information in a way that works for you and consistent with your cultural sensitivities (in languages other than English, in braille, in large print, or other alternate formats, etc.)

Your plan is required to ensure that all services, both clinical and non-clinical, are provided in a culturally competent manner and are accessible to all enrollees, including those with limited English proficiency, limited reading skills, hearing incapacity, or those with diverse cultural and ethnic backgrounds. Examples of how a plan may meet these accessibility requirements include, but are not limited to: provision of translator services, interpreter services, teletypewriters, or TTY (text telephone or teletypewriter phone) connection.

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

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

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

If you have any trouble getting information from our plan in a format that is accessible and appropriate for you, please call to file a grievance with Customer Service at 503-574-8000 or 1-800-603-2340 (TTY: 711). You may also file a complaint with Medicare by calling 1-800-MEDICARE (1-800-633-4227) or directly with the Office for Civil Rights by calling 1-800-368-1019 or TTY 1-800-537-7697.

Section 1.2 We must ensure that you get timely access to your covered services

You have the right to choose a primary care provider (PCP) in the plan’s network to provide and arrange for your covered services. You also have the right to go to a women’s health specialist (such as a gynecologist) without a referral.
You have the right to get appointments and covered services from the plan’s network of providers within a reasonable amount of time. This includes the right to get timely services from specialists when you need that care.

If you think that you are not getting your medical care within a reasonable amount of time, Chapter 7 tells what you can do.

### Section 1.3 We must protect the privacy of your personal health information

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

- Your “personal health information” includes the personal information you gave us when you enrolled in this plan as well as your medical records and other medical and health information.

- You have rights related to your information and controlling how your health information is used. We give you a written notice, called a “Notice of Privacy Practice,” that tells about these rights and explains how we protect the privacy of your health information.

### How do we protect the privacy of your health information?

- We make sure that unauthorized people don’t see or change your records.

- Except for the circumstances noted below, if we intend to give your health information to anyone who isn’t providing your care or paying for your care, we are required to get written permission from you or someone you have given legal power to make decisions for you first.

- There are certain exceptions that do not require us to get your written permission first. These exceptions are allowed or required by law.
  - We are required to release health information to government agencies that are checking on quality of care.
  - Because you are a member of our plan through Medicare, we are required to give Medicare your health information. If Medicare releases your information for research or other uses, this will be done according to Federal statutes and regulations; typically, this requires that information that uniquely identifies you not be shared.

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

You have the right to look at your medical records held at the plan, and to get a copy of your records. We are allowed to charge you a fee for making copies. You also have the right to ask us to make additions or corrections to your medical records. If you ask us to do this, we will work with your healthcare provider to decide whether the changes should be made.
You have the right to know how your health information has been shared with others for any purposes that are not routine.

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

The full scope of our privacy practices is described in our Notice of Privacy Practices and may be found at www.ProvidenceHealthAssurance.com/PrivacyPractices and at the end of your new member handbook.

You need to know that information about your health care is protected and confidential. Providence Health Assurance respects the privacy of our members and takes great care to decide when it is appropriate to share health information. For more information, please review the Notice available at www.ProvidenceHealthAssurance.com/PrivacyPractices.

### Section 1.4 We must give you information about the plan, its network of providers, and your covered services

As a member of Providence Medicare Focus Medical (HMO), you have the right to get several kinds of information from us.

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

- **Information about our plan.** This includes, for example, information about the plan’s financial condition.
- **Information about our network providers.** You have the right to get information about the qualifications of the providers in our network and how we pay the providers in our network.
- **Information about your coverage and the rules you must follow when using your coverage.** Chapters 3 and 4 provide information regarding medical services.
- **Information about why something is not covered and what you can do about it.** Chapter 7 provides information on asking for a written explanation on why a medical service is not covered or if your coverage is restricted. Chapter 7 also provides information on asking us to change a decision, also called an appeal.

### Section 1.5 We must support your right to make decisions about your care

You have the right to know your treatment options and participate in decisions about your health care

You have the right to get full information from your doctors and other health care providers. Your providers must explain your medical condition and your treatment choices in a way that you can understand.
You also have the right to participate fully in decisions about your health care. To help you make decisions with your doctors about what treatment is best for you, your rights include the following:

- **To know about all of your choices.** You have the right to be told about all of the treatment options that are recommended for your condition, no matter what they cost or whether they are covered by our plan.

- **To know about the risks.** You have the right to be told about any risks involved in your care. You must be told in advance if any proposed medical care or treatment is part of a research experiment. You always have the choice to refuse any experimental treatments.

- **The right to say “no.”** You have the right to refuse any recommended treatment. This includes the right to leave a hospital or other medical facility, even if your doctor advises you not to leave. Of course, if you refuse treatment, you accept full responsibility for what happens to your body as a result.

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

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

- Fill out a written form to give someone the legal authority to make medical decisions for you if you ever become unable to make decisions for yourself.

- Give your doctors written instructions about how you want them to handle your medical care if you become unable to make decisions for yourself.

The legal documents that you can use to give your directions in advance 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 use an “advance directive” to give your instructions, here is what to do:

- **Get the form.** You can get an advance directive form from your lawyer, from a social worker, or from some office supply stores. You can sometimes get advance directive forms from organizations that give people information about Medicare.

- **Fill it out and sign it.** Regardless of where you get this form, keep in mind that it is a legal document. You should consider having a lawyer help you prepare it.

- **Give copies to appropriate people.** You should give a copy of the form to your doctor and to the person you name on the form who can make decisions for you if you can’t. You may want to give copies to close friends or family members. Keep a copy at home.

If you know ahead of time that you are going to be hospitalized, and you have signed an advance directive, **take a copy with you to the hospital.**
Chapter 6 Your rights and responsibilities

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

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

**What if your instructions are not followed?**

If you have signed an advance directive, and you believe that a doctor or hospital did not follow the instructions in it, you may file a complaint with:

**OREGON:**
Oregon Medical Board
Chief Investigator
1500 SW 1st Ave. #620
Portland, OR 97201-5847
971-673-2702 or 1-877-254-6263

**WASHINGTON:**
Washington State Department of Health
Health Systems Quality Assurance
Complaint Intake
P.O. Box 47857
Olympia, WA 98504-7857
360-236-4700
Email: HSQAComplaintIntake@doh.wa.gov

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**Section 1.6** You have the right to make complaints and to ask us to reconsider decisions we have made

If you have any problems, concerns, or complaints and need to request coverage, or make an appeal, Chapter 7 of this document tells what you can do. Whatever you do – ask for a coverage decision, make an appeal, or make a complaint – we are required to treat you fairly.

**Section 1.7** What can you do if you believe you are being treated unfairly or your rights are not being respected?

If it is about discrimination, call the Office for Civil Rights

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

**Is it about something else?**

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

- You can call Customer Service.
Chapter 6 Your rights and responsibilities

- You can call the SHIP. For details, go to Chapter 2, Section 3.
- Or, you can call Medicare at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week (TTY 1-877-486-2048).

Section 1.8 How to get more information about your rights

There are several places where you can get more information about your rights:

- You can call Customer Service.
- You can call the SHIP. For details, go to Chapter 2, Section 3.
- You can contact Medicare.
  - You can visit the Medicare website to read or download the publication “Medicare Rights & Protections.” (The publication is available at: www.medicare.gov/Pubs/pdf/11534-Medicare-Rights-and-Protections.pdf.)
  - Or, you can call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week (TTY 1-877-486-2048).

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

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

- Get familiar with your covered services and the rules you must follow to get these covered services. Use this Evidence of Coverage to learn what is covered for you and the rules you need to follow to get your covered services.
  - Chapters 3 and 4 give the details about your medical services.
- If you have any other health insurance coverage in addition to our plan, or separate prescription drug coverage, you are required to tell us. Chapter 1 tells you about coordinating these benefits.
- Tell your doctor and other health care providers that you are enrolled in our plan. Show your plan membership card whenever you get your medical care.
- Help your doctors and other providers help you by giving them information, asking questions, and following through on your care.
  - To help get the best care, tell your doctors and other health providers about your health problems. Follow the treatment plans and instructions that you and your doctors agree upon.
  - Make sure your doctors know all of the drugs you are taking, including over-the-counter drugs, vitamins, and supplements.
  - If you have any questions, be sure to ask and get an answer you can understand.
• **Be considerate.** We expect all our members to respect the rights of other patients. We also expect you to act in a way that helps the smooth running of your doctor’s office, hospitals, and other offices.

• **Pay what you owe.** As a plan member, you are responsible for these payments:
  - You must pay your plan premiums.
  - You must continue to pay a premium for your Medicare Part B to remain a member of the plan.
  - For some of your medical services covered by the plan, you must pay your share of the cost when you get the service.

• **If you move within our service area, we need to know** so we can keep your membership record up to date and know how to contact you.

• **If you move outside of our plan service area, you cannot remain a member of our plan.**

• If you move, it is also important to tell Social Security (or the Railroad Retirement Board).
CHAPTER 7:
What to do if you have a problem or complaint (coverage decisions, appeals, complaints)
SECTION 1 Introduction

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

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

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

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

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

Section 1.2 What about the legal terms?

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

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

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

SECTION 2 Where to get more information and personalized assistance

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

**State Health Insurance Assistance Program (SHIP)**

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

The services of SHIP counselors are free. You will find phone numbers and website URLs in Chapter 2, Section 3 of this document.

**Medicare**

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

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

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

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

**Is your problem or concern about your benefits or coverage?**

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

Yes.

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

No.

Skip ahead to Section 9 at the end of this chapter: “How to make a complaint about quality of care, waiting times, customer service or other concerns.”
Chapter 7 What to do if you have a problem or complaint (coverage decisions, appeals, complaints)

COVERAGE DECISIONS AND APPEALS

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

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

Coverage decisions and appeals deal with problems related to your benefits and coverage for medical services, including payment. This is the process you use for issues such as whether something is covered or not and the way in which something is covered.

Asking for coverage decisions prior to receiving services

A coverage decision is a decision we make about your benefits and coverage or about the amount we will pay for your medical services or drugs. For example, your plan network doctor makes a (favorable) coverage decision for you whenever you receive medical care from him or her or if your network doctor refers you to a medical specialist. You or your doctor can also contact us and ask for a coverage decision if your doctor is unsure whether we will cover a particular medical service or refuses to provide medical care you think that you need. In other words, if you want to know if we will cover a medical service before you receive it, you can ask us to make a coverage decision for you. In limited circumstances a request for a coverage decision will be dismissed, which means we won’t review the request. Examples of when a request will be dismissed include if the request is incomplete, if someone makes the request on your behalf but isn’t legally authorized to do so or if you ask for your request to be withdrawn. If we dismiss a request for a coverage decision, we will send a notice explaining why the request was dismissed and how to ask for a review of the dismissal.

