Independence

January 1 – December 31, 2024

Evidence of Coverage:

Your Medicare Health Benefits and Services as a Member of Personal Choice 65℠ Medical-Only PPO

This document gives you the details about your Medicare health care coverage from January 1 – December 31, 2024. **This is an important legal document. Please keep it in a safe place.**

For questions about this document, please contact our Member Help Team at 1-888-718-3333. (TTY users should call 711). Hours are seven days a week, 8 a.m. to 8 p.m. Please note that on weekends and holidays from April 1 through September 30, your call may be sent to voicemail. This call is free.

This plan, Personal Choice 65 Medical-Only, is offered by QCC Insurance Company, a subsidiary of Independence Blue Cross, LLC (Independence). (When this *Evidence of Coverage* says "we," "us," or "our," it means QCC Insurance Company. When it says "plan" or "our plan," it means Personal Choice 65 Medical-Only.)

To receive this document in an alternate format such as braille, large print, or audio, please contact our Member Help Team.

Benefits, premiums, and/or copayments/coinsurance may change on January 1, 2025.

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

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

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

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OMB Approval 0938-1051 (Expires: February 29, 2024)

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CHAPTER 1:
Getting started as a member

SECTION 1 Introduction

Section 1.1 You are enrolled in Personal Choice 65 Medical-Only PPO, which is a Medicare PPO

You are covered by Medicare, and you have chosen to get your Medicare health care coverage through our plan, Personal Choice 65 Medical-Only PPO. We are required to cover all Part A and Part B services. However, cost-sharing and provider access in this plan differ from Original Medicare.

Personal Choice 65 Medical-Only is a Medicare Advantage PPO Plan (PPO stands for Preferred Provider Organization). Like all Medicare health plans, this Medicare PPO is approved by Medicare and run by a private company. This plan does not include Part D prescription drug coverage.

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

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

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

The words *coverage* and *covered services* refer to the medical care and services available to you as a member of Personal Choice 65 Medical-Only.

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

If you are confused or concerned, or just have a question, please contact our Member Help Team.

Section 1.3 Legal information about the *Evidence of Coverage*

This *Evidence of Coverage* is part of our contract with you about how Personal Choice 65 Medical-Only covers your care. Other parts of this contract include your enrollment form and any notices you receive from us about changes to your coverage or conditions that affect your coverage. These notices are sometimes called *riders* or *amendments*.

The contract is in effect for months in which you are enrolled in Personal Choice 65 Medical-Only between January 1, 2024, and December 31, 2024.

Each calendar year, Medicare allows us to make changes to the plans that we offer. This means we can change the costs and benefits of Personal Choice 65 Medical-Only after December 31, 2024. We can also choose to stop offering the plan in your service area, after December 31, 2024.

Medicare (the Centers for Medicare & Medicaid Services) must approve Personal Choice 65 Medical-Only each year. You can continue each year to get Medicare coverage as a member of our plan as long as we choose to continue to offer the plan and Medicare renews its approval of the plan.

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

Section 2.1 Your eligibility requirements

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

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

Section 2.2 Here is the plan service area for Personal Choice 65 Medical-Only

Personal Choice 65 Medical-Only is available only to individuals who live in our plan service area. To remain a member of our plan, you must continue to reside in the plan service area. The service area is described below.

Our service area includes these counties in Pennsylvania: Bucks and Philadelphia.

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

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

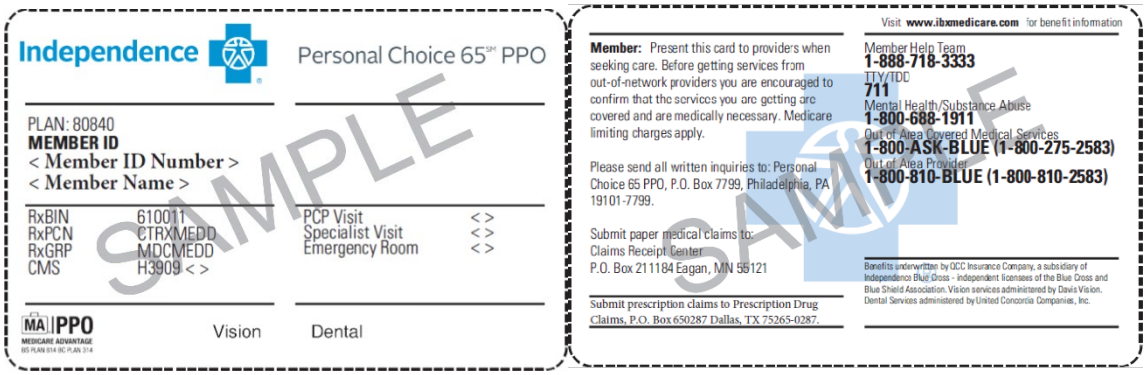
Section 2.3 U.S. Citizen or Lawful Presence

A member of a Medicare health plan must be a U.S. citizen or lawfully present in the United States. Medicare (the Centers for Medicare & Medicaid Services) will notify Personal Choice 65 Medical-Only if you are not eligible to remain a member on this basis. Personal Choice 65 Medical-Only must disenroll you if you do not meet this requirement.

SECTION 3 Important membership materials you will receive

Section 3.1 Your plan membership card

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



Do NOT use your red, white, and blue Medicare card for covered medical services while you are a member of this plan. If you use your Medicare card instead of your Personal Choice 65 Medical-Only membership card, you may have to pay the full cost of medical services yourself. Keep your Medicare card in a safe place. You may be asked to show it if you need hospital services, hospice services, or participate in Medicare-approved clinical research studies also called clinical trials.

If your plan membership card is damaged, lost, or stolen, call our Member Help Team right away and we will send you a new card.

Section 3.2 Provider Directory

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

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

The most recent list of providers and suppliers is available on our website at www.ibxmedicare.com/directory.

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

SECTION 4 Your monthly costs for Personal Choice 65 Medical-Only

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

Medicare Part B premiums differ for people with different incomes. If you have questions about these premiums review your copy of *Medicare & You 2024* handbook, the section called *2024 Medicare Costs*. If you need a copy, you can download it from the Medicare website

(www.medicare.gov). Or, you can order a printed copy by phone at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users call 1-877-486-2048.

Section 4.1 Plan premium

As a member of our plan, you pay a monthly plan premium. For 2024, the monthly premium for Personal Choice 65 Medical-Only is $138.00.

Section 4.2 Monthly Medicare Part B Premium

Many members are required to pay other Medicare premiums

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

SECTION 5 More information about your monthly premium

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

There are five ways you can pay your plan premium.

Option 1: Paying by check

Direct Pay – Your monthly premium bill is sent to your home. You should write your check payable to Personal Choice 65 Medical-Only (not payable to CMS or HHS) and send it directly to us.

You are enrolled in a plan that charges a monthly premium, and you should be aware of the following:

- You will receive a bill around the 25th day of every month.
- Your premium is due on the 15th day of every month, unless stated otherwise on your bill.
- Your bank may apply a penalty to your account if your check is returned because of insufficient funds.

Checks should be mailed to:

Independence Blue Cross
PO Box 825420
Philadelphia, PA 19182-5420

Payments can also be made in person at:

Independence LIVE
1919 Market Street, 2nd Floor
Philadelphia, PA 19103
8 a.m. to 4 p.m., Monday through Friday

Note: The Independence LIVE hours are subject to change.

Note: Independence LIVE accepts payments made by checks and money orders. We cannot accept cash payments.

Please do not write any notes or correspondence to us on your premium bill.

Option 2: Paying your premium on our website

Direct Pay members who have registered on our website at www.ibx.com/login will be able to view and/or pay their invoices directly online when they log in at www.ibx.com/login. You can pay directly from your bank account through our e-Bill system.

To schedule payments, the user must create a bank account profile and then select a payment date. Please note that payments must be scheduled on business days. They cannot be scheduled on weekends or holidays. In addition, all payments must be scheduled at least two business days prior to the payment due date. If a payment date is not chosen, the calendar will default to the first available payment date. You can also choose to have your payment drawn from either a checking or savings account. Payments may be scheduled for a one-time withdrawal or on a recurring basis. The frequency of recurring withdrawals may be determined by the member (i.e., monthly, bimonthly, quarterly, etc.). Since our plan's members are invoiced monthly, we recommend that you schedule your recurring payments for once each month.

You are excluded from this option if you have selected the following payment options: Electronic Funds Transfer (EFT) (Option 3), direct payment deductions from your monthly Railroad Retirement Board benefit check (Option 4), or direct payment deductions from your monthly Social Security check (Option 5).

For more information regarding this payment option, please contact our Member Help Team.

Option 3: Having your monthly plan premium automatically withdrawn from your bank account

Electronic Funds Transfer (EFT) – A fully automatic, computerized way to have your monthly premium payment deducted directly from your bank account.

EFT deductions occur monthly on the 5th day of each month unless the 5th falls on a weekend or bank holiday. At that time, the deduction occurs on the next business day.

If you are interested in the EFT option, please contact our Member Help Team.

After completing the EFT application, please continue to pay your monthly premium directly to the plan until you receive confirmation of enrollment in the EFT program. To avoid overpayment, you can specify a start date for the EFT when you select it as your payment method. If an overpayment does occur, you can request that the amount be refunded or applied as a credit towards your next month's payment. The automated EFT may take up to one to two billing cycles to go into effect from the date of your request for enrollment.

Option 4: Having your plan premium taken out of your monthly Railroad Retirement Board (RRB) benefit check

You can have the plan premium taken out of your monthly Railroad Retirement Board (RRB) benefit check. For more information on how to pay your plan premium this way, please contact our Member Help Team. We will be happy to help you set this up.

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

Changing the way you pay your plan premium. If you decide to change the option by which you pay your plan premium, it can take up to three months for your new payment method to take effect. While we are processing your request for a new payment method, you are responsible for making sure that your plan premium is paid on time. To change your payment method, please contact our Member Help Team or log in at www.ibx.com/login to change it directly. If you are new to your plan, you may indicate your payment choice on the enrollment form or call our Member Help Team for assistance.

What to do if you are having trouble paying your premium

Your plan premium is due in our office by the 15th of the month. If we have not received your payment by the 28th of the month, we will send you a notice reminding you that your account has a balance due.

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

Section 5.2 Can we change your monthly plan premium during the year?

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

SECTION 6 Keeping your plan membership record up to date

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

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

Let us know about these changes:

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

If any of this information changes, please let us know by calling our Member Help Team.

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

SECTION 7 How other insurance works with our plan

Other insurance

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

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

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

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

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

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

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

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

CHAPTER 2:
Important phone numbers and resources

SECTION 1 Personal Choice 65 Medical-Only contacts (How to contact us, including how to reach our Member Help Team)

How to contact our plan's Member Help Team

For assistance with claims, billing or member card questions, please call or write to our Personal Choice 65 Medical-Only Member Help Team. We will be happy to help you.

Method	Member Help Team – Contact Information
CALL	1-888-718-3333 Calls to this number are free. 7 days a week, 8 a.m. to 8 p.m. Please note that on weekends and holidays from April 1 through September 30, your call may be sent to voicemail. Our Member Help Team also has free language interpreter services available for non-English speakers.
TTY/TDD	711 Calls to this number are free. 7 days a week, 8 a.m. to 8 p.m. Please note that on weekends and holidays from April 1 through September 30, your call may be sent to voicemail.
FAX	1-888-289-3029 215-238-7960
WRITE	Personal Choice 65 Medical-Only PO Box 7799 Philadelphia, PA 19101-7799
WEBSITE	www.ibxmedicare.com

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

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

Method	Coverage Decisions for Medical Care – Contact Information
CALL	1-800-ASK-BLUE (1-800-275-2583) Calls to this number are free. 7 days a week, 8 a.m. to 8 p.m. Please note that on weekends and holidays from April 1 through September 30, your call may be sent to voicemail.
TTY/TDD	711 Calls to this number are free. 7 days a week, 8 a.m. to 8 p.m. Please note that on weekends and holidays from April 1 through September 30, your call may be sent to voicemail.
WRITE	Personal Choice 65 Medical-Only Clinical Precertification 1901 Market Street Philadelphia, PA 19103
WEBSITE	www.ibxmedicare.com

How to contact us when you are asking for an appeal about your medical care

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

Method	Appeals for Medical Care – Contact Information
CALL	1-888-718-3333 Calls to this number are free. 7 days a week, 8 a.m. to 8 p.m. Please note that on weekends and holidays from April 1 through September 30, your call may be sent to voicemail.
TTY/TDD	711 Calls to this number are free. 7 days a week, 8 a.m. to 8 p.m. Please note that on weekends and holidays from April 1 through September 30, your call may be sent to voicemail.
FAX	1-888-289-3008 215-988-2001
WRITE	Personal Choice 65 Medical-Only Medicare Member Appeals Unit PO Box 13652 Philadelphia, PA 19101-3652
WEBSITE	www.ibxmedicare.com

How to contact us when you are making a complaint about your medical care

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

Method	Complaints about Medical Care – Contact Information
CALL	1-888-718-3333 Calls to this number are free. 7 days a week, 8 a.m. to 8 p.m. Please note that on weekends and holidays from April 1 through September 30, your call may be sent to voicemail.
TTY/TDD	711 Calls to this number are free. 7 days a week, 8 a.m. to 8 p.m. Please note that on weekends and holidays from April 1 through September 30, your call may be sent to voicemail.
FAX	1-888-289-3008 215-988-2001
WRITE	Personal Choice 65 Medical-Only Medicare Member Appeals Unit PO Box 13652 Philadelphia, PA 19101-3652
MEDICARE WEBSITE	You can submit a complaint about Personal Choice 65 Medical-Only directly to Medicare. To submit an online complaint to Medicare, go to www.medicare.gov/MedicareComplaintForm/home.aspx.

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

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

Please note: If you send us a payment request and we deny any part of your request, you can appeal our decision. See Chapter 7 (*What to do if you have a problem or complaint (coverage decisions, appeals, complaints)*) for more information.

Method	Payment Requests – Contact Information
CALL	1-888-718-3333 Calls to this number are free. 7 days a week, 8 a.m. to 8 p.m. Please note that on weekends and holidays from April 1 through September 30, your call may be sent to voicemail.
TTY/TDD	711 Calls to this number are free. 7 days a week, 8 a.m. to 8 p.m. Please note that on weekends and holidays from April 1 through September 30, your call may be sent to voicemail.
FAX	1-888-289-3029 215-238-7960
WRITE	Independence Blue Cross Claims Receipt Center PO Box 211184 Eagan, MN 55121
WEBSITE	www.ibxmedicare.com

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

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

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

Method	Medicare – Contact Information
CALL	1-800-MEDICARE, or 1-800-633-4227 Calls to this number are free. 24 hours a day, 7 days a week.
TTY	1-877-486-2048 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free.

Method	Medicare – Contact Information
WEBSITE	www.medicare.gov This is the official government website for Medicare. It gives you up-to-date information about Medicare and current Medicare issues. It also has information about hospitals, nursing homes, physicians, home health agencies, and dialysis facilities. It includes documents you can print directly from your computer. You can also find Medicare contacts in your state. The Medicare website also has detailed information about your Medicare eligibility and enrollment options with the following tools: • **Medicare Eligibility Tool:** Provides Medicare eligibility status information • **Medicare Plan Finder:** Provides personalized information about available Medicare prescription drug plans, Medicare health plans, and Medigap (Medicare Supplement Insurance) policies in your area. These tools provide an *estimate* of what your out-of-pocket costs might be in different Medicare plans. You can also use the website to tell Medicare about any complaints you have about Personal Choice 65 Medical-Only: • **Tell Medicare about your complaint:** You can submit a complaint about Personal Choice 65 Medical-Only directly to Medicare. To submit a complaint to Medicare, go to www.medicare.gov/MedicareComplaintForm/home.aspx. Medicare takes your complaints seriously and will use this information to help improve the quality of the Medicare program. If you don't have a computer, your local library or senior center may be able to help you visit this website using its computer. Or, you can call Medicare and tell them what information you are looking for. They will find the information on the website and review the information with you. You can call Medicare at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

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

The State Health Insurance Assistance Program (SHIP) is a government program with trained counselors in every state. In Pennsylvania, the SHIP is called Pennsylvania Medicare Education and Decision Insight (PA MEDI).

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

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

METHOD TO ACCESS SHIP and OTHER RESOURCES:

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

Method	PA MEDI (Pennsylvania SHIP) – Contact Information
CALL	1-800-783-7067 Monday through Friday, 8 a.m. to 5 p.m.
WRITE	Pennsylvania Medicare Education and Decision Insight (PA MEDI) Commonwealth of Pennsylvania Department of Aging 555 Walnut Street, 5th Floor Harrisburg, PA 17101-1919
WEBSITE	www.aging.pa.gov/aging-services/medicare-counseling/Pages/default.aspx

SECTION 4 Quality Improvement Organization

There is a designated Quality Improvement Organization for serving Medicare beneficiaries in each state. For Pennsylvania, the Quality Improvement Organization is called Livanta.

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

You should contact Livanta in any of these situations:

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

Method	Livanta (Pennsylvania's Quality Improvement Organization) – Contact Information
CALL	1-888-396-4646 Monday through Friday, 9 a.m. to 5 p.m., and Saturday and Sunday, 11 a.m. to 3 p.m. 24-hour voicemail service is available.
TTY	1-888-985-2660 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.
WRITE	Livanta LLC BFCC-QIO Program 10820 Guilford Road Suite 202 Annapolis Junction, MD 20701-1105
WEBSITE	www.livantaqio.com

SECTION 5 Social Security

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

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

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

SECTION 6 Medicaid

Medicaid is a joint Federal and state government program that helps with medical costs for certain people with limited incomes and resources. Some people with Medicare are also eligible for Medicaid. The programs offered through Medicaid help people with Medicare pay their Medicare costs, such as their Medicare premiums. These **Medicare Savings Programs** include:

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

To find out more about Medicaid and its programs, contact the Pennsylvania Department of Public Welfare – Office of Medical Assistance Programs (OMAP).

Method	Pennsylvania Department of Public Welfare Office of Medical Assistance Programs (OMAP) – Contact Information
CALL	1-800-537-8862
WRITE	Pennsylvania Department of Public Welfare Office of Medical Assistance Programs (OMAP) Health and Welfare Building, Room 515 PO Box 2675 Harrisburg, PA 17105-2675
WEBSITE	www.dhs.pa.gov/Services/Assistance/Pages/Medical-Assistance.aspx

SECTION 7 How to contact the Railroad Retirement Board

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

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

SECTION 8 Do you have group insurance or other health insurance from an employer?

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

CHAPTER 3:
Using the plan for your medical services

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

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

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

Section 1.1 What are network providers and covered services?

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

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

As a Medicare health plan, Personal Choice 65 Medical-Only must cover all services covered by Original Medicare and must follow Original Medicare's coverage rules.

Personal Choice 65 Medical-Only will generally cover your medical care as long as:

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

provider who is not eligible to participate in Medicare. If you go to a provider who is not eligible to participate in Medicare, you will be responsible for the full cost of the services you receive. Check with your provider before receiving services to confirm that they are eligible to participate in Medicare.

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

Section 2.1 You may choose a primary care provider (PCP) to provide and oversee your medical care

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

When you become a member of Personal Choice 65 Medical-Only, you may select a plan physician as your primary care provider. All primary care providers meet state requirements and are trained to give you basic medical care. A primary care provider is usually a family or general practitioner or an internist who knows the plan's network and can guide you to a plan specialist when needed. You do not need your primary care provider's approval to visit a specialist. You need prior authorization from our plan to receive some in-network covered services, as outlined in Section 2.2 below.

Your PCP will provide you with basic medical care and help to arrange or coordinate covered services that you receive as a plan member. These covered services include:

- X-rays;
- Therapies;
- Care from doctors who are specialists; and
- Follow-up care.

How do you choose your PCP?

As a Personal Choice 65 Medical-Only member, you may select a PCP to coordinate your care. A PCP is not required, but we encourage you to select one.

Whether you already have a PCP or are searching for one, our *Provider/Pharmacy Directory* will help you confirm their in-network status or help you locate one in your plan's network that's best suited for your needs. Our online *Find a Provider* tool can help you find in-network providers (doctor, hospital, and other medical facilities). Our online *Find a Provider* tool is available at www.ibxmedicare.com/providerfinder.

There are two ways you can select a PCP:

- To select your PCP online, log in or register at www.ibx.com/login.
- Or call our Member Help Team, who can assist you in finding and selecting a PCP.

Once you select your PCP, you will receive an updated member ID card with your PCP name, phone number, and laboratory information.

Changing your PCP

You may change your PCP for any reason, at any time. Also, it's possible that your PCP might leave our plan's network of providers and you would have to find a new PCP in our plan or you will pay more for covered services.

To change your PCP, call our Member Help Team or log in or register at www.ibx.com/login. The change will be effective the first day of the month following the request for change. If you call, be sure to inform our Member Help Team representative if you are seeing any specialists or receiving covered services that your PCP approved (such as home health services and durable medical equipment). Our Member Help Team representative will then:

- Help you continue to receive specialty care and covered services when you change your PCP;
- Verify that your chosen PCP is accepting new patients; and
- Change your membership record to show the name of your new PCP.

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

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

- Routine women's health care, which includes breast exams, screening mammograms (X-rays of the breast), Pap tests, and pelvic exams.
- Flu shots, COVID-19 vaccinations, and pneumonia vaccinations
- Emergency services from network providers or from out-of-network providers
- Urgently needed services are covered services that are not emergency services, provided when the network providers are temporarily unavailable or inaccessible or when the enrollee is out of the service area. For example, you need immediate care during the weekend. Services must be immediately needed and medically necessary.
- Kidney dialysis services that you get at a Medicare-certified dialysis facility when you are temporarily outside the plan's service area or when your provider for this service is temporarily unavailable or inaccessible. The cost-sharing you pay the plan for dialysis can never exceed the cost-sharing in Original Medicare. If you are outside the plan's service area and obtain the dialysis from a provider that is outside the plan's network, your cost-sharing cannot exceed the cost-sharing you pay in network. However, if your usual in-network provider for dialysis is temporarily unavailable and you choose to obtain services inside the service area from a provider outside the plan's network, the cost-sharing for the dialysis may be higher. If possible, please let us know before you leave the service area so we can help arrange for you to have maintenance dialysis while you are away.

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

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

- Oncologists care for patients with cancer.
- Cardiologists care for patients with heart conditions.

- Orthopedists care for patients with certain bone, joint, or muscle conditions.

If you need specialized care, you do not need a referral to see a medical specialist, mental/behavioral health specialist, or other network providers for in-network services. However, you are required to seek approval in advance to get certain procedures or covered services. This is called getting prior authorization. In the network portion of a PPO, some in-network medical services are covered only if your doctor or the other network provider gets prior authorization from our plan. In a PPO, you do not need prior authorization to obtain out-of-network services, but we encourage you to contact us to receive it. Our plan will determine whether the service you are requesting is medically necessary and authorized under our plan rules. Covered services that need prior authorization are marked in the Medical Benefits Chart in Chapter 4, Section 2.1.

To find an in-network medical specialist or mental/behavioral health specialist, visit www.ibxmedicare.com/directory.

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

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

- Even though our network of providers may change during the year, Medicare requires that we furnish you with uninterrupted access to qualified doctors and specialists.
- We will notify you that your provider is leaving our plan so that you have time to select a new provider.
    - If your primary care or behavioral health provider leaves our plan, we will notify you if you have seen that provider within the past three years.
    - If any of your other providers leave our plan, we will notify you if you are assigned to the provider, currently receive care from them, or have seen them within the past three months.
- We will assist you in selecting a new qualified in-network provider that you may access for continued care.
- If you are undergoing medical treatment or therapies with your current provider, you have the right to request, and we will work with you to ensure, that the medically necessary treatment or therapies you are receiving continues.
- We will provide you with information about the different enrollment periods available to you and options you may have for changing plans.
- We will arrange for any medically necessary covered benefit outside of our provider network, but at in-network cost-sharing, when an in-network provider or benefit is unavailable or inadequate to meet your medical needs. Prior authorization is required in these instances.
- If you find out your doctor or specialist is leaving your plan, please contact us so we can assist you in finding a new provider to manage your care.
- If you believe we have not furnished you with a qualified provider to replace your previous provider or that your care is not being appropriately managed, you have the right to file a quality-of-care complaint to the QIO, a quality-of-care grievance to the plan, or both. Please see Chapter 7.

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

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

- You can get your care from an out-of-network provider; however, in most cases that provider must be eligible to participate in Medicare. Except for emergency care, we cannot pay a provider who is not eligible to participate in Medicare. If you receive care from a provider who is not eligible to participate in Medicare, you will be responsible for the full cost of the services you receive. Check with your provider before receiving services to confirm that they are eligible to participate in Medicare.
- You don't need to get a referral or prior authorization when you get care from out-of-network providers. However, before getting services from out-of-network providers you may want to ask for a pre-visit coverage decision to confirm that the services you are getting are covered and are medically necessary. (See Chapter 7, Section 4 for information about asking for coverage decisions.) This is important because:
  - Without a pre-visit coverage decision, if we later determine that the services are not covered or were not medically necessary, we may deny coverage and you will be responsible for the entire cost. If we say we will not cover your services, you have the right to appeal our decision not to cover your care. See Chapter 7 (*What to do if you have a problem or complaint*) to learn how to make an appeal.
- It is best to ask an out-of-network provider to bill the plan first. But, if you have already paid for the covered services, we will reimburse you for our share of the cost for covered services. Or if an out-of-network provider sends you a bill that you think we should pay, you can send it to us for payment. See Chapter 5 (*Asking us to pay our share of a bill you have received for covered medical services*) for information about what to do if you receive a bill or if you need to ask for reimbursement.
- If you are using an out-of-network provider for emergency care, urgently needed services, or out-of-area dialysis, you may not have to pay a higher cost-sharing amount. See Section 3 for more information about these situations.

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

Section 3.1 Getting care if you have a medical emergency

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

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

If you have a medical emergency:

- **Get help as quickly as possible.** Call 911 for help or go to the nearest emergency room or hospital. Call for an ambulance if you need it. You do *not* need to get approval or a referral first from your PCP. You do not need to use a network doctor. You may get covered emergency medical care whenever you need it, anywhere in the United States or its territories, and from any provider with an appropriate state license even if they are not part of our network. Our plan also covers worldwide emergency and urgent care services outside of the United States. See Chapter 4 (*Medical Benefits Chart (what is covered and what you pay)*) for more information. For assistance, please call our Member Help Team for details if traveling outside the United States.
- **As soon as possible, make sure that our plan has been told about your emergency.** We need to follow up on your emergency care. You or someone else should call to tell us about your emergency care, usually within 48 hours. The number to call us is located on the back of your member ID card.

What is covered if you have a medical emergency?

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

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

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

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

What if it wasn't a medical emergency?

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

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

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

What are urgently needed services?

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

As a member of our plan, you can receive your care from an in-network or out-of-network urgent care facility at the same cost-sharing amount. See Chapter 4, Section 2.1 for details about

copayments. The urgent care facilities in our network can be found in the *Provider/Pharmacy Directory*, on our website at www.ibxmedicare.com/directory, or by calling our Member Help Team. As soon as possible, make sure that our plan has been told about your care. We need to follow up on your care. You or someone else should call to tell us about your care, usually within 48 hours. The number to call us is located on the back of your member ID card.

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

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

You require urgently needed services to treat a non-emergency, unforeseen medical illness, injury, or condition that requires immediate medical care.

Section 3.3 Getting care during a disaster

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

Please visit the following website: www.ibxmedicare.com for information on how to obtain needed care during a disaster.

If you cannot use a network provider during a disaster, your plan will allow you to obtain care from out-of-network providers at in-network cost-sharing.

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

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

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

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

Personal Choice 65 Medical-Only covers all medically necessary services as listed in the Medical Benefits Chart in Chapter 4 of this document. If you receive services not covered by our plan, you are responsible for paying the full cost of services.

For covered services that have a benefit limitation, you also pay the full cost of any services you get after you have used up your benefit for that type of covered service. If you pay for services once you reach your benefit limit for those services, or for services not covered by Original Medicare, your out-of-pocket expenses will not count toward your out-of-pocket maximum. You can call our Member Help Team when you want to know how much of your benefit limit you have already used.

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

Section 5.1 What is a clinical research study?

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

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

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

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

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

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

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

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

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

After Medicare has paid its share of the cost for these services, our plan will pay the difference between the cost-sharing in Original Medicare and your in-network cost-sharing as a member of our plan. This means you will pay the same amount for the services you receive as part of the

study as you would if you received these services from our plan. However, you are required to submit documentation showing how much cost-sharing you paid. Please see Chapter 5 for more information for submitting requests for payments.

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

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

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

Do you want to know more?

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

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

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

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

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

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

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

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

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

Medicare Inpatient Hospital and Inpatient Mental Health Care coverage limits will apply. Please refer to the Medical Benefits Chart in Chapter 4 for information on these limits.

SECTION 7 Rules for ownership of durable medical equipment

Section 7.1 Will you own the durable medical equipment after making a certain number of payments under our plan?

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

In Original Medicare, people who rent certain types of DME own the equipment after paying copayments for the item for 13 months. As a member of Personal Choice 65 Medical-Only, however, you usually will not acquire ownership of rented DME items no matter how many copayments you make for the item while a member of our plan, even if you made up to 12 consecutive payments for the DME item under Original Medicare before you joined our plan. Under certain limited circumstances, we will transfer ownership of the DME item to you. Call our Member Help Team for more information.

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

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

Example 1: You made 12 or fewer consecutive payments for the item in Original Medicare and then joined our plan. The payments you made in Original Medicare do not count.

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

Section 7.2 Rules for oxygen equipment, supplies, and maintenance

What oxygen benefits are you entitled to?

If you qualify for Medicare oxygen equipment coverage, Personal Choice 65 Medical-Only will cover:

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

If you leave Personal Choice 65 Medical-Only or no longer medically require oxygen equipment, then the oxygen equipment must be returned.

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

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

CHAPTER 4:

Medical Benefits Chart (what is covered and what you pay)

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

This chapter provides a Medical Benefits Chart that lists your covered services and shows how much you will pay for each covered service as a member of Personal Choice 65 Medical-Only. Later in this chapter, you can find information about medical services that are not covered. It also explains limits on certain services.

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

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

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

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

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

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

- Your **in-network maximum out-of-pocket amount (MOOP)** is $5,000. This is the most you pay during the calendar year for covered Medicare Part A and Part B services received from network providers. The amounts you pay for copayments and coinsurance for covered services from network providers count toward this in-network maximum out-of-pocket amount. (The amounts you pay for plan premiums and services from out-of-network providers do not count toward your in-network maximum out-of-pocket amount. In addition, amounts you pay for some services do not count toward your in-network maximum out-of-pocket amount. These services are marked with an asterisk in the Medical Benefits Chart.) If you have paid $5,000 for covered Part A and Part B services from network providers, you will not have any out-of-pocket costs for the rest of the year when you see our network providers. However, you must continue to pay your plan premium and the Medicare Part B premium (unless your Part B premium is paid for you by Medicaid or another third party).
- Your **combined maximum out-of-pocket amount** is $8,950. This is the most you pay during the calendar year for covered Medicare Part A and Part B services received from both in-network and out-of-network providers. The amounts you pay for copayments and coinsurance for covered services count toward this combined maximum out-of-pocket amount. (The amounts you pay for your plan premiums do not count toward your combined maximum out-of-pocket amount. In addition, amounts you pay for some services do not count toward your combined maximum out-of-pocket amount. These services are marked with an asterisk in the Medical Benefits Chart.) If you have paid $8,950 for covered services, you will have 100% coverage and will not have any out-of-pocket costs for the rest of the

year for covered Part A and Part B services. However, you must continue to pay your plan premium and the Medicare Part B premium (unless your Part B premium is paid for you by Medicaid or another third party).

Section 1.3 Our plan also limits your out-of-pocket costs for certain types of services

In addition to the in-network and combined maximum out-of-pocket amounts for covered Part A and Part B services (see Section 1.2 above), we also have a separate maximum out-of-pocket amount that applies only to certain types of services.

The plan has a maximum out-of-pocket amount for the following types of services:

- The maximum out-of-pocket amount for in-network inpatient hospital care is $1,440. Once you have paid $1,440 out of pocket for in-network inpatient hospital care, the plan will cover these services at no cost to you for the rest of the in-network inpatient hospital care stay. Both the maximum out-of-pocket amount for Part A and Part B medical services and the maximum out-of-pocket amount for in-network inpatient hospital care apply to your covered in-network inpatient hospital care. This means that once you have paid either $5,000 for Part A and Part B medical services or $1,440 for your in-network inpatient hospital care, the plan will cover your in-network inpatient hospital care at no cost to you for the rest of the in-network inpatient hospital care stay.
- The maximum out-of-pocket amount for in-network inpatient mental health care is $1,440. Once you have paid $1,440 out of pocket for in-network inpatient mental health care, the plan will cover these services at no cost to you for the rest of the in-network inpatient mental health care stay. Both the maximum out-of-pocket amount for Part A and Part B medical services and the maximum out-of-pocket amount for in-network inpatient mental health care apply to your covered in-network inpatient mental health care. This means that once you have paid either $5,000 for Part A and Part B medical services or $1,440 for your in-network inpatient mental health care, the plan will cover your in-network inpatient mental health care at no cost to you for the rest of the in-network inpatient mental health care stay.

The Medical Benefits Chart in Section 2 shows the service category out-of-pocket maximums.

Section 1.4 Our plan does not allow providers to balance bill you

As a member of Personal Choice 65 Medical-Only, an important protection for you is that you only have to pay your cost-sharing amount when you get services covered by our plan. Providers may not add additional separate charges, called **balance billing**. This protection applies even if we pay the provider less than the provider charges for a service and even if there is a dispute and we don't pay certain provider charges.

Here is how this protection works.

- If your cost-sharing is a copayment (a set amount of dollars, for example, $15.00), then you pay only that amount for any covered services from a network provider. You will generally have higher copays when you obtain care from out-of-network providers.
- If your cost-sharing is a coinsurance (a percentage of the total charges), then you never pay more than that percentage. However, your cost depends on which type of provider you see:
    - If you receive the covered services from a network provider, you pay the coinsurance percentage multiplied by the plan's reimbursement rate (as determined in the contract between the provider and the plan).

- If you receive the covered services from an out-of-network provider who participates with Medicare, you pay the coinsurance percentage multiplied by the Medicare payment rate for participating providers.
- If you receive the covered services from an out-of-network provider who does not participate with Medicare, you pay the coinsurance percentage multiplied by the Medicare payment rate for non-participating providers.

- If you believe a provider has balance billed you, call our Member Help Team.

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

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

The Medical Benefits Chart on the following pages lists the services Personal Choice 65 Medical-Only covers and what you pay out of pocket for each service. The services listed in the Medical Benefits Chart are covered only when the following coverage requirements are met:

- Your Medicare-covered services must be provided according to the coverage guidelines established by Medicare.
- Your services (including medical care, services, supplies, equipment, and Part B prescription drugs) *must* be medically necessary. Medically necessary means that the services, supplies, or drugs are needed for the prevention, diagnosis, or treatment of your medical condition and meet accepted standards of medical practice.
- Some of the services listed in the Medical Benefits Chart are covered as in-network services *only* if your doctor or other network provider gets approval in advance (sometimes called prior authorization) from Personal Choice 65 Medical-Only.
  - Some Part B drugs require precertification. Please refer to the Precertification List at www.ibxmedicare.com/precert or contact our Member Help Team.
  - Covered medical services and durable medical equipment (DME) that need approval in advance are marked by an asterisk in the Medical Benefits Chart. For more information about prior authorizations and a list of durable medical equipment suppliers, please visit our website at www.ibxmedicare.com.
  - You never need approval in advance for out-of-network services from out-of-network providers.
  - While you don't need approval in advance for out-of-network services, you or your doctor can ask us to make a coverage decision in advance.

Other important things to know about our coverage:

- For benefits where your cost-sharing is a coinsurance percentage, the amount you pay depends on what type of provider you receive the services from:
  - If you receive the covered services from a network provider, you pay the coinsurance percentage multiplied by the plan's reimbursement rate (as determined in the contract between the provider and the plan).
  - If you receive the covered services from an out-of-network provider who participates with Medicare, you pay the coinsurance percentage multiplied by the Medicare payment rate for participating providers.

- If you receive the covered services from an out-of-network provider who does not participate with Medicare, you pay the coinsurance percentage multiplied by the Medicare payment rate for non-participating providers.

- Like all Medicare health plans, we cover everything that Original Medicare covers. For some of these benefits, you pay *more* in our plan than you would in Original Medicare. For others, you pay *less.* (If you want to know more about the coverage and costs of Original Medicare, look in your *Medicare & You 2024* handbook. View it online at www.medicare.gov or ask for a copy by calling 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.)
- For all preventive services that are covered at no cost under Original Medicare, we also cover the service at no cost to you. However, if you also are treated or monitored for an existing medical condition during the visit when you receive the preventive service, a copayment will apply for the care received for the existing medical condition.
- If Medicare adds coverage for any services during 2024, either Medicare or our plan will cover those services.

Important Benefit Information for Enrollees with Certain Chronic Conditions

- If you are diagnosed by a plan provider with the following chronic condition(s) identified below and meet certain medical criteria, you may be eligible for other targeted supplemental benefits and/or targeted reduced cost-sharing:
  - Diabetes
  - Congestive heart failure

  For further detail, please go to the **Help with Certain Chronic Conditions** row in the Medical Benefits Chart below.

Important Benefit Information for Enrollees with Chronic Conditions

- If you are diagnosed with the following chronic condition(s) identified below and meet certain criteria, you may be eligible for special supplemental benefits for the chronically ill.
  - Diabetes
  - Depression or depressive disorders
- The benefits mentioned are a part of our special supplemental benefits program for the chronically ill. Not all members qualify.
- Please go to the *Special Supplemental Benefits for the Chronically Ill* row in the below Medical Benefits Chart for further detail.
- Please contact us to find out exactly which benefits you are eligible for.

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

Medical Benefits Chart

Services that are covered for you	What you must pay when you get these services
 **Abdominal aortic aneurysm screening** A one-time screening ultrasound for people at risk. The plan only covers this screening if you have certain risk factors and if you get an order for it from your physician, physician assistant, nurse practitioner, or clinical nurse specialist. Risk factors for abdominal aortic aneurysm are: • A family history of abdominal aortic aneurysms; • A man aged 65 to 75 who has smoked at least 100 cigarettes in his lifetime You're considered at risk if you meet one of the criteria listed above.	**In network:** There is no coinsurance or copayment for members eligible for this preventive screening. **Out-of-network:** 30% coinsurance for beneficiaries eligible for this preventive screening **In or out-of-network:** If you receive a separate additional non-preventive evaluation and/or service, a copayment will apply. The copayment amount depends on the provider type or place of service.

Services that are covered for you	What you must pay when you get these services
Acupuncture for chronic low back pain Covered services include: Up to 12 visits in 90 days are covered for Medicare beneficiaries under the following circumstances: For the purpose of this benefit, chronic low back pain is defined as: • lasting 12 weeks or longer; • nonspecific, in that it has no identifiable systemic cause (i.e., not associated with metastatic, inflammatory, infectious disease, etc.); • not associated with surgery; and • not associated with pregnancy. An additional eight sessions will be covered for those patients demonstrating an improvement. No more than 20 acupuncture treatments may be administered annually. Treatment must be discontinued if the patient is not improving or is regressing. Provider Requirements: Physicians (as defined in 1861(r)(1) of the Social Security Act (the Act)) may furnish acupuncture in accordance with applicable state requirements. Physician assistants (PAs), nurse practitioners (NPs)/clinical nurse specialists (CNSs) (as identified in 1861(aa) (5) of the Act), and auxiliary personnel may furnish acupuncture if they meet all applicable state requirements and have: • a masters or doctoral level degree in acupuncture or Oriental Medicine from a school accredited by the Accreditation Commission on Acupuncture and Oriental Medicine (ACAOM); and, (continued)	**In network:** $20 copayment per visit for Medicare-covered and routine services **Out-of-network:** 30% coinsurance per visit for out-of-network Medicare-covered and routine services * Copayment for routine acupuncture visits do not count toward your maximum out-of-pocket amount.

Services that are covered for you	What you must pay when you get these services
Acupuncture for chronic low back pain (continued) • a current, full, active, and unrestricted license to practice acupuncture in a State, Territory, or Commonwealth (i.e., Puerto Rico) of the United States, or District of Columbia. Auxiliary personnel furnishing acupuncture must be under the appropriate level of supervision of a physician, PA, or NP/CNS required by our regulations at 42 CFR §§ 410.26 and 410.27. **Non-Medicare-covered services include:** Our plan covers up to six sessions per calendar year for routine acupuncture treatment. Patients must have one of the following conditions to receive routine acupuncture services: headache (migraine and tension), post-operative nausea and vomiting, chemotherapy-induced nausea and vomiting, low back pain, chronic neck pain, pain from osteoarthritis of the knee and hip.	
Ambulance services Covered ambulance services, whether for an emergency or non-emergency situation, include fixed wing, rotary wing, and ground ambulance services, to the nearest appropriate facility that can provide care only if they are furnished to a member whose medical condition is such that other means of transportation could endanger the person's health or if authorized by the plan. If the covered ambulance services are not for an emergency situation, it should be documented that the member's condition is such that other means of transportation could endanger the person's health and that transportation by ambulance is medically required.	**In network:** * Prior authorization is required for non-emergency Medicare-covered ambulance. **In or out-of-network:** $175 copayment per one-way trip by ground or air ambulance Copayment is not waived if admitted. Some restrictions, including destination, may apply. Please note: If you refuse transport when an ambulance is dispatched, the plan will not cover the cost of the ambulance and you will be responsible for the full cost of the service. A round-trip for dialysis may require prior approval.

Services that are covered for you	What you must pay when you get these services
Annual physical exam You may receive an annual physical examination. The annual physical examination includes a comprehensive review of systems and physical examination, including but not limited to the following: detailed family history, hands-on examination, general appearance, and EKG screening, heart, lung, head, and neck examinations.	**In network:** There is no coinsurance or copayment for an annual physical exam. **Out-of-network:** 30% coinsurance for the annual physical exam
Annual wellness visit If you've had Part B for longer than 12 months, you can get an annual wellness visit to develop or update a personalized prevention plan based on your current health and risk factors. This is covered once every 12 months. **Note**: Your first annual wellness visit can't take place within 12 months of your *Welcome to Medicare* preventive visit. However, you don't need to have had a *Welcome to Medicare* visit to be covered for annual wellness visits after you've had Part B for 12 months. Annual wellness visits are covered once a calendar year.	**In network:** There is no coinsurance or copayment for the annual wellness visit. **Out-of-network:** 30% coinsurance for the annual wellness visit **In or out-of-network:** If you receive a separate additional non-preventive evaluation and/or service, a copayment will apply. The copayment amount depends on the provider type or place of service.
Bone mass measurement For qualified individuals (generally, this means people at risk of losing bone mass or at risk of osteoporosis), the following services are covered every 24 months or more frequently if medically necessary: procedures to identify bone mass, detect bone loss, or determine bone quality, including a physician's interpretation of the results.	**In network:** There is no coinsurance or copayment for Medicare-covered bone mass measurement. **Out -of-network:** 30% coinsurance for the bone mass measurement **In or out-of-network:** If you receive a separate additional non-preventive evaluation and/or service, a copayment will apply. The copayment amount depends on the provider type or place of service.

Services that are covered for you	What you must pay when you get these services
Breast cancer screening (mammograms) Covered services include: • One baseline mammogram between the ages of 35 and 39 • One screening mammogram every 12 months for women aged 40 and older • Clinical breast exams once every 24 months	**In network:** There is no coinsurance or copayment for covered screening mammograms. **Out-of-network:** 30% coinsurance for covered screening mammograms **In or out-of-network:** If you receive a separate additional non-preventive evaluation and/or service, a copayment will apply. The copayment amount depends on the provider type or place of service. If you receive a preventive test that turns into a diagnostic test or service during the procedure, there will be no copayment for that diagnostic test.
Cardiac rehabilitation services Comprehensive programs of cardiac rehabilitation services that include exercise, education, and counseling are covered for members who meet certain conditions with a doctor's order. The plan also covers intensive cardiac rehabilitation programs that are typically more rigorous or more intense than cardiac rehabilitation programs.	**In network:** $5 copayment per provider, per visit **Out-of-network:** 30% coinsurance for cardiac rehabilitation services

Services that are covered for you	What you must pay when you get these services
Cardiovascular disease risk reduction visit (therapy for cardiovascular disease) We cover one visit per year with your primary care doctor to help lower your risk for cardiovascular disease. During this visit, your doctor may discuss aspirin use (if appropriate), check your blood pressure, and give you tips to make sure you're eating healthy.	**In network:** There is no coinsurance or copayment for the intensive behavioral therapy cardiovascular disease preventive benefit. **Out-of-network:** 30% coinsurance for the intensive behavioral therapy cardiovascular disease preventive benefit **In or out-of-network:** If you receive a separate additional non-preventive evaluation and/or service, a copayment will apply. The copayment amount depends on the provider type or place of service.
Cardiovascular disease testing Blood tests for the detection of cardiovascular disease (or abnormalities associated with an elevated risk of cardiovascular disease) once every 5 years (60 months).	**In network:** There is no coinsurance or copayment for cardiovascular disease testing that is covered once every five years. **Out-of-network:** 30% coinsurance for cardiovascular disease testing that is covered once every 5 years **In or out-of-network:** If you receive a separate additional non-preventive evaluation and/or service, a copayment will apply. The copayment amount depends on the provider type or place of service.

Services that are covered for you	What you must pay when you get these services
Cervical and vaginal cancer screening Covered services include: • For all women: Pap tests and pelvic exams are covered once every 24 months • If you are at high risk of cervical or vaginal cancer or you are of childbearing age and have had an abnormal Pap test within the past 3 years: one Pap test every 12 months	**In network:** There is no coinsurance or copayment for Medicare-covered preventive Pap and pelvic exams. **Out-of-network:** 30% coinsurance for Medicare-covered preventive Pap and pelvic exams **In or out-of-network:** If you receive a separate additional non-preventive evaluation and/or service, a copayment will apply. The copayment amount depends on the provider type or place of service.
Chiropractic services Covered services include: • Manual manipulation of the spine to correct subluxation • Routine chiropractic care, up to six combined in- and out-of-network supplemental visits per year o Six routine chiropractic visits include manual manipulation for maintenance chiropractic care.	**In network:** Manual manipulation: $20 copayment per visit Routine services: $20 copayment per visit **Out-of-network:** Manual manipulation: 30% coinsurance per visit Routine services: 30% coinsurance per visit **In or out-of-network:** * Copayments and coinsurance for routine chiropractic visits do not count toward your maximum out-of-pocket amount.

Services that are covered for you	What you must pay when you get these services
Colorectal cancer screening The following screening tests are covered: • Colonoscopy has no minimum or maximum age limitation and is covered once every 120 months (10 years) for patients not at high risk, or 48 months after a previous flexible sigmoidoscopy for patients who are not at high risk for colorectal cancer, and once every 24 months for high-risk patients after a previous screening colonoscopy or barium enema. • Flexible sigmoidoscopy for patients 45 years and older. Once every 120 months for patients not at high risk after the patient received a screening colonoscopy. Once every 48 months for high-risk patients from the last flexible sigmoidoscopy or barium enema. • Screening fecal-occult blood tests for patients 45 years and older. Once every 12 months. • Multitarget stool DNA for patients 45 to 85 years of age and not meeting high-risk criteria. Once every 3 years. • Blood-based Biomarker Tests for patients 45 to 85 years of age and not meeting high-risk criteria. Once every 3 years. • Barium Enema as an alternative to colonoscopy for patients at high risk and 24 months since the last screening barium enema or the last screening colonoscopy. • Barium Enema as an alternative to flexible sigmoidoscopy for patient not at high risk and 45 years or older. Once at least 48 months following the last screening barium enema or screening flexible sigmoidoscopy. Colorectal cancer screening tests include a follow-up screening colonoscopy after a Medicare-covered non-invasive stool-based colorectal cancer screening test returns a positive result.	**In network:** There is no coinsurance or copayment for a Medicare-covered colorectal cancer screening exam. **Out-of-network:** 30% coinsurance for a Medicare-covered colorectal cancer screening exam **In or out-of-network:** If you receive a separate additional non-preventive evaluation and/or service, a copayment will apply. The copayment amount depends on the provider type or place of service. If you receive a preventive test that turns into a diagnostic test or service during the procedure, there will be no copayment for that diagnostic test.

Dental services

In general, preventive dental services (such as cleaning, routine dental exams, and dental X-rays) are not covered by Original Medicare. However, Medicare currently pays for dental services in a limited number of circumstances, specifically when that service is an integral part of specific treatment of a beneficiary's primary medical condition. Some examples include reconstruction of the jaw following fracture or injury, tooth extractions done in preparation for radiation treatment for cancer involving the jaw, or oral exams preceding kidney transplantation.

In addition, we cover the following non-Medicare-covered services:

- One oral exam and cleaning every six months
- One set of dental bitewing X-rays every 12 months
- One periapical X-ray every three years
- One full-mouth/panoramic X-ray every three years

Dental implants are not covered by Personal Choice 65 Medical-Only plans.

We also cover the following non-Medicare-covered comprehensive dental services:

- Restorative Services (Fillings white or silver - one per tooth every 24 months)
- Endodontics (Root Canals - one per tooth per lifetime, Crowns - one every five years per tooth)
- Periodontics (Scaling and root planing - 1 every 36 months per mouth quadrant)
- Extractions (Simple extractions - no frequency limits)

(continued)

Medicare-covered dental services

In network:

$35 copayment

Out-of-network:

30% coinsurance

Search for in-network providers that provide Medicare-covered dental services through our *Provider Finder* at www.ibxmedicare.com/providerfinder.

Non-Medicare-covered routine dental services

In network:

$0 copayment per visit for one exam and cleaning every six months

$0 copayment for one set of dental bitewing X-rays every 12 months

$0 copayment for one periapical X-ray every three years

$0 copayment for one full-mouth/panoramic X-ray every three years

For in-network dental services use a participating **United Concordia - Concordia Choice Plus Medicare Advantage** dental network provider for in-network routine and comprehensive dental coverage not covered by Original Medicare.

Search for a participating **United Concordia - Concordia Choice Plus Medicare Advantage** network dentist through our *Find a Dentist* tool at www.ibxmedicare.com/findadentist.

Out-of-network:

80% coinsurance for exams and cleanings

80% coinsurance for dental X-rays

Services that are covered for you	What you must pay when you get these services
Dental services (continued) • Prosthodontics (Dentures - one set every four years, Denture realignment/adjustment - one every 24 months, Partials/Bridges - one per mouth quadrant at one every four years, implant-supported or abutment-supported crowns – one every five years) • Oral Surgery (Surgical removal of erupted tooth or residual tooth roots, removal of impacted teeth – one procedure per tooth per year) • 60-minute anesthesia session covered in full per session	***Non-Medicare-covered comprehensive dental services*** **In or out-of-network:** Combined $1,500 in- or out-of-network annual plan maximum allowance every year for the following comprehensive dental services: restorative services, endodontics, periodontics, extractions, prosthodontics, other oral/maxillofacial surgery, and other services **In network:** 20% coinsurance for the following comprehensive dental services: restorative services, endodontics, periodontics, and extractions 40% coinsurance for the following comprehensive dental services: prosthodontics, other oral/maxillofacial surgery, and other services **Out-of-network** 80% coinsurance for the following comprehensive dental services: restorative services, endodontics, periodontics, extractions, prosthodontics, other oral/maxillofacial surgery, and other services For in-network dental services use a participating **United Concordia - Concordia Choice Plus Medicare Advantage** dental network provider for in-network routine and comprehensive dental coverage not covered by Original Medicare. Search for a participating **United Concordia - Concordia Choice Plus Medicare Advantage** network dentist through our *Find a Dentist* tool at www.ibxmedicare.com/findadentist. * Non-Medicare-covered routine and comprehensive dental services do not count towards your annual out-of-pocket maximum.

Services that are covered for you	What you must pay when you get these services
Depression screening We cover one screening for depression per year. The screening must be done in a primary care setting that can provide follow-up treatment and/or referrals.	**In network:** There is no coinsurance or copayment for an annual depression screening visit. **Out-of-network:** 30% coinsurance for an annual depression screening visit **In or out-of-network:** If you receive a separate additional non-preventive evaluation and/or service, a copayment will apply. The copayment amount depends on the provider type or place of service.
Diabetes screening We cover this screening (includes fasting glucose tests) if you have any of the following risk factors: high blood pressure (hypertension), history of abnormal cholesterol and triglyceride levels (dyslipidemia), obesity, or a history of high blood sugar (glucose). Tests may also be covered if you meet other requirements, like being overweight and having a family history of diabetes. Based on the results of these tests, you may be eligible for up to two diabetes screenings every 12 months.	**In network:** There is no coinsurance or copayment for the Medicare covered diabetes screening tests. **Out-of-network:** 30% coinsurance for Medicare-covered diabetes screening tests **In or out-of-network:** If you receive a separate additional non-preventive evaluation and/or service, a copayment will apply. The copayment amount depends on the provider type or place of service.

Services that are covered for you	What you must pay when you get these services
Diabetes self-management training, diabetic services and supplies For all people who have diabetes (insulin and non-insulin users). Covered services include: • Supplies to monitor your blood glucose: Blood glucose monitor, blood glucose test strips, lancet devices and lancets, and glucose-control solutions for checking the accuracy of test strips and monitors. • For people with diabetes who have severe diabetic foot disease: One pair per calendar year of therapeutic custom-molded shoes (including inserts provided with such shoes) and two additional pairs of inserts, or one pair of depth shoes and three pairs of inserts (not including the non-customized removable inserts provided with such shoes). Coverage includes fitting. (continued)	**In network:** There is no coinsurance or copayment for beneficiaries eligible for the diabetes self-management training preventive benefit $0 copayment for diabetic test strips and glucose monitors $0 copayment for lancets and solutions $0 copayment for custom-molded shoes and inserts $0 copayment for insulin pumps and related supplies 20% coinsurance for plan-specified flash glucose monitors *Prior authorization is required for select diabetic supplies.

Services that are covered for you	What you must pay when you get these services
Diabetes self-management training, diabetic services and supplies (continued)	
• Diabetes self-management training is covered under certain conditions. **Test strips and monitors must be obtained from preferred vendors Accu-Chek and OneTouch. Test strips and monitors from any other vendor will not be covered.** Lancets, solutions, insulin pumps and related supplies from any brand are available to members. If Accu-Chek and OneTouch test strips do not work with your current monitor, please call your PCP to request a prescription for a replacement monitor. Freestyle Libre is the only covered flash glucose monitoring device. **Note:** Continuous glucose monitoring devices are covered under the durable medical equipment (DME) benefit. Please refer to the DME benefit chart in Chapter 4, Section 2.1.	**Out-of-network:** 30% coinsurance for the diabetes self-management training preventive benefit 30% coinsurance for diabetic test strips and monitors 30% copayment for lancets and solutions 30% coinsurance for custom-molded shoes and inserts 30% coinsurance for insulin pumps and related supplies **In or out-of-network:** For diabetic self-management training, if you receive a separate additional non-preventive evaluation and/or service, a copayment will apply. The copayment amount depends on the provider type or place of service.

Services that are covered for you	What you must pay when you get these services
Durable medical equipment (DME) and related supplies (For a definition of durable medical equipment, see Chapter 10 of this document as well as Chapter 3, Section 7.) Covered items include, but are not limited to: wheelchairs, crutches, powered mattress systems, diabetic supplies, hospital beds ordered by a provider for use in the home, IV infusion pumps, speech-generating devices, oxygen equipment, nebulizers, and walkers. We cover all medically necessary DME covered by Original Medicare. If our supplier in your area does not carry a particular brand or manufacturer, you may ask them if they can special-order it for you. The most recent list of suppliers is available on our website at www.ibxmedicare.com.	**In network:** 20% coinsurance for Medicare-covered durable medical equipment Your cost-sharing for Medicare oxygen equipment coverage is 20% coinsurance, every month. Your cost-sharing will not change after being enrolled for 36 months. * Prior authorization is required for certain items. Please refer to the Precertification List (Website URL listed at the beginning of Chapter 4, Section 2.1) or contact our Member Help Team. **Out-of-network:** 30% coinsurance for Medicare-covered durable medical equipment Your cost-sharing for Medicare oxygen equipment coverage is 30% coinsurance, every month. Your cost-sharing will not change after being enrolled for 36 months.

Services that are covered for you	What you must pay when you get these services
Emergency care Emergency care refers to services that are: • Furnished by a provider qualified to furnish emergency services, and • Needed to evaluate or stabilize an emergency medical condition. A medical emergency is when you, or any other prudent layperson with an average knowledge of health and medicine, believe that you have medical symptoms that require immediate medical attention to prevent loss of life (and, if you are a pregnant woman, loss of an unborn child), loss of a limb, or loss of function of a limb. The medical symptoms may be an illness, injury, severe pain, or a medical condition that is quickly getting worse. Cost-sharing for necessary emergency services furnished out of network is the same as for such services furnished in network. Emergency care is covered worldwide. Worldwide ambulance services are not covered.	**In or out-of-network:** $100 copayment per visit Copayment not waived if admitted to hospital If you receive emergency care outside of the United States, you must pay for your care, and submit the claim for reimbursement consideration. For details on submitting a reimbursement, see Chapter 7, Section 5.5. If you receive emergency care at an out-of-network hospital and need inpatient care after your emergency condition is stabilized, you must move to a network hospital to pay the in-network cost-sharing amount for the part of your stay after you are stabilized. If you stay at the out-of-network hospital, your stay will be covered but you will pay the out-of-network cost-sharing amount for the part of your stay after you are stabilized. * Copayments for emergency services received outside of the United States do not count toward your maximum out-of-pocket amount and are not waived if admitted.

Services that are covered for you	What you must pay when you get these services
Health and wellness education programs **Enhanced Disease Management:** Services are targeted to members with chronic health conditions. A case manager is assigned to a member following an acute admission. The case manager will focus on educating the member about the condition, reviewing medications, and post-discharge planning. In addition, the case manager will teach the member to recognize early warning signs, and coordinate action with the treating physician if the condition deteriorates. The case manager's activities can include scheduling and tracking of physician appointments or in-home nursing visits, coordinating transportation needs, and installation and monitoring of telemonitoring equipment. **Fitness Benefit:** Members receive a physical and mental fitness program through a plan specific vendor with the goal of improving general health and well-being. The program includes: • Access to a participating gym network • On-demand and livestreamed digital content • Home kits • Vendor curated activities that are exercise driven to promote physical activity • Access to a digital platform that exercises the brain to improve aspects of cognition memory, attention, focus and brain speed Members must use a One Pass™ network gym/fitness center and enroll in the One Pass program. Gym memberships and services received from non-One Pass fitness centers will be denied. For more information, log in or register at www.youronepass.com or call 1-877-504-6830 (TTY/TDD: 711), Monday through Friday, from 9 a.m. to 10 p.m.	**In or out-of-network**: There is no coinsurance or copayment for health and wellness education programs. If you receive a separate additional non-preventive evaluation and/or service, a copayment will apply. The copayment amount depends on the provider type or place of service. There is no coinsurance or copayment for the fitness benefit.

Services that are covered for you	What you must pay when you get these services
Health and wellness education programs (continued) **Health Education:** Registered Nurse Health Coaches and Behavioral Health Case Managers who are specialized Registered Nurses and Licensed Social Workers periodically assess each member's health care and provide outreach and guidance on a variety of topics. Registered Nurse Health Coaches and Behavioral Health Case Managers seek to help members manage their conditions through monitoring, education, teaching self-care, and adopting healthy lifestyle changes. **Nursing Hotline:** Members can call 1-800-ASK-BLUE (1-800-275-2583) (TTY/TDD: 711) 24 hours a day, 7 days a week. The hotline is staffed by nurses who will assist with questions and concerns about all health conditions and will provide support for managing chronic conditions.	

Services that are covered for you	What you must pay when you get these services
Hearing services	
Diagnostic hearing and balance evaluations performed by your provider to determine if you need medical treatment are covered as outpatient care when furnished by a physician, audiologist, or other qualified provider.	***Medicare-covered hearing services*** **In network:** $35 copayment **Out-of-network:** 30% coinsurance Search for in-network providers that provide Medicare-covered hearing services through our *Provider Finder* at ibxmedicare.com/providerfinder
In addition, we cover the following non-Medicare-covered routine services include: **Basic hearing evaluations and hearing aids must be provided by a TruHearing® provider.** All hearing services that are not covered by Medicare must be obtained by a TruHearing provider. Any care received from a non-participating provider will not be covered by the plan. To obtain routine hearing services, you must contact TruHearing at 1-855-541-6173 to schedule an appointment with a participating TruHearing provider. • Routine hearing exams (not covered by Medicare), covered once every year • Unlimited fitting and evaluation for hearing aids (continued)	***Non-Medicare-covered routine hearing services*** $0 copayment per visit with a TruHearing provider for each routine hearing exam There is no coinsurance or copayment for hearing aid fitting and evaluation when obtained by a TruHearing provider. Hearing services and hearing aids received from non-participating TruHearing providers and not scheduled through TruHearing are not covered. * Copayments for routine hearing services do not count toward your maximum out-of-pocket amount. $499 copayment per year, per ear for Advanced hearing aids; or, $799 copayment per year, per ear for Premium hearing aids when purchased through TruHearing You must use a participating **TruHearing provider** for in-network routine hearing coverage not covered by Original Medicare. Search for a participating **TruHearing** provider at www.ibxmedicare.com/hearing

Services that are covered for you	What you must pay when you get these services
Hearing services (continued) • Up to two TruHearing-branded hearing aids every year (one per ear, per year). This benefit is limited to TruHearing's Advanced and Premium hearing aids, which come in various styles and colors. Both Advanced and Premium hearing aids are available in rechargeable style options. You must see a TruHearing provider to use this benefit. Hearing aid services include: o 60-day trial period o 3-year extended warranty for loss or irreparable damage o 80 batteries per aid for non-rechargeable models • Benefit does not include or cover any of the following: o Ear molds o Hearing aid accessories o Additional provider visits o Additional batteries; batteries when a rechargeable hearing aid is purchased o Hearing aids that are not TruHearing-branded hearing aids o Costs associated with loss and damage warranty claims Costs associated with excluded items are the responsibility of the member and not covered by the plan.	

Services that are covered for you	What you must pay when you get these services
Help with Certain Chronic Conditions **Transportation services** Members must be diagnosed with both of the following conditions to be eligible to receive the transportation benefit from a plan-specified vendor: • Diabetes • Congestive heart failure (CHF) The transportation benefit includes 24 one-way trips per year to plan-approved medical facilities. Modes of transportation include taxi, rideshare services, van, medical sedan, and wheelchair van. Mileage limits of 80 miles per one-way trip apply. For more information visit www.ibxmedicare.com/bookaride. When booking their rides, members can specify the mode of transportation they need.	$0 copayment for transportation services
HIV screening For people who ask for an HIV screening test or who are at increased risk for HIV infection, we cover: • One screening exam every 12 months For women who are pregnant, we cover: • Up to three screening exams during a pregnancy	**In network:** There is no coinsurance or copayment for members eligible for Medicare-covered preventive HIV screening. **Out-of-network:** 30% coinsurance for members eligible for Medicare-covered preventive HIV screening **In or out-of-network:** If you receive a separate additional non-preventive evaluation and/or service, a copayment will apply. The copayment amount depends on the provider type or place of service.

Services that are covered for you	What you must pay when you get these services
Home health agency care Prior to receiving home health services, a doctor must certify that you need home health services and will order home health services to be provided by a home health agency. You must be homebound, which means leaving home is a major effort. Covered services include, but are not limited to: • Part-time or intermittent skilled nursing and home health aide services (to be covered under the home health care benefit, your skilled nursing and home health aide services combined must total fewer than 8 hours per day and 35 hours per week) • Physical therapy, occupational therapy, and speech therapy • Medical and social services • Medical equipment and supplies	**In network:** There is no coinsurance or copayment for home health agency care. * Prior authorization is required (includes home infusion therapy). **Out-of-network:** 30% coinsurance for home health agency care **In or out-of-network:** For a definition of Homebound see Chapter 10.

Services that are covered for you	What you must pay when you get these services
Home infusion therapy Home infusion therapy involves the intravenous or subcutaneous administration of drugs or biologicals to an individual at home. The components needed to perform home infusion include the drug (for example, antivirals, immune globulin), equipment (for example, a pump), and supplies (for example, tubing and catheters). Covered services include, but are not limited to: • Professional services, including nursing services, furnished in accordance with the plan of care • Patient training and education not otherwise covered under the durable medical equipment benefit • Remote monitoring • Monitoring services for the provision of home infusion therapy and home infusion drugs furnished by a qualified home infusion therapy supplier	**In network:** $0 copayment for home infusion therapy services **Out-of-network:** 30% coinsurance for home infusion therapy services * Prior authorization is required.

Services that are covered for you	What you must pay when you get these services
Hospice care You are eligible for the hospice benefit when your doctor and the hospice medical director have given you a terminal prognosis certifying that you're terminally ill and have 6 months or less to live if your illness runs its normal course. You may receive care from any Medicare-certified hospice program. Your plan is obligated to help you find Medicare-certified hospice programs in the plan's service area, including those the MA organization owns, controls, or has a financial interest in. Your hospice doctor can be a network provider or an out-of-network provider. Covered services include: • Drugs for symptom control and pain relief • Short-term respite care • Home care When you are admitted to a hospice you have the right to remain in your plan; if you chose to remain in your plan you must continue to pay plan premiums. <u>For hospice services and for services that are covered by Medicare Part A or B and are related to your terminal prognosis:</u> Original Medicare (rather than our plan) will pay your hospice provider for your hospice services and any Part A and Part B services related to your terminal prognosis. While you are in the hospice program, your hospice provider will bill Original Medicare for the services that Original Medicare pays for. You will be billed Original Medicare cost-sharing. (continued)	**In network:** $0 copayment for a one-time hospice consultation with your primary care provider $35 copayment for a one-time hospice consultation with a specialist **Out-of-network:** 30% coinsurance for a one-time hospice consultation **In or out-of-network:** When you enroll in a Medicare-certified hospice program, your hospice services and your Part A and Part B services related to your terminal prognosis are paid for by Original Medicare, not Personal Choice 65 Medical-Only. For a definition of Respite Care, see Chapter 10.

Services that are covered for you	What you must pay when you get these services
Hospice care (continued) For services that are covered by Medicare Part A or B and are not related to your terminal prognosis: If you need non-emergency, non-urgently needed services that are covered under Medicare Part A or B and that are not related to your terminal prognosis, your cost for these services depends on whether you use a provider in our plan's network and follow plan rules (such as if there is a requirement to obtain prior authorization). • If you obtain the covered services from a network provider and follow plan rules for obtaining service, you only pay the plan cost-sharing amount for in-network services. • If you obtain the covered services from an out-of-network provider, you pay the plan cost-sharing for out-of-network services. For services that are covered by Personal Choice 65 Medical-Only but are not covered by Medicare Part A or B: Personal Choice 65 Medical-Only will continue to cover plan-covered services that are not covered under Part A or B whether or not they are related to your terminal prognosis. You pay your plan cost-sharing amount for these services. **Note:** If you need non-hospice care (care that is not related to your terminal prognosis), you should contact us to arrange the services. Our plan covers hospice consultation services (one time only) for a terminally ill person who hasn't elected the hospice benefit.	

Services that are covered for you	What you must pay when you get these services
Immunizations Covered Medicare Part B services include: • Pneumonia vaccine • Flu shots, each flu season in the fall and winter, with additional flu shots if medically necessary • Hepatitis B vaccine if you are at high or intermediate risk of getting Hepatitis B • COVID-19 vaccine • Other vaccines if you are at risk and they meet Medicare Part B coverage rules	**In network:** There is no coinsurance or copayment for the pneumonia, influenza, Hepatitis B, and COVID-19 vaccines. **Out-of-network**: 30% coinsurance for the pneumonia, influenza, Hepatitis B, and COVID-19 vaccines **In or out-of-network:** If you receive a separate additional non-preventive evaluation and/or service, a copayment will apply. The copayment amount depends on the provider type or place of service.

Inpatient hospital care

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

Unlimited days per admission. Covered services include but are not limited to:

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

In network:

$240 copayment per day for days 1-6 per admission

There is no coinsurance or copayment for additional days per admission.

$1,440 maximum copayment per admission

$0 copayment for inpatient hospital stay due to COVID-19 diagnosis

A cost-sharing is charged for each inpatient stay.

If you get authorized inpatient care at an out-of-network hospital after your emergency condition is stabilized, your cost is the cost-sharing you would pay at a network hospital.

* Prior authorization is required.

Out-of-network:

30% coinsurance per admission

30% coinsurance for inpatient hospital stay due to COVID-19 diagnosis

In or out-of-network:

Copayment or coinsurance does not apply for the day of discharge.

(continued)

Services that are covered for you	What you must pay when you get these services
Inpatient hospital care (continued) • Transplant providers may be local or outside of the service area. If our in-network transplant services are outside the community pattern of care, you may choose to go locally as long as the local transplant providers are willing to accept the Original Medicare rate. If Personal Choice 65 Medical-Only provides transplant services at a location outside the pattern of care for transplants in your community and you choose to obtain transplants at this distant location, we will arrange or pay for appropriate lodging and transportation costs for you and a companion. • Blood — including storage and administration. All components of blood are covered beginning with the first pint used. • Physician services **Note:** To be an inpatient, your provider must write an order to admit you formally as an inpatient of the hospital. Even if you stay in the hospital overnight, you might still be considered an outpatient. If you are not sure if you are an inpatient or an outpatient, you should ask the hospital staff. You can also find more information in a Medicare fact sheet called *Are You a Hospital Inpatient or Outpatient? If You Have Medicare – Ask!* This fact sheet is available on the Web at https://www.medicare.gov/sites/default/files/2021-10/11435-Inpatient-or-Outpatient.pdf or by calling 1-800-MEDICARE (1-800-633-4227). TTY users call 18774862048. You can call these numbers for free, 24 hours a day, 7 days a week.	

Services that are covered for you	What you must pay when you get these services
Inpatient services in a psychiatric hospital • Covered services include mental health care services that require a hospital stay • Unlimited days per admission in an acute care hospital • 190-day lifetime benefit maximum for services in a freestanding psychiatric hospital	**In network:** $240 copayment per day for days 1-6 per admission $1,440 maximum copayment per admission There is no coinsurance or copayment for additional days per admission. A cost-sharing is charged for each inpatient stay. * Prior authorization is required. **Out-of-network:** 30% coinsurance per admission **In or out-of-network:** Copayment or coinsurance does not apply for the day of discharge.

Services that are covered for you	What you must pay when you get these services
Inpatient stay: Covered services received in a hospital or SNF during a non-covered inpatient stay If you have exhausted your inpatient benefits or if the inpatient stay is not reasonable and necessary, we will not cover your inpatient stay. However, in some cases, we will cover certain services you receive while you are in the hospital or the skilled nursing facility (SNF). Covered services include, but are not limited to: • Physician services • Diagnostic tests (like lab tests) • X-ray, radium, and isotope therapy including technician materials and services • Surgical dressings • Splints, casts and other devices used to reduce fractures and dislocations • Prosthetics and orthotics devices (other than dental) that replace all or part of an internal body organ (including contiguous tissue), or all or part of the function of a permanently inoperative or malfunctioning internal body organ, including replacement or repairs of such devices • Leg, arm, back, and neck braces; trusses, and artificial legs, arms, and eyes including adjustments, repairs, and replacements required because of breakage, wear, loss, or a change in the patient's physical condition • Physical therapy, speech therapy, and occupational therapy	**In network:** There is no coinsurance or copayment for inpatient services covered during a non-covered inpatient stay. **Out-of-network:** 30% coinsurance for inpatient services covered during a non-covered inpatient stay

Services that are covered for you	What you must pay when you get these services
Medical nutrition therapy This benefit is for people with diabetes, renal (kidney) disease (but not on dialysis), or after a kidney transplant when ordered by your doctor. We cover 3 hours of one-on-one counseling services during your first year that you receive medical nutrition therapy services under Medicare (this includes our plan, any other Medicare Advantage plan, or Original Medicare), and two hours each year after that. If your condition, treatment, or diagnosis changes, you may be able to receive more hours of treatment with a physician's order. A physician must prescribe these services and renew their order yearly if your treatment is needed into the next calendar year. Our plan covers up to four additional visits for Medicare-covered medical nutrition therapy for people with diabetes, renal (kidney) disease (but not on dialysis), or after a kidney transplant when ordered by your doctor. Additional four non-Medicare-covered medical nutrition therapy visits for routine medical conditions, such as congestive heart failure (CHF), high blood pressure, high cholesterol, and gluten intolerance	**In network:** There is no coinsurance or copayment for members eligible for Medicare-covered medical nutrition therapy services. There is no coinsurance or copayment for up to four medical nutritional therapy visits for routine medical conditions (non-Medicare). **Out-of-network:** 30% coinsurance for members eligible for Medicare-covered medical nutrition therapy services 30% coinsurance for up to four medical nutritional therapy visits for routine medical conditions (non-Medicare) **In or out-of-network:** If you receive a separate additional non-preventive evaluation and/or service, a copayment will apply. The copayment amount depends on the provider type or place of service. * Medical nutrition therapy requires a physician's order or prescription.

Services that are covered for you	What you must pay when you get these services
Medicare Diabetes Prevention Program (MDPP) MDPP services will be covered for eligible Medicare beneficiaries under all Medicare health plans. MDPP is a structured health behavior change intervention that provides practical training in long-term dietary change, increased physical activity, and problem-solving strategies for overcoming challenges to sustaining weight loss and a healthy lifestyle.	**In network:** There is no coinsurance or copayment for the MDPP benefit. **Out-of-network:** 30% coinsurance for the MDPP benefit **In or out-of-network:** If you receive a separate additional non-preventive evaluation and/or service, a copayment will apply. The copayment amount depends on the provider type or place of service.

Medicare Part B prescription drugs

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

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

The following link will take you to a list of Part B Drugs that may be subject to Step Therapy: www.ibxmedicare.com/partbstep

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

In network:

0% - 20% coinsurance for Part B drugs, including chemotherapy drugs

$35 copayment for a one-month supply of insulin.

Certain Part B Drugs may be subject to Step Therapy.

***** Prior authorization is required for certain Part B and chemotherapy injectable drugs when administered in the physician's office or outpatient setting. Please refer to the Precertification List (Website URL listed at the beginning of Chapter 4, Section 2.1) or contact our Member Help Team.

For a list of these drugs, call our Member Help Team.

Out-of-network:

30% coinsurance for Part B drugs, including chemotherapy drugs

Services that are covered for you	What you must pay when you get these services
Obesity screening and therapy to promote sustained weight loss If you have a body mass index of 30 or more, we cover intensive counseling to help you lose weight. This counseling is covered if you get it in a primary care setting, where it can be coordinated with your comprehensive prevention plan. Talk to your primary care doctor or practitioner to find out more.	**In network:** There is no coinsurance or copayment for preventive obesity screening and therapy. **Out-of-network:** 30% coinsurance for preventive obesity screening and therapy **In or out-of-network:** If you receive a separate additional non-preventive evaluation and/or service, a copayment will apply. The copayment amount depends on the provider type or place of service.
Opioid treatment program services Members of our plan with opioid use disorder (OUD) can receive coverage of services to treat OUD through an Opioid Treatment Program (OTP) which includes the following services: • U.S. Food and Drug Administration (FDA)-approved opioid agonist and antagonist medication-assisted treatment (MAT) medications • Dispensing and administration of MAT medications (if applicable) • Substance use counseling • Individual and group therapy • Toxicology testing • Intake activities • Periodic assessments	**In network:** $5 copayment **Out-of-network:** 30% coinsurance

Services that are covered for you	What you must pay when you get these services
Outpatient diagnostic tests and therapeutic services and supplies Covered services include, but are not limited to: • X-rays • Radiation (radium and isotope) therapy including technician materials and supplies • Surgical supplies, such as dressings • Splints, casts and other devices used to reduce fractures and dislocations • Laboratory tests • Blood — including storage and administration. All components of blood are covered beginning with the first pint used • Other outpatient diagnostic tests, e.g., ultrasounds and sleep studies (home or outpatient) • EKG screening • MRI/MRA, CT scans, PET scans, nuclear cardiology studies, proton beam therapy	**In network:** *EKG Screening:* There is no coinsurance or copayment for an EKG screening. *Laboratory Tests:* There is no coinsurance or copayment for laboratory tests. *Radiation Therapy:* $75 copayment per provider, per date of service $0 copayment for radiation therapy with a diagnosis of breast cancer *Routine Radiology (e.g., X-ray, radiology, diagnostic services, ultrasounds):* $40 copayment per provider, per date of service *Complex Radiology (e.g., MRI/MRA, CT scans, nuclear cardiology studies):* $175 copayment per provider, per date of service If services are performed at an ambulatory surgical center (ASC) or an outpatient hospital facility (OHF), you may be responsible for a $150 (ASC) or $300 (OHF) copayment per visit. $0 copayment for certain diagnostic tests (e.g., home-based sleep studies provided by a home health agency, or diagnostic mammogram that results from a preventive mammogram * Prior authorization is required for certain services. Please refer to the Precertification List (Website URL listed at the beginning of Chapter 4, Section 2.1) or contact our Member Help Team.

(continued)

Services that are covered for you	What you must pay when you get these services
Outpatient diagnostic tests and therapeutic services and supplies (continued)	
	Out-of-network: *EKG Screening:* 30% coinsurance *Laboratory Tests:* 30% coinsurance *Radiation Therapy:* 30% coinsurance per provider, per date of service *Routine Radiology (e.g., X-ray, radiology, diagnostic services, ultrasounds):* 30% coinsurance per provider, per date of service *Complex Radiology (e.g., MRI/MRA, CT scans, nuclear cardiology studies):* 30% coinsurance per provider, per date of service If services are performed at an ambulatory surgical center (ASC) or an outpatient hospital facility (OHF), you may be responsible for a 30% coinsurance per visit. **In or out-of-network:** Please check with your provider prior to scheduling services to see if the site is identified as part of a hospital, as the higher outpatient hospital facility copayment or coinsurance would apply.

Services that are covered for you	What you must pay when you get these services
Outpatient hospital observation Observation services are hospital outpatient services given to determine if you need to be admitted as an inpatient or can be discharged. For outpatient hospital observation services to be covered, they must meet the Medicare criteria and be considered reasonable and necessary. Observation services are covered only when provided by the order of a physician or another individual authorized by state licensure law and hospital staff bylaws to admit patients to the hospital or order outpatient tests. **Note:** Unless the provider has written an order to admit you as an inpatient to the hospital, you are an outpatient and pay the cost-sharing amounts for outpatient hospital services. Even if you stay in the hospital overnight, you might still be considered an outpatient. If you are not sure if you are an outpatient, you should ask the hospital staff. You can also find more information in a Medicare fact sheet called *Are You a Hospital Inpatient or Outpatient? If You Have Medicare – Ask!* This fact sheet is available on the Web at https://www.medicare.gov/sites/default/files/2021-10/11435-Inpatient-or-Outpatient.pdf or by calling 1-800-MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048. You can call these numbers for free, 24 hours a day, 7 days a week.	**In network:** $300 copayment per stay for outpatient observation stays **Out-of-network:** 30% coinsurance for outpatient observation stays **In or out-of-network:** $100 emergency care copayment will apply to any outpatient observation stay of less than 8 hours

Services that are covered for you	What you must pay when you get these services
Outpatient hospital services We cover medically-necessary services you get in the outpatient department of a hospital for diagnosis or treatment of an illness or injury. Covered services include, but are not limited to: • Services in an emergency department or outpatient clinic, such as observation services or outpatient surgery • Laboratory and diagnostic tests billed by the hospital • Mental health care, including care in a partial-hospitalization program, if a doctor certifies that inpatient treatment would be required without it • X-rays and other radiology services billed by the hospital • Medical supplies such as splints and casts • Certain drugs and biologicals that you can't give yourself **Note:** Unless the provider has written an order to admit you as an inpatient to the hospital, you are an outpatient and pay the cost-sharing amounts for outpatient hospital services. Even if you stay in the hospital overnight, you might still be considered an outpatient. If you are not sure if you are an outpatient, you should ask the hospital staff. You can also find more information in a Medicare fact sheet called *Are You a Hospital Inpatient or Outpatient? If You Have Medicare – Ask!* This fact sheet is available on the Web at https://www.medicare.gov/sites/default/files/2021-10/11435-Inpatient-or-Outpatient.pdf or by calling 1-800-MEDICARE (1-800-633-4227). TTY users call 18774862048. You can call these numbers for free, 24 hours a day, 7 days a week. (continued)	**In network:** $300 copayment per day for outpatient hospital services See Outpatient surgery, including services provided at hospital outpatient facilities and ambulatory surgical centers for more information. * Prior authorization is required for certain services. Please refer to the Precertification List (Website URL listed at the beginning of Chapter 4, Section 2.1) or contact our Member Help Team. **Out-of-network:** 30% coinsurance for a Medicare-covered colorectal cancer screening exam (Colorectal screening) when received in an outpatient hospital or ambulatory surgical center. 30% coinsurance for outpatient hospital surgery **In or out-of-network:** See Colorectal cancer screening for more information about: • Colorectal cancer screening See Durable medical equipment and related supplies for more information about: • Durable medical equipment See Emergency care for more information about: • Emergency room See Medicare Part B prescription drugs for more information about: • Part B drugs

Services that are covered for you	What you must pay when you get these services
Outpatient hospital services (continued)	See Outpatient diagnostic tests and therapeutic supplies and services for more information about: • Complex radiology (MRI/MRA, CT scans, nuclear cardiology studies) • EKG screening • Laboratory tests • Radiation therapy • Routine radiology (X-ray, radiology, diagnostic services, ultrasounds) See Outpatient mental health care or Outpatient substance abuse services for more information about: • Mental health or substance abuse services See Outpatient rehabilitation services for more information about: • Rehabilitation therapy (physical, occupational, or speech therapy) See Outpatient surgery, including services provided at hospital outpatient facilities and ambulatory surgical centers for more information about: • Outpatient surgery See Prosthetic devices and related supplies for more information about: • Prosthetic devices Please check with your provider prior to scheduling services to see if the site is identified as part of a hospital, as the higher outpatient hospital facility copayment or coinsurance would apply. For definitions of Diagnostic Colonoscopy and colorectal screening, see Chapter 10 of this document.

Services that are covered for you	What you must pay when you get these services
Outpatient mental health care Covered services include: Mental health services provided by a state-licensed psychiatrist or doctor, clinical psychologist, clinical social worker, clinical nurse specialist, licensed professional counselor (LPC), licensed marriage and family therapist (LMFT), nurse practitioner (NP), physician assistant (PA), or other Medicare-qualified mental health care professional as allowed under applicable state laws. If you receive partial hospitalization benefits, please see Partial hospitalization services for prior authorization restrictions.	**In network:** $30 copayment for each individual therapy session $20 copayment for each group therapy session Must use an in-network behavioral health provider. **Out-of-network:** 30% coinsurance for each individual/group therapy session **In or out-of-network:** * Prior authorization is required for some services.
Outpatient rehabilitation services Covered services include: physical therapy, occupational therapy, and speech language therapy. Outpatient rehabilitation services are provided in various outpatient settings, such as hospital outpatient departments, independent therapist offices, and Comprehensive Outpatient Rehabilitation Facilities (CORFs).	**In network:** $20 copayment per provider, per date of service *Prior authorization is required. **Out-of-network:** 30% coinsurance per provider, per date of service

Services that are covered for you	What you must pay when you get these services
Outpatient substance abuse services Personal Choice 65 provides outpatient services to help with conditions related to drug or alcohol abuse. Coverage includes care and treatment for alcohol or drug abuse provided by an acute hospital or mental health facility provider. Care and treatment includes, but is not limited to, the diagnosis and treatment of substance misuse, rehabilitation therapy, counseling, and outpatient detoxification by a licensed behavioral health provider (such as a psychiatrist, clinical psychologist, nurse, or certified addiction counselor). If you receive partial hospitalization benefits, please see Partial hospitalization services for prior authorization restrictions.	**In network:** $30 copayment for each individual therapy session $20 copayment for each group therapy session **Out-of-network:** 30% coinsurance for each individual/group therapy session

Services that are covered for you	What you must pay when you get these services
Outpatient surgery, including services provided at hospital outpatient facilities and ambulatory surgical centers **Note:** If you are having surgery in a hospital facility, you should check with your provider about whether you will be an inpatient or outpatient. Unless the provider writes an order to admit you as an inpatient to the hospital, you are an outpatient and pay the cost-sharing amounts for outpatient surgery. Even if you stay in the hospital overnight, you might still be considered an outpatient.	**In network:** Ambulatory Surgical Center: $150 copayment per date of service Outpatient Hospital Facility: $300 copayment per date of service There is no coinsurance or copayment for a Medicare-covered colorectal cancer screening exam (Colorectal screening). A copayment will not apply for a Preventive Colonoscopy that becomes diagnostic when received in an outpatient hospital or ASC. * Prior authorization is required for certain services. Please refer to the Precertification List (Website URL listed at the beginning of Chapter 4, Section 2.1) or contact our Member Help Team. **Out-of-network:** Ambulatory Surgical Center: 30% coinsurance per date of service Outpatient Hospital Facility: 30% coinsurance per date of service 30% coinsurance for a Medicare-covered colorectal cancer screening exam (Colorectal screening) **In or out-of-network:** Please check with your provider prior to scheduling services to see if the site is identified as part of a hospital, as the higher outpatient hospital facility copayment would apply. For copayment information for non-surgical services, refer to Outpatient hospital services. For definitions of Diagnostic Colonoscopy and colorectal screening, see Chapter 10 of this document.

Services that are covered for you	What you must pay when you get these services
Over-the-counter (OTC) items Your IBX Care Card can be used to purchase eligible over-the-counter (OTC) items in-store at participating retail locations. Eligible OTC items include first-aid supplies, vitamins, cold and allergy medicine, and more. You can also use your IBX Care Card to place an order for eligible OTC items by phone or online via catalog for delivery through our dedicated vendor. Non-eligible items or items purchased at non-participating retail locations will NOT be covered. Only our vendor/specified online retailer(s) may be used for online orders. For additional details on the OTC benefit, including placing an order, participating retailers, and a list of eligible items, please visit www.ibxmedicare.com/carecard or contact our Member Help Team.	$30 quarterly allowance for eligible over-the-counter (OTC) items The OTC allowance is preloaded on the IBX Care Card. The allowance does not carry forward to the next quarter if it is not used.
Palliative care Palliative care program offered by our plan will be provided to members and is typically available to individuals 12 to 18 months before end-of-life care (hospice). The palliative care services are home-based and actively manage all aspects of a member's physical health, psychosocial, and spiritual needs. The emphasis of the care program helps to manage pain, stress, and symptom relief. Members have access to a palliative care case management team 24/7.	**In or out-of-network:** $0 copayment for home-based palliative care services provided through our palliative care case management program For a definition of Palliative Care, see Chapter 10 of this document.

Services that are covered for you	What you must pay when you get these services
Partial hospitalization services and intensive outpatient services *Partial hospitalization* is a structured program of active psychiatric treatment provided as a hospital outpatient service, or by a community mental health center, that is more intense than the care received in your doctor's or therapist's office and is an alternative to inpatient hospitalization. Intensive outpatient service is a structured program of active behavioral (mental) health therapy treatment provided in a hospital outpatient department, a community mental health center, a Federally qualified health center, or a rural health clinic that is more intense than the care received in your doctor's or therapist's office but less intense than partial hospitalization.	**In network:** $30 copayment per provider, per date of service * Prior authorization is required. **Out-of-network:** 30% coinsurance per provider, per date of service

Services that are covered for you	What you must pay when you get these services
Physician/Practitioner services, including doctor's office visits Covered services include: • Medically-necessary medical care or surgery services furnished in a physician's office, certified ambulatory surgical center, hospital outpatient department, or any other location • Consultation, diagnosis, and treatment by a specialist • Basic hearing and balance exams performed by your specialist, if your doctor orders it to see if you need medical treatment • Certain telehealth services, including: PCP visits; specialist and other health care professional visits; and physical therapy, occupational therapy, and speech therapy visits. ○ You have the option of getting these services through an in-person visit or by telehealth. If you choose to get one of these services by telehealth, you must use a network provider who offers the service by telehealth. Please check with your health care provider for instructions on how to access their telehealth services, as well as any technology requirements (audio/video). • Telehealth services for monthly end-stage renal disease-related visits for home dialysis members in a hospital-based or critical access hospital-based renal dialysis center, renal dialysis facility, or the member's home • Telehealth services to diagnose, evaluate, or treat symptoms of a stroke, regardless of your location	**In network:** *Primary Care Provider:* $0 copayment per visit *Specialist:* $35 copayment per visit $35 copayment for non-routine Medicare-covered dental services in a specialist office $35 copayment per visit, per provider type for each Medicare-covered hearing exam *Other health care professional:* $35 copayment per visit *Physical therapy/occupational therapy/speech therapy:* $20 copayment per visit * Prior authorization is required for select in-network services. **Out-of-network:** *Primary Care Provider:* 30% coinsurance *Specialist:* 30% coinsurance 30% coinsurance for non-routine Medicare-covered dental services 30% coinsurance for non-routine Medicare-covered hearing services Additional telehealth services for PCP visits, specialist visits, and physical therapy/occupational therapy/speech therapy received out-of-network will not be covered.

(continued)

Services that are covered for you	What you must pay when you get these services
Physician/Practitioner services, including doctor's office visits (continued)	
• Telehealth services for members with a substance use disorder or co-occurring mental health disorder, regardless of their location • Telehealth services for diagnosis, evaluation, and treatment of mental health disorders if: o You have an in-person visit within 6 months prior to your first telehealth visit o You have an in-person visit every 12 months while receiving these telehealth services o Exceptions can be made to the above for certain circumstances • Telehealth services for mental health visits provided by Rural Health Clinics and Federally Qualified Health Centers • Virtual check-ins (for example, by phone or video chat) with your doctor for 5-10 minutes **if:** o You're not a new patient **and** o The check-in isn't related to an office visit in the past 7 days **and** o The check-in doesn't lead to an office visit within 24 hours or the soonest available appointment	Medicare-covered telehealth for outpatient mental health care and outpatient substance abuse services are covered out-of-network. See Outpatient mental health care and Outpatient substance abuse services for further detail. **In network:** *Mental health/substance abuse therapy services:* $30 copayment for each individual therapy session $20 copayment for each group therapy session Must use an in-network behavioral health provider **In or out-of-network:** Please check with your provider prior to scheduling services to see if the site is identified as part of a hospital, as the higher outpatient hospital facility copayment would apply.

(continued)

Services that are covered for you	What you must pay when you get these services
Physician/Practitioner services, including doctor's office visits (continued) • Evaluation of video and/or images you send to your doctor, and interpretation and follow-up by your doctor within 24 hours **if:** o You're not a new patient **and** o The evaluation isn't related to an office visit in the past 7 days **and** o The evaluation doesn't lead to an office visit within 24 hours or the soonest available appointment • Consultation your doctor has with other doctors by phone, internet, or electronic health record • Second opinion by another network provider prior to surgery • Non-routine dental care (covered services are limited to surgery of the jaw or related structures, setting fractures of the jaw or facial bones, extraction of teeth to prepare the jaw for radiation treatments of neoplastic cancer disease, or services that would be covered when provided by a physician)	

Services that are covered for you	What you must pay when you get these services
Podiatry services Covered services include: • Diagnosis and the medical or surgical treatment of injuries and diseases of the feet (such as hammer toe or heel spurs) • Routine foot care for members with certain medical conditions affecting the lower limbs (Medicare-covered podiatry) • Routine foot care for members, up to six supplemental visits per year (non-Medicare-covered podiatry).	**In network:** $20 copayment per visit for Medicare-covered care $20 copayment per visit for non-Medicare-covered routine care **Out-of-network:** 30% coinsurance per visit for Medicare-covered care 30% coinsurance per visit for non-Medicare-covered routine care **In or out-of-network:** * Copayments or coinsurance for routine podiatry visits do not count toward your maximum out-of-pocket amount.
Prostate cancer screening exams For men aged 50 and older, covered services include the following once every 12 months: • Digital rectal exam • Prostate Specific Antigen (PSA) test	**In network:** There is no coinsurance or copayment for an annual PSA test. **Out-of-network:** 30% coinsurance for an annual PSA test **In or out-of-network:** If you receive a separate additional non-preventive evaluation and/or service, a copayment will apply. The copayment amount depends on the provider type or place of service.

Services that are covered for you	What you must pay when you get these services
Prosthetic devices and related supplies Devices (other than dental) that replace all or part of a body part or function. These include, but are not limited to: colostomy bags and supplies directly related to colostomy care, pacemakers, braces, prosthetic shoes, artificial limbs, and breast prostheses (including a surgical brassiere after a mastectomy). Includes certain supplies related to prosthetic devices, and repair and/or replacement of prosthetic devices. Also includes some coverage following cataract removal or cataract surgery – see **Vision Care** later in this section for more detail.	**In network:** 20% coinsurance for prosthetics * Prior authorization is required for certain items. Please refer to the Precertification List (Website URL listed at the beginning of Chapter 4, Section 2.1) or contact our Member Help Team. **Out-of-network:** 30% coinsurance for prosthetics

Services that are covered for you	What you must pay when you get these services
Pulmonary rehabilitation services Comprehensive programs of pulmonary rehabilitation are covered for members who have moderate to very severe chronic obstructive pulmonary disease (COPD) and an order for pulmonary rehabilitation from the doctor treating the chronic respiratory disease.	**In network:** $5 copayment per provider, per date of service **Out-of-network:** 30% coinsurance per provider, per date of service
Screening and counseling to reduce alcohol misuse We cover one alcohol misuse screening for adults with Medicare (including pregnant women) who misuse alcohol, but aren't alcohol dependent. If you screen positive for alcohol misuse, you can get up to four brief face-to-face counseling sessions per year (if you're competent and alert during counseling) provided by a qualified primary care doctor or practitioner in a primary care setting.	**In network:** There is no coinsurance or copayment for the Medicare-covered screening and counseling to reduce alcohol misuse preventive benefit. **Out-of-network:** 30% coinsurance for the Medicare-covered screening and counseling to reduce alcohol misuse preventive benefit **In or out-of-network:** If you receive a separate additional non-preventive evaluation and/or service, a copayment will apply. The copayment amount depends on the provider type or place of service.

Services that are covered for you	What you must pay when you get these services
Screening for lung cancer with low dose computed tomography (LDCT) For qualified individuals, an LDCT is covered every 12 months. **Eligible members are**: people aged 50 – 77 years who have no signs or symptoms of lung cancer, but who have a history of tobacco smoking of at least 20 pack-years and who currently smoke or have quit smoking within the last 15 years, who receive a written order for LDCT during a lung cancer screening counseling and shared decision-making visit that meets the Medicare criteria for such visits and be furnished by a physician or qualified non-physician practitioner. *For LDCT lung cancer screenings after the initial LDCT screening:* the member must receive a written order for LDCT lung cancer screening, which may be furnished during any appropriate visit with a physician or qualified non-physician practitioner. If a physician or qualified non-physician practitioner elects to provide a lung cancer screening counseling and shared decision-making visit for subsequent lung cancer screenings with LDCT, the visit must meet the Medicare criteria for such visits.	**In network:** There is no coinsurance or copayment for the Medicare-covered counseling and shared decision-making visit or for the LDCT. **Out-of-network:** 30% coinsurance for the Medicare-covered counseling and shared decision-making visit or for the LDCT **In or out-of-network:** If you receive a separate additional non-preventive evaluation and/or service, a copayment will apply. The copayment amount depends on the provider type or place of service. * Prior authorization is required.

Services that are covered for you	What you must pay when you get these services
Screening for sexually transmitted infections (STIs) and counseling to prevent STIs We cover sexually transmitted infection (STI) screenings for chlamydia, gonorrhea, syphilis, and Hepatitis B. These screenings are covered for pregnant women and for certain people who are at increased risk for an STI when the tests are ordered by a primary care provider. We cover these tests once every 12 months or at certain times during pregnancy. We also cover up to two individual 20- to 30-minute, face-to-face high-intensity behavioral counseling sessions each year for sexually active adults at increased risk for STIs. We will only cover these counseling sessions as a preventive service if they are provided by a primary care provider and take place in a primary care setting, such as a doctor's office.	**In network:** There is no coinsurance or copayment for the Medicare-covered screening for STIs and counseling for STIs preventive benefit. **Out-of-network:** 30% coinsurance for the Medicare-covered screening for STIs and counseling for STIs preventive benefit. **In or out-of-network:** If you receive a separate additional non-preventive evaluation and/or service, a copayment will apply. The copayment amount depends on the provider type or place of service.

Services that are covered for you	What you must pay when you get these services
Services to treat kidney disease Covered services include: • Kidney disease education services to teach kidney care and help members make informed decisions about their care. For members with stage IV chronic kidney disease when referred by their doctor, we cover up to six sessions of kidney disease education services per lifetime • Outpatient dialysis treatments (including dialysis treatments when temporarily out of the service area, as explained in Chapter 3, or when your provider for this service is temporarily unavailable or inaccessible) • Inpatient dialysis treatments (if you are admitted as an inpatient to a hospital for special care) • Self-dialysis training (includes training for you and anyone helping you with your home dialysis treatments) • Home dialysis equipment and supplies • Certain home support services (such as, when necessary, visits by trained dialysis workers to check on your home dialysis, to help in emergencies, and check your dialysis equipment and water supply) Certain drugs for dialysis are covered under your Medicare Part B drug benefit. For information about coverage for Part B drugs, please go to the section, **Medicare Part B prescription drugs**.	**In network:** There is no copayment for kidney disease education services. **Out-of-network:** 30% coinsurance for kidney disease education services **In or out-of-network:** 20% coinsurance for dialysis services *Inpatient dialysis*: No additional copayment or coinsurance for inpatient dialysis when received during an inpatient hospital stay. If performed at the provider's office, only dialysis coinsurance should apply.

Services that are covered for you	What you must pay when you get these services
Skilled nursing facility (SNF) care (For a definition of skilled nursing facility care, see Chapter 10 of this document. Skilled nursing facilities are sometimes called SNFs.) 100 days per Medicare benefit period. A prior hospital stay is not required. Covered services include but are not limited to: • Semiprivate room (or a private room if medically necessary) • Meals, including special diets • Skilled nursing services • Physical therapy, occupational therapy, and speech therapy • Drugs administered to you as part of your plan of care (this includes substances that are naturally present in the body, such as blood clotting factors.) • Blood — including storage and administration. All components of blood are covered beginning with the first pint used. • Medical and surgical supplies ordinarily provided by SNFs • Laboratory tests ordinarily provided by SNFs • X-rays and other radiology services ordinarily provided by SNFs • Use of appliances such as wheelchairs ordinarily provided by SNFs • Physician/Practitioner services (continued)	**In network:** $0 copayment per day for days 1-20 $203 copayment per day for days 21-100 * Prior authorization is required. **Out-of-network:** 30% coinsurance **In or out-of-network:** A benefit period is the way that both our plan and Original Medicare measures your use of hospital and skilled nursing facility (SNF) services. Our plan uses benefit periods for skilled nursing facility stays, but we do not use benefit periods to measure inpatient hospital stays. A benefit period begins the day you go into a hospital or skilled nursing facility. The benefit period ends when you haven't received any inpatient hospital care (or skilled care in an SNF) for 60 days in a row. If you go into a hospital or a skilled nursing facility after one benefit period has ended, a new benefit period begins. There is no limit to the number of benefit periods.

Services that are covered for you	What you must pay when you get these services
Skilled nursing facility (SNF) care (continued) Generally, you will get your SNF care from network facilities. However, under certain conditions listed below, you may be able to pay in-network cost-sharing for a facility that isn't a network provider, if the facility accepts our plan's amounts for payment. • 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) • An SNF where your spouse or domestic partner is living at the time you leave the hospital	
Smoking and tobacco use cessation (counseling to stop smoking or tobacco use) If you use tobacco, but do not have signs or symptoms of tobacco-related disease: We cover two counseling quit attempts within a 12-month period as a preventive service with no cost to you. Each counseling attempt includes up to four face-to-face visits. If you use tobacco and have been diagnosed with a tobacco-related disease or are taking medicine that may be affected by tobacco: We cover cessation counseling services. We cover two counseling quit attempts within a 12-month period; however, you will pay the applicable cost-sharing. Each counseling attempt includes up to four face-to-face visits.	**In network:** There is no coinsurance or copayment for the Medicare-covered smoking and tobacco use cessation preventive benefits. **Out-of-network:** 30% coinsurance for the Medicare-covered smoking and tobacco use cessation preventive benefits **In or out-of-network:** If you receive a separate additional non-preventive evaluation and/or service, a copayment will apply. The copayment amount depends on the provider type or place of service.

Services that are covered for you	What you must pay when you get these services
Special Supplemental Benefits for the Chronically Ill **Grocery benefit** Grocery boxes will be provided for a maximum of four weeks per year, per member. Members must be diagnosed with **both** of the following conditions to be eligible to receive the grocery benefit from a plan-specified vendor: • Diabetes • Depression or depressive disorders	$0 copayment for grocery benefit
Supervised Exercise Therapy (SET) SET is covered for members who have symptomatic peripheral artery disease (PAD). Up to 36 sessions over a 12-week period are covered if the SET program requirements are met. The SET program must: • Consist of sessions lasting 30 – 60 minutes, comprising a therapeutic exercise-training program for PAD in patients with claudication • Be conducted in a hospital outpatient setting or a physician's office • Be delivered by qualified auxiliary personnel necessary to ensure benefits exceed harms, and who are trained in exercise therapy for PAD • Be under the direct supervision of a physician, physician assistant, or nurse practitioner/clinical nurse specialist who must be trained in both basic and advanced life support techniques SET may be covered beyond 36 sessions over 12 weeks for an additional 36 sessions over an extended period of time if deemed medically necessary by a health care provider.	**In network:** $5 copayment per visit **Out-of-network:** 30% coinsurance

Telemedicine visits

Teladoc Health must be used for telemedicine visits.

You have convenient and confidential access to quality board-certified, U.S.-licensed doctors for non-emergent general medical visits, mental/behavioral health visits, and dermatology consultations through Teladoc. Connect virtually from the comfort of your home via your computer, tablet, or smartphone. Additional telehealth services received from other in-network providers will include an in-office copay. Not all services can be provided as a telehealth visit. See the Physician/Practitioner services, including doctor's office visits section of medical benefits chart for more information on covered additional telehealth services.

General medical visits

24/7 access to talk to a doctor for non-emergency conditions like the flu, allergies, coughs, sore throats, rashes and more.

Visits can be scheduled by calling 1-800-835-2362 (TTY/TDD: 711), online at teladochealth.com/signin, or via the Teladoc Health mobile app.

Mental/behavioral health visits

Access to talk to a therapist or psychiatrist by appointment, 7 days a week from 7 a.m. to 9 p.m., by phone or video for depression, anxiety, stress and more. You can choose to see the same provider for recurring visits.

Visits must be scheduled online at teladochealth.com/signin, or via the Teladoc Health mobile app.

Mental/behavioral health visits must be scheduled via the online platform www.teladochealth.com/signin. Visits cannot be scheduled by phone. Members must complete a mental health assessment via the website platform prior to scheduling.

Dermatology consultations

Access to a dermatologist for diagnosing and treating skin conditions like eczema, psoriasis, acne and more.

(continued)

General medical visits *(focused on non-emergent medical conditions by connecting to a state-licensed physician)*

$0 copayment per visit

Mental/behavioral health *visits (focused on therapy and counseling services by connecting to a state-licensed therapist or psychiatrist)*

$0 copayment per visit

Dermatology consultations (*focused on diagnosing and treating skin, hair, and nail conditions by connecting members to board-certified dermatologists*)

$0 copayment per visit

Services that are covered for you	What you must pay when you get these services
Telemedicine visits (continued) Dermatology consultations are not real-time visits. You can upload images via the secure online platform available 24/7 at teladochealth.com/signin, or via the Teladoc Health mobile app. You can ask follow-up questions via one message after the consultation for up to 7 days. You may initiate more than 1 dermatology consultation at a time. You may consult with the same Dermatology provider each time. *Teladoc Health is not available internationally. Members must complete a comprehensive medical history assessment either online or by telephone with a designated Teladoc Health representative, prior to receiving telemedicine services.	
Urgently needed services Urgently needed services are provided to treat a non-emergency, unforeseen medical illness, injury, or condition that requires immediate medical care but, given your circumstances, it is not possible, or it is unreasonable, to obtain services from network providers. If it is unreasonable given your circumstances to immediately obtain the medical care from a network provider, then your plan will cover the urgently needed services from a provider out of network. Services must be immediately needed and medically necessary. Examples of urgently needed services that the plan must cover out of network if: You are temporarily outside the service area of the plan and require medically needed immediate services for an unforeseen condition but it is not a medical emergency; or it is unreasonable given your circumstances to immediately obtain the medical care from a network provider. Cost-sharing for necessary urgently needed services furnished out of network is the same as for such services furnished in network. Urgently needed services are covered worldwide. For a list of network urgent care centers, please call our Member Help Team.	**In or out-of-network:** Retail clinic: $5 copayment Urgent care center: $60 copayment Worldwide urgent care: $100 copayment Copayment not waived if admitted to inpatient hospital For a definition of Retail Clinic, see Chapter 10 of this document. If you receive emergency care outside of the United States, you must pay for your care, and submit the claim for reimbursement consideration. For details on submitting a reimbursement, see Chapter 7, Section 5.5. * Copayments for urgently needed services received outside of the United States do not count toward your maximum out-of-pocket amount and are not waived if admitted.

Services that are covered for you	What you must pay when you get these services
Vision care Covered services include: • Outpatient physician services for the diagnosis and treatment of diseases and injuries of the eye, including treatment for age-related macular degeneration. Original Medicare doesn't cover routine eye exams (eye refractions) for eyeglasses/contacts. • For people who are at high risk of glaucoma, we will cover one glaucoma screening each year. People at high risk of glaucoma include: people with a family history of glaucoma, people with diabetes, African Americans who are age 50 and older, and Hispanic Americans who are 65 or older. • For people with diabetes, screening for diabetic retinopathy is covered once per year. • One pair of eyeglasses or contact lenses after each cataract surgery that includes insertion of an intraocular lens. (If you have two separate cataract operations, you cannot reserve the benefit after the first surgery and purchase two eyeglasses after the second surgery.) • Our plan covers the Medicare-covered standard frames and lenses for cataracts up to the Medicare allowed amount. • NOTE: Upgrades such as deluxe frames, progressive lenses, and additional lens upgrades (including but not limited to transition, scratch-resistant, or tinted lenses) are not covered for glasses/lenses after cataract surgery. You may pay for upgrades yourself if you choose. (continued)	***Medicare-covered vision care:*** **In network:** $35 copayment for each Medicare-covered eye exam There is no coinsurance or copayment for a diabetic retinal eye exam or dilated retinal eye exam. There is no coinsurance or copayment for Medicare-covered glaucoma screenings. There is no coinsurance or copayment for one pair of Medicare-covered standard eyeglasses or contact lenses after each cataract surgery. **Out-of-network:** 30% coinsurance for each Medicare-covered eye exam 30% coinsurance for a diabetic retinal eye exam or dilated retinal eye exam 30% coinsurance for Medicare-covered glaucoma screenings 30% coinsurance of the Medicare-covered amount for one pair of Medicare-covered standard eyeglasses or contact lenses after each cataract surgery **In or out-of-network:** If you receive a separate additional non-preventive evaluation and/or service, a copayment will apply. The copayment amount depends on the provider type or place of service. Search for in-network providers that provide Medicare-covered vision care through our *Find a Provider* tool at www.ibxmedicare.com/providerfinder.

Services that are covered for you	What you must pay when you get these services
Vision care (continued) In addition, we cover the following non-Medicare-covered routine vision services: • One routine eye exam (not covered by Medicare) covered every year • Eyewear: one pair of eyeglass frames and lenses, or contact lenses in lieu of frames and lenses. Covered every year. Personal Choice 65 does not cover lens upgrades, including but not limited to deluxe frames, transition, progressive, scratch-resistant, polish or tinted lenses, or vision/lens insurance. (continued)	***Non-Medicare-covered routine vision care:*** **In network routine:** $0 copayment for routine eye exam every year Search for a participating **Davis Vision** network providers at www.ibxmedicare.com/davisvision. If you purchase glasses (eyeglass frames and lenses) in the Davis Vision Collection, frames and lenses are covered in full (some restrictions may apply). **Out-of-network:** 80% coinsurance You must pay up front and submit a claim for out-of-network vision care. **In or out-of-network routine vision care:** $150 allowance every year for contact lenses in lieu of routine eyewear (frames and lenses)

Services that are covered for you	What you must pay when you get these services
Vision care (continued)	If you purchase glasses (frames and lenses) outside of the Davis Vision Collection but at a Davis Vision provider, you are covered up to the combined in- and out-of-network allowance shown below (see noted restrictions in left column). If you purchase glasses (frames and lenses) from Visionworks, you are covered up to the combined in- and out-of-network allowance shown below (see noted restrictions in left column). Eyewear (frames and lenses or contact lenses) has a combined $150 allowance per year that applies when you are in or out-of-network. For glasses (frames and lenses) from national Visionworks providers there is a combined $250 allowance per year that applies when you are in or out-of-network. * Routine vision services (exams and eyewear) do not count towards your annual out-of-pocket maximum.
Welcome to Medicare preventive visit The plan covers the one-time *Welcome to Medicare* preventive visit. The visit includes a review of your health, as well as education and counseling about the preventive services you need (including certain screenings and shots), and referrals for other care if needed. **Important:** We cover the *Welcome to Medicare* preventive visit only within the first 12 months you have Medicare Part B. When you make your appointment, let your doctor's office know you would like to schedule your *Welcome to Medicare* preventive visit.	**In network:** There is no coinsurance or copayment for the *Welcome to Medicare* preventive visit. **Out-of-network:** 30% coinsurance for the *Welcome to Medicare* preventive visit. **In or out-of-network:** If you receive a separate additional non-preventive evaluation and/or service, a copayment will apply. The copayment amount depends on the provider type or place of service.

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

If you do not permanently move, but you are continuously absent from our plan's service area for more than six months, we usually must disenroll you from our plan. However, we offer as a supplemental benefit a visitor/traveler program in 48 states and 2 territories, which will allow you to remain enrolled in our plan when you are outside of our service area for less than 12 months. Under our visitor/traveler program you may receive all plan covered services at in-network cost-sharing. Please contact the plan for assistance in locating a provider when using the visitor/traveler benefit.

If you are in the visitor/traveler area, you can stay enrolled in our plan for up to 12 months. If you have not returned to the plan's service area within 12 months, you will be disenrolled from the plan. Our plan has relationships with other Blue Cross and/or Blue Shield licensees (Host Blues) referred to generally as the Medicare Advantage Program. When members access health care services outside the geographic area that the plan covers, the claims for those services will be processed through the Medicare Advantage Program and presented to our plan for payment in accordance with the rules of the Medicare Advantage Program policies then in effect. The Medicare Advantage Program available to members under this agreement is described generally below.

The Visitor/Travel Program will include Blue Medicare Advantage PPO network coverage of all Part A, Part B, and Supplemental benefits offered by your plan outside your service area in 48 states and 2 territories: Alabama, Arizona, Arkansas, California, Colorado, Connecticut, Delaware, District of Columbia, Florida, Georgia, Hawaii, Idaho, Illinois, Indiana, Iowa, Kansas, Kentucky, Louisiana, Maine, Maryland, Massachusetts, Michigan, Minnesota, Mississippi, Missouri, Montana, Nebraska, Nevada, New Hampshire, New Jersey, New Mexico, New York, North Carolina, North Dakota, Ohio, Oklahoma, Oregon, Pennsylvania, Puerto Rico, Rhode Island, South Carolina, South Dakota, Tennessee, Texas, Utah, Vermont, Virginia, Washington, Wisconsin, and West Virginia. For some of the states listed, Medicare Advantage PPO networks are only available in portions of the state.

Please call our Member Help Team to determine which states do not have statewide, in-network PPO coverage and in what areas within the state you can receive services within our PPO network.

If you visit participating providers in any geographic area where this benefit is offered, you will pay the same cost-sharing level (in-network cost-sharing) you would pay if you received covered benefits from in-network providers in your service area.

To obtain additional information about this plan benefit, you may:

- Call our Member Help Team;
- Call 1-800-810-BLUE to find out what providers you may visit when out of state;
- Visit the *Doctor Hospital Finder* at www.BCBS.com to find a participating provider.

Your Member Liability Calculation

The cost of the service, on which member liability (copayment/coinsurance) is based, will be either:

- The Medicare allowable amount for covered services, or
- The amount either our plan negotiates with the provider or the local Blue Medicare Advantage plan negotiates with its provider on behalf of Personal Choice 65 Medical-Only

members, if applicable. The amount negotiated may be either higher than, lower than, or equal to the Medicare allowable amount.

SECTION 3 What services are not covered by the plan?

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

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

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

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

The only exception is if the service is appealed and decided upon appeal to be a medical service that we should have paid for or covered because of your specific situation. (For information about appealing a decision we have made to not cover a medical service, go to Chapter 7, Section 5.3 in this document.)

Services not covered by Medicare	Not covered under any condition	Covered only under specific conditions
Acupuncture		• Available for people with chronic low back pain under certain circumstances. • Routine non-Medicare-covered services: o Covered for headache (migraine and tension), post-operative nausea and vomiting, chemotherapy-induced nausea and vomiting, low back pain, chronic neck pain, pain from osteoarthritis of the knee and hip.

Services not covered by Medicare	Not covered under any condition	Covered only under specific conditions
Cosmetic surgery or procedures		• Covered in cases of an accidental injury or for improvement of the functioning of a malformed body member. • Covered for all stages of reconstruction for a breast after a mastectomy, as well as for the unaffected breast to produce a symmetrical appearance.
Custodial care Custodial care is personal care that does not require the continuing attention of trained medical or paramedical personnel, such as care that helps you with activities of daily living, such as bathing or dressing.	**Not covered under any condition**	
Dental implants	**Not covered under any condition**	
Experimental medical and surgical procedures, equipment and medications Experimental procedures and items are those items and procedures determined by Original Medicare to not be generally accepted by the medical community.		• May be covered by Original Medicare under a Medicare-approved clinical research study or by our plan. (See Chapter 3, Section 5 for more information on clinical research studies.)

Services not covered by Medicare	Not covered under any condition	Covered only under specific conditions
Fees charged for care by your immediate relatives or members of your household	**Not covered under any condition**	
Full-time nursing care in your home	**Not covered under any condition**	
Homemaker services include basic household assistance, including light housekeeping or light meal preparation.	**Not covered under any condition**	
Naturopath services (uses natural or alternative treatments)	**Not covered under any condition**	
Non-routine dental care		• Dental care required to treat illness or injury may be covered as inpatient or outpatient care. • Your plan may include some non-Medicare covered comprehensive dental services. Please go to the Dental services row in the Medical Benefits Chart for further detail.
Orthopedic shoes or supportive devices for the feet		• Shoes that are part of a leg brace and are included in the cost of the brace. Orthopedic or therapeutic shoes for people with diabetic foot disease.

Services not covered by Medicare	Not covered under any condition	Covered only under specific conditions
Personal items in your room at a hospital or a skilled nursing facility, such as a telephone or a television	**Not covered under any condition**	
Private room in a hospital		• Covered only when medically necessary.
Radial keratotomy, LASIK surgery, and other low vision aids.		• Eye exam and one pair of Medicare covered standard eyeglasses (or contact lenses) are covered for people after cataract surgery. • Routine eye exams and eyewear.
Reversal of sterilization procedures and/or non-prescription contraceptive supplies	**Not covered under any condition**	
Routine chiropractic care		• Manual manipulation of the spine to correct a subluxation is covered. • Routine supplemental visits, up to six per year, are covered.
Routine foot care		• Some limited coverage provided according to Medicare guidelines (e.g., if you have diabetes). • Routine supplemental visits, up to six per year, are covered.

Services not covered by Medicare	Not covered under any condition	Covered only under specific conditions
Services considered not reasonable and necessary, according to Original Medicare standards	**Not covered under any condition**	
Worldwide ambulance services	**Not covered under any condition**	

CHAPTER 5:

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

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

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

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

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

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

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

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

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

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

- You only have to pay your cost-sharing amount when you get covered services. We do not allow providers to add additional separate charges, called balance billing. This protection (that you never pay more than your cost-sharing amount) applies even if we pay the provider less than the provider charges for a service and even if there is a dispute and we don't pay certain provider charges.
- Whenever you get a bill from a network provider that you think is more than you should pay, send us the bill. We will contact the provider directly and resolve the billing problem.
- If you have already paid a bill to a network provider, but you feel that you paid too much, send us the bill along with documentation of any payment you have made and ask us to pay you back the difference between the amount you paid and the amount you owed under the plan.

3. If you are retroactively enrolled in our plan

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

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

All of the examples above are types of coverage decisions. This means that if we deny your request for payment, you can appeal our decision. Chapter 7 of this document (*What to do if you have a problem or complaint (coverage decisions, appeals, complaints)*) has information about how to make an appeal.

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

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

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

- You don't have to use the form, but it will help us process the information faster.

Whether you choose to use the form or not, the following information is needed in order for us to identify you and process your request for payment:

- Member name
- Member ID number (located on your member ID card)

- Member date of birth
- Date of service
- Procedure code (located on the bill or receipt from the provider)
- Diagnosis code (located on the bill or receipt from the provider)
- Billed charges/amounts
- Provider name and National Provider Identifier (NPI)
- Receipt or proof of payment

- Either download a copy of the form from our website (www.ibxmedicare.com) or call our Member Help Team and ask for the form.

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

Independence Blue Cross
Claims Receipt Center
PO Box 211184
Eagan, MN 55121

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

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

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

- If we decide that the medical care is covered and you followed all the rules, we will pay for our share of the cost. If you have already paid for the service, we will mail your reimbursement of our share of the cost to you. If you have not paid for the service yet, we will mail the payment directly to the provider.
- If we decide that the medical care is *not* covered, or you did *not* follow all the rules, we will not pay for our share of the cost. We will send you a letter explaining the reasons why we are not sending the payment and your right to appeal that decision.

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

If you think we have made a mistake in turning down your request for payment or the amount we are paying, you can make an appeal. If you make an appeal, it means you are asking us to change the decision we made when we turned down your request for payment. The appeals process is a formal process with detailed procedures and important deadlines. For details on how to make this appeal, go to Chapter 7 of this document.

CHAPTER 6:
Your rights and responsibilities

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

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

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

We may request demographic information from you, such as race, ethnicity, sexual orientation, and gender identity. We may also request information about social needs essential to your wellbeing. Sharing this information with us helps us better understand and meet the diverse needs of our members. Your response to our request for demographic information is optional.

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

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

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

If you have any trouble getting information from our plan in a format that is accessible and appropriate for you, seeing a women's health specialist or finding a network specialist, please call to file a grievance with our Member Help Team at 1-888-718-3333. (TTY users should call 711). You may also file a complaint with Medicare by calling 1-800-MEDICARE (1-800-633-4227) or directly with the Office for Civil Rights 1-800-368-1019 or TTY 1-800-537-7697.

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

You have the right to choose a provider in the plan's network. You also have the right to go to a women's health specialist (such as a gynecologist) without a referral and still pay the in-network cost-sharing amount.

You have the right to get appointments and covered services from your providers *within a reasonable amount of time*. This includes the right to get timely services from specialists when you need that care.

If you think that you are not getting your medical care within a reasonable amount of time, Chapter 7, Section 9 of this document tells what you can do.

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

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

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

How do we protect the privacy of your health information?

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

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

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

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

If you have questions or concerns about the privacy of your personal health information, please call our Member Help Team.

Independence is committed to protecting the privacy of our members' personal health information. Part of that commitment is complying with the Privacy Rule of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), which requires us to take additional measures to protect personal information and to inform our members about those measures.

The Notice of Privacy Practices describes how Independence may use and disclose a member's personal health information and how a member of an Independence health plan can get access to this information. For details on our practices, available privacy forms, and HIPAA requirements, please visit www.ibxmedicare.com/privacy. You can also call to request a copy of the Notice of Privacy Practices by contacting our Member Help Team.

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

As a member of Personal Choice 65 Medical-Only, you have the right to get several kinds of information from us.

If you want any of the following kinds of information, please call our Member Help Team:

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

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

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

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

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

- **To know about all of your choices.** You have the right to be told about all of the treatment options that are recommended for your condition, no matter what they cost or whether they are covered by our plan.
- **To know about the risks.** You have the right to be told about any risks involved in your care. You must be told in advance if any proposed medical care or treatment is part of a research experiment. You always have the choice to refuse any experimental treatments.
- **The right to say "no."** You have the right to refuse any recommended treatment. This includes the right to leave a hospital or other medical facility, even if your doctor advises you not to leave. Of course, if you refuse treatment, you accept full responsibility for what happens to your body as a result.

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

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

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

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

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

- **Get the form.** You can get an advance directive form from your lawyer, from a social worker, or from some office supply stores. You can sometimes get advance directive forms from organizations that give people information about Medicare. You can also contact our Member Help Team to ask for the forms.
- **Fill it out and sign it.** Regardless of where you get this form, keep in mind that it is a legal document. You should consider having a lawyer help you prepare it.
- **Give copies to appropriate people.** You should give a copy of the form to your doctor and to the person you name on the form who can make decisions for you if you can't. You may want to give copies to close friends or family members. Keep a copy at home.

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

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

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

What if your instructions are not followed?

If you have signed an advance directive, and you believe that a doctor or hospital did not follow the instructions in it, you may file a complaint with the Pennsylvania Department of Health. You may call the Complaint Hotline at 1-800-254-5164 or use the online form at apps.health.pa.gov/dohforms/FacilityComplaint.aspx.

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

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

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

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

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

Is it about something else?

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

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

Section 1.8 How to get more information about your rights

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

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

You also have the right to make recommendations regarding our rights and responsibilities policy by calling our Member Help Team.

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

Things you need to do as a member of the plan are listed below. If you have any questions, please call our Member Help Team.

- **Get familiar with your covered services and the rules you must follow to get these covered services.** Use this *Evidence of Coverage* document to learn what is covered for you and the rules you need to follow to get your covered services.
  - Chapters 3 and 4 give the details about your medical services.
- **If you have any other health insurance coverage in addition to our plan, or separate prescription drug coverage, you are required to tell us.** Chapter 1 tells you about coordinating these benefits.
- **Tell your doctor and other health care providers that you are enrolled in our plan.** Show your plan membership card whenever you get your medical care.
- **Help your doctors, other providers, and Independence help you by giving them information, asking questions, and following through on your care.**
  - To help get the best care, tell your doctors, other health providers, and Independence about your health problems. Participate in developing mutually agreed-upon treatment goals, to the degree possible. Follow the treatment plans and instructions that you and your doctors agree upon.
  - Make sure your doctors know all of the drugs you are taking, including over-the-counter drugs, vitamins, and supplements.
  - If you have any questions, be sure to ask and get an answer you can understand.
- **Be considerate.** We expect all our members to respect the rights of other patients. We also expect you to act in a way that helps the smooth running of your doctor's office, hospitals, and other offices.
- **Pay what you owe.** As a plan member, you are responsible for these payments:
  - You must pay your plan premiums.
  - You must continue to pay your Medicare Part B premiums to remain a member of the plan.
  - For some of your medical services covered by the plan, you must pay your share of the cost when you get the service.
- **If you move *within* our plan service area, we need to know** so we can keep your membership record up to date and know how to contact you.
- **If you move *outside* our plan service area, you cannot remain a member of our plan.**
- If you move, it is also important to tell Social Security (or the Railroad Retirement Board).

SECTION 3 Member communications

Section 3.1 Member connections

There are many ways that you can connect with our plan and manage your health care coverage, whether on paper or online.

Health Needs Assessment

You may receive a health risk assessment survey that helps us learn more about your health care needs. The information provided will not affect your enrollment in the plan or your premium.

Personal Health Visit

Personal health visits are a convenient way to get personalized health assessment and advice in a relaxed setting and are offered to you at **no extra cost**. This service is optional, does not affect your current health insurance benefits or premiums, and does not replace your annual wellness visit.

Member Site

Log in or register at www.ibx.com/login anytime and anywhere to find all your health and benefit information in one place. Access your member ID card, the *Provider/Pharmacy* Finder, the status of recent claims, and important messages. You can also visit our website at www.ibxmedicare.com for plan documents, health and wellness information, and more.

Find a Doctor or Hospital

Our online *Find a Provider* tool helps you find an in-network provider. You can search for medical providers and facilities within the tool at www.ibxmedicare.com/providerfinder. The information about network providers available on the *Find a Provider* tool includes:

- Name, address, and telephone numbers
- Professional qualifications
- Specialty
- Medical school attended
- Residency completion
- Board certification status

Medical Technology Assessment

Our plan uses the technology assessment process to assure that new drugs, procedures, or devices are safe and effective before approving them as a covered service. When new technology becomes available, or, at the request of a practitioner or member, the plan researches all scientific information available from these expert sources. Following this analysis, the plan:

- Decides about when a new drug, procedure, or device has been proven to be safe and effective; and
- Uses this information to determine when an item becomes a covered service.

The review and evaluation of available clinical and scientific information is done by expert sources. These sources include, but are not limited to:

- Publications from government agencies;
- Peer-reviewed journals;
- Professional guidelines;
- Regional and national experts;
- Clinical trials; and
- Manufacturers' literature.

Section 3.2 Utilization management reviews

The professional providers, independent medical consultants, medical directors, or nurses that perform utilization review services are not compensated or given incentives based on coverage review decisions. Medical directors and nurses are salaried and contracted external physicians and other professional consultants are compensated on a per case-reviewed basis, regardless of the coverage determination. The health benefit plan does not specifically reward or provide financial incentives for issuing denials of coverage. There are no financial incentives for such individuals, which would encourage utilization review decisions that result in underutilization.

CHAPTER 7:

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

SECTION 1 Introduction

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

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

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

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

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

Section 1.2 What about the legal terms?

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

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

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

SECTION 2 Where to get more information and personalized assistance

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

State Health Insurance Assistance Program (SHIP).

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

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

Medicare

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

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

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

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

Is your problem or concern about your benefits or coverage?

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

Yes.

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

No.

Skip ahead to **Section 9** at the end of this chapter: **How to make a complaint about quality of care, waiting times, customer service or other concerns.**

COVERAGE DECISIONS AND APPEALS

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

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

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

Asking for coverage decisions prior to receiving benefits

A coverage decision is a decision we make about your benefits and coverage or about the amount we will pay for your medical care. For example, if your plan network doctor refers you to a medical specialist not inside the network, this referral is considered a favorable coverage

decision unless either your network doctor can show that you received a standard denial notice for this medical specialist, or the *Evidence of Coverage* makes it clear that the referred service is never covered under any condition. You or your doctor can also contact us and ask for a coverage decision if your doctor is unsure whether we will cover a particular medical service or refuses to provide medical care you think that you need. In other words, if you want to know if we will cover medical care before you receive it, you can ask us to make a coverage decision for you. In limited circumstances a request for a coverage decision will be dismissed, which means we won't review the request. Examples of when a request will be dismissed include if the request is incomplete, if someone makes the request on your behalf but isn't legally authorized to do so or if you ask for your request to be withdrawn. If we dismiss a request for a coverage decision, we will send a notice explaining why the request was dismissed and how to ask for a review of the dismissal.

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

Making an appeal

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

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

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

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

If you are not satisfied with the decision at the Level 2 appeal, you may be able to continue through additional levels of appeal (Section 8 in this chapter explains the Level 3, 4, and 5 appeals processes).

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

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

- You **can call us at our Member Help Team**.
- You **can get free help** from your State Health Insurance Assistance Program.
- **Your doctor can make a request for you.** If your doctor helps with an appeal past Level 2, they will need to be appointed as your representative. Please call our Member Help Team and ask for the *Appointment of Representative* form. (The form is also available on Medicare's website at www.cms.gov/Medicare/CMS-Forms/CMS-Forms/downloads/cms1696.pdf or on our website at www.ibxmedicare.com.)
  - For medical care or Part B prescription drugs, your doctor can request a coverage decision or a Level 1 appeal on your behalf. If your appeal is denied at Level 1, it will be automatically forwarded to Level 2.
- **You can ask someone to act on your behalf.** If you want to, you can name another person to act for you as your *representative* to ask for a coverage decision or make an appeal.
  - If you want a friend, relative, or another person to be your representative, call our Member Help Team and ask for the *Appointment of Representative* form. (The form is also available on Medicare's website at www.cms.gov/Medicare/CMS-Forms/CMS-Forms/downloads/cms1696.pdf or on our website at www.ibxmedicare.com.) The form gives that person permission to act on your behalf. It must be signed by you and by the person who you would like to act on your behalf. You must give us a copy of the signed form.
  - While we can accept an appeal request without the form, we cannot begin or complete our review until we receive it. If we do not receive the form within 44 calendar days after receiving your appeal request (our deadline for making a decision on your appeal), your appeal request will be dismissed. If this happens, we will send you a written notice explaining your right to ask the independent review organization to review our decision to dismiss your appeal.
- **You also have the right to hire a lawyer.** You may contact your own lawyer or get the name of a lawyer from your local bar association or other referral service. There are also groups that will give you free legal services if you qualify. However, **you are not required to hire a lawyer** to ask for any kind of coverage decision or appeal a decision.

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

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

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

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

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

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

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

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

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

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

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

Legal Terms
When a coverage decision involves your medical care, it is called an **organization determination.** A *fast coverage decision* is called an **expedited determination.**

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

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

- You may *only ask* for coverage for medical care items and/or services (not requests for payment for items and/or services already received).
- You can get a fast coverage decision *only* if using the standard deadlines could *cause serious harm to your health or hurt your ability to function.*
- **If your doctor tells us that your health requires a fast coverage decision, we will automatically agree to give you a fast coverage decision.**
- **If you ask for a fast coverage decision on your own, without your doctor's support, we will decide whether your health requires that we give you a fast coverage decision.** If we do not approve a fast coverage decision, we will send you a letter that:
  - Explains that we will use the standard deadlines.
  - Explains if your doctor asks for the fast coverage decision, we will automatically give you a fast coverage decision.
  - Explains that you can file a *fast complaint* about our decision to give you a standard coverage decision instead of the fast coverage decision you requested.

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

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

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

For standard coverage decisions we use the standard deadlines.

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

- **However**, if you ask for more time, or if we need more information that may benefit you, **we can take up to 14 more days** if your request is for a medical item or service. If we take extra days, we will tell you in writing. We can't take extra time to make a decision if your request is for a Medicare Part B prescription drug.
- If you believe we should *not* take extra days, you can file a *fast complaint.* We will give you an answer to your complaint as soon as we make the decision. (The process for making a complaint is different from the process for coverage decisions and appeals. See Section 9 of this chapter for information on complaints.)

For fast coverage decisions we use an expedited timeframe.

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

- **However,** if you ask for more time, or if we need more information that may benefit you, **we can take up to 14 more days**. If we take extra days, we will tell you in writing,. We can't take extra time to make a decision if your request is for a Medicare Part B prescription drug.
- If you believe we should *not* take extra days, you can file a *fast complaint*. (See Section 9 of this chapter for information on complaints.) We will call you as soon as we make the decision.
- **If our answer is no to part or all of what you requested,** we will send you a written statement that explains why we said no.

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

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

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

Legal Terms
An appeal to the plan about a medical care coverage decision is called a plan **reconsideration.** A fast appeal is also called an **expedited reconsideration.**

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

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

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

Step 2: Ask our plan for an appeal or a Fast Appeal

- **If you are asking for a standard appeal, submit your standard appeal in writing.** You may also ask for an appeal by calling us. Chapter 2 has contact information.
- **If you are asking for a fast appeal, make your appeal in writing or call us.** Chapter 2 has contact information.
- **You must make your appeal request within 60 calendar days** from the date on the written notice we sent to tell you our answer on the coverage decision. If you miss this deadline and have a good reason for missing it, explain the reason your appeal is late when you make your appeal. We may give you more time to make your appeal. Examples of good cause may include a serious illness that prevented you from contacting us or if we provided you with incorrect or incomplete information about the deadline for requesting an appeal.
- **You can ask for a copy of the information regarding your medical decision. You and your doctor may add more information to support your appeal.**

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

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

Deadlines for a fast appeal

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

organization for a Level 2 appeal. The independent review organization will notify you in writing when it receives your appeal.

Deadlines for a standard appeal

- For standard deadlines, we must give you our answer **within 30 calendar days** after we receive your appeal. If your request is for a Medicare Part B prescription drug you have not yet received, we will give you our answer **within 7 calendar days** after we receive your appeal. We will give you our decision sooner if your health condition requires us to.
  - However, if you ask for more time, or if we need more information that may benefit you, **we can take up to 14 more calendar days** if your request is for a medical item or service**.** If we take extra days, we will tell you in writing. We can't take extra time to make a decision if your request is for a Medicare Part B prescription drug.
  - If you believe we should *not* take extra days, you can file a fast complaint. When you file a fast complaint, we will give you an answer to your complaint within 24 hours. (For more information about the process for making complaints, including fast complaints, see Section 9 of this chapter.)
  - If we do not give you an answer by the deadline (or by the end of the extended time period), we will send your request to a Level 2 appeal, where an independent review organization will review the appeal. Section 5.4 explains the Level 2 appeal process.
- **If our answer is yes to part or all of what you requested,** we must authorize or provide the coverage within 30 calendar days if your request is for a medical item or service, or **within 7 calendar days** if your request is for a Medicare Part B prescription drug.
- **If our plan says no to part or all of your appeal**, we will automatically send your appeal to the independent review organization for a Level 2 appeal.

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

Legal Term
The formal name for the *independent review organization* is the **Independent Review Entity.** It is sometimes called the **IRE.**

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

Step 1: The independent review organization reviews your appeal.

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

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

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

If you had a standard appeal at Level 1, you will also have a standard appeal at Level 2

- For the *standard appeal* if your request is for a medical item or service, the review organization must give you an answer to your Level 2 appeal **within 30 calendar days** of when it receives your appeal. If your request is for a Medicare Part B prescription drug, the review organization must give you an answer to your Level 2 appeal **within 7 calendar days** of when it receives your appeal.
- However, if your request is for a medical item or service and the independent review organization needs to gather more information that may benefit you, **it can take up to 14 more calendar days**. The independent review organization can't take extra time to make a decision if your request is for a Medicare Part B prescription drug.

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

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

- **If the review organization says yes to part or all of a request for a medical item or service,** we must authorize the medical care coverage within 72 hours or provide the service within 14 calendar days after we receive the decision from the review organization for standard requests. For expedited requests, we have 72 hours from the date we receive the decision from the review organization.
- **If the review organization says yes to part or all of a request for a Medicare Part B prescription drug,** we must authorize or provide the Part B prescription drug within **72 hours** after we receive the decision from the review organization for **standard requests**. **For expedited requests**, we have **24 hours** from the date we receive the decision from the review organization.
- **If this organization says no to part or all of your appeal**, it means they agree with us that your request (or part of your request) for coverage for medical care should not be approved. (This is called upholding the decision. It is also called turning down your appeal.) In this case, the independent review organization will send you a letter:
  - Explaining its decision.
  - Notifying you of the right to a Level 3 appeal if the dollar value of the medical care coverage meets a certain minimum. The written notice you get from the independent review organization will tell you the dollar amount you must meet to continue the appeals process.
  - Telling you how to file a Level 3 appeal.

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

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

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

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

Asking for reimbursement is asking for a coverage decision from us

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

- **If we say yes to your request**: If the medical care is covered and you followed all the rules, we will send you the payment for our share of the cost within 60 calendar days after we receive your request. If you haven't paid for the medical care, we will send the payment directly to the provider.
- **If we say no to your request**: If the medical care is not covered, or you did not follow all the rules, we will not send payment. Instead, we will send you a letter that says we will not pay for the medical care and the reasons why.

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

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

- We must give you our answer within 60 calendar days after we receive your appeal. If you are asking us to pay you back for medical care you have already received and paid for, you are not allowed to ask for a fast appeal.
- If the independent review organization decides we should pay, we must send you or the provider the payment within 30 calendar days. If the answer to your appeal is yes at any stage of the appeals process after Level 2, we must send the payment you requested to you or to the provider within 60 calendar days.

SECTION 6 How to ask us to cover a longer inpatient hospital stay if you think you are being discharged too soon

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

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

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

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

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

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

2. **You will be asked to sign the written notice to show that you received it and understand your rights.**
   - You or someone who is acting on your behalf will be asked to sign the notice.
   - Signing the notice shows *only* that you have received the information about your rights. The notice does not give your discharge date. Signing the notice **does *not* mean** you are agreeing on a discharge date.

3. **Keep your copy** of the notice handy so you will have the information about making an appeal (or reporting a concern about quality of care) if you need it.
   - If you sign the notice more than two days before your discharge date, you will get another copy before you are scheduled to be discharged.
   - To look at a copy of this notice in advance, you can call our Member Help Team or 1-800 MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048. You can also see the notice online at www.cms.gov/Medicare/Medicare-General-Information/BNI/HospitalDischargeAppealNotices.

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

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

- **Follow the process.**
- **Meet the deadlines.**
- **Ask for help if you need it**. If you have questions or need help at any time, please call our Member Help Team. Or call your State Health Insurance Assistance Program, a government organization that provides personalized assistance.

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

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

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

How can you contact this organization?

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

Act quickly:

- To make your appeal, you must contact the Quality Improvement Organization *before* you leave the hospital and **no later than midnight the day of your discharge.**
  - If you meet this deadline, you may stay in the hospital *after* your discharge date *without paying for it* while you wait to get the decision from the Quality Improvement Organization.
  - If you do *not* meet this deadline, and you decide to stay in the hospital after your planned discharge date, *you may have to pay all of the costs* for hospital care you receive after your planned discharge date.

- If you miss the deadline for contacting the Quality Improvement Organization, and you still wish to appeal, you must make an appeal directly to our plan instead. For details about this other way to make your appeal, see Section 6.4.

- Once you request an immediate review of your hospital discharge the Quality Improvement Organization will contact us. By noon of the day after we are contacted, we will give you a **Detailed Notice of Discharge**. This notice gives your planned discharge date and explains in detail the reasons why your doctor, the hospital, and we think it is right (medically appropriate) for you to be discharged on that date.
- You can get a sample of the **Detailed Notice of Discharge** by calling our Member Help Team or 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. (TTY users should call 1-877-486-2048.) Or you can see a sample notice online at www.cms.gov/Medicare/Medicare-General-Information/BNI/HospitalDischargeAppealNotices.

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

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

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

What happens if the answer is yes?

- If the review organization says *yes*, **we must keep providing your covered inpatient hospital services for as long as these services are medically necessary.**
- You will have to keep paying your share of the costs (such as deductibles or copayments, if these apply). In addition, there may be limitations on your covered hospital services.

What happens if the answer is no?

- If the review organization says *no*, they are saying that your planned discharge date is medically appropriate. If this happens, **our coverage for your inpatient hospital services will end** at noon on the day *after* the Quality Improvement Organization gives you its answer to your appeal.
- If the review organization says *no* to your appeal and you decide to stay in the hospital, then **you may have to pay the full cost** of hospital care you receive after noon on the day after the Quality Improvement Organization gives you its answer to your appeal.

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

- If the Quality Improvement Organization has said *no* to your appeal, *and* you stay in the hospital after your planned discharge date, then you can make another appeal. Making another appeal means you are going on to *Level 2* of the appeals process.

Section 6.3 Step-by-step: How to make a Level 2 appeal to change your hospital discharge date

During a Level 2 appeal, you ask the Quality Improvement Organization to take another look at their decision on your first appeal. If the Quality Improvement Organization turns down your Level 2 appeal, you may have to pay the full cost for your stay after your planned discharge date.

Step 1: Contact the Quality Improvement Organization again and ask for another review.

- You must ask for this review **within 60 calendar days** after the day the Quality Improvement Organization said *no* to your Level 1 appeal. You can ask for this review only if you stay in the hospital after the date that your coverage for the care ended.

Step 2: The Quality Improvement Organization does a second review of your situation

- Reviewers at the Quality Improvement Organization will take another careful look at all of the information related to your appeal.

Step 3: Within 14 calendar days of receipt of your request for a Level 2 appeal, the reviewers will decide on your appeal and tell you their decision.

If the review organization says yes:

- **We must reimburse you** for our share of the costs of hospital care you have received since noon on the day after the date your first appeal was turned down by the Quality Improvement Organization. **We must continue providing coverage for your inpatient hospital care for as long as it is medically necessary.**
- You must continue to pay your share of the costs and coverage limitations may apply.

If the review organization says no:

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

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

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

Section 6.4 What if you miss the deadline for making your Level 1 appeal to change your hospital discharge date?

Legal Term
A *fast review* (or *fast appeal*) is also called an **expedited appeal.**

You can appeal to us instead

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

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

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

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

- ***Ask for a fast review***. This means you are asking us to give you an answer using the *fast* deadlines rather than the *standard* deadlines. Chapter 2 has contact information.

Step 2: We do a fast review of your planned discharge date, checking to see if it was medically appropriate.

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

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

- **If we say yes to your appeal,** it means we have agreed with you that you still need to be in the hospital after the discharge date. We will keep providing your covered inpatient hospital services for as long as they are medically necessary. It also means that we have agreed to reimburse you for our share of the costs of care you have received since the date when we said your coverage would end. (You must pay your share of the costs and there may be coverage limitations that apply.)
- **If we say no to your appeal,** we are saying that your planned discharge date was medically appropriate. Our coverage for your inpatient hospital services ends as of the day we said coverage would end.
    - If you stayed in the hospital *after* your planned discharge date, then **you may have to pay the full cost** of hospital care you received after the planned discharge date.

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

Step-by-Step: Level 2 *Alternate* Appeal Process

Legal Term
The formal name for the *independent review organization* is the **Independent Review Entity.** It is sometimes called the **IRE.**

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

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

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

Step 2: The independent review organization does a fast review of your appeal. The reviewers give you an answer within 72 hours.

- Reviewers at the independent review organization will take a careful look at all of the information related to your appeal of your hospital discharge.
- **If this organization says *yes* to your appeal,** then we must pay you back for our share of the costs of hospital care you received since the date of your planned discharge. We must also continue the plan's coverage of your inpatient hospital services for as long as it is medically necessary. You must continue to pay your share of the costs. If there are coverage limitations, these could limit how much we would reimburse or how long we would continue to cover your services.
- **If this organization says *no* to your appeal,** it means they agree that your planned hospital discharge date was medically appropriate.
    - The written notice you get from the independent review organization will tell you how to start a Level 3 appeal with the review process, which is handled by an Administrative Law Judge or attorney adjudicator.

Step 3: If the independent review organization turns down your appeal, you choose whether you want to take your appeal further

- There are three additional levels in the appeals process after Level 2 (for a total of five levels of appeal). If reviewers say no to your Level 2 appeal, you decide whether to accept their decision or go on to Level 3 appeal.
- Section 8 in this chapter tells more about Levels 3, 4, and 5 of the appeals process.

SECTION 7 How to ask us to keep covering certain medical services if you think your coverage is ending too soon

Section 7.1 *This section is only about three services:* Home health care, skilled nursing facility care, and Comprehensive Outpatient Rehabilitation Facility (CORF) services

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

When we decide it is time to stop covering any of the three types of care for you, we are required to tell you in advance. When your coverage for that care ends, *we will stop paying our share of the cost for your care.*

If you think we are ending the coverage of your care too soon, **you can appeal our decision**. This section tells you how to ask for an appeal.

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

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

1. **You receive a notice in writing** at least two days before our plan is going to stop covering your care. The notice tells you:
   - The date when we will stop covering the care for you.
   - How to request a *fast track appeal* to request us to keep covering your care for a longer period of time.
2. **You, or someone who is acting on your behalf, will be asked to sign the written notice to show that you received it.** Signing the notice shows *only* that you have received the information about when your coverage will stop. **Signing it does not mean you agree** with the plan's decision to stop care.

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

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

- **Follow the process.**
- **Meet the deadlines.**

- **Ask for help if you need it**. If you have questions or need help at any time, please call our Member Help Team. Or call your State Health Insurance Assistance Program, a government organization that provides personalized assistance.

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

This **Quality Improvement Organization** is a group of doctors and other health care experts who are paid by the Federal government to check on and help improve the quality of care for people with Medicare. This includes reviewing plan decisions about when it's time to stop covering certain kinds of medical care. These experts are not part of our plan.

Step 1: Make your Level 1 appeal: contact the Quality Improvement Organization and ask for a *fast-track appeal*. You must act quickly.

How can you contact this organization?

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

Act quickly:

- You must contact the Quality Improvement Organization to start your appeal by noon of the day before the effective date on the Notice of Medicare Non-Coverage.
- If you miss the deadline for contacting the Quality Improvement Organization, and you still wish to file an appeal, you must make an appeal directly to us instead. For details about this other way to make your appeal, see Section 7.5.

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

Legal Term
Detailed Explanation of Non-Coverage. Notice that provides details on reasons for ending coverage.

What happens during this review?

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

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

What happens if the reviewers say yes?

- If the reviewers say *yes* to your appeal, then **we must keep providing your covered services for as long as it is medically necessary.**
- You will have to keep paying your share of the costs (such as deductibles or copayments if these apply). There may be limitations on your covered services.

What happens if the reviewers say no?

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

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

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

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

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

Step 1: Contact the Quality Improvement Organization again and ask for another review.

- You must ask for this review **within 60 days** after the day when the Quality Improvement Organization said *no* to your Level 1 appeal. You can ask for this review only if you continued getting care after the date that your coverage for the care ended.

Step 2: The Quality Improvement Organization does a second review of your situation.

- Reviewers at the Quality Improvement Organization will take another careful look at all of the information related to your appeal.

Step 3: Within 14 days of receipt of your appeal request, reviewers will decide on your appeal and tell you their decision.

What happens if the review organization says yes?

- **We must reimburse you** for our share of the costs of care you have received since the date when we said your coverage would end. **We must continue providing coverage** for the care for as long as it is medically necessary.

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

What happens if the review organization says no?

- It means they agree with the decision made to your Level 1 appeal.
- The notice you get will tell you in writing what you can do if you wish to continue with the review process. It will give you the details about how to go on to the next level of appeal, which is handled by an Administrative Law Judge or attorney adjudicator.

Step 4: If the answer is no, you will need to decide whether you want to take your appeal further.

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

Section 7.5 What if you miss the deadline for making your Level 1 appeal?

You can appeal to us instead

As explained above, you must act quickly to contact the Quality Improvement Organization to start your first appeal (within a day or two, at the most). If you miss the deadline for contacting this organization, there is another way to make your appeal. If you use this other way of making your appeal, *the first two levels of appeal are different.*

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

Legal Term
A *fast review* (or *fast appeal*) is also called an **expedited appeal**.

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

- **Ask for a fast review**. This means you are asking us to give you an answer using the *fast* deadlines rather than the *standard* deadlines. Chapter 2 has contact information.

Step 2: We do a fast review of the decision we made about when to end coverage for your services.

- During this review, we take another look at all of the information about your case. We check to see if we were following all the rules when we set the date for ending the plan's coverage for services you were receiving.

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

- **If we say yes to your appeal,** it means we have agreed with you that you need services longer, and will keep providing your covered services for as long as it is medically

necessary. It also means that we have agreed to reimburse you for our share of the costs of care you have received since the date when we said your coverage would end. (You must pay your share of the costs and there may be coverage limitations that apply.)

- **If we say no to your appeal,** then your coverage will end on the date we told you and we will not pay any share of the costs after this date.
- If you continued to get home health care, or skilled nursing facility care, or Comprehensive Outpatient Rehabilitation Facility (CORF) services *after* the date when we said your coverage would end, then **you will have to pay the full cost** of this care.

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

Legal Term
The formal name for the *independent review organization* is the **Independent Review Entity.** It is sometimes called the **IRE.**

Step-by-Step: Level 2 *Alternate* Appeal Process

- During the Level 2 appeal, an **independent review organization** reviews the decision we made to your *fast appeal.* This organization decides whether the decision should be changed. **The independent review organization is an independent organization that is hired by Medicare**. This organization is not connected with our plan and it is not a government agency. This organization is a company chosen by Medicare to handle the job of being the independent review organization. Medicare oversees its work.

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

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

Step 2: The independent review organization does a fast review of your appeal. The reviewers give you an answer within 72 hours.

- Reviewers at the independent review organization will take a careful look at all of the information related to your appeal.
- **If this organization says *yes* to your appeal,** then we must pay you back for our share of the costs of care you have received since the date when we said your coverage would end. We must also continue to cover the care for as long as it is medically necessary. You must continue to pay your share of the costs. If there are coverage limitations, these could limit how much we would reimburse or how long we would continue to cover services.
- **If this organization says *no* to your appeal,** it means they agree with the decision our plan made to your first appeal and will not change it.

- The notice you get from the independent review organization will tell you in writing what you can do if you wish to go on to a Level 3 appeal.

Step 3: If the independent review organization says no to your appeal, you choose whether you want to take your appeal further.

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

SECTION 8 Taking your appeal to Level 3 and beyond

Section 8.1 Appeal Levels 3, 4, and 5 for Medical Service Requests

This section may be appropriate for you if you have made a Level 1 appeal and a Level 2 appeal, and both of your appeals have been turned down.

If the dollar value of the item or medical service you have appealed meets certain minimum levels, you may be able to go on to additional levels of appeal. If the dollar value is less than the minimum level, you cannot appeal any further. The written response you receive to your Level 2 appeal will explain how to make a Level 3 appeal.

For most situations that involve appeals, the last three levels of appeal work in much the same way. Here is who handles the review of your appeal at each of these levels.

Level 3 appeal	**An Administrative Law Judge or an attorney adjudicator who works for the Federal government** will review your appeal and give you an answer.

- **If the Administrative Law Judge or attorney adjudicator says yes to your appeal, the appeals process *may* or *may not* be over**. Unlike a decision at a Level 2 appeal, we have the right to appeal a Level 3 decision that is favorable to you. If we decide to appeal, it will go to a Level 4 appeal.
    - If we decide *not* to appeal, we must authorize or provide you with the medical care within 60 calendar days after receiving the Administrative Law Judge's or attorney adjudicator's decision.
    - If we decide to appeal the decision, we will send you a copy of the Level 4 appeal request with any accompanying documents. We may wait for the Level 4 appeal decision before authorizing or providing the medical care in dispute.
- **If the Administrative Law Judge or attorney adjudicator says no to your appeal, the appeals process *may* or *may* not be over**.
    - If you decide to accept this decision that turns down your appeal, the appeals process is over.
    - If you do not want to accept the decision, you can continue to the next level of the review process. The notice you get will tell you what to do for a Level 4 appeal.

Level 4 appeal	**The Medicare Appeals Council** (Council) will review your appeal and give you an answer. The Council is part of the Federal government.

- **If the answer is yes, or if the Council denies our request to review a favorable Level 3 appeal decision, the appeals process *may* or *may not* be over**. Unlike a decision at Level 2, we have the right to appeal a Level 4 decision that is favorable to you. We will decide whether to appeal this decision to Level 5.
    - If we decide *not* to appeal the decision, we must authorize or provide you with the medical care within 60 calendar days after receiving the Council's decision.
    - If we decide to appeal the decision, we will let you know in writing.
- **If the answer is no or if the Council denies the review request, the appeals process *may* or *may not* be over**.
    - If you decide to accept this decision that turns down your appeal, the appeals process is over.
    - If you do not want to accept the decision, you may be able to continue to the next level of the review process. If the Council says no to your appeal, the notice you get will tell you whether the rules allow you to go on to a Level 5 appeal and how to continue with a Level 5 appeal.

Level 5 appeal	A judge at the **Federal District Court** will review your appeal.

- A judge will review all of the information and decide *yes* or *no* to your request. This is a final answer. There are no more appeal levels after the Federal District Court.

MAKING COMPLAINTS

SECTION 9 How to make a complaint about quality of care, waiting times, customer service, or other concerns

Section 9.1 What kinds of problems are handled by the complaint process?

The complaint process is *only* used for certain types of problems. This includes problems related to quality of care, waiting times, and the customer service. Here are examples of the kinds of problems handled by the complaint process.

Complaint	Example
Quality of your medical care	• Are you unhappy with the quality of the care you have received (including care in the hospital)?
Respecting your privacy	• Did someone not respect your right to privacy or share confidential information?

Complaint	Example
Disrespect, poor customer service, or other negative behaviors	• Has someone been rude or disrespectful to you? • Are you unhappy with our Member Help Team? • Do you feel you are being encouraged to leave the plan?
Waiting times	• Are you having trouble getting an appointment, or waiting too long to get it? • Have you been kept waiting too long by doctors or other health professionals? Or by our Member Help Team or other staff at the plan? ○ Examples include waiting too long on the phone, in the waiting or exam room.
Cleanliness	• Are you unhappy with the cleanliness or condition of a clinic, hospital, or doctor's office?
Information you get from us	• Did we fail to give you a required notice? • Is our written information hard to understand?
Timeliness (These types of complaints are all related to the timeliness of our actions related to coverage decisions and appeals)	If you already asked us for a coverage decision or made an appeal, and you think that we are not responding quickly enough, you can make a complaint about our slowness. Here are examples: • You asked us for a *fast coverage decision* or a *fast appeal*, and we have said no; you can make a complaint. • You believe we are not meeting the deadlines for coverage decisions or appeals; you can make a complaint. • You believe we are not meeting deadlines for covering or reimbursing you for certain medical items or services that were approved; you can make a complaint. • You believe we failed to meet required deadlines for forwarding your case to the independent review organization; you can make a complaint.

Section 9.2 How to make a complaint

Legal Terms

- A **Complaint** is also called a **grievance.**
- **Making a complaint** is also called **filing a grievance.**
- **Using the process for complaints** is also called **using the process for filing a grievance.**
- A **fast complaint** is also called an **expedited grievance.**

Section 9.3 Step-by-step: Making a complaint

Step 1: Contact us promptly – either by phone or in writing.

- **Usually, calling our Member Help Team is the first step.** If there is anything else you need to do, our Member Help Team will let you know.
- **If you do not wish to call (or you called and were not satisfied), you can put your complaint in writing and send it to us.** If you put your complaint in writing, we will respond to your complaint in writing.

  Here is our formal procedure for answering grievances:

  - Standard Grievance Process

    If we cannot resolve your complaint over the phone, we have a formal procedure to review your issues. We call this the grievance complaint process. To use the formal grievance procedure, please call 1-888-718-3333 (TTY/TDD: 711) seven days a week, 8 a.m. to 8 p.m. Please note that on weekends and holidays from April 1 through September 30, your call may be sent to voicemail. Or, mail a written request to Personal Choice 65 Medical-Only Medicare Member Appeals Unit, PO Box 13652, Philadelphia, PA 19101-3652. You will receive notification of the resolution of your grievance.

  - Expedited (Fast) Grievance Process

    As a member, you may file an expedited grievance with our plan for the following reasons:

    - Our decision to invoke an extension to the organization determination or reconsideration of time frames; and/or
    - Our refusal to grant a member's request for an expedited organization determination or reconsideration.

    We must respond within 24 hours of receiving your expedited grievance request. To file an expedited grievance, please call 1-888-718-3333 (TTY/TDD: 711) seven days a week, 8 a.m. to 8 p.m. Please note that on weekends and holidays from April 1 through September 30, your call may be sent to voicemail. Or, mail a written request to Personal Choice 65 Medical-Only Medicare Member Appeals Unit, PO Box 13652, Philadelphia, PA 19101-3652.

You can also submit your complaint to us by fax (see Chapter 2 for more information).

- The **deadline** for making a complaint is 60 calendar days from the time you had the problem you want to complain about.

Step 2: We look into your complaint and give you our answer.

- **If possible, we will answer you right away.** If you call us with a complaint, we may be able to give you an answer on the same phone call.
- **Most complaints are answered within 30 calendar days.** If we need more information and the delay is in your best interest or if you ask for more time, we can take up to 14 more calendar days (44 calendar days total) to answer your complaint. If we decide to take extra days, we will tell you in writing.
- **If you are making a complaint because we denied your request for a fast coverage decision or a fast appeal, we will automatically give you a fast complaint.** If you have a fast complaint, it means we will give you **an answer within 24 hours.**
- **If we do not agree** with some or all of your complaint or don't take responsibility for the problem you are complaining about, we will include our reasons in our response to you.

Section 9.4 You can also make complaints about quality of care to the Quality Improvement Organization

When your complaint is about *quality of care*, you also have two extra options:

- **You can make your complaint directly to the Quality Improvement Organization**.
  - The Quality Improvement Organization is a group of practicing doctors and other health care experts paid by the Federal government to check and improve the care given to Medicare patients. Chapter 2 has contact information.

Or

- **You can make your complaint to both the Quality Improvement Organization and us at the same time.**

Section 9.5 You can also tell Medicare about your complaint

You can submit a complaint about Personal Choice 65 Medical-Only directly to Medicare. To submit a complaint to Medicare, go to www.medicare.gov/MedicareComplaintForm/home.aspx. You may also call 1-800-MEDICARE (1-800-633-4227). TTY/TDD users can call 1-877-486-2048.

CHAPTER 8:
Ending your membership in the plan

SECTION 1 Introduction to ending your membership in our plan

Ending your membership in Personal Choice 65 Medical-Only may be **voluntary** (your own choice) or **involuntary** (not your own choice):

- You might leave our plan because you have decided that you *want* to leave. Sections 2 and 3 provide information on ending your membership voluntarily.
- There are also limited situations where we are required to end your membership. Section 5 tells you about situations when we must end your membership.

If you are leaving our plan, our plan must continue to provide your medical care and you will continue to pay your cost-share until your membership ends.

SECTION 2 When can you end your membership in our plan?

Section 2.1 You can end your membership during the Annual Enrollment Period

You can end your membership in our plan during the **Annual Enrollment Period** (also known as the **Annual Open Enrollment Period**). During this time, review your health and drug coverage and decide about coverage for the upcoming year.

- **The Annual Enrollment Period** is from **October 15 to December 7**.
- **Choose to keep your current coverage or make changes to your coverage for the upcoming year**. If you decide to change to a new plan, you can choose any of the following types of plans:
  - Another Medicare health plan, with or without prescription drug coverage.
  - Original Medicare *with* a separate Medicare prescription drug plan.

    OR

  - Original Medicare *without* a separate Medicare prescription drug plan.
- **Your membership will end in our plan** when your new plan's coverage begins on January 1.

Section 2.2 You can end your membership during the Medicare Advantage Open Enrollment Period

You have the opportunity to make *one* change to your health coverage during the **Medicare Advantage Open Enrollment Period**.

- **The annual Medicare Advantage Open Enrollment Period is** from January 1 to March 31.
- **During the annual Medicare Advantage Open Enrollment Period** you can:
  - Switch to another Medicare Advantage Plan with or without prescription drug coverage.
  - Disenroll from our plan and obtain coverage through Original Medicare. If you choose to switch to Original Medicare during this period, you can also join a separate Medicare prescription drug plan at that time.

- **Your membership will end** on the first day of the month after you enroll in a different Medicare Advantage plan or we get your request to switch to Original Medicare. If you also choose to enroll in a Medicare prescription drug plan, your membership in the drug plan will begin the first day of the month after the drug plan gets your enrollment request.

Section 2.3 In certain situations, you can end your membership during a Special Enrollment Period

In certain situations, members of Personal Choice 65 Medical-Only may be eligible to end their membership at other times of the year. This is known as a **Special Enrollment Period**.

You may be eligible to end your membership during a Special Enrollment Period if any of the following situations apply to you. These are just examples, for the full list you can contact the plan, call Medicare, or visit the Medicare website (www.medicare.gov):

- Usually, when you have moved.
- If you have Medicaid.
- If we violate our contract with you.
- If you are getting care in an institution, such as a nursing home or long-term care (LTC) hospital.
- If you enroll in the Program of All-inclusive Care for the Elderly (PACE).

The enrollment time periods vary depending on your situation.

To find out if you are eligible for a Special Enrollment Period, please call Medicare at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users call 1-877-486-2048. If you are eligible to end your membership because of a special situation, you can choose to change both your Medicare health coverage and prescription drug coverage. You can choose:

- Another Medicare health plan with or without prescription drug coverage.
- Original Medicare *with* a separate Medicare prescription drug plan.
- - *or* - Original Medicare *without* a separate Medicare prescription drug plan.

When will your membership end? Your membership will usually end on the first day of the month after your request to change your plan is received.

Section 2.4 Where can you get more information about when you can end your membership?

If you have any questions about ending your membership, you can:

- **Call our Member Help Team**.
- Find the information in the ***Medicare & You 2024*** handbook.
- Contact **Medicare** at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

SECTION 3 How do you end your membership in our plan?

The table below explains how you should end your membership in our plan.

If you would like to switch from our plan to:	This is what you should do:
• Another Medicare health plan.	• Enroll in the new Medicare health plan. • You will automatically be disenrolled from Personal Choice 65 Medical-Only when your new plan's coverage begins.
• Original Medicare *with* a separate Medicare prescription drug plan.	• Enroll in the new Medicare prescription drug plan. • You will automatically be disenrolled from Personal Choice 65 Medical-Only when your new plan's coverage begins.
• Original Medicare *without* a separate Medicare prescription drug plan.	• **Send us a written request to disenroll.** Contact our Member Help Team if you need more information on how to do this. • You can also contact **Medicare**, at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week, and ask to be disenrolled. TTY users should call 1-877-486-2048. • You will be disenrolled from Personal Choice 65 Medical-Only when your coverage in Original Medicare begins.

Note: If you also have creditable prescription drug coverage (e.g., standalone PDP) and disenroll from that coverage, you may have to pay a Part D late enrollment penalty if you join a Medicare drug plan later after going without creditable prescription drug coverage for 63 days or more in a row.

SECTION 4 Until your membership ends, you must keep getting your medical items, services through our plan

Until your membership ends and your new Medicare coverage begins, you must continue to get your medical items, services through our plan.

- **Continue to use our network providers to receive medical care.**
- **If you are hospitalized on the day that your membership ends, your hospital stay will be covered by our plan until you are discharged** (even if you are discharged after your new health coverage begins).

SECTION 5 Personal Choice 65 Medical-Only must end your membership in the plan in certain situations

Section 5.1 When must we end your membership in the plan?

Personal Choice 65 Medical-Only must end your membership in the plan if any of the following happen:

- If you no longer have Medicare Part A and Part B.
- If you move out of our service area.
- If you are away from our service area for more than twelve months.
  - If you move or take a long trip, call our Member Help Team to find out if the place you are moving or traveling to is in our plan's area.
- If you become incarcerated (go to prison).
- If you are no longer a United States citizen or lawfully present in the United States.
- If you intentionally give us incorrect information when you are enrolling in our plan and that information affects your eligibility for our plan. (We cannot make you leave our plan for this reason unless we get permission from Medicare first.)
- If you let someone else use your membership card to get medical care. (We cannot make you leave our plan for this reason unless we get permission from Medicare first.)
  - If we end your membership because of this reason, Medicare