

This is Your 2009 Evidence of Coverage (EOC)

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FOR PLAN USE ONLY

CMS102108 H0602 1580001 AB Basic
CMS102108 H0602 1582001 FR Gold
CMS102108 H0602 1584001 FR Standard
CMS102108 H0602 1586001 M Standard
CMS102108 H0602 1598001 FR Thrifty
CMS121008 H0602 1605001 B Basic

CMS102108 H0602 1581001 WS Standard
CMS102108 H0602 1583001 WS Plus
CMS102108 H0602 1585001 M Gold
CMS102108 H0602 1597001 WS Thrifty
CMS102108 H0602 1599001 M Thrifty
CMS121008 H0602 1606001 B Standard

1. Introduction

Thank you for being a Member of our Plan!

This is your Evidence of Coverage, which explains how to get your Medicare health care through our Plan, a Medicare Cost Plan. You are still covered by Medicare, but you are getting your health care through our Plan.

This Evidence of Coverage, together with your enrollment form, riders including optional supplemental benefit brochures and amendments that we send to you, is our contract with you. The Evidence of Coverage explains your rights, benefits, and responsibilities as a Member of our Plan and is in effect from January 1, 2009 - December 31, 2009. Our plan's contract with the Centers for Medicare & Medicaid Services (CMS) is renewed annually, and availability of coverage beyond the end of the current contract year is not guaranteed.

This Evidence of Coverage will explain to you:

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

This Section of the EOC has important information about:

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

Eligibility Requirements

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

The geographic service area for our Plan.

The state and counties in our service area are listed below:

The RMHP Plus – WS, RMHP Standard – WS, and RMHP Thrifty – WS are offered in the following Colorado counties:

Alamosa	Eagle	La Plata	Pitkin	Summit
Archuleta	Garfield	Mesa	Rio Blanco	
Chaffee	Grand	Mineral	Rio Grande	
Conejos	Gunnison	Moffat	Routt	
Costilla	Hinsdale	Montezuma	Saguache	
Delta	Jackson	Montrose	San Juan	
Dolores	Lake	Ouray	San Miguel	

The RMHP Gold – FR, RMHP Standard – FR, and RMHP Thrifty – FR are offered in the following Colorado counties:

Bent	Gilpin	Morgan	Washington
Cheyenne	Huerfano	Otero	Yuma
Clear Creek	Kiowa	Park	
Crowley	Kit Carson	Phillips	
Custer	Las Animas	Prowers	
Elbert	Lincoln	Pueblo	
Fremont	Logan	Sedgwick	

The RMHP Gold – M, RMHP Standard – M, and RMHP Thrifty – M are offered in the following Colorado counties:

Adams	Boulder	Denver	Jefferson
Arapahoe	Broomfield	Douglas	

How do I keep my membership record up to date?

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

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

Materials that you will receive from our Plan

Plan membership card

While you are a Member of our Plan, you may use our membership card for services covered by this plan at network providers while in Colorado. If you see non-network providers in Colorado or anywhere else in the country for services (except emergent and urgent care), you can show your red, white, and blue Medicare card. The Medicare Program will pay for these services and you will have to pay the original Medicare cost-sharing amounts yourself.

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

The Provider Directory gives you a list of network providers

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

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

Your monthly plan premium

As a Member of our Plan, you pay:

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

Your monthly premium will be higher if you are single (file an individual tax return) and your yearly income is more than \$85,000, or if you are married (file a joint tax return) and your yearly income is more than \$170,000.)

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If your Yearly Income is		In 2009, you pay
File individual tax return	File joint tax return	
\$85,000 or below	\$170,000 or below	\$96.40
\$85,001-\$107,000	\$170,001-\$214,000	\$134.90
\$107,001-\$160,000	\$214,001-\$320,000	\$192.70
\$160,001-\$213,000	\$320,001-\$426,000	\$250.50
Above \$213,000	Above \$426,000	\$308.30

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

Your monthly premium for our Plan is listed in Section 10. (If you signed up for extra benefits, also called “optional supplemental benefits”, then you pay an additional premium each month for these extra benefits.) If you have any questions about your Plan premiums or the payment options, please call Customer Service.

Monthly Plan Premium Payment Options

There are two ways to pay your monthly plan premium. Please mark your selected method on the enrollment form.

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

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

You can pay your premium by check:

Quarterly Invoice Billing – RMHP will mail you a quarterly premium billing invoice. This option requires pre-payment for the entire quarter. Quarterly payments are due the first day of the month and the amount due is for the full three months. You will receive the invoice the month prior to the start of the quarter.

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You can send us your plan premium check in the following ways:

- 1) By mail to: P.O. Box 172285, Denver, CO 80217
- 2) In person at: 2775 Crossroads Boulevard, Grand Junction, CO 81506

Instead of paying by check, you can have your monthly plan premium deducted from your bank account or charged to your credit card:

Monthly Bank Draft – RMHP will withdraw your monthly premiums directly from your bank account. With this option, RMHP will not mail you an invoice and you do not need worry about mailing your payment on time. Although premiums are due on the first day of the month, your account will not be drafted until the 4th day of the month (or the next business day if the 4th falls on a weekend).

Monthly Credit Card Automation – RMHP will automatically request monthly payment from your credit card company. With this option, RMHP will not mail you an invoice and you do not need worry about mailing your payment on time. Although premiums are due on the first of the month, your credit card will not be billed until the 4th of the month (or the next business day if the 4th falls on a weekend).

To initiate either the monthly bank draft or the monthly credit card automation, call Customer Service and ask for a Payment Options form.

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

Contact Customer Service for more information on how to pay your monthly plan premium this way.

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

If your monthly plan premiums are late or you have not been paying your copayments, or coinsurance, we will tell you in writing that if you don't pay your monthly plan premium, copayments, or coinsurance, by a certain date, which includes a grace period, we will end your membership in our Plan." Our plans grace period is 20 days. If we end your membership, you will have your Original Medicare Plan coverage.

Should you decide later to re-enroll in our Plan, or to enroll in another plan that we offer, you will have to pay any late monthly plan premiums, copayments or coinsurance that you didn't pay from your previous enrollment in our Plan.

If you signed up for extra benefits ("optional supplemental benefits"), and you don't pay the additional monthly plan premium for these extra benefits on time, we will tell you in writing that if you don't pay the monthly plan premium for these extra benefits within 20 days we will end coverage for the extra benefits. If you want to terminate your extra benefits, you must notify us in advance or we will end your membership.

Important Information

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

2. How You Get Care

How You Get Care

What are “providers”?

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

What are “network providers”?

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

What are “covered services”?

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

What do you pay for “covered services”?

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

Providers you can use to get services covered by our Plan

If you get original Medicare services from an out-of-network provider then you must pay the original Medicare cost-sharing amounts – except in an emergency or if the services were urgently needed. You can find the original Medicare cost-sharing amounts in the *Medicare & You* handbook or by calling 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048. If you get covered supplemental benefits, such as dental services, from an out-of-network provider then you must pay the entire cost of the service. If an out-of-network provider sends you a bill that you think we should pay, please contact Customer Service. Generally, it is best to ask an out-of-network provider to bill the Original Medicare Plan first, and then to bill us for the remaining amount. We may require the out-of-network provider to bill the Original Medicare Plan. We will then pay any applicable Medicare coinsurance and deductibles minus your copayments on your behalf. Note: If we do not cover services furnished by an out-of-network provider, the services will be covered by Original Medicare if they are Medicare-covered services. In this case you would be responsible for Original Medicare cost-sharing amounts.

Choosing Your Primary Care Physician (PCP)

What is a PCP?

When you become a Member of our Plan, you must choose a network provider to be your PCP. Your PCP is a health care professional who meets state requirements and is trained to give you basic medical care. As we explain below, you will get your routine or basic care from your PCP. Your PCP will also coordinate the rest of the covered services you get as a Member of our Plan. Your PCP will provide most of your care and will help you arrange or coordinate the rest of the covered services you get as a Member of Plan.

How to choose a PCP?

To receive covered services, you must select a PCP from our Provider Directory at the time of enrollment. If you do not select a PCP, you generally will have to pay more for services you receive. Before selecting a PCP, you should check with the PCP's office to be sure that the PCP is accepting new Plan Members. You may select a PCP from any county in the service area. The name and office telephone number of your PCP is printed on your membership card. You can change your PCP, as explained later in this section. Call Customer Service at the telephone number listed in Section 1 for additional information or to select your PCP.

What types of providers may act as a PCP?

You should choose a Medical Doctor or a Doctor of Osteopathy as your PCP. Nurse Practitioners and certain clinics can act as a PCP in some Rural Health Areas when approved by our medical director. Your PCP should have a specialty in Internal Medicine, Family Medicine, or Obstetrics and Gynecology. A provider with any other specialty requires approval from our medical director before they can act as your PCP.

How do you get care from your PCP?

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

- your x-rays
- laboratory tests
- therapies
- care from doctors who are specialists
- hospital admissions, and
- follow-up care.

“Coordinating” your services includes checking or consulting with other contracting providers about your care and how it is going. In some cases, your PCP will need to get prior authorization (prior approval) from us for certain services if you do not want to pay Original Medicare deductibles and coinsurance amounts. Since your PCP will provide and coordinate your medical care, you should have all of your past medical records sent to your PCP’s office. Section 3 tells you how we will protect the privacy of your medical records and personal health information.

Getting care from doctors, specialists, and hospitals

You are encouraged to see your PCP for your routine health care services. In most cases, health care services obtained from your PCP have a lower copayment than health care services obtained from a contracting specialist or other contracting provider. A specialist is a doctor who provides health care services for a specific disease or part of the body. Examples include oncologists (who care for patients with cancer), cardiologists (who care for patients with heart conditions), and orthopedists (who care for patients with certain bone, joint, or muscle conditions). If you need services from a specialist or contracting provider other than your PCP, you do NOT need a referral (approval in advance) from your PCP. For some covered services, your contracting specialist or other contracting provider must get approval in advance from the Plan before you obtain the services. This is called getting “prior authorization.”

If you do not want to pay Original Medicare deductibles and coinsurance amounts, it is very important to get a prior authorization before you see a non-contracting provider (except for urgent or emergency services). If you don’t have a prior authorization before you receive services from a non- contracting provider (except for urgent or emergency services), you will have to pay the Original Medicare out-of-pocket amounts.

If you reside in one of the following Colorado counties, you are required to use certain providers for mental health care to be covered by the Plan. These providers are listed in the Provider Directory. For a copy of the Provider Directory, call Customer Service or visit our website at www.rmhp.org.

Adams, Alamosa, Arapahoe, Bent, Boulder, Broomfield, Chaffee, Cheyenne, Clear Creek, Conejos, Costilla, Crowley, Custer, Denver, Douglas, Elbert, El Paso, Fremont, Gilpin, Hinsdale, Huerfano, Jefferson, Kiowa, Kit Carson, Larimer, Las Animas, Lincoln, Logan, Mineral, Morgan, Otero, Park, Phillips, Prowers, Pueblo, Rio Grande, Saguache, Sedgwick, Teller, Washington, Weld, Yuma

Remember, you can get care from non-contracting providers without a referral. However, if you use non-contracting providers for care that is not emergency care or urgently needed care, you will have to pay Original Medicare out-of-pocket amounts for your care.

Self-referrals

There are certain times when you may be able to get certain services without a referral from your PCP.

You will get most of your routine or basic care from your PCP. Your PCP can also coordinate your covered services.

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You do not need to have a referral from your PCP to see another plan provider. When you obtain services on your own, we say that you have “Self-referred”.

If you get self-referred services, you still have to pay a copayment. However, if you get a self-referred service from a plan provider, you will only have to pay the Plan copayment. If you go to a non-plan provider for these services, you will have to pay more.

The following services may be self-referred:

- Routine women’s health care, which include breast exams, mammograms (X-rays of the breast), Pap tests, and pelvic exams as long as you get them from a network provider
- Flu shots pneumonia vaccinations as long as you get them from a network provider”.
- Emergency services, whether you get these services from network providers or out-of-network providers
- Urgently needed care that you get from out-of-network providers when you are temporarily outside the Plan’s service area or when you are in the service area but, because of unusual or extraordinary circumstances, the Network providers are temporarily unavailable or inaccessible.

How can you switch to another PCP?

You may change your PCP for any reason, at any time. To change your PCP, call Customer Service at the telephone number listed in Section 1. They will check to be sure the PCP you want to switch to is accepting new patients. Customer Service will change your membership record to show the name of your new PCP and tell you when the change to your new PCP will take effect. They will also send you a new membership card that shows the name and phone number of your new PCP.

What if your doctor or other provider leaves your plan?

Sometimes a network provider you are using might leave the Plan. If this happens, you will have to switch to another provider who is part of our Plan. Customer Service can assist you in finding and selecting another provider.

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

What is a “medical emergency”?

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

If you have a medical emergency:

- Get medical help as quickly as possible. Call 911 for help or go to the nearest emergency room, hospital, or urgent care center. You don't need to get approval or a referral first from your doctor or other network provider.
- As soon as possible, make sure that we know about your emergency, because we need to be involved in following up on your emergency care. You or someone else should call to tell us about your emergency care, usually within 48 hours. Our number is on your Member ID card.

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

What is covered if you have a medical emergency?

- You may get covered emergency medical care whenever you need it, anywhere in the United States.
- **Ambulance** services are covered in situations where other means of transportation in the United States would endanger your health. (See the benefits chart in Section 10 for more detailed information.)
- For Members of the RMHP Gold or Plus plan, the same copayments apply for emergency services when you are out of the country. See Section 10 for more information.

What if it wasn't a medical emergency?

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

What is urgently needed care?

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

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

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

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

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

How to get urgently needed care

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

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

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

When you receive emergency or urgently needed health care services from a provider who is not part of our network, you are responsible for paying your plan cost sharing amount and you should tell the provider to bill our Plan for the balance of the payment they are due. However, if you have received a bill from the provider, please send that claim to Rocky Mountain Health Plans, P.O. Box 10600, Grand Junction, CO 81502-5600 so we can pay the provider the amount they are owed. If you have any questions about what to pay a provider or where to send a paper claim you may call Customer Service.

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

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

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

For covered services that have a benefit limitation, you pay the full cost of any services you get after you have used up your benefit for that type of covered service, unless your plan offers, as a covered supplemental benefit, coverage beyond the Original Medicare Plan limits.

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

How can you participate in a clinical trial?

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

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

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

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

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

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

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

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

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

Introduction to your rights and protections

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

Your right to be treated with dignity, respect and fairness

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

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

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

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

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

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

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

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

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

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

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

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

2009 Evidence of Coverage (EOC)

If you want to have an advance directive, you can get a form from your lawyer, from a social worker, or from some office supply stores. You can sometimes get advance directive forms from organizations that give people information about Medicare. Regardless of where you get this form, keep in mind that it is a legal document. You should consider having a lawyer help you prepare it. It is important to sign this form and keep a copy at home. You should give a copy of the form to your doctor and to the person you name on the form as the one to make decisions for you if you can't. You may want to give copies to close friends or family members as well.

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

Remember, it is your choice whether you want to fill out an advance directive (including whether you want to sign one if you are in the hospital). According to law, no one can deny you care or discriminate against you based on whether or not you have signed an advance directive. If you have signed an advance directive, and you believe that a doctor or hospital hasn't followed the instructions in it, you may file a complaint with the Colorado Department of Public Health and Environment – Health Facilities. You can call them at 303-692-2800, Monday through Friday, 8:00 a.m. to 5:00 p.m. Mountain Time. TTY users should call 303-691-7700.

Your right to get information about our Plan

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

Your right to get information in other formats

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

Your right to get information about our network providers

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

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

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

Your right to make complaints

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

How to get more information about your rights

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

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

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

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

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

Your responsibilities as a member of our Plan include:

- Getting familiar with your coverage and the rules you must follow to get care as a member. You can use this booklet to learn about your coverage, what you have to pay, and the rules you need to follow. Call Customer Service if you have questions.

2009 Evidence of Coverage (EOC)

- Using all of your insurance coverage. If you have additional health insurance coverage besides our Plan, it is important that you use your other coverage in combination with your coverage as a member of our Plan to pay your health care expenses. This is called “coordination of benefits” because it involves coordinating all of the health benefits that are available to you.
- **You are required to tell our Plan if you have additional health insurance coverage. Call Customer Service.**
- Notifying out-of-network providers when seeking care (unless it is an emergency) that although you are enrolled in our Plan, the provider should bill original Medicare. You should present your plan enrollment card and your Medicare card.
- Giving your doctor and other providers the information they need to care for you, and following the treatment plans and instructions that you and your doctors agree upon. Be sure to ask your doctors and other providers if you have any questions and have them explain your treatment in a way you can understand.
- Acting in a way that supports the care given to other patients and helps the smooth running of your doctor’s office, hospitals, and other offices.
- Paying your plan premiums and coinsurance or copayment for your covered services. You must pay for services that aren’t covered.
- Notifying us if you move. If you move within our service area, we need to keep your membership record up-to-date. If you move outside of our plan service area, you cannot remain a member of our plan, but we can let you know if we have a plan in that area.
- Letting us know if you have any questions, concerns, problems, or suggestions. If you do, please call Customer Service.

4. How to File a Grievance

What is a Grievance?

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

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

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

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

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

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

Who may file a grievance

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

Filing a grievance with our Plan

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

If you want to complain to us regarding any of the issues described above, you must call or send us a letter within 60 days of any notice to you from us, or within 60 days of the date on which you have knowledge or should have had knowledge of the event or subject matter of the grievance.

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

Fast Grievances

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

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

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

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

Introduction

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

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

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

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

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

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

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

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

PART 1. Requests for medical care or services or payment

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

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

Initial Determinations

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

The following are examples of requests for initial determinations:

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

Who may ask for an initial determination?

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

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

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

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

Asking for a standard decision

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

If you need assistance after business hours on weekends and holidays, you can call the Express Scripts help desk toll free at 866-503-5409, 24 hours a day, seven days a week. TTY users should call 800-899-2114, 24 hours a day, 7 days a week free of charge.

Asking for a fast decision

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

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

If you need assistance after business hours on weekends and holidays, you can call the Express Scripts help desk toll free at 866-503-5409, 24 hours a day, seven days a week. TTY users should call 800-899-2114, 24 hours a day, 7 days a week free of charge.

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

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

What happens when you request an initial determination?

- For a decision about payment for Part C medical care or services you already received. If we do not need more information to make a decision, we have up to 30 days to make a decision after we receive your request, although a small number of decisions may take longer. However, if we need more information in order to make a decision, we have up to 60 days from the date of the receipt of your request to make a decision. You will be told in writing when we make a decision.

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

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

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

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

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

What happens if we decide completely in your favor?

- For a decision about payment for Part C medical care or services you already received. Generally, we must send payment no later than 30 days after we receive your request, although a small number of decisions may take up to 60 days. If we need more information in order to make a decision, we have up to 60 days from the date of the receipt of your request to make payment.

- For a standard decision about Part C medical care or services you have not yet received. We must authorize or provide your requested care within 14 days of receiving your request. If we extended the time needed to make our decision, we will authorize or provide your medical care before the extended time period expires.

- For a fast decision about Part C medical care or services you have not yet received. We must authorize or provide your requested care within 72 hours of receiving your request. If we extended the time needed to make our decision, we will authorize or provide your medical care before the extended time period expires.

What happens if we decide against you?

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

Appeal Level 1: Appeal to the Plan

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

Who may file your appeal of the initial determination?

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

How soon must you file your appeal?

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

How to file your appeal

1. Asking for a standard appeal

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

2. Asking for a fast appeal

If you are appealing a decision we made about giving you a Part C medical care or service that you have not received yet, you and/or your doctor will need to decide if you need a fast appeal. The rules about asking for a fast appeal are the same as the rules about asking for a fast initial determination. You, your doctor, or your representative may ask us for a fast appeal by calling, faxing, or writing us at the numbers or address listed under **Part C Appeals** (for appeals about Part C medical care or services) in Section 8.

Faxed requests submitted after normal business hours will be received and reviewed at the start of business on the next regular business day.

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

Getting information to support your appeal

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

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

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

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

How soon must we decide on your appeal?

- For a decision about payment for Part C medical care or services you already received.
After we receive your appeal request, we have 60 days to decide. If we do not decide within 60 days, your appeal automatically goes to Appeal Level 2.
- For a standard decision about Part C medical care or services you have not yet received.
After we receive your appeal, we have 30 days to decide, but will decide sooner if your health condition requires. However, if you ask for more time, or if we find that helpful information is missing, we can take up to 14 more days to make our decision. If we do not tell you our decision within 30 days (or by the end of the extended time period), your request will automatically go to Appeal Level 2.
- For a fast decision about Part C medical care or services you have not yet received.
After we receive your appeal, we have 72 hours to decide, but will decide sooner if your health condition requires. However, if you ask for more time, or if we find that helpful information is missing, we can take up to 14 more days to make our decision. If we do not decide within 72 hours (or by the end of the extended time period), your request will automatically go to Appeal Level 2.

What happens if we decide completely in your favor?

- For a decision about payment for Part C medical care or services you already received.
We must pay within 60 days of receiving your appeal request.
- For a standard decision about Part C medical care or services you have not yet received.
We must authorize or provide your requested care within 30 days of receiving your appeal request. If we extended the time needed to decide your appeal, we will authorize or provide your requested care before the extended time period expires.
- For a fast decision about Part C medical care or services you have not yet received.
We must authorize or provide your requested care within 72 hours of receiving your appeal request. If we extended the time needed to decide your appeal, we will authorize or provide your requested care before the extended time period expires.

Appeal Level 2: Independent Review Entity (IRE)

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

How to file your appeal

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

How soon must the IRE decide?

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

If the IRE decides completely in your favor:

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

- For a decision about payment for Part C medical care or services you already received. We must pay within 30 days after we receive notice reversing our decision.
- For a standard decision about Part C medical care or services you have not yet received. We must authorize your requested Part C medical care or service within 72 hours, or provide it to you within 14 days after we receive notice reversing our decision.
- For a fast decision about Part C medical care or services. We must authorize or provide your requested Part C medical care or services within 72 hours after we receive notice reversing our decision.

Appeal Level 3: Administrative Law Judge (ALJ)

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

How to file your appeal

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

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

How soon will the Judge make a decision?

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

If the Judge decides in your favor:

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

Appeal Level 4: Medicare Appeals Council (MAC)

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

How to file your appeal

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

How soon will the Council make a decision?

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

If the Council decides in your favor:

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

Appeal Level 5: Federal Court

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

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

How to file your appeal

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

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

How soon will the Judge make a decision?

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

If the Judge decides in your favor:

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

If the Judge decides against you:

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

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

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

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

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

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

Information you should receive during your hospital stay

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

- Your right to get all medically necessary hospital services paid for by the Plan (except for any applicable copayments or deductibles).
- Your right to be involved in any decisions that the hospital, your doctor, or anyone else makes about your hospital services and who will pay for them.

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- Your right to get services you need after you leave the hospital.
- Your right to appeal a discharge decision and have your hospital services paid for by us during the appeal (except for any applicable copayments or deductibles).

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

Review of your hospital discharge by the Quality Improvement Organization

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

What is the “Quality Improvement Organization”?

“QIO” stands for Quality Improvement Organization. The QIO is a group of doctors and other health care experts paid by the federal government to check on and help improve the care given to Medicare patients. They are not part of the Plan or the hospital. There is one QIO in each state. QIOs have different names, depending on which state they are in. In Colorado, the QIO is called the Colorado Foundation for Medical Care. The doctors and other health experts in the Colorado Foundation for Medical Care review certain types of complaints made by Medicare patients. These include complaints from Medicare patients who think their hospital stay is ending too soon.

Getting the Colorado Foundation for Medical Care to review your hospital discharge

You must quickly contact the Colorado Foundation for Medical Care. The Important Message from Medicare gives the name and telephone number of the Colorado Foundation for Medical Care and tells you what you must do.

- You must ask the Colorado Foundation for Medical Care for a **“fast review”** of your discharge. This “fast review” is also called an “immediate review.”
- You must request a review from the Colorado Foundation for Medical Care no later than the day you are scheduled to be discharged from the hospital. **If you meet this deadline, you may stay in the hospital after your discharge date without paying for it while you wait to get the decision from the Colorado Foundation for Medical Care.**
- The Colorado Foundation for Medical Care will look at your medical information provided to the Colorado Foundation for Medical Care by us and the hospital.

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- During this process, you will get a notice called the Detailed Notice of Discharge, giving the reasons why we believe that your discharge date is medically appropriate. Call Customer Service or 1-800-MEDICARE (1-800-633-4227 - TTY users should call 1-877-486-2048) to get a sample notice or see it online at <http://www.cms.hhs.gov/BNI/>)
- The Colorado Foundation for Medical Care will decide, within one day after receiving the medical information it needs, whether it is medically appropriate for you to be discharged on the date that has been set for you.

What happens if the Colorado Foundation for Medical Care decides in your favor?

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

What happens if the Colorado Foundation for Medical Care agrees with the discharge?

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

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

What happens if you appeal the Colorado Foundation for Medical Care decision?

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

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

What if you do not ask the Colorado Foundation for Medical Care for a review by the deadline?

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

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

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

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

When you are a patient in a Skilled Nursing Facility (SNF), Home Health Agency (HHA), or Comprehensive Outpatient Rehabilitation Facility (CORF), you have the right to get all the SNF, HHA or CORF care covered by the Plan that is necessary to diagnose and treat your illness or injury. The day we end coverage for your SNF, HHA or CORF services is based on when these services are no longer medically necessary. This part explains what to do if you believe that coverage for your services is ending too soon.

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

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

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

Getting Colorado Foundation for Medical Care review of our decision to end coverage

You have the right to appeal our decision to end coverage for your services. As explained in the notice you get from your provider, you may ask the Colorado Foundation for Medical Care to do an independent review of whether it is medically appropriate to end coverage for your services.

How soon do you have to ask for the Colorado Foundation for Medical Care to review?

You must quickly contact the Colorado Foundation for Medical Care. The written notice you get from your provider gives the name and telephone number of the Colorado Foundation for Medical Care and tells you what you must do.

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

What will happen during the Colorado Foundation for Medical Care's review?

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

The Colorado Foundation for Medical Care will make a decision within one full day after it receives all the information it needs.

What happens if the Colorado Foundation for Medical Care decides in your favor?

We will continue to cover your SNF, HHA or CORF services (except for any applicable copayments) for as long as it is medically necessary and you have not exceeded our Plan coverage limitations as described in Section 10.

What happens if the Colorado Foundation for Medical Care agrees that your coverage should end?

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

What happens if you appeal the Colorado Foundation for Medical Care decision?

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

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

What if you do not ask the Colorado Foundation for Medical Care for a review by the deadline?

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

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

- If we decide, based on the fast appeal, that coverage for your services should continue, we will continue to cover your SNF, HHA, or CORF services (except for any applicable copayments) for as long as it is medically necessary and you have not exceeded our Plan coverage limitations as described in Section 10.
- If we decide that you should not have continued getting services, we will not cover any services you received after the termination date.

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

6. Ending your Membership

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

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

Voluntarily ending your membership

You may end your membership in our Plan at any time during the year and go to the Original Medicare Plan. Your membership will end on the first of the month following your request to our Plan. To end your membership, you must make this request in writing to us. Contact us if you need more information on how to do this. If you have drug coverage through our plan and you leave our plan during the year, you will have the opportunity to join another Medicare prescription drug plan when you leave.

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

Enrollment Period	When?	Effective Date
Fall Open Enrollment (Annual Election Period) Time to review health and drug coverage and make changes.	Every year from November 15 to December 31	January 1
Medicare Advantage (MA) Open Enrollment MA-Eligible beneficiaries can make one change to their health plan coverage. However you cannot use this period to drop Medicare prescription drug coverage.	Every year from January 1 to March 31	First day of next month after plan receives your enrollment request

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

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

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

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

If you see out-of-network providers to obtain medical services, the services are covered under Original Medicare. You will be responsible for the Original Medicare cost-sharing for such services, with the exception of emergent and urgently needed services.

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

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

Involuntarily ending your membership

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

- If you do not stay continuously enrolled in Medicare **Part B**.
- If you move out of the service area or are away from the service area for more than 6 months you cannot remain a member of our Plan. And we must end your membership (“disenroll” you)”. If you plan to move or take a long trip, please call Customer Service to find out if the place you are moving to or traveling to is in our Plan’s service area. However, if you move and your move is still outside our service area, will be disenrolled from our Plan, as stated above. Section 10 gives more information about getting care when you are away from the service area.
- If you intentionally give us incorrect information on your enrollment request that would affect your eligibility to enroll in our Plan.
- If you behave in a way that is unruly, uncooperative, abusive, or disruptive, to the extent that your continued enrollment seriously impairs our ability to arrange or provide medical care for you or for others who are members of our Plan. We cannot make you leave our Plan for this reason unless we get permission first from Medicare.
- If you let someone else use your plan membership card to get medical care. If you are disenrolled for this reason, CMS may refer your case to the Inspector General for additional investigation.
- If you do not pay the basic plan premiums or cost-sharing, we will tell you in writing before you are required to leave our Plan.

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

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

7. Definitions of Important Words Used in the EOC

Appeal – An appeal is a special kind of complaint you make if you disagree with a decision to deny a request for health care services or payment for services you already received. For example, you may ask for an appeal if our Plan doesn't pay for a/an item/service you think you should be able to receive. Section 5 explains appeals, including the process involved in making an appeal.

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

The type of care that is covered depends on whether you are considered an inpatient for hospital and SNF stays. You must be admitted to the hospital as an inpatient, not just under observation. You are an inpatient in a SNF only if your care in the SNF meets certain standards for skilled level of care. Specifically, in order to be an inpatient in a SNF, you must need daily skilled-nursing or skilled-rehabilitation care, or both.

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

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

Covered services – The general term we use in this EOC to mean all of the health care services and supplies that are covered by our Plan.

Creditable Prescription Drug Coverage – Coverage (for example, from an employer or union) that is at least as good as Medicare's prescription drug coverage.

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

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

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

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

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

Evidence of Coverage (EOC) and Disclosure Information – This document, along with your enrollment form [and any other attachments, 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.

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

Home health aide – A home health aide provides services that don't need the skills of a licensed nurse or therapist, such as help with personal care (e.g., bathing, using the toilet, dressing, or carrying out the prescribed exercises). Home health aides do not have a nursing license or provide therapy.

Home health care – Skilled nursing care and certain other health care services that you get in your home for the treatment of an illness or injury. Covered services are listed in the Benefits Chart in Section 10 under the heading "Home health care." If you need home health care services, our Plan will cover these services for you provided the Medicare coverage requirements are met. Home health care can include services from a **home health aide** if the services are part of the home health plan of care for your illness or injury. They aren't covered unless you are also getting a covered skilled service. Home health services don't include the services of housekeepers, food service arrangements, or full-time nursing care at home.

Hospice care – A special way of caring for people who are terminally ill and providing counseling for their families. Hospice care is physical care and counseling that is given by a team of people who are part of a Medicare-certified public agency or private company. Depending on the situation, this care may be given in the home, a hospice facility, a hospital, or a nursing home. Care from a hospice is meant to help patients in the last months of life by giving comfort and relief from pain. The focus is on care, not cure. For more information on hospice care visit www.medicare.gov and under "Search Tools" choose "Find a Medicare Publication" to view or download the publication "Medicare Hospice Benefits." Or, call 1-800-MEDICARE (1-800-633-4227. TTY users should call 1-877-486-2048)

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

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

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

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

Medicare Cost Plan – Cost plan means a plan operated by a Health Maintenance Organization (HMO) or Competitive Medical Plan (CMP) in accordance with a cost-reimbursed contract under section 1876(h) of the Act.

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

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

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

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

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Optional supplemental benefits – Non-Medicare-covered benefits that can be purchased for an additional premium and are not included in your package of benefits. If you choose to have optional supplemental benefits, you may have to pay an additional premium. You must voluntarily elect Optional Supplemental Benefits in order to get them.

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

Original Medicare Plan – (“Traditional Medicare” or “Fee-for-service” Medicare) The Original Medicare Plan is the way many people get their health care coverage. It is the national pay-per-visit program that lets you go to any doctor, hospital, or other health care provider that accepts Medicare. You must pay the deductible. Medicare pays its share of the Medicare-approved amount, and you pay your share. Original Medicare has two parts: Part A (Hospital Insurance) and Part B (Medical Insurance) and is available everywhere in the United States.

Out-of-network provider or out-of-network facility – A provider or facility with which we have not arranged to coordinate or provide covered services to Members of our Plan. Out-of-network providers are providers that are not employed, owned, or operated by our Plan or are not under contract to deliver covered services to you. Using out-of-network providers or facilities is explained in this EOC in Section 2.

Part C – see “Medicare Advantage (MA) Plan”

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

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

Prior authorization – Approval in advance to get services AND/OR certain drugs that may or may not be on our formulary. In an HMO with a referral model some in-network services are covered only if your doctor or other network provider gets “prior authorization” from our Plan. Covered services that need prior authorization are marked in the Benefits Chart in Section 10.”

Quality Improvement Organization (QIO) – Groups of practicing doctors and other health care experts that are paid by the federal government to check and improve the care given to Medicare patients. They must review your complaints about the quality of care given by Medicare Providers. See Section 8 for information about how to contact the QIO in your state and Section 5 for information about making complaints to the QIO.

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

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

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

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

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

8. Helpful Phone Numbers and Resources

Contact Information for our Plan's Customer Service

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

CALL	800-346-4643 Calls to this number are free. (970-243-7050 within Mesa County). 8:00 a.m. to 5:00 p.m., Mountain Time, Monday through Friday.
TTY/TDD	800-704-6370 This number requires special telephone equipment. Calls to this number are free. (970-248-5019 within Mesa County).
FAX	970-244-7880
WRITE	Post Office Box 10600 Grand Junction, Colorado 81502-5600
VISIT	2775 Crossroads Boulevard, Grand Junction, Colorado 81506
WEBSITE	www.rmhp.org

Contact Information for Grievances, Organizations Determinations, and Appeals

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

CALL	800-346-4643 Calls to this number are free. (970-243-7050 within Mesa County), 8:00 a.m. to 5:00 p.m., Mountain Time, Monday through Friday.
TTY/TDD	800-704-6370 This number requires special telephone equipment. Calls to this number are free. (970-248-5019 within Mesa County).
FAX	877-201-7302
WRITE	Post Office Box 10600 Grand Junction, Colorado 81502-5600.

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

2009 Evidence of Coverage (EOC)

Part C Grievances (about your Medical Care and Services)

- CALL** 800-346-4643 Calls to this number are free. (970-243-7050 within Mesa County), 8:00 a.m. to 5:00 p.m., Mountain Time, Monday through Friday.
- TTY/TDD** 800-704-6370 This number requires special telephone equipment. Calls to this number are free. (970-248-5019 within Mesa County).
- FAX** 970-244-7880
- WRITE** Post Office Box 10600
Grand Junction, Colorado 81502-5600

For information about Part C grievances, see Section 4.

Part C Appeals (about your Medical Care and Services)

- CALL** 800-346-4643 Calls to this number are free. (970-243-7050 within Mesa County), 8:00 a.m. to 5:00 p.m., Mountain Time, Monday through Friday.
- TTY/TDD** 800-704-6370 This number requires special telephone equipment. Calls to this number are free. (970-248-5019 within Mesa County).
- FAX** 970-244-7828
- WRITE** RMHP, Member Appeals Department, Post Office Box 60007, Grand Junction, Colorado 81506-8758.

For information about Part C appeals, see Section 5.

Other important contacts

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

The Senior Health Insurance Assistance Program of Colorado (SHIP)

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

2009 Evidence of Coverage (EOC)

You may contact The Senior Health Insurance Assistance Program of Colorado at 1560 Broadway, Suite 850, Denver, Colorado 80202 or call 888-696-7213 toll free. The Denver regional affiliate can be accessed statewide by calling toll free 1-800-544-9181 or 303-899-5151, 8:00 a.m. to 5:00 p.m., Mountain Time, Monday through Friday. TTY users should call 303-894-7455. You may also find the website for The Senior Health Insurance Assistance Program of Colorado at www.medicare.gov under “Search Tools” by selecting “Helpful Phone Numbers and Websites.”

Colorado Foundation for Medical Care (QIO)

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

You may contact the Colorado Foundation of Medical Care at:

Colorado Foundation for Medical Care
23 Inverness Way East, Suite 100
Englewood, CO 80112-5708

Monday through Friday 8:00 a.m. to 4:30 p.m. Mountain time
Telephone: 303-695-3333
800-727-7086 toll free
TTY users should call: 877-486-2048 toll free

How to contact the Medicare program

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

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

Medicaid

Medicaid is a state government program that helps with medical costs for some people with limited incomes and resources. Some people with Medicare are also eligible for Medicaid. Medicaid has programs that can help pay for your Medicare premiums and other costs, if you qualify. To find out more about Medicaid and its programs, contact the Colorado Department of Health Care Policy and Financing at 1570 Grant Street, Denver, Colorado 80203 or call 800-221-3943 toll-free, or 303-866-3513 in the Metro Denver area, Monday through Friday 8:00 a.m. to 5:00 p.m., Mountain Time. TTY users should call 800-659-2656 toll free.

Social Security

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

Colorado Ryan White Title II ADAP – a State Pharmacy Assistance Program (SPAP)

The Colorado Ryan White Title II ADAP (SPAP) is a state organization that provides limited-income and medically needy senior citizens and individuals with disabilities financial help for prescription drugs. You may contact the Colorado Ryan White Title II ADAP at the Department of Health Care Policy and Financing, 1570 Grant Street, Denver, Colorado 80203-1818. 303-866-3513 or 1-800-221-3943 (TTY Users use Colorado Relay 1-800-659-2656) for information about any SPAPs in Colorado. The website for the Colorado Ryan White Title II ADAP is www.chcpf.state.co.us/default.asp.

Railroad Retirement Board

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

Employer (or “Group”) Coverage

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

9. Legal Notices

Notice about governing law

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

Notice about nondiscrimination

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

Who Pays First?

If you are age 65 or older and have coverage under a group health plan of an employer with twenty (20) or more employees, either based on your own current employment or the current employment of a spouse, you must use the benefits under that plan first. Similarly, if you have Medicare because of disability and are covered under a group health plan of an employer with one hundred (100) or more employees (or a multiple employer plan that includes an employer of one hundred or more employees) either through your own current employment or that of a family Member, you must use the benefits under that plan first. In such cases, you will only receive benefits not covered by your employer group plan through this Evidence of Coverage. A special rule applies if you have or develop End Stage Renal Disease (ESRD). If you have (or develop) ESRD and are covered under an employer group plan, you must use the benefits of that plan for the first thirty (30) months after becoming eligible for Medicare because of ESRD. Medicare is the primary payer after this coordination period. (However, if your employer group plan coverage was secondary to Medicare when you developed ESRD because it was not based on current employment as described above, Medicare continues to be primary payer.)

A Member shall not be entitled to obtain double recovery for medical, hospital or other health services provided to the Member.

Coordination of benefits protects you from higher plan premiums. The end result is more affordable health care.

Third-Party Liability

Medicare law gives the Plan the right to recover payments from certain “third party” insurance companies (described below) or from you if you were paid by one of those companies. Because of this, the Plan may ask you for information about other insurance you may have. If you have other insurance, you can help the Plan obtain payment from the other insurer by promptly providing the information the Plan requests.

The following procedures apply if the Plan pays or incurs costs or expenses for covered services provided to you for injuries, illnesses or conditions for which you have a legal claim against a third party, employer or insurer. If you recover or are owed any money from such a person, the Plan has the right to recover the full amount of the benefits that the Plan paid, up to, but not more than, the amount that you recovered or are owed by that person.

Right of Subrogation

If the Plan pays or incurs costs or expenses for services provided to you for injuries, illness or conditions that you have a legal claim against a third party, employer or insurer, then the Plan will become the owner of all rights, claims, remedies and security existing on your behalf against such third party, employer or insurer up to the costs or expenses paid or incurred, or that in the future may be paid or incurred, by the Plan on your behalf to the extent allowed by law, with full power and authority to enforce such claim in the name of the Plan. For the purposes of this section, “third party” means any person or entity, including, but not limited to, a member other than the member to whom the Plan is subrogated.

If the Plan enforces recovery of these amounts from such third party, employer or insurer, or to obtain information about your claims against such third party, employer or insurer, you must cooperate with the Plan in the:

- securing and giving of evidence as shall be reasonable or necessary in connection with recovery efforts, including attending depositions, hearings and trials,
- furnishing of information and documents, and
- assisting in the securing of other witnesses in the conduct of administrative or legal proceedings.

If the Plan is unsuccessful in obtaining recovery against such third party, employer or insurer because of your failure to cooperate with the Plan, you will be liable for all costs and expenses incurred by the Plan for such injuries, illness or condition.

Reimbursement of Proceeds

If you recover or are paid any money or property from a third party, employer or insurer, for payment of any claim or judgment for injury, illness or condition caused by the third party or employer, you must hold this payment in trust for the benefit of and promptly pay the Plan up to the costs or expenses paid or incurred, or that in the future may be paid or incurred, by the Plan for covered services related to such injury, illness or condition. You agree that such monies, proceeds or property shall be paid over to the Plan regardless of whether the money, property or proceeds are specifically designated or allocated for a particular type of injury or claim, regardless of whether you were or were not fully compensated for all losses or damages suffered in connection with such injury, illness or condition, and regardless of whether the money, proceeds or property were paid or recovered in connection with a lawsuit, in settlement of a claim or lawsuit or otherwise. The Plan's right of reimbursement shall have first priority over any claim to be fully compensated for losses or damages suffered in connection with such injury, illness or condition. The Plan's right of reimbursement will also have first priority over any claim you make to be fully or partially compensated for your efforts to secure money, proceeds or property used to satisfy, in whole or in part, the Plan's right of reimbursement.

Settlement of Third-Party Liability Claims

You shall not, without prior written consent of the Plan, grant any type of release to or enter into any settlement with any third party, employer or insurer of any claim for damages resulting from injuries, illness or condition for which the Plan paid or incurred, or in the future may pay or incur, costs or expenses for covered services provided to you and for which you have a legal claim against such third party, employer or insurer. If you grant such a release or enter into such settlement without the Plan's prior written consent, the Plan may, at its option, refuse to provide benefits related to such injury, illness or condition. In addition, if you grant such a release or enter into such settlement without the Plan's prior written consent, the Plan may recover from you any amounts paid to you for such claims up to all amounts paid or incurred, or that in the future may be paid or incurred, by the Plan for covered services related to such injury, illness or condition. All amounts received or to be received by you for or on account of medical, hospital or other health services you may need in the future for such injury, illness or condition will be placed in trust at a financial institution designated by the Plan for payment of such services.

Confidentiality and Release of Information

Information from your medical records and information from providers or hospitals shall be kept confidential. It will not be shared with anyone without your written consent, except as provided below and as expressly allowed or permitted by applicable state and federal laws or requirements (including review programs to achieve quality medical care and efforts to combat fraud and abuse).

2009 Evidence of Coverage (EOC)

By enrolling in the Plan, you authorize the Plan to obtain and review all medical records, hospital records, medical reports or other documents or information relating to covered services provided to you under this Evidence of Coverage. You must sign a consent for release of such records and information to the Plan at the time covered services are provided to you if required by the Plan or the provider of such covered services. You shall promptly sign a consent for release of such information to the Plan upon request of the Plan if the Plan believes that such additional written consent is necessary. You authorize the Plan to copy and deliver copies of all such records to any contracting provider providing covered services to you. You authorize the Plan to release such records and information for the purposes of administration of this Evidence of Coverage. The Plan shall keep such information confidential and will not disclose the same without your consent except as is necessary in connection with administration of this Evidence of Coverage, or for use in medical research and education without your identification information.

General Provisions

Member Non-Liability

In the event the Plan fails to reimburse a contracting provider's charges for covered services or in the event that the Plan fails to pay a non-contracting provider for prior authorized services, you shall not be liable for any sums owed by the Plan.

However, if you receive services from non-contracting providers without prior authorization, except for emergency services, or urgent care services, the Plan will not pay for those services. Original Medicare will pay for Medicare covered services and you will be responsible for coinsurance and deductibles under Original Medicare.

The Plan's Contracting Arrangements

The relationship between the Plan and contracting providers and other providers shall be one of independent contractors. Contracting providers and other providers are not the agents or employees of the Plan, nor is the Plan or any employee of the Plan the employee or agent of any contracting provider or other provider. The Plan is not an insurer against, nor liable for, the negligence or other wrongful act or omission of any contracting provider or other provider, their employees or other person or agency, or for any act or omission of any Member. Any contracting provider or other provider, their employees or agents, are solely responsible for covered services provided to Members. All Members acknowledge that the Plan is not authorized to, and does not, practice medicine.

In order to obtain quality service in an efficient manner, the Plan pays its contracting providers using various payment methods, including capitation, per diem, incentive and discounted fee-for-service arrangements. Capitation means paying a fixed dollar amount per month for each Member assigned to the provider. Per diem means paying a fixed dollar amount per day for all services rendered. Incentive means a payment that is based on appropriate medical management by the Provider. Discounted fee-for-service means paying the provider's usual, customary and regular fee discounted by an agreed-to percentage.

You are entitled to ask if the Plan has special financial arrangements with our physicians that can affect the use of referrals and other services that you might need. To get this information, call the Plan's Member Services at the telephone number listed on the cover of this booklet and request information about the Plan's physician payment arrangements.

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

Your Monthly Premium for Our Plan

Your monthly premium for our Plan is \$73.00

If you signed up for extra benefits, also called “optional supplemental benefits”, then you pay an additional premium each month for these extra benefits. If you have any questions about your Plan premiums or the payment programs, please call Customer Service.

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

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

How Much You Pay for Part C Medical Benefits

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

What do you pay for covered services?

Copayments and coinsurance are the amounts you pay for covered services.

- A **“copayment”** is a payment you make for your share of the cost of certain covered services you get. A copayment is a set amount per service. You pay it when you get the service.
- **“Coinsurance”** is a payment you make for your share of the cost of certain covered services you receive. Coinsurance is a percentage of the cost of the service. You pay your coinsurance when you get the service. Check the benefits chart for more information on your coinsurance for covered services.

Benefits Chart

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

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

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

Benefits chart – your covered services

What you must pay when you get these covered services

Inpatient Services

Inpatient hospital care

- You are covered for 90-days each benefit period. A benefit period begins the day you go to a hospital or skilled nursing facility. The benefit period ends when you have not received hospital or skilled nursing care or 60 days in a row. If you go into the hospital after one benefit period has ended, a new benefit period begins. There is no limit to the number of benefit periods you can have.
- You are covered for an additional 60 Medicare-covered lifetime reserve hospital days. Lifetime reserve days can only be used once.

Covered services include:

- Semi-private room (or a private room if medically necessary)
- Meals including special diets
- Regular nursing services
- Costs of special care units (such as intensive or coronary care units)
- Drugs and medications
- Lab tests
- X-rays and other radiology services
- Necessary surgical and medical supplies
- Use of appliances, such as wheelchairs
- Operating and recovery room costs
- Physical, occupational, and speech language therapy

You pay 100% for each hospital stay.

Benefits chart – your covered services

What you must pay when you get these covered services

Inpatient hospital care – continued

- 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.
- Blood – including storage and administration. Coverage of whole blood and packed red cells begins with the first pint of blood that you need.
- Physician Services

IMPORTANT FOR MEMBERS ELIGIBLE FOR MEDICARE PART B ONLY:

If you are eligible for Part B only, coverage for inpatient services is limited to payment of Part B services only. Part A services are not covered. You are responsible for these costs.

Inpatient mental health care

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

You are covered for 90 days per benefit period. Inpatient care in a contracting and Medicare approved psychiatric hospital is covered for one hundred ninety (190) days per lifetime. The 190-day limit does not apply to mental health care provided in a psychiatric unit of a general hospital.

A benefit period begins the day you go to a hospital or skilled nursing facility. The benefit period ends when you have not received hospital or skilled nursing care for 60 days in a row. If you go into the hospital after one benefit period has ended, a new benefit period begins. There is no limit to the number of benefit periods you can have.

You pay 100% for each hospital stay.

Benefits chart – your covered services

What you must pay when you get these covered services

Inpatient mental health care – continued

IMPORTANT FOR MEMBERS ELIGIBLE FOR MEDICARE PART B ONLY:

If you are eligible for Part B only, coverage for inpatient services is limited to payment of Part B services only. Part A services are not covered. You are responsible for these costs.

Skilled nursing facility (SNF) care

- You are covered for Medicare-covered stays at Skilled Nursing Facilities after a required 3-day prior hospital stay.
- You are covered for 100 days each benefit period. A benefit period begins the day you go to a hospital or skilled nursing facility. The benefit period ends when you have not received hospital or skilled nursing care for 60 days in a row. If you go into the hospital after one benefit period has ended, a new benefit period begins. There is no limit to the number of benefit periods you can have.

You pay 100% for each stay at a Skilled Nursing Facility.

Benefits chart – your covered services

What you must pay when you get these covered services

Skilled nursing facility (SNF) care – continued

Covered services include:

- Semiprivate room (or a private room if medically necessary)
- Meals, including special diets
- Regular nursing services
- Physical therapy, occupational therapy, and speech therapy
- Drugs administered to you as part of your plan of care (This includes substances that are naturally present in the body, such as blood clotting factors)
- Blood - including storage and administration. Coverage of whole blood and packed red cells begins with the first pint of blood that you need.
- Medical and surgical supplies ordinarily provided by SNFs
- Laboratory tests ordinarily provided by SNFs
- X-rays and other radiology services ordinarily provided by SNFs
- Use of appliances such as wheelchairs ordinarily provided by SNFs
- Physician services
- A nursing home or continuing care retirement community where you were living right before you went to the hospital (as long as it provides skilled nursing facility care).
- A SNF where your spouse is living at the time you leave the hospital.

IMPORTANT FOR MEMBERS ELIGIBLE FOR MEDICARE PART B ONLY:

If you are eligible for Part B only, coverage for inpatient services is limited to payment of Part B services only. Part A services are not covered. You are responsible for these costs.

Benefits chart – your covered services

What you must pay when you get these covered services

Inpatient services covered when the hospital or SNF days aren't, or are no longer, covered

Covered services include:

- Physician services
- Tests (like X-ray or lab tests)
- X-ray, radium, and isotope therapy including technician materials and services
- Surgical dressings, splints, casts and other devices used to reduce fractures and dislocations
- Prosthetics and Orthotics devices (other than dental) that replace all or part of an internal body organ (including contiguous tissue), or all or part of the function of a permanently inoperative or malfunctioning internal body organ, including replacement or repairs of such devices
- Leg, arm, back, and neck braces; trusses, and artificial legs, arms, and eyes including adjustments, repairs, and replacements required because of breakage, wear, loss, or a change in the patient's physical condition
- Physical therapy, speech therapy, and occupational therapy

You pay the applicable copayment or coinsurance for the type of service you receive.

Home health agency care

Covered services include:

- Part-time or intermittent skilled nursing and home health aide services (To be covered under the home health care benefit, your skilled nursing and home health aide services combined must total less than eight hours per day and 35 or fewer hours per week)

There is no copayment for Medicare-covered home health care.

Benefits chart – your covered services

What you must pay when you get these covered services

Home health agency care – continued

- Physical therapy, occupational therapy, and speech therapy
- Medical social services
- Medical equipment and supplies

Hospice care

You may receive care from any Medicare-certified hospice program. The Original Medicare Plan (rather than our Plan) will pay the hospice provider for the services you receive. Your hospice doctor can be a network provider or an out-of-network provider. You will still be a plan Member and will continue to get the rest of your care that is unrelated to your terminal condition through our Plan. Covered services include:

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

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

You pay 100% for Hospice care.

Benefits chart – your covered services

What you must pay when you get these covered services

Outpatient Services

Physician services, including doctor office visits

Covered services include:

- Office visits, including medical and surgical care in a physician's office or certified ambulatory surgical center
- Consultation, diagnosis, and treatment by a specialist
- Hearing and balance exams, if your doctor orders it to see if you need medical treatment.
- Telehealth office visits including consultation, diagnosis and treatment by a specialist
- Second opinion by another network provider prior to surgery
- Outpatient hospital services
- Non-routine dental care (covered services are limited to surgery of the jaw or related structures, setting fractures of the jaw or facial bones, extraction of teeth to prepare the jaw for radiation treatments of neoplastic cancer disease, or services that would be covered when provided by a doctor)

You pay a \$15 copayment for each office visit to your PCP

You pay a \$35 copayment for each office visit to other health care providers.

Chiropractic services

Covered services include:

- Manual manipulation of the spine to correct subluxation

You pay a \$10 copayment for each visit.

Benefits chart – your covered services

What you must pay when you get these covered services

<p>Podiatry services</p> <p>Covered services include:</p> <ul style="list-style-type: none"> • Treatment of injuries and diseases of the feet (such as hammer toe or heel spurs). • Routine foot care for Members with certain medical conditions affecting the lower limbs. 	<p>You pay a \$35 copayment for each office visit.</p>
<p>Outpatient mental health care (including Partial Hospitalization Services)</p> <p>Covered services include:</p> <ul style="list-style-type: none"> • Mental health services provided by a doctor, clinical psychologist, clinical social worker, clinical nurse specialist, nurse practitioner, physician assistant, or other Medicare-qualified mental health care professional as allowed under applicable state laws. “Partial hospitalization” is a structured program of active treatment that is more intense than the care received in your doctor’s or therapist’s office and is an alternative to inpatient hospitalization. <p>IMPORTANT: If you reside in one of the following Colorado counties, you are required to use certain providers for mental health care to be covered by our Plan. These providers are listed in the Provider Directory. For a copy of the Provider Directory, visit our website at www.rmhp.org or call Customer Service.</p> <p>Adams, Alamosa, Arapahoe, Bent, Boulder, Broomfield, Chaffee, Cheyenne, Clear Creek, Conejos, Costilla, Crowley, Custer, Denver, Douglas, Elbert, El Paso, Fremont, Gilpin, Hinsdale, Huerfano, Jefferson, Kiowa, Kit Carson, Larimer, Las Animas, Lincoln, Logan, Mineral, Morgan, Otero, Park, Phillips, Prowers, Pueblo, Rio Grande, Saguache, Sedgwick, Teller, Washington, Weld and Yuma counties.</p>	<p>You pay a \$15 copayment for each office visit to your PCP</p> <p>You pay a \$35 copayment for each office visit to other health care providers.</p> <p>\$250 copayment per admission for partial hospitalization services.</p>

Benefits chart – your covered services	What you must pay when you get these covered services
<p>Outpatient substance abuse services</p>	<p>You pay a \$15 copayment for each office visit to your PCP</p> <p>You pay a \$35 copayment for each office visit to other health care providers.</p>
<p>Outpatient surgery (including services provided at ambulatory surgical centers)</p>	<p>You pay a \$250 copayment for each visit to an outpatient hospital facility or ambulatory surgical center for outpatient surgery or invasive diagnostic services.</p>
<p>Ambulance services</p> <p>Covered ambulance services include fixed wing, rotary wing, and ground ambulance services, to the nearest appropriate facility that can provide care only if they are furnished to a member whose medical condition is such that other means of transportation are contraindicated (could endanger the person’s health). The member’s condition must require both the ambulance transportation itself and the level of service provided in order for the billed service to be considered medically necessary. Non-emergency transportation by ambulance is appropriate if it is documented that the member’s condition is such that other means of transportation are contraindicated (could endanger the person’s health) and that transportation by ambulance is medically required.</p>	<p>You pay a \$100 copayment for each trip in an ambulance.</p>
<p>Emergency care</p>	<p>You pay a \$50 copayment for each visit to the emergency room. If you are admitted as an inpatient within 24 hours for the same condition, the emergency care copayment is waived.</p> <p>If you get inpatient care at a non-plan hospital after your emergency condition is stabilized, your cost is the cost-sharing you would pay at a plan hospital. However, if you refuse reasonable, medically appropriate transfer to a plan-contracting inpatient facility, your cost-sharing might be higher.</p>

Benefits chart – your covered services	What you must pay when you get these covered services
<p>Urgently needed care</p>	<p>You pay a \$35 copayment for each urgent care visit.</p>
<p>Outpatient rehabilitation services Covered services include: physical therapy, occupational therapy, speech language therapy, and cardiac rehabilitative therapy</p>	<p>You pay a \$10 copayment for each visit to a physical, occupational or speech therapist.</p> <p>There is no copayment for visits to a Comprehensive Outpatient Rehabilitation Facility (CORF) for outpatient rehabilitation services.</p> <p>There is no copayment for cardiac rehabilitation or pulmonary therapy service</p>
<p>Durable medical equipment and related supplies Covered items include: wheelchairs, crutches, hospital bed, IV infusion pump, oxygen equipment, nebulizer, and walker. (See definition of “durable medical equipment” in Section 7.)</p>	<p>You pay 20% of the cost for each item.</p>
<p>Prosthetic devices and related supplies – (other than dental) that replace a body part or function. These include colostomy bags and supplies directly related to colostomy care, pacemakers, braces, prosthetic shoes, artificial limbs, and breast prostheses (including a surgical brassiere after a mastectomy). Includes certain supplies related to prosthetic devices, and repair and/or replacement of prosthetic devices. Also includes some coverage following cataract removal or cataract surgery – see “Vision Care” later in this section for more detail.</p>	<p>You pay 20% of the cost for each item.</p>

Benefits chart – your covered services

What you must pay when you get these covered services

<p>Diabetes self-monitoring, training and supplies – for all people who have diabetes (insulin and non-insulin users). Covered services include:</p> <ul style="list-style-type: none"> • Blood glucose monitor, blood glucose test strips, lancet devices and lancets, and glucose-control solutions for checking the accuracy of test strips and monitors • One pair per calendar year of therapeutic shoes for people with diabetes who have severe diabetic foot disease, including fitting of shoes or inserts • Self-management training is covered under certain conditions • For persons at risk of diabetes: Fasting plasma glucose tests. One fasting plasma glucose test every calendar year. 	<p>You pay 20% of the cost for supplies including blood glucose monitors, test strips, lancet devices, and therapeutic shoes.</p> <p>There is no copayment for Diabetes self-monitoring training.</p> <p>There is no copayment for laboratory tests. An office visit copayment may apply.</p>
<p>Medical nutrition therapy – for people with diabetes, renal (kidney) disease (but not on dialysis), and after a transplant when referred by your doctor.</p>	<p>There is no copayment for medical nutrition therapy.</p>
<p>Outpatient diagnostic tests and therapeutic services and supplies</p> <p>Covered services include:</p> <ul style="list-style-type: none"> • X-rays • Radiation therapy • Surgical supplies, such as dressings • Supplies, such as splints and casts • Laboratory tests • Blood – Coverage of storage and administration begins with the first pint of blood that you need. <p>Other outpatient diagnostic tests</p> <ul style="list-style-type: none"> • MRI/PET/CT scans 	<p>There is no copayment for x-ray services. An office visit copayment may apply.</p> <p>You pay a 20% copayment for each outpatient radiation therapy visit.</p> <p>You pay 20% of the cost for disposable medical supplies.</p> <p>There is no copayment for laboratory tests. An office visit copayment may apply.</p> <p>There is no copayment for blood in addition to the applicable facility copayment.</p> <p>You pay a \$250 copayment for each visit for other outpatient diagnostic procedures and tests in an outpatient facility.</p>

Benefits chart – your covered services	What you must pay when you get these covered services
<p>Outpatient diagnostic tests and therapeutic services and supplies – continued</p>	<p>You pay:</p> <ul style="list-style-type: none"> ■ a \$150 copayment for MRI and PET scans. ■ a \$75 copayment for CT scans. <p>Authorization rules may apply.</p>
<p>Vision care</p> <p>Covered services include:</p> <ul style="list-style-type: none"> • Outpatient physician services for eye care. • For people who are at high risk of glaucoma, such as people with a family history of glaucoma, people with diabetes, and African-Americans who are age 50 and older: glaucoma screening once per year • One pair of eyeglasses or contact lenses after each cataract surgery that includes insertion of an intraocular lens. Corrective lenses/frames (and replacements) needed after a cataract removal without a lens implant. 	<p>You pay:</p> <ul style="list-style-type: none"> ■ a \$15 copayment for each diagnostic visit for eye care to your PCP. ■ a \$35 copayment for each diagnostic visit for eye care to a specialist or other health care provider. <p>There is no copayment for Medicare-covered eye glasses.</p>
Preventive Care and Screening Tests	
<p>Abdominal Aortic Aneurysm Screening</p> <p>A one-time screening ultrasound for people at risk. Medicare only covers this screening if you get a referral for it as a result of your “Welcome to Medicare” physical exam.</p>	<p>There is no copayment for each abdominal aortic aneurysm screening. An office visit copayment may apply.</p>
<p>Bone-mass measurements</p> <p>For qualified individuals (generally, this means people at risk of losing bone mass or at risk of osteoporosis), the following services are covered every 2 years or more frequently if medically necessary: procedures to identify bone mass, detect bone loss, or determine bone quality, including a physician's interpretation of the results.</p>	<p>There is no copayment for each bone mass measurement.</p>

Benefits chart – your covered services

What you must pay when you get these covered services

Colorectal screening

For people 50 and older, the following are covered:

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

For people at high risk of colorectal cancer, we cover:

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

For people not at high risk of colorectal cancer, we cover:

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

Additional Benefit: You are covered for one annual Colorectal Screening Exam every year, including any exam covered by Medicare.

There is no copayment for colorectal cancer screenings or laboratory services.

An office visit copayment may apply.

Immunizations

Covered services include:

- Pneumonia vaccine
- Flu shots, once a year in the fall or winter
- Hepatitis B vaccine if you are at high or intermediate risk of getting Hepatitis B
- Other vaccines if you are at risk

There is no copayment for immunizations.

Mammography screening

Covered services include:

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

Additional Benefit: You are covered for one annual screening Mammogram every year, including any exam covered by Medicare.

There is no copayment for mammograms. An office visit copayment may apply.

Benefits chart – your covered services

What you must pay when you get these covered services

<p>Pap tests, pelvic exams, and clinical breast exam</p> <p>Covered services include:</p> <ul style="list-style-type: none">• For all women, Pap tests, pelvic exams, and clinical breast exams are covered once every 24 months• If you are at high risk of cervical cancer or have had an abnormal Pap test and are of childbearing age: one Pap test every 12 months <p>Additional Benefit: You are covered for one annual screening pap smear and pelvic every year, including any exam covered by Medicare.</p>	<p>There is no copayment for pap tests, or clinical breast exams.</p> <p>There is no copayment for pelvic exams.</p> <p>An office visit copayment may apply.</p>
<p>Prostate cancer screening exams</p> <p>For men age 50 and older, covered services include the following - once every 12 months:</p> <ul style="list-style-type: none">• Digital rectal exam• Prostate Specific Antigen (PSA) test <p>Additional Benefit: You are covered for one annual Prostate Screening Exam every year, including any exam covered by Medicare.</p>	<p>There is no copayment for prostate cancer screening exams or laboratory tests. An office visit copayment may apply.</p>
<p>Cardiovascular disease testing</p> <p>Blood tests for the detection of cardiovascular disease (or abnormalities associated with an elevated risk of cardiovascular disease). One cardiovascular disease blood test every calendar year.</p>	<p>There is no copayment for laboratory tests. An office visit copayment may apply.</p>

Benefits chart – your covered services

What you must pay when you get these covered services

Physical exams

For all Members, the following are covered:

- One Physical Exam every calendar year. This exam includes the following services:
 - Bone Mass Measurement tests for Members at risk;
 - Cardiovascular Screening;
 - Colorectal Screening Exams;
 - Diabetes screening for Members at risk;
 - For women: Mammogram, Pap Smears, Pelvic Exam;
 - For men: Prostate Cancer Screening Exam.

For services done independent of the Physical Exam, a separate doctor's office visit copayment may apply. See individual services under "Preventive Care and Screening Tests" above for details.

There is no copayment for each physical exam.

Benefits chart – your covered services

What you must pay when you get these covered services

Other Services

Dialysis (Kidney)

Covered services include:

- Outpatient dialysis treatments
- Inpatient dialysis treatments (if you are admitted to a hospital for special care)
- Self-dialysis training (includes training for you and anyone helping you with your home dialysis treatments)
- Home dialysis equipment and supplies

Certain home support services (such as, when necessary, visits by trained dialysis workers to check on your home dialysis, to help in emergencies, and check your dialysis equipment and water supply)

There is no copayment for renal dialysis.

You pay 100% for a Medicare-covered stay at a contracting hospital or non-contracting hospital when approved by RMHP.

You pay:

- \$15 copayment for each office visit to your PCP for self-dialysis training.
- \$35 copayment for each office visit to any other health care provider for self-dialysis training.

You pay 20% of the cost for home dialysis equipment and supplies.

Medicare Part B Prescription Drugs

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

- Drugs that usually aren't self-administered by the patient and are injected while you are getting physician services
- Drugs you take using durable medical equipment (such as nebulizers) that was authorized by the plan
- Clotting factors you give yourself by injection if you have hemophilia
- Immunosuppressive Drugs, if you were enrolled in Medicare Part A at the time of the organ transplant

For drugs covered under Original Medicare:

You pay 20% of the cost of the Prescription Drugs covered under Part B of Original Medicare.

*If filled at a pharmacy, these drugs will not be covered by the Plan.

There is no benefit limit on the drugs covered under Original Medicare.

This plan does not cover Part D outpatient prescription drugs.

Benefits chart – your covered services

What you must pay when you get these covered services

Medicare Part B Prescription Drugs – continued

- Injectable osteoporosis drugs, if you are homebound, have a bone fracture that a doctor certifies was related to post-menopausal osteoporosis, and cannot self-administer the drug
- Antigens
- Certain oral anti-cancer drugs and anti-nausea drugs
- Certain drugs for home dialysis, including heparin, the antidote for heparin when medically necessary, topical anesthetics*, and erythropoiesis-stimulating agents (such as Epogen®, Procrit®, Epoetin Alfa, Aranesp®, or Darbepoetin Alfa)
- Intravenous Immune Globulin for the home treatment of primary immune deficiency diseases

Benefits chart – your covered services

What you must pay when you get these covered services

Additional Benefits

Dental Services

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

You pay the applicable copayment or coinsurance for the type of service you receive.

Hearing Services

- Diagnostic hearing exams.

Routine hearing services are excluded.

You pay:

- \$15 copayment for each office visit to your PCP.
- \$35 copayment for each office visit to any other health care provider.

Health and wellness education programs

- Newsletter
- Disease Management

You pay no copayment for health and wellness programs.

Extra “optional supplemental” benefits you can buy

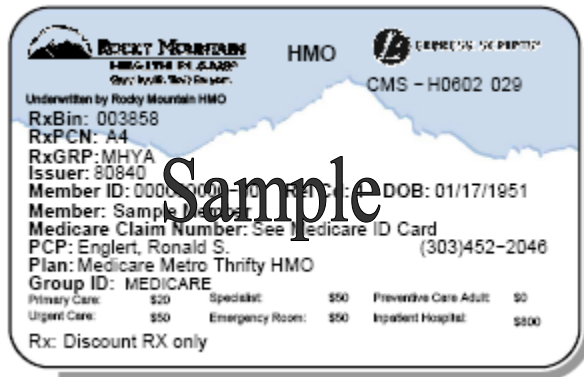
This plan does not offer any optional supplemental benefits.

Getting care using our Plan’s traveler benefit

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

Sample plan membership card

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



General Exclusions

Introduction

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

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

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

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

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

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

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

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HEALTH PLANS®
Good health. That's the plan.

November 2008

THIS AMENDMENT TO YOUR MEDICARE EVIDENCE OF COVERAGE (EOC) amends the Rocky Mountain Health Maintenance Organization, Inc. Medicare Cost Plan Evidence of Coverage for 2009 as provided in this Amendment. This Amendment is effective January 1, 2009.

Evidence of Coverage

Under the heading “The geographic service area for our Plan” a new fourth unnumbered paragraph is added with the following language:

RMHP AB Basic, RMHP B Basic, and RMHP B Standard are offered in all counties in the state of Colorado except Baca, and in the following counties in the state of Wyoming: Big Horn, Carbon, Goshen, Hot Springs, Laramie, Niobrara, Park, Platte, Uinta, and Washakie.

For questions, please call Customer Service at 970-243-7050 or 800-346-4643, 8:00 a.m. to 5:00 p.m., Mountain Time, Monday through Friday. If you are hearing impaired and use TTY equipment, call 800-704-6370. Para asistencia en español llame al 800-346-4643.

Sincerely,

Rocky Mountain Health Plans