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

Making an appeal

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

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

If we do not dismiss your case but say no to all or part of your Level 1 appeal, you can go on to a Level 2 appeal. The Level 2 appeal is conducted by an independent review organization that is not connected to us. (Appeals for medical services and Part B drugs will be automatically sent to the independent review organization for a Level 2 appeal – you do not need to do anything. If you are not satisfied with the decision at the Level 2 appeal, you may be able to continue through additional levels of appeal (Section 8 in this chapter explains the Level 3, 4, and 5 appeals processes).

Section 4.2 How to get help when you are asking for a coverage decision or making an appeal

Here are resources if you decide to ask for any kind of coverage decision or appeal a decision:

- You can call us at Customer Service.
- You can get free help from your SHIP.
- Your doctor can make a request for you. If your doctor helps with an appeal past Level 2, they will need to be appointed as your representative. Please call Customer Service and ask for the “Appointment of Representative” form. (The form is also available on Medicare’s website at www.cms.gov/Medicare/CMS-Forms/CMS-Forms/downloads/cms1696.pdf or on our website at www.ProvidenceHealthAssurance.com/MemberForms.)
  - For medical care or Part B prescription drugs, your doctor can request a coverage decision or a Level 1 appeal on your behalf. If your appeal is denied at Level 1, it will be automatically forwarded to Level 2.
- You can ask someone to act on your behalf. If you want to, you can name another person to act for you as your “representative” to ask for a coverage decision or make an appeal.
  - If you want a friend, relative, or other person to be your representative, call Customer Service and ask for the “Appointment of Representative” form. (The form is also available on Medicare’s website at www.cms.gov/Medicare/CMS-Forms/CMS-Forms/downloads/cms1696.pdf or on our website at www.ProvidenceHealthAssurance.com/MemberForms.) The form gives that person permission to act on your behalf. It must be signed by you and by the person who you would like to act on your behalf. You must give us a copy of the signed form.
  - While we can accept an appeal request without the form, we cannot begin or complete our review until we receive it. If we do not receive the form within 44
calendar days after receiving your appeal request (our deadline for making a decision on your appeal), your appeal request will be dismissed. If this happens, we will send you a written notice explaining your right to ask the independent review organization to review our decision to dismiss your appeal.

- **You also have the right to hire a lawyer.** You may contact your own lawyer, or get the name of a lawyer from your local bar association or other referral service. There are also groups that will give you free legal services if you qualify. However, you are not required to hire a lawyer to ask for any kind of coverage decision or appeal a decision.

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

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

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

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

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

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

This section is about your benefits for medical care and services. These benefits are described in Chapter 4 of this document: *Medical Benefits Chart (what is covered and what you pay).* To keep things simple, we generally refer to “medical care coverage” or “medical care” which includes medical items and services as well as Medicare Part B prescription drugs. In some cases, different rules apply to a request for a Part B prescription drug. In those cases, we will explain how the rules for Part B prescription drugs are different from the rules for medical items and services.

This section tells what you can do if you are in any of the five following situations:
Chapter 7 What to do if you have a problem or complaint (coverage decisions, appeals, complaints)

1. You are not getting certain medical care you want, and you believe that this care is covered by our plan. **Ask for a coverage decision. Section 5.2.**

2. Our plan will not approve the medical care your doctor or other medical provider wants to give you, and you believe that this care is covered by the plan. **Ask for a coverage decision. Section 5.2.**

3. You have received medical care that you believe should be covered by the plan, but we have said we will not pay for this care. **Make an appeal. Section 5.3.**

4. You have received and paid for medical care that you believe should be covered by the plan, and you want to ask our plan to reimburse you for this care. **Send us the bill. Section 5.5.**

5. You are being told that coverage for certain medical care you have been getting that we previously approved will be reduced or stopped, and you believe that reducing or stopping this care could harm your health. **Make an appeal. Section 5.3.**

**Note:** If the coverage that will be stopped is for hospital care, home health care, skilled nursing facility care, or Comprehensive Outpatient Rehabilitation Facility (CORF) services, you need to read Sections 6 and 7 of this Chapter. Special rules apply to these types of care.

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

<table>
<thead>
<tr>
<th>Legal Terms</th>
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<tbody>
<tr>
<td>When a coverage decision involves your medical care, it is called an “<strong>organization determination.</strong>”</td>
</tr>
<tr>
<td>A “fast coverage decision” is called an “<strong>expedited determination.</strong>”</td>
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</table>

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

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

- You may *only ask* for coverage for medical care *you have not yet received*.
- You can get a fast coverage decision *only if* using the standard deadlines could *cause serious harm to your health or hurt your ability to function*.
- If your doctor tells us that your health requires a “fast coverage decision,” we will automatically agree to give you a fast coverage decision.
Chapter 7 What to do if you have a problem or complaint (coverage decisions, appeals, complaints)

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

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

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

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

*For standard coverage decisions, we use the standard deadlines.*

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

- **However,** if you ask for more time, or if we need more information that may benefit you, we **can take up to 14 more days** if your request is for a medical item or service. If we take extra days, we will tell you in writing. We can’t take extra time to make a decision if your request is for a Medicare Part B prescription drug.

- If you believe we should not take extra days, you can file a “fast complaint.” We will give you an answer to your complaint as soon as we make the decision. (The process for making a complaint is different from the process for coverage decisions and appeals. See Section 9 of this chapter for information on complaints.)

*For Fast Coverage decisions, we use an expedited timeframe*

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

- **However,** if you ask for more time, or if we need more that may benefit you, we **can take up to 14 more days**. If we take extra days, we will tell you in writing. We can’t take extra time to make a decision if your request is for a Medicare Part B prescription drug.
Chapter 7 What to do if you have a problem or complaint (coverage decisions, appeals, complaints)

- If you believe we should not take extra days, you can file a “fast complaint.” (See Section 9 of this chapter for information on complaints.) We will call you as soon as we make the decision.

- If our answer is no to part or all of what you requested, we will send you a written statement that explains why we said no.

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

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

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

<table>
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<th>Legal Terms</th>
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<tr>
<td>An appeal to the plan about a medical care coverage decision is called a plan “reconsideration.”</td>
</tr>
<tr>
<td>A “fast appeal” is also called an “expedited reconsideration.”</td>
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</tbody>
</table>

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

A “standard appeal” is usually made within 30 days. A “fast appeal” is generally made within 72 hours.

- If you are appealing a decision we made about coverage for care that you have not yet received, you and/or your doctor will need to decide if you need a “fast appeal.” If your doctor tells us that your health requires a “fast appeal,” we will give you a fast appeal.

- The requirements for getting a “fast appeal” are the same as those for getting a “fast coverage decision” in Section 5.2 of this chapter.

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

- If you are asking for a standard appeal, submit your standard appeal in writing. Chapter 2 has contact information.

- If you are asking for a fast appeal, make your appeal in writing or call us. Chapter 2 has contact information.

- You must make your appeal request within 60 calendar days from the date on the written notice we sent to tell you our answer on the coverage decision. If you miss this deadline and have a good reason for missing it, explain the reason your appeal is late when you make your appeal. We may give you more time to make your appeal. Examples of good cause may include a serious illness that prevented
you from contacting us or if we provided you with incorrect or incomplete information about the deadline for requesting an appeal.

- **You can ask for a copy of the information regarding your medical decision.** You and your doctor may add more information to support your appeal.

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

- When our plan is reviewing your appeal, we take a careful look at all of the information. We check to see if we were following all the rules when we said no to your request.

- We will gather more information if needed, possibly contacting you or your doctor.

**Deadlines for a “fast appeal”**

- For fast appeals, we must give you our answer **within 72 hours after we receive your appeal**. We will give you our answer sooner if your health requires us to.
  - However, if you ask for more time, or if we need more information that may benefit you, we **can take up to 14 more calendar days** if your request is for a medical item or service. If we take extra days, we will tell you in writing. We can’t take extra time if your request is for a Medicare Part B prescription drug.
  - If we do not give you an answer within 72 hours (or by the end of the extended time period if we took extra days), we are required to automatically send your request on to Level 2 of the appeals process, where it will be reviewed by an independent review organization. Section 5.4 explains the Level 2 appeal process.

- **If our answer is yes to part or all of what you requested**, we must authorize or provide the coverage we have agreed to provide within 72 hours after we receive your appeal.

- **If our answer is no to part or all of what you requested**, we will send you our decision in writing and automatically forward your appeal to the independent review organization for a Level 2 appeal. The independent review organization will notify you in writing when it receives your appeal.

**Deadlines for a “standard appeal”**

- For standard appeals, we must give you our answer **within 30 calendar days** after we receive your appeal. If your request is for a Medicare Part B prescription drug you have not yet received, we will give you our answer **within 7 calendar days** after we receive your appeal. We will give you our decision sooner if your health condition requires us to.
  - However, if you ask for more time, or if we need more information that may benefit you, **we can take up to 14 more calendar days** if your request is for a medical item or service. If we take extra days, we will tell you in writing. We can’t take extra time to make a decision if your request is for a Medicare Part B prescription drug.
If you believe we should not take extra days, you can file a “fast complaint.” When you file a fast complaint, we will give you an answer to your complaint within 24 hours. (See Section 9 of this chapter for information on complaints.)

If we do not give you an answer by the deadline (or by the end of the extended time period), we will send your request to a Level 2 appeal, where an independent review organization will review the appeal. Section 5.4 explains the Level 2 appeal process.

- If our answer is yes to part or all of what you requested, we must authorize or provide the coverage within 30 calendar days if your request is for a medical item or service, or within 7 calendar days if your request is for a Medicare Part B prescription drug.
- If our plan says no to part or all of your appeal, we will automatically send your appeal to the independent review organization for a Level 2 appeal.

### Section 5.4 Step-by-step: How a Level 2 appeal is done

<table>
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<th>Legal Term</th>
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<tr>
<td>The formal name for the “independent review organization” is the “Independent Review Entity.” It is sometimes called the “IRE.”</td>
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The independent review organization is an independent organization hired by Medicare. It is not connected with us and is not a government agency. This organization decides whether the decision we made is correct or if it should be changed. Medicare oversees its work.

### Step 1: The independent review organization reviews your appeal.

- We will send the information about your appeal to this organization. This information is called your “case file.” **You have the right to ask us for a copy of your case file.**
- You have a right to give the independent review organization additional information to support your appeal.
- Reviewers at the independent review organization will take a careful look at all of the information related to your appeal.

If you had a “fast appeal” at Level 1, you will also have a “fast appeal” at Level 2

- For the “fast appeal,” the review organization must give you an answer to your Level 2 appeal within 72 hours of when it receives your appeal.
- However, if your request is for a medical item or service and the independent review organization needs to gather more information that may benefit you, it can take up to 14 more calendar days. The independent review organization can’t take extra time to make a decision if your request is for a Medicare Part B prescription drug.
If you had a “standard appeal” at Level 1, you will also have a “standard appeal” at Level 2

- For the “standard appeal,” if your request is for a medical item or service, the review organization must give you an answer to your Level 2 appeal within 30 calendar days of when it receives your appeal. If your request is for a Medicare Part B prescription drug, the review organization must give you an answer to your Level 2 appeal within 7 calendar days of when it receives your appeal.

- However, if your request is for a medical item or service and the independent review organization needs to gather more information that may benefit you, it can take up to 14 more calendar days. The independent review organization can’t take extra time to make a decision if your request is for a Medicare Part B prescription drug.

Step 2: The independent review organization gives you their answer.

The independent review organization will tell you its decision in writing and explain the reasons for it.

- If the review organization says yes to part or all of a request for a medical item or service, we must authorize the medical care coverage within 72 hours or provide the service within 14 calendar days after we receive the decision from the review organization for standard requests. For expedited requests, we have or within 72 hours from the date we receive the decision from the review organization.

- If the review organization says yes to part or all of a request for a Medicare Part B prescription drug, we must authorize or provide the Part B prescription drug within 72 hours after we receive the decision from the review organization for standard requests. For expedited requests we have 24 hours from the date we receive the decision from the review organization.

- If this organization says no to part or all of your appeal, it means they agree with us that your request (or part of your request) for coverage for medical care should not be approved. (This is called “upholding the decision” or “turning down your appeal.”) In this case, the independent review organization will send you a letter:
  - Explaining its decision
  - Notifying you of the right to a Level 3 appeal if the dollar value of the medical care coverage meets a certain minimum. The written notice you get from the independent review organization will tell you the dollar amount you must meet to continue the appeals process.
  - Telling you how to file a Level 3 appeal.

Step 3: If your case meets the requirements, you choose whether you want to take your appeal further.

- There are three additional levels in the appeals process after Level 2 (for a total of five levels of appeal). If you want to go to a Level 3 appeal, the details on how to do this are in the written notice you get after your Level 2 appeal.
Chapter 7 What to do if you have a problem or complaint (coverage decisions, appeals, complaints)

- The Level 3 appeal is handled by an Administrative Law Judge or attorney adjudicator. Section 8 in this chapter explains the Level 3, 4, and 5 appeals processes.

### Section 5.5 What if you are asking us to pay you for our share of a bill you have received for medical care?

Chapter 5 describes when you may need to ask for reimbursement or to pay a bill you have received from a provider. It also tells how to send us the paperwork that asks us for payment.

**Asking for reimbursement is asking for a coverage decision from us**

If you send us the paperwork asking for reimbursement, you are asking for a coverage decision. To make this decision, we will check to see if the medical care you paid for is a covered service. We will also check to see if you followed all the rules for using your coverage for medical care.

- **If we say yes to your request:** If the medical care is covered and you followed all the rules, we will send you the payment for our share of the cost within 60 calendar days after we receive your request. If you haven’t paid for the services, we will send the payment directly to the provider.

- **If we say no to your request:** If the medical care is not covered, or you did not follow all the rules, we will not send payment. Instead, we will send you a letter that says we will not pay for the services and the reasons why.

If you do not agree with our decision to turn you down, you can make an appeal. If you make an appeal, it means you are asking us to change the coverage decision we made when we turned down your request for payment.

**To make this appeal, follow the process for appeals that we describe in Section 5.3.** For appeals concerning reimbursement, please note:

- We must give you our answer within 60 calendar days after we receive your appeal. (If you are asking us to pay you back for medical care you have already received and paid for, you are not allowed to ask for a fast appeal.)

- If the independent review organization decides we should pay, we must send you or the provider the payment within 30 calendar days. If the answer to your appeal is yes at any stage of the appeals process after Level 2, we must send the payment you requested to you or to the provider within 60 calendar days.
SECTION 6 How to ask us to cover a longer inpatient hospital stay if you think the doctor is discharging you too soon

When you are admitted to a hospital, you have the right to get all of your covered hospital services that are necessary to diagnose and treat your illness or injury.

During your covered hospital stay, your doctor and the hospital staff will be working with you to prepare for the day when you will leave the hospital. They will help arrange for care you may need after you leave.

- The day you leave the hospital is called your “discharge date.”
- When your discharge date is decided, your doctor or the hospital staff will tell you.
- If you think you are being asked to leave the hospital too soon, you can ask for a longer hospital stay and your request will be considered.

Section 6.1 During your inpatient hospital stay, you will get a written notice from Medicare that tells about your rights

Within two days of being admitted to the hospital, you will be given a written notice called An Important Message from Medicare about Your Rights. Everyone with Medicare gets a copy of this notice. If you do not get the notice from someone at the hospital (for example, a caseworker or nurse), ask any hospital employee for it. If you need help, please call Customer Service or 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week (TTY 1-877-486-2048).

1. **Read this notice carefully and ask questions if you don’t understand it.** It tells you:
   - Your right to receive Medicare-covered services during and after your hospital stay, as ordered by your doctor. This includes the right to know what these services are, who will pay for them, and where you can get them.
   - Your right to be involved in any decisions about your hospital stay.
   - Where to report any concerns you have about quality of your hospital care.
   - Your right to request an immediate review of the decision to discharge you if you think you are being discharged from the hospital too soon. This is a formal, legal way to ask for a delay in your discharge date so that we will cover your hospital care for a longer time.

2. **You will be asked to sign the written notice to show that you received it and understand your rights.**
   - You or someone who is acting on your behalf will be asked to sign the notice.
Chapter 7 What to do if you have a problem or complaint (coverage decisions, appeals, complaints)

- Signing the notice shows only that you have received the information about your rights. The notice does not give your discharge date. Signing the notice does not mean you are agreeing on a discharge date.

3. Keep your copy of the notice handy so you will have the information about making an appeal (or reporting a concern about quality of care) if you need it.

- If you sign the notice more than two days before your discharge date, you will get another copy before you are scheduled to be discharged.
- To look at a copy of this notice in advance, you can call Customer Service or 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048. You can also see the notice online at www.cms.gov/Medicare/Medicare-General-Information/BNI/HospitalDischargeappealNotices.

Section 6.2 Step-by-step: How to make a Level 1 appeal to change your hospital discharge date

If you want to ask for your inpatient hospital services to be covered by us for a longer time, you will need to use the appeals process to make this request. Before you start, understand what you need to do and what the deadlines are.

- Follow the process.
- Meet the deadlines.
- Ask for help if you need it. If you have questions or need help at any time, please call Customer Service. Or call your SHIP, a government organization that provides personalized assistance.

During a Level 1 appeal, the Quality Improvement Organization reviews your appeal. It checks to see if your planned discharge date is medically appropriate for you.

The Quality Improvement Organization is a group of doctors and other health care professionals paid by the Federal government to check on and help improve the quality of care for people with Medicare. This includes reviewing hospital discharge dates for people with Medicare. These experts are not part of our plan.

Step 1: Contact the Quality Improvement Organization for your state and ask for an immediate review of your hospital discharge. You must act quickly.

How can you contact this organization?

- The written notice you received (An Important Message from Medicare About Your Rights) tells you how to reach this organization. Or find the name, address, and phone number of the Quality Improvement Organization for your state in Chapter 2.
Act quickly:

- To make your appeal, you must contact the Quality Improvement Organization before you leave the hospital and no later than midnight the day of your discharge.
  - If you meet this deadline, you may stay in the hospital after your discharge date without paying for it while you wait to get the decision from the Quality Improvement Organization.
  - If you do not meet this deadline, and you decide to stay in the hospital after your planned discharge date, you may have to pay all of the costs for hospital care you receive after your planned discharge date.
- If you miss the deadline for contacting the Quality Improvement Organization, and you still wish to appeal, you must make an appeal directly to our plan instead. For details about this other way to make your appeal, see Section 6.4.

Once you request an immediate review of your hospital discharge the Quality Improvement Organization will contact us. By noon of the day after we are contacted we will give you a Detailed Notice of Discharge. This notice gives your planned discharge date and explains in detail the reasons why your doctor, the hospital, and we think it is right (medically appropriate) for you to be discharged on that date.

You can get a sample of the Detailed Notice of Discharge by calling Customer Service or 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. (TTY users should call 1-877-486-2048.) Or you can see a sample notice online at www.cms.gov/Medicare/Medicare-General-Information/BNI/HospitalDischargeAppealNotices.

Step 2: The Quality Improvement Organization conducts an independent review of your case.

- Health professionals at the Quality Improvement Organization (“the reviewers”) will ask you (or your representative) why you believe coverage for the services should continue. You don’t have to prepare anything in writing, but you may do so if you wish.
- The reviewers will also look at your medical information, talk with your doctor, and review information that the hospital and we have given to them.
- By noon of the day after the reviewers told us of your appeal, you will get a written notice from us that gives your planned discharge date. This notice also explains in detail the reasons why your doctor, the hospital, and we think it is right (medically appropriate) for you to be discharged on that date.

Step 3: Within one full day after it has all the needed information, the Quality Improvement Organization will give you its answer to your appeal.

What happens if the answer is yes?

- If the review organization says yes, we must keep providing your covered inpatient hospital services for as long as these services are medically necessary.
What happens if the answer is no?

• If the review organization says no, they are saying that your planned discharge date is medically appropriate. If this happens, our coverage for your inpatient hospital services will end at noon on the day after the Quality Improvement Organization gives you its answer to your appeal.

• If the review organization says no to your appeal and you decide to stay in the hospital, then you may have to pay the full cost of hospital care you receive after noon on the day after the Quality Improvement Organization gives you its answer to your appeal.

Step 4: If the answer to your Level 1 appeal is no, you decide if you want to make another appeal.

• If the Quality Improvement Organization has said no to your appeal, and you stay in the hospital after your planned discharge date, then you can make another appeal. Making another appeal means you are going on to “Level 2” of the appeals process.
Improvement Organization. We must continue providing coverage for your inpatient hospital care for as long as it is medically necessary.

- You must continue to pay your share of the costs and coverage limitations may apply.

**If the review organization says no:**

- It means they agree with the decision they made on your Level 1 appeal. This is called “upholding the decision.”
- The notice you get will tell you in writing what you can do if you wish to continue with the review process.

**Step 4: If the answer is no, you will need to decide whether you want to take your appeal further by going on to Level 3.**

- There are three additional levels in the appeals process after Level 2 (for a total of five levels of appeal). If you want to go to a Level 3 appeal, the details on how to do this are in the written notice you get after your Level 2 appeal decision.
- The Level 3 appeal is handled by an Administrative Law Judge or attorney adjudicator. Section 8 in this chapter tells more about Levels 3, 4, and 5 of the appeals process.

**Section 6.4 What if you miss the deadline for making your Level 1 appeal?**

<table>
<thead>
<tr>
<th>Legal Term</th>
</tr>
</thead>
<tbody>
<tr>
<td>A “fast review” (or “fast appeal”) is also called an <strong>expedited appeal.”</strong></td>
</tr>
</tbody>
</table>

**You can appeal to us instead**

As explained above, you must act quickly to start your Level 1 appeal of your hospital discharge. If you miss the deadline for contacting the Quality Improvement Organization, there is another way to make your appeal.

If you use this other way of making your appeal, the first two levels of appeal are different.

**Step-by-Step: How to make a Level 1 Alternate appeal**

**Step 1: Contact us and ask for a “fast review.”**

- Ask for a “fast review.” This means you are asking us to give you an answer using the “fast” deadlines rather than the “standard” deadlines. Chapter 2 has contact information.
Step 2: We do a “fast review” of your planned discharge date, checking to see if it was medically appropriate.

- During this review, we take a look at all of the information about your hospital stay. We check to see if your planned discharge date was medically appropriate. We see if the decision about when you should leave the hospital was fair and followed all the rules.

Step 3: We give you our decision within 72 hours after you ask for a “fast review.”

- If we say yes to your appeal, it means we have agreed with you that you still need to be in the hospital after the discharge date. We will keep providing your covered inpatient hospital services for as long as they are medically necessary. It also means that we have agreed to reimburse you for our share of the costs of care you have received since the date when we said your coverage would end. (You must pay your share of the costs and there may be coverage limitations that apply.)

- If we say no to your appeal, we are saying that your planned discharge date was medically appropriate. Our coverage for your inpatient hospital services ends as of the day we said coverage would end.
  - If you stayed in the hospital after your planned discharge date, then you may have to pay the full cost of hospital care you received after the planned discharge date.

Step 4: If we say no to your appeal, your case will automatically be sent on to the next level of the appeals process.

Step-by-Step: Level 2 Alternate appeal Process

<table>
<thead>
<tr>
<th>Legal Term</th>
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</thead>
<tbody>
<tr>
<td>The formal name for the “independent review organization” is the “Independent Review Entity.” It is sometimes called the “IRE.”</td>
</tr>
</tbody>
</table>

The independent review organization is an independent organization hired by Medicare. It is not connected with our plan and is not a government agency. This organization decides whether the decision we made is correct or if it should be changed. Medicare oversees its work.

Step 1: We will automatically forward your case to the independent review organization.

- We are required to send the information for your Level 2 appeal to the independent review organization within 24 hours of when we tell you that we are saying no to your first appeal. (If you think we are not meeting this deadline or other deadlines, you can make a complaint. Section 9 of this chapter tells how to make a complaint.)
Section 7.1  

This section is only about three services:  
Home health care, skilled nursing facility care, and Comprehensive Outpatient Rehabilitation Facility (CORF) services

When you are getting home health services, skilled nursing care, or rehabilitation care (Comprehensive Outpatient Rehabilitation Facility), you have the right to keep getting your covered services for that type of care for as long as the care is needed to diagnose and treat your illness or injury.

When we decide it is time to stop covering any of the three types of care for you, we are required to tell you in advance. When your coverage for that care ends, we will stop paying our share of the cost for your care.
If you think we are ending the coverage of your care too soon, you can appeal our decision. This section tells you how to ask for an appeal.

Section 7.2  We will tell you in advance when your coverage will be ending

Legal Term

“Notice of Medicare Non-Coverage.” It tells you how you can request a “fast-track appeal.” Requesting a fast-track appeal is a formal, legal way to request a change to our coverage decision about when to stop your care.

1. **You receive a notice in writing** at least two days before our plan is going to stop covering your care. The notice tells you:
   - The date when we will stop covering the care for you.
   - How to request a “fast track appeal” to request us to keep covering your care for a longer period of time.

2. **You, or someone who is acting on your behalf, will be asked to sign the written notice to show that you received it.** Signing the notice shows only that you have received the information about when your coverage will stop. **Signing it does not mean you agree** with the plan’s decision to stop care.

Section 7.3  Step-by-step: How to make a Level 1 appeal to have our plan cover your care for a longer time

If you want to ask us to cover your care for a longer period of time, you will need to use the appeals process to make this request. Before you start, understand what you need to do and what the deadlines are.

- **Follow the process.**
- **Meet the deadlines.**
- **Ask for help if you need it.** If you have questions or need help at any time, please call Customer Service. Or call your SHIP, a government organization that provides personalized assistance.

**During a Level 1 appeal, the Quality Improvement Organization reviews your appeal.** It decides if the end date for your care is medically appropriate.

The **Quality Improvement Organization** is a group of doctors and other health care experts paid by the Federal government to check on and help improve the quality of care for people with Medicare. This includes reviewing plan decisions about when it’s time to stop covering certain kinds of medical care. These experts are not part of our plan.
Step 1: Make your Level 1 appeal: contact the Quality Improvement Organization and ask for a *fast-track appeal*. You must act quickly.

*How can you contact this organization?*
- The written notice you received (*Notice of Medicare Non-Coverage*) tells you how to reach this organization. Or find the name, address, and phone number of the Quality Improvement Organization for your state in Chapter 2.

*Act quickly:*
- You must contact the Quality Improvement Organization to start your appeal by noon of the day before the effective date on the Notice of Medicare Non-Coverage.

*Your deadline for contacting this organization.*
- If you miss the deadline for contacting the Quality Improvement Organization, and you still wish to file an appeal, you must make an appeal directly to us instead. For details about this other way to make your appeal, see Section 7.5.

**Step 2: The Quality Improvement Organization conducts an independent review of your case.***

<table>
<thead>
<tr>
<th>Legal Term</th>
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</thead>
<tbody>
<tr>
<td>“Detailed Explanation of Non-Coverage.” Notice that provides details on reasons for ending coverage.</td>
</tr>
</tbody>
</table>

*What happens during this review?*
- Health professionals at the Quality Improvement Organization ("the reviewers") will ask you, or your representative, why you believe coverage for the services should continue. You don’t have to prepare anything in writing, but you may do so if you wish.
- The review organization will also look at your medical information, talk with your doctor, and review information that our plan has given to them.
- By the end of the day the reviewers tell us of your appeal, you will get the *Detailed Explanation of Non-Coverage* from us that explains in detail our reasons for ending our coverage for your services.

**Step 3: Within one full day after they have all the information they need, the reviewers will tell you their decision.***

*What happens if the reviewers say yes?*
- If the reviewers say yes to your appeal, then we must keep providing your covered services for as long as it is medically necessary.
- You will have to keep paying your share of the costs (such as deductibles or copayments, if these apply). There may be limitations on your covered services.
Chapter 7 What to do if you have a problem or complaint (coverage decisions, appeals, complaints)

What happens if the reviewers say no?

- If the reviewers say no, then your coverage will end on the date we have told you.
- If you decide to keep getting the home health care, or skilled nursing facility care, or Comprehensive Outpatient Rehabilitation Facility (CORF) services after this date when your coverage ends, then you will have to pay the full cost of this care yourself.

Step 4: If the answer to your Level 1 appeal is no, you decide if you want to make another appeal.

- If reviewers say no to your Level 1 appeal – and you choose to continue getting care after your coverage for the care has ended – then you can make a Level 2 appeal.

Section 7.4 Step-by-step: How to make a Level 2 appeal to have our plan cover your care for a longer time

During a Level 2 appeal, you ask the Quality Improvement Organization to take another look at the decision on your first appeal. If the Quality Improvement Organization turns down your Level 2 appeal, you may have to pay the full cost for your home health care, or skilled nursing facility care, or Comprehensive Outpatient Rehabilitation Facility (CORF) services after the date when we said your coverage would end.

Step 1: Contact the Quality Improvement Organization again and ask for another review.

- You must ask for this review within 60 days after the day when the Quality Improvement Organization said no to your Level 1 appeal. You can ask for this review only if you continued getting care after the date that your coverage for the care ended.

Step 2: The Quality Improvement Organization does a second review of your situation.

- Reviewers at the Quality Improvement Organization will take another careful look at all of the information related to your appeal.

Step 3: Within 14 days of receipt of your appeal request, reviewers will decide on your appeal and tell you their decision.

What happens if the review organization says yes?

- We must reimburse you for our share of the costs of care you have received since the date when we said your coverage would end. We must continue providing coverage for the care for as long as it is medically necessary.
- You must continue to pay your share of the costs and there may be coverage limitations that apply.
Chapter 7 What to do if you have a problem or complaint (coverage decisions, appeals, complaints)

What happens if the review organization says no?

- It means they agree with the decision made to your Level 1 appeal.
- The notice you get will tell you in writing what you can do if you wish to continue with the review process. It will give you the details about how to go on to the next level of appeal, which is handled by an Administrative Law Judge or attorney adjudicator.

Step 4: If the answer is no, you will need to decide whether you want to take your appeal further.

- There are three additional levels of appeal after Level 2, for a total of five levels of appeal. If you want to go on to a Level 3 appeal, the details on how to do this are in the written notice you get after your Level 2 appeal decision.
- The Level 3 appeal is handled by an Administrative Law Judge or attorney adjudicator. Section 8 in this chapter tells more about Levels 3, 4, and 5 of the appeals process.

Section 7.5 What if you miss the deadline for making your Level 1 appeal?

You can appeal to us instead

As explained above, you must act quickly to start your Level 1 appeal (within a day or two, at the most). If you miss the deadline for contacting the Quality Improvement Organization, there is another way to make your appeal. If you use this other way of making your appeal, the first two levels of appeal are different.

Step-by-Step: How to make a Level 1 Alternate appeal

<table>
<thead>
<tr>
<th>Legal Term</th>
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</thead>
<tbody>
<tr>
<td>A “fast review” (or “fast appeal”) is also called an “expedited appeal.”</td>
</tr>
</tbody>
</table>

Step 1: Contact us and ask for a “fast review.”

- Ask for a “fast review.” This means you are asking us to give you an answer using the “fast” deadlines rather than the “standard” deadlines. Chapter 2 has contact information.

Step 2: We do a “fast review” of the decision we made about when to end coverage for your services.

- During this review, we take another look at all of the information about your case. We check to see if we were following all the rules when we set the date for ending the plan’s coverage for services you were receiving.

Step 3: We give you our decision within 72 hours after you ask for a “fast review”

- If we say yes to your appeal, it means we have agreed with you that you need services longer, and will keep providing your covered services for as long as they are medically
necessary. It also means that we have agreed to reimburse you for our share of the costs of care you have received since the date when we said your coverage would end. (You must pay your share of the costs and there may be coverage limitations that apply.)

- **If we say no to your appeal,** then your coverage will end on the date we told you and we will not pay any share of the costs after this date.

- If you continued to get home health care, or skilled nursing facility care, or Comprehensive Outpatient Rehabilitation Facility (CORF) services after the date when we said your coverage would end, then you will have to pay the full cost of this care.

**Step 4: If we say no to your appeal, your case will automatically go on to the next level of the appeals process.**

<table>
<thead>
<tr>
<th>Legal Term</th>
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</thead>
<tbody>
<tr>
<td>The formal name for the “independent review organization” is the “Independent Review Entity.” It is sometimes called the “IRE.”</td>
</tr>
</tbody>
</table>

**Step-by-Step: Level 2 Alternate appeal Process**

During the Level 2 appeal, an independent review organization reviews the decision we made to your “fast appeal.” This organization decides whether the decision should be changed. The independent review organization is an independent organization that is hired by Medicare. This organization is not connected with our plan and it is not a government agency. This organization is a company chosen by Medicare to handle the job of being the independent review organization. Medicare oversees its work.

**Step 1: We automatically forward your case to the independent review organization.**

- We are required to send the information for your Level 2 appeal to the independent review organization within 24 hours of when we tell you that we are saying no to your first appeal. (If you think we are not meeting this deadline or other deadlines, you can make a complaint. Section 9 of this chapter tells how to make a complaint.)

**Step 2: The independent review organization does a “fast review” of your appeal. The reviewers give you an answer within 72 hours.**

- Reviewers at the independent review organization will take a careful look at all of the information related to your appeal.

- **If this organization says yes to your appeal,** then we must pay you back for our share of the costs of care you have received since the date when we said your coverage would end. We must also continue to cover the care for as long as it is medically necessary. You must continue to pay your share of the costs. If there are coverage limitations, these could limit how much we would reimburse or how long we would continue to cover services.
If this organization says no to your appeal, it means they agree with the decision our plan made to your first appeal and will not change it.

The notice you get from the independent review organization will tell you in writing what you can do if you wish to go on to a Level 3 appeal.

Step 3: If the independent review organization says no to your appeal, you choose whether you want to take your appeal further.

- There are three additional levels of appeal after Level 2, for a total of five levels of appeal. If you want to go on to a Level 3 appeal, the details on how to do this are in the written notice you get after your Level 2 appeal decision.
- A Level 3 appeal is reviewed by an Administrative Law Judge or attorney adjudicator. Section 8 in this chapter tells more about Levels 3, 4, and 5 of the appeals process.

SECTION 8 Taking your appeal to Level 3 and beyond

Section 8.1 Appeal Levels 3, 4 and 5 for Medical Service Requests

This section may be appropriate for you if you have made a Level 1 appeal and a Level 2 appeal, and both of your appeals have been turned down.

If the dollar value of the item or medical service you have appealed meets certain minimum levels, you may be able to go on to additional levels of appeal. If the dollar value is less than the minimum level, you cannot appeal any further. The written response you receive to your Level 2 appeal will explain how to make a Level 3 appeal.

For most situations that involve appeals, the last three levels of appeal work in much the same way. Here is who handles the review of your appeal at each of these levels.

<table>
<thead>
<tr>
<th>Level 3 appeal</th>
<th>An Administrative Law Judge or an attorney adjudicator who works for the Federal government will review your appeal and give you an answer.</th>
</tr>
</thead>
</table>

- If the Administrative Law Judge or attorney adjudicator says yes to your appeal, the appeals process may or may not be over. Unlike a decision at a Level 2 appeal, we have the right to appeal a Level 3 decision that is favorable to you. If we decide to appeal it will go to a Level 4 appeal.
  - If we decide not to appeal, we must authorize or provide you with the service within 60 calendar days after receiving the Administrative Law Judge’s or attorney adjudicator’s decision.
  - If we decide to appeal the decision, we will send you a copy of the Level 4 appeal request with any accompanying documents. We may wait for the Level 4 appeal decision before authorizing or providing the service in dispute.
Chapter 7 What to do if you have a problem or complaint (coverage decisions, appeals, complaints)

- If the Administrative Law Judge or attorney adjudicator says no to your appeal, the appeals process *may* or *may not* be over.
  - If you decide to accept this decision that turns down your appeal, the appeals process is over.
  - If you do not want to accept the decision, you can continue to the next level of the review process. The notice you get will tell you what to do for a Level 4 appeal.

**Level 4 appeal**  The Medicare Appeals Council (Council) will review your appeal and give you an answer. The Council is part of the Federal government.

- If the answer is yes, or if the Council denies our request to review a favorable Level 3 appeal decision, the appeals process *may* or *may not* be over. Unlike a decision at Level 2, we have the right to appeal a Level 4 decision that is favorable to you. We will decide whether to appeal this decision to Level 5.
  - If we decide *not* to appeal the decision, we must authorize or provide you with the service within 60 calendar days after receiving the Council’s decision.
  - If we decide to appeal the decision, we will let you know in writing.

- If the answer is no or if the Council denies the review request, the appeals process *may* or *may not* be over.
  - If you decide to accept this decision that turns down your appeal, the appeals process is over.
  - If you do not want to accept the decision, you may be able to continue to the next level of the review process. If the Council says no to your appeal, the notice you get will tell you whether the rules allow you to go on to a Level 5 appeal and how to continue with a Level 5 appeal.

**Level 5 appeal**  A judge at the Federal District Court will review your appeal.

- A judge will review all of the information and decide *yes* or *no* to your request. This is a final answer. There are no more appeal levels after the Federal District Court.
MAKING COMPLAINTS

SECTION 9 How to make a complaint about quality of care, waiting times, customer service, or other concerns

Section 9.1 What kinds of problems are handled by the complaint process?

The complaint process is only used for certain types of problems. This includes problems related to quality of care, waiting times, and the customer service. Here are examples of the kinds of problems handled by the complaint process.

<table>
<thead>
<tr>
<th>Complaint</th>
<th>Example</th>
</tr>
</thead>
<tbody>
<tr>
<td>Quality of your medical care</td>
<td>• Are you unhappy with the quality of the care you have received (including care in the hospital)?</td>
</tr>
<tr>
<td>Respecting your privacy</td>
<td>• Did someone not respect your right to privacy or shared confidential information?</td>
</tr>
</tbody>
</table>
| Disrespect, poor customer service, or other negative behaviors | • Has someone been rude or disrespectful to you?  
• Are you unhappy with our Customer Service?  
• Do you feel you are being encouraged to leave the plan? |
| Waiting times                      | • Are you having trouble getting an appointment, or waiting too long to get it?  
• Have you been kept waiting too long by doctors, pharmacists, or other health professionals? Or by our Customer Service or other staff at the plan?  
  ○ Examples include waiting too long on the phone, in the waiting or exam room, or getting a prescription. |
| Cleanliness                        | • Are you unhappy with the cleanliness or condition of a clinic, hospital, or doctor’s office? |
| Information you get from us        | • Did we fail to give you a required notice?  
• Is our written information hard to understand? |
Chapter 7 What to do if you have a problem or complaint (coverage decisions, appeals, complaints)

<table>
<thead>
<tr>
<th>Complaint</th>
<th>Example</th>
</tr>
</thead>
<tbody>
<tr>
<td>Timeliness</td>
<td>If you have asked for a coverage decision or made an appeal, and you think that we are not responding quickly enough, you can make a complaint about our slowness. Here are examples:</td>
</tr>
<tr>
<td>(These types of complaints are all related to the timeliness of our actions related to coverage decisions and appeals)</td>
<td>• You asked us for a “fast coverage decision” or a “fast appeal,” and we have said no; you can make a complaint.</td>
</tr>
<tr>
<td></td>
<td>• You believe we are not meeting the deadlines for coverage decisions or appeals: you can make a complaint.</td>
</tr>
<tr>
<td></td>
<td>• You believe we are not meeting deadlines for covering or reimbursing you for certain medical services that were approved; you can make a complaint.</td>
</tr>
<tr>
<td></td>
<td>• You believe we failed to meet required deadlines for forwarding your case to the independent review organization; you can make a complaint.</td>
</tr>
</tbody>
</table>

Section 9.2 How to make a complaint

Legal Terms

- A “Complaint” is also called a “grievance.”
- “Making a complaint” is also called “filing a grievance.”
- “Using the process for complaints” is also called “using the process for filing a grievance.”
- A “fast complaint” is also called an “expedited grievance.”

Section 9.3 Step-by-step: Making a complaint

Step 1: Contact us promptly – either by phone or in writing.

- Usually, calling Customer Service is the first step. If there is anything else you need to do, Customer Service will let you know.
- If you do not wish to call (or you called and were not satisfied), you can put your complaint in writing and send it to us. If you put your complaint in writing, we will respond to your complaint in writing.
- If you have a complaint, you or your appointed representative may call 503-574-8000 or 1-800-603-2340 (TTY: 711). You may also send your complaint in writing to the Appeals and Grievances Department at the following address: Providence Health...
Chapter 7 What to do if you have a problem or complaint (coverage decisions, appeals, complaints)

Assurance, Attn: Appeals and Grievances Department, P.O. Box 4158, Portland, OR 97208-4158.

- The **deadline** for making a complaint is 60 calendar days from the time you had the problem you want to complain about.

**Step 2: We look into your complaint and give you our answer.**

- **If possible, we will answer you right away.** If you call us with a complaint, we may be able to give you an answer on the same phone call.

- **Most complaints are answered within 30 calendar days.** If we need more information and the delay is in your best interest or if you ask for more time, we can take up to 14 more calendar days (44 calendar days total) to answer your complaint. If we decide to take extra days, we will tell you in writing.

- **If you are making a complaint because we denied your request for a “fast coverage decision” or a “fast appeal,” we will automatically give you a “fast complaint.”** If you have a “fast complaint,” it means we will give you an answer within 24 hours.

- **If we do not agree** with some or all of your complaint or don’t take responsibility for the problem you are complaining about, we will include our reasons in our response to you.

**Section 9.4 You can also make complaints about quality of care to the Quality Improvement Organization**

When your complaint is about *quality of care*, you also have two extra options:

- **You can make your complaint directly to the Quality Improvement Organization.** The Quality Improvement Organization is a group of practicing doctors and other health care experts paid by the Federal government to check and improve the care given to Medicare patients. Chapter 2 has contact information.

  Or

- **You can make your complaint to both the Quality Improvement Organization and us at the same time.**

**Section 9.5 You can also tell Medicare about your complaint**

You can submit a complaint about Providence Medicare Focus Medical (HMO) directly to Medicare. To submit a complaint to Medicare, go to www.medicare.gov/MedicareComplaintForm/home.aspx. You may also call 1-800-MEDICARE (1-800-633-4227). TTY/TDD users can call 1-877-486-2048.
CHAPTER 8: Ending your membership in the plan
SECTION 1  Introduction to ending your membership in our plan

Ending your membership in Providence Medicare Focus Medical (HMO) may be voluntary (your own choice) or involuntary (not your own choice):

- You might leave our plan because you have decided that you want to leave. Sections 2 and 3 provide information on ending your membership voluntarily.
- There are also limited situations where we are required to end your membership. Section 5 tells you about situations when we must end your membership.

If you are leaving our plan, our plan must continue to provide your medical care and you will continue to pay your cost share until your membership ends.

SECTION 2  When can you end your membership in our plan?

<table>
<thead>
<tr>
<th>Section 2.1</th>
<th>You can end your membership during the Annual Enrollment Period</th>
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</table>

You can end your membership in our plan during the Annual Enrollment Period (also known as the “Annual Open Enrollment Period”). During this time, review your health and drug coverage and decide about coverage for the upcoming year.

- The Annual Enrollment Period is from October 15 to December 7.
- Choose to keep your current coverage or make changes to your coverage for the upcoming year. If you decide to change to a new plan, you can choose any of the following types of plans:
  - Another Medicare health plan, with or without prescription drug coverage.
  - Original Medicare with a separate Medicare prescription drug plan.
    OR
  - Original Medicare without a separate Medicare prescription drug plan.
- Your membership will end in our plan when your new plan’s coverage begins on January 1.

<table>
<thead>
<tr>
<th>Section 2.2</th>
<th>You can end your membership during the Medicare Advantage Open Enrollment Period</th>
</tr>
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</table>

You have the opportunity to make one change to your health coverage during the Medicare Advantage Open Enrollment Period.

- The annual Medicare Advantage Open Enrollment Period is from January 1 to March 31.
Chapter 8 Ending your membership in the plan

- **During the annual Medicare Advantage Open Enrollment Period** you can:
  - Switch to another Medicare Advantage Plan with or without prescription drug coverage.
  - Disenroll from our plan and obtain coverage through Original Medicare. If you choose to switch to Original Medicare during this period, you can also join a separate Medicare prescription drug plan at that time.

- **Your membership will end** on the first day of the month after you enroll in a different Medicare Advantage plan or we get your request to switch to Original Medicare. If you also choose to enroll in a Medicare prescription drug plan, your membership in the drug plan will begin the first day of the month after the drug plan gets your enrollment request.

### Section 2.3 In certain situations, you can end your membership during a Special Enrollment Period

In certain situations, members of Providence Medicare Focus Medical (HMO) may be eligible to end their membership at other times of the year. This is known as a **Special Enrollment Period**.

**You may be eligible to end your membership during a Special Enrollment Period** if any of the following situations apply to you. These are just examples, for the full list, you can contact the plan, call Medicare, or visit the Medicare website (www.medicare.gov):

- Usually, when you have moved.
- If you have Medicaid (Oregon Health Plan or Washington Apple Health).
- If we violate our contract with you.
- If you get care in an institution, such as a nursing home or long-term care (LTC) hospital.
- If you enroll in the Program of All-inclusive Care for the Elderly (PACE).

The enrollment time periods vary depending on your situation.

**To find out if you are eligible for a Special Enrollment Period**, please call Medicare at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users call 1-877-486-2048. If you are eligible to end your membership because of a special situation, you can choose to change both your Medicare health coverage and prescription drug coverage. You can choose:

- Another Medicare health plan with or without prescription drug coverage.
- Original Medicare with a separate Medicare prescription drug plan.

**OR**

- Original Medicare without a separate Medicare prescription drug plan.

**Your membership will usually end** on the first day of the month after your request to change your plan is received.
Section 2.4 Where can you get more information about when you can end your membership?

If you have any questions about ending your membership you can:

- **Call Customer Service.**
- Find the information in the *Medicare & You 2023* handbook.
- Contact Medicare at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week (TTY 1-877-486-2048).

SECTION 3 How do you end your membership in our plan?

The table below explains how you should end your membership in our plan.

<table>
<thead>
<tr>
<th>If you would like to switch from our plan to:</th>
<th>This is what you should do:</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Another Medicare health plan.</td>
<td>- Enroll in the new Medicare health plan.</td>
</tr>
<tr>
<td></td>
<td>- You will automatically be disenrolled from Providence Medicare Focus Medical (HMO) when your new plan’s coverage begins.</td>
</tr>
<tr>
<td>- Original Medicare with a separate Medicare prescription drug plan.</td>
<td>- Enroll in the new Medicare prescription drug plan.</td>
</tr>
<tr>
<td></td>
<td>- You will automatically be disenrolled from Providence Medicare Focus Medical (HMO) when your new plan’s coverage begins.</td>
</tr>
<tr>
<td>- Original Medicare without a separate Medicare prescription drug plan.</td>
<td>- <strong>Send us a written request to disenroll.</strong> Contact Customer Service if you need more information on how to do this.</td>
</tr>
<tr>
<td></td>
<td>- You can also contact Medicare, at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week, and ask to be disenrolled. TTY users should call 1-877-486-2048.</td>
</tr>
<tr>
<td></td>
<td>- You will be disenrolled from Providence Medicare Focus Medical (HMO) when your coverage in Original Medicare begins.</td>
</tr>
</tbody>
</table>
SECTION 4 Until your membership ends, you must keep getting your medical services through our plan

Until your membership ends, and your new Medicare coverage begins, you must continue to get your medical care through our plan.

- Continue to use our network providers to receive medical care.
- If you are hospitalized on the day that your membership ends, your hospital stay will be covered by our plan until you are discharged (even if you are discharged after your new health coverage begins).

SECTION 5 Providence Medicare Focus Medical (HMO) must end your membership in the plan in certain situations

Section 5.1 When must we end your membership in the plan?

Providence Medicare Focus Medical (HMO) must end your membership in the plan if any of the following happen:

- If you no longer have Medicare Part A and Part B.
- If you move out of our service area.
- If you are away from our service area for more than six months.
  - If you move or take a long trip, call Customer Service to find out if the place you are moving or traveling to is in our plan’s area.
- If you become incarcerated (go to prison).
- If you are no longer a United States citizen or lawfully present in the United States.
- If you intentionally give us incorrect information when you are enrolling in our plan and that information affects your eligibility for our plan. (We cannot make you leave our plan for this reason unless we get permission from Medicare first.)
- If you continuously behave in a way that is disruptive and makes it difficult for us to provide medical care for you and other members of our plan. (We cannot make you leave our plan for this reason unless we get permission from Medicare first.)
- If you let someone else use your membership card to get medical care. (We cannot make you leave our plan for this reason unless we get permission from Medicare first.)
  - If we end your membership because of this reason, Medicare may have your case investigated by the Inspector General.
- If you do not pay the plan premiums for 90 days.
Chapter 8 Ending your membership in the plan

- Premium payments are first applied to your medical premium. If you have chosen to receive optional supplemental benefits, the payment is then applied to that premium.
  - If partial payment is made and it does not cover your medical premium, you could potentially be disenrolled from your medical coverage AND your optional supplemental coverage after 90 days.
  - If partial payment is made and it does not cover your optional supplemental premium, your coverage could potentially be downgraded to remove optional supplemental coverage after 90 days.
- We must notify you in writing that you have 90 days to pay the plan premium before we end your membership.

Where can you get more information?

If you have questions or would like more information on when we can end your membership, call Customer Service.

<table>
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<tr>
<th>Section 5.2</th>
<th>We cannot ask you to leave our plan for any health-related reason</th>
</tr>
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</table>

Providence Medicare Focus Medical (HMO) is not allowed to ask you to leave our plan for any health-related reason.

What should you do if this happens?

If you feel that you are being asked to leave our plan because of a health-related reason, call Medicare at 1-800-MEDICARE (1-800-633-4227) 24 hours a day, 7 days a week. (TTY 1-877-486-2048).

<table>
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<tr>
<th>Section 5.3</th>
<th>You have the right to make a complaint if we end your membership in our plan</th>
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</table>

If we end your membership in our plan, we must tell you our reasons in writing for ending your membership. We must also explain how you can file a grievance or make a complaint about our decision to end your membership.
CHAPTER 9: Legal notices
SECTION 1 Notice about governing law

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

SECTION 2 Notice about non-discrimination

We don’t discriminate based on race, ethnicity, national origin, color, religion, sex, gender, age, sexual orientation, mental or physical disability, health status, claims experience, medical history, genetic information, evidence of insurability, or geographic location within the service area. All organizations that provide Medicare Advantage plans, like our plan, must obey Federal laws against discrimination, including Title VI of the Civil Rights Act of 1964, the Rehabilitation Act of 1973, the Age Discrimination Act of 1975, the Americans with Disabilities Act, Section 1557 of the Affordable Care Act, all other laws that apply to organizations that get Federal funding, and any other laws and rules that apply for any other reason.

If you want more information or have concerns about discrimination or unfair treatment, please call the Department of Health and Human Services’ Office for Civil Rights at 1-800-368-1019 (TTY 1-800-537-7697) or your local Office for Civil Rights. You can also review information from the Department of Health and Human Services’ Office for Civil Rights at https://www.hhs.gov/ocr/index.

If you have a disability and need help with access to care, please call us at Customer Service. If you have a complaint, such as a problem with wheelchair access, Customer Service can help.

SECTION 3 Notice about Medicare Secondary Payer subrogation rights

We have the right and responsibility to collect for covered Medicare services for which Medicare is not the primary payer. According to CMS regulations at 42 CFR sections 422.108 and 423.462, Providence Medicare Focus Medical (HMO), as a Medicare Advantage Organization, will exercise the same rights of recovery that the Secretary exercises under CMS regulations in subparts B through D of part 411 of 42 CFR and the rules established in this section supersede any State laws.

SECTION 4 Notice about Unusual Circumstances

The following are examples of unusual circumstances: complete or partial destruction of facilities, war riot, civil insurrection, labor disputes, not within the control of Providence Health Assurance, major disaster, disability of significant part of hospital personnel, epidemic, or
similar causes. If due to unusual circumstances, the rendition or provision of services and other benefits covered under this agreement is delayed or impractical, Providence Health Assurance will, within limitation of available facilities and personnel, use its best efforts to provide services and other benefits covered under this agreement. With regard to unusual circumstances neither Providence Health Assurance, hospitals, nor any physician shall have any liability for obligation on account of delay or such failure to provide services or other benefits.

SECTION 5 Third Party Liability

This section describes your duties if you receive services for which any third party may be responsible. A “third party” is any person other than you or Providence (the “first” and “second” parties), and includes any insurer providing any coverage available to you.

1. Once any third party is found responsible and able to pay for services you have received, Providence will not cover those services.

2. Providence will need detailed information from you. A questionnaire will be sent to you by the Phia Group or Providence Medicare Advantage Plans, which must be completed and returned as soon as possible. If you have any questions, please contact us. A Providence Medicare Advantage Plans employee who specializes in this area can help you.

3. If you make a claim against a third party, you must notify that party of Providence’s interest.

4. To the fullest extent permitted by Medicare, Providence is entitled to repayment from any money recovered from a third party, whether or not the recovery is described or for something other than medical expenses and whether or not you are “made whole” for your losses. Providence is entitled to be repaid from any workers’ compensation recovery whether or not a loss is found compensable under those laws.

5. Providence is entitled to be repaid the full value of benefits, calculated using Providence’s usual and customary charges, less a pro rata share of the expenses and attorney fees incurred to make the recovery.

6. Before accepting settlement of a third-party claim, you must notify Providence in writing of the terms offered.

7. If Providence is not repaid by the third party, you must repay Providence. Providence may request refunds from your medical providers, who will then bill you.

8. You must cooperate with Providence in obtaining repayments from third parties in relation to services that have been covered/paid for by Providence. If you hire an attorney, you must require the attorney to facilitate reimbursement to Providence to the fullest extent permitted by law for any recoveries from third parties.
9. After you receive a third-party recovery, you must pay all medical expenses for treatment of the illness or injury that Providence would otherwise pay.

10. Only when you prove to Providence’s satisfaction that the recovery has been exhausted will Providence again begin paying. Providence will then pay the amount of the cost of services that exceeds the net recovery.

11. If you fail to repay Providence, Providence may recover the repayment out of future benefits owed under this Plan or refer your account to an outside collection agency to recover monies owed to Providence.

12. If you do not make a claim against a responsible third party, or fail to cooperate with Providence in any claim you do make, Providence may collect directly from the third party. To the fullest extent permitted by Medicare, Providence may assume your rights against a third party, may sue the third party in your name, may intervene in any suit you bring, and place a lien on any recovery to the extent Providence has paid benefits, or has incurred expenses to obtain a recovery.

13. Any failure to comply with your duties as described herein may, to the fullest extent permitted by applicable law, result in a denial of payment for benefits by Providence and/or termination of your coverage.
CHAPTER 10:
Definitions of important words
Chapter 10 Definitions of important words

**Ambulatory Surgical Center** – An Ambulatory Surgical Center is an entity that operates exclusively for the purpose of furnishing outpatient surgical services to patients not requiring hospitalization and whose expected stay in the center does not exceed 24 hours.

**Annual Enrollment Period** – The time period of October 15 until December 7 of each year when members can change their health or drug plans or switch to Original Medicare.

**Appeal** – An appeal is something you do if you disagree with our decision to deny a request for coverage of health care services or payment for services you already received. You may also make an appeal if you disagree with our decision to stop services that you are receiving.

**Balance Billing** – When a provider (such as a doctor or hospital) bills a patient more than the plan’s allowed cost-sharing amount. As a member of Providence Medicare Focus Medical (HMO), you only have to pay our plan’s cost-sharing amounts when you get services covered by our plan. We do not allow providers to “balance bill” or otherwise charge you more than the amount of cost sharing your plan says you must pay.

**Benefit Period** – The way that both our plan and Original Medicare measure your use of skilled nursing facility (SNF) services. A benefit period begins the day you go into a skilled nursing facility. The benefit period ends when you have not received any skilled care in a SNF for 60 days in a row. If you go into a skilled nursing facility after one benefit period has ended, a new benefit period begins. There is no limit to the number of benefit periods.

**Centers for Medicare & Medicaid Services (CMS)** – The Federal agency that administers Medicare.

**Chronic-Care Special Needs Plan** – C-SNPs are SNPs that restrict enrollment to special needs individuals with specific severe or disabling chronic conditions, defined in 42 CFR 422.2. A C-SNP must have specific attributes that go beyond the provision of basic Medicare Parts A and B services and care coordination that is required of all Medicare Advantage Coordinated Care Plans, in order to receive the special designation and marketing and enrollment accommodations provided to C-SNPs.

**Coinsurance** – An amount you may be required to pay, expressed as a percentage (for example 20%) as your share of the cost for services.

**Complaint** – The formal name for “making a complaint” is “filing a grievance.” The complaint process is used only for certain types of problems. This includes problems related to quality of care, waiting times, and the customer service you receive. It also includes complaints if your plan does not follow the time periods in the appeal process.

**Comprehensive Outpatient Rehabilitation Facility (CORF)** – A facility that mainly provides rehabilitation services after an illness or injury, including physical therapy, social or psychological services, respiratory therapy, occupational therapy and speech-language pathology services, and home environment evaluation services.
Chapter 10 Definitions of important words

**Copayment (or “copay”)** – An amount you may be required to pay as your share of the cost for a medical service or supply, like a doctor’s visit, hospital outpatient visit, or a prescription. A copayment is a set amount (for example $10), rather than a percentage.

**Cost Sharing** – Cost sharing refers to amounts that a member has to pay when services are received. (This is in addition to the plan’s monthly premium.) Cost sharing includes any combination of the following three types of payments: (1) any deductible amount a plan may impose before services are covered; (2) any fixed “copayment” amount that a plan requires when a specific service is received; or (3) any “coinsurance” amount, a percentage of the total amount paid for a service, that a plan requires when a specific service is received.

**Covered Services** – The term we use to mean all of the health care services and supplies that are covered by our plan.

**Creditable Prescription Drug Coverage** – Prescription drug coverage (for example, from an employer or union) that is expected to pay, on average, at least as much as Medicare’s standard prescription drug coverage. People who have this kind of coverage when they become eligible for Medicare can generally keep that coverage without paying a penalty, if they decide to enroll in Medicare prescription drug coverage later.

**Custodial Care** – Custodial care is personal care provided in a nursing home, hospice, or other facility setting when you do not need skilled medical care or skilled nursing care. Custodial care, provided by people who do not have professional skills or training, includes help with activities of daily living like bathing, dressing, eating, getting in or out of a bed or chair, moving around, and using the bathroom. It may also include the kind of health-related care that most people do themselves, like using eye drops. Medicare doesn’t pay for custodial care.

**Customer Service** – A department within our plan responsible for answering your questions about your membership, benefits, grievances, and appeals.

**Deductible** – The amount you must pay for health care before our plan pays.

**Disenroll** or **Disenrollment** – The process of ending your membership in our plan.

**Dual Eligible Special Needs Plans (D-SNP)** – D-SNPs enroll individuals who are entitled to both Medicare (title XVIII of the Social Security Act) and medical assistance from a state plan under Medicaid (title XIX). States cover some Medicare costs, depending on the state and the individual’s eligibility.

**Durable Medical Equipment (DME)** – Certain medical equipment that is ordered by your doctor for medical reasons. Examples include walkers, wheelchairs, crutches, powered mattress systems, diabetic supplies, IV infusion pumps, speech generating devices, oxygen equipment, nebulizers, or hospital beds ordered by a provider for use in the home.

**Emergency** – A medical emergency is when you, or any other prudent layperson with an average knowledge of health and medicine, believe that you have medical symptoms that require immediate medical attention to prevent loss of life (and, if you are a pregnant woman, loss of an
Definitions of important words

unborn child), loss of a limb, or loss of function of a limb, or loss of or serious impairment to a bodily function. The medical symptoms may be an illness, injury, severe pain, or a medical condition that is quickly getting worse.

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

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

**Extra Help** – A Medicare or a State program to help people with limited income and resources pay Medicare prescription drug program costs, such as premiums, deductibles, and coinsurance.

**Grievance** – A type of complaint you make about our plan or providers, including a complaint concerning the quality of your care. This does not involve coverage or payment disputes.

**Home Health Aide** – A person who provides services that do not need the skills of a licensed nurse or therapist, such as help with personal care (e.g., bathing, using the toilet, dressing, or carrying out the prescribed exercises).

**Hospice** – A benefit that provides special treatment for a member who has been medically certified as terminally ill, meaning having a life expectancy of 6 months or less. We, your plan, must provide you with a list of hospices in your geographic area. If you elect hospice and continue to pay premiums you are still a member of our plan. You can still obtain all medically necessary services as well as the supplemental benefits we offer.

**Hospital Inpatient Stay** – A hospital stay when you have been formally admitted to the hospital for skilled medical services. Even if you stay in the hospital overnight, you might still be considered an “outpatient.”

**Initial Enrollment Period** – When you are first eligible for Medicare, the period of time when you can sign up for Medicare Part A and Part B. If you’re eligible for Medicare when you turn 65, your Initial Enrollment Period is the 7-month period that begins 3 months before the month you turn 65, includes the month you turn 65, and ends 3 months after the month you turn 65.

**Low Income Subsidy (LIS)** – See “Extra Help.”

**Maximum Out-of-Pocket Amount** – The most that you pay out-of-pocket during the calendar year for in-network covered services. Amounts you pay for your plan premiums and Medicare Part A and Part B premiums do not count toward the maximum out-of-pocket amount.

**Medicaid (or Medical Assistance)** – A joint Federal and State program that helps with medical costs for some people with low incomes and limited resources. State Medicaid programs vary, but most health care costs are covered if you qualify for both Medicare and Medicaid.
Medically Necessary – Services, supplies, or drugs that are needed for the prevention, diagnosis, or treatment of your medical condition and meet accepted standards of medical practice.

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

Medicare Advantage Open Enrollment Period – The time period from January 1 until March 31 when members in a Medicare Advantage plan can cancel their plan enrollment and switch to another Medicare Advantage plan, or obtain coverage through Original Medicare. If you choose to switch to Original Medicare during this period, you can also join a separate Medicare prescription drug plan at that time. The Medicare Advantage Open Enrollment Period is also available for a 3-month period after an individual is first eligible for Medicare.

Medicare Advantage (MA) Plan – Sometimes called Medicare Part C. A plan offered by a private company that contracts with Medicare to provide you with all your Medicare Part A and Part B benefits. A Medicare Advantage Plan can be an i) HMO, ii) PPO, a iii) Private Fee-for-Service (PFFS) plan, or a iv) Medicare Medical Savings Account (MSA) plan. Besides choosing from these types of plans, a Medicare Advantage HMO or PPO plan can also be a Special Needs Plan (SNP). In most cases, Medicare Advantage Plans also offer Medicare Part D (prescription drug coverage). These plans are called Medicare Advantage Plans with Prescription Drug Coverage. Providence Medicare Focus Medical (HMO) does not offer Medicare prescription drug coverage.

Medicare-Covered Services – Services covered by Medicare Part A and Part B. All Medicare health plans must cover all of the services that are covered by Medicare Part A and B. The term Medicare-Covered Services does not include the extra benefits, such as vision, dental or hearing, that a Medicare Advantage plan may offer.

Medicare Health Plan – A Medicare health plan is offered by a private company that contracts with Medicare to provide Part A and Part B benefits to people with Medicare who enroll in the plan. This term includes all Medicare Advantage Plans, Medicare Cost Plans, Special Needs Plans, Demonstration/Pilot Programs, and Programs of All-inclusive Care for the Elderly (PACE).

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

“Medigap” (Medicare Supplement Insurance) Policy – Medicare supplement insurance sold by private insurance companies to fill “gaps” in Original Medicare. Medigap policies only work with Original Medicare. (A Medicare Advantage Plan is not a Medigap policy.)

Member (Member of our Plan, or “Plan Member”) – A person with Medicare who is eligible to get covered services, who has enrolled in our plan, and whose enrollment has been confirmed by the Centers for Medicare & Medicaid Services (CMS).
Network Provider – “Provider” is the general term for doctors, other health care professionals, hospitals, and other health care facilities that are licensed or certified by Medicare and by the State to provide health care services. “Network providers” have an agreement with our plan to accept our payment as payment in full, and in some cases to coordinate as well as provide covered services to members of our plan. Network providers are also called “plan providers.”

Optional Supplemental Benefits – Non-Medicare-covered benefits that can be purchased for an additional premium and are not included in your package of benefits. You must voluntarily elect Optional Supplemental Benefits in order to get them.

Organization Determination – A decision our plan makes about whether items or services are covered or how much you have to pay for covered items or services. Organization determinations are called “coverage decisions” in this document.

Original Medicare (“Traditional Medicare” or “Fee-for-service” Medicare) – Original Medicare is offered by the government, and not a private health plan like Medicare Advantage Plans and prescription drug plans. Under Original Medicare, Medicare services are covered by paying doctors, hospitals, and other health care providers payment amounts established by Congress. You can see any doctor, hospital, or other health care provider that accepts Medicare. You must pay the deductible. Medicare pays its share of the Medicare-approved amount, and you pay your share. Original Medicare has two parts: Part A (Hospital Insurance) and Part B (Medical Insurance) and is available everywhere in the United States.

Out-of-Network Provider or Out-of-Network Facility – A provider or facility that does not have a contract with our plan to coordinate or provide covered services to members of our plan. Out-of-network providers are providers that are not employed, owned, or operated by our plan.

Out-of-Pocket Costs – See the definition for “cost sharing” above. A member’s cost-sharing requirement to pay for a portion of services received is also referred to as the member’s “out-of-pocket” cost requirement.

PACE plan – A PACE (Program of All-Inclusive Care for the Elderly) plan combines medical, social, and long-term care (LTC) services for frail people to help people stay independent and living in their community (instead of moving to a nursing home) as long as possible. People enrolled in PACE plans receive both their Medicare and Medicaid benefits through the plan.

Part C – see “Medicare Advantage (MA) Plan.”

Part D – The voluntary Medicare Prescription Drug Benefit Program.

Preferred Provider Organization (PPO) Plan – A Preferred Provider Organization plan is a Medicare Advantage Plan that has a network of contracted providers that have agreed to treat plan members for a specified payment amount. A PPO plan must cover all plan benefits whether they are received from network or out-of-network providers. Member cost sharing will generally be higher when plan benefits are received from out-of-network providers. PPO plans have an annual limit on your out-of-pocket costs for services received from network (preferred) providers.
and a higher limit on your total combined out-of-pocket costs for services from both network (preferred) and out-of-network (non-preferred) providers.

**Premium** – The periodic payment to Medicare, an insurance company, or a health care plan for health or prescription drug coverage.

**Primary Care Provider (PCP)** – The doctor or other provider you see first for most health problems. In many Medicare health plans, you must see your primary care provider before you see any other health care provider.

**Prior Authorization** – Approval in advance to get services. Covered services that need prior authorization are marked in the Benefits Chart in Chapter 4.

**Prosthetics and Orthotics** – Medical devices including, but are not limited to, arm, back and neck braces; artificial limbs; artificial eyes; and devices needed to replace an internal body part or function, including ostomy supplies and enteral and parenteral nutrition therapy.

**Quality Improvement Organization (QIO)** – A group of practicing doctors and other health care experts paid by the Federal government to check and improve the care given to Medicare patients.

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

**Service Area** – A geographic area where you must live to join a particular health plan. For plans that limit which doctors and hospitals you may use, it’s also generally the area where you can get routine (non-emergency) services. The plan must disenroll you if you permanently move out of the plan’s service area.

**Skilled Nursing Facility (SNF) Care** – Skilled nursing care and rehabilitation services provided on a continuous, daily basis, in a skilled nursing facility. Examples of care include physical therapy or intravenous injections that can only be given by a registered nurse or doctor.

**Special Enrollment Period** – A set time when members can change their health or drug plans or return to Original Medicare. Situations in which you may be eligible for a Special Enrollment Period include: if you move outside the service area, if you move into a nursing home, or if we violate our contract with you.

**Special Needs Plan** – A special type of Medicare Advantage Plan that provides more focused health care for specific groups of people, such as those who have both Medicare and Medicaid, who reside in a nursing home, or who have certain chronic medical conditions.

**Supplemental Security Income (SSI)** – A monthly benefit paid by Social Security to people with limited income and resources who are disabled, blind, or age 65 and older. SSI benefits are not the same as Social Security benefits.
**Urgently Needed Services** – Covered services that are not emergency services, provided when the network providers are temporarily unavailable or inaccessible or when the enrollee is out of the service area. For example, you need immediate care during the weekend. Services must be immediately needed and medically necessary.
Providence Medicare Focus Medical (HMO) Customer Service

<table>
<thead>
<tr>
<th>Method</th>
<th>Customer Service – Contact Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>CALL</td>
<td>503-574-8000 or 1-800-603-2340</td>
</tr>
<tr>
<td></td>
<td>Calls to this number are free. Hours are 8 a.m. to 8 p.m. (Pacific Time), seven days a week.</td>
</tr>
<tr>
<td></td>
<td>Customer Service also has free language interpreter services available for non-English speakers.</td>
</tr>
<tr>
<td>TTY</td>
<td>711</td>
</tr>
<tr>
<td></td>
<td>Calls to this number are free. Hours are 8 a.m. to 8 p.m. (Pacific Time), seven days a week.</td>
</tr>
<tr>
<td>FAX</td>
<td>503-574-8608</td>
</tr>
<tr>
<td>WRITE</td>
<td>Providence Health Assurance</td>
</tr>
<tr>
<td></td>
<td>Attn: Customer Service Team</td>
</tr>
<tr>
<td></td>
<td>P.O. Box 5548</td>
</tr>
<tr>
<td></td>
<td>Portland, OR 97228-5548</td>
</tr>
<tr>
<td>WEBSITE</td>
<td><a href="http://www.ProvidenceHealthAssurance.com">www.ProvidenceHealthAssurance.com</a></td>
</tr>
</tbody>
</table>

State Health Insurance Assistance Program

State Health Insurance Assistance Program is a state program that gets money from the Federal government to give free local health insurance counseling to people with Medicare.

Please see Chapter 2, Section 3 for more information about the State Health Insurance Assistance Programs in Oregon and Washington.

PRA Disclosure Statement According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1051. If you have comments or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.
Multi-Language Insert

Multi-language Interpreter Services

English: We have free interpreter services to answer any questions you may have about our health or drug plan. To get an interpreter, just call us at 1-800-603-2340 (TTY: 711). Someone who speaks English/Language can help you. This is a free service.

Spanish: Tenemos servicios de intérprete sin costo alguno para responder cualquier pregunta que pueda tener sobre nuestro plan de salud o medicamentos. Para hablar con un intérprete, por favor llame al 1-800-603-2340 (TTY: 711). Alguien que hable español le podrá ayudar. Este es un servicio gratuito.

Chinese Mandarin: 我们提供免费的翻译服务，帮助您解答关于健康或药物保险的任何疑问。如果需要此翻译服务，请致电 1-800-603-2340 (TTY: 711)。我们的中文工作人员很乐意帮助您。这是一项免费服务。

Chinese Cantonese: 您對我們的健康或藥物保險可能存有疑問，為此我們提供免費的翻譯服務。如需翻譯服務，請致電 1-800-603-2340 (TTY: 711)。我們講中文的人員將樂意為您提供幫助。這是一項免費服務。


French: Nous proposons des services gratuits d'interprétation pour répondre à toutes vos questions relatives à notre régime de santé ou d'assurance-médicaments. Pour accéder au service d'interprétation, il vous suffit de nous appeler au 1-800-603-2340 (TTY: 711). Un interlocuteur parlant Français pourra vous aider. Ce service est gratuit.


Korean: 당사는 의료 보험 또는 약품 보험에 관한 질문에 답해 드리고자 무료 통역 서비스를 제공하고 있습니다. 통역 서비스를 이용하려면 전화 1-800-603-2340 (TTY: 711)번으로 문의해 주십시오. 한국어를 하는 담당자가 도와 드릴 것입니다. 이 서비스는 무료로 운영됩니다.

Russian: Если у вас возникнут вопросы относительно страхового или медикаментного плана, вы можете воспользоваться нашими бесплатными услугами переводчиков. Чтобы воспользоваться услугами переводчика, позвоните нам по телефону 1-800-603-2340 (TTY: 711). Вам окажет помощь сотрудник, который говорит по-русски. Данная услуга бесплатная.


Hindi: हमारे स्वास्थ्य या दवा की योजना के बारे में आपके किसी भी प्रश्न के जवाब देने के लिए हमारे पास मुफ्त दुभाकिया सेवाएँ उपलब्ध हैं. एक दुभाकिया प्राप्त करने के लिए, बस हमें 1-800-603-2340 (TTY: 711) पर फोन करें. कोई व्यक्ति जो हिंदी बोलता है आपकी मदद कर सकता है. यह एक मुफ्त सेवा है.

Italian: È disponibile un servizio di interpretariato gratuito per rispondere a eventuali domande sul nostro piano sanitario e farmaceutico. Per un interprete, contattare il numero 1-800-603-2340 (TTY: 711). Un nostro incaricato che parla Italiano fornisce l'assistenza necessaria. È un servizio gratuito.

Português: Disponemos de serviços de interpretação gratuitos para responder a qualquer questão que tenha acerca do nosso plano de saúde ou de medicação. Para obter um intérprete, contacte-nos através do número 1-800-603-2340 (TTY: 711). Irá encontrar alguém que fale o idioma Português para o ajudar. Este serviço é gratuito.

French Creole: Nou genyen sèvis entèprèt gratis pou reponn tout kesyon ou ta genyen konsènan plan medikal oswa dwòg nou an. Pou jwenn yon entèprèt, jis rele nou nan 1-800-603-2340 (TTY: 711). Yon moun ki pale Kreyòl kapab ede w. Sa a se yon sèvis ki gratis.

Polish: Umożliwiamy bezpłatne skorzystanie z usług tłumacza ustnego, który pomoże w uzyskaniu odpowiedzi na temat planu zdrowotnego lub dawkowania leków. Aby skorzystać z pomocy tłumacza znającego język polski, należy zadzwonić pod numer 1-800-603-2340 (TTY: 711). Ta usługa jest bezpłatna.

Japanese: 当社の健康保険または薬品処方薬プランに関するご質問にお答えするために、無料の通訳サービスがありますございます。通訳をご用命になるには、1-800-603-2340 (TTY: 711) にお電話ください。日本語を話す者が支援いたします。これは無料のサービスです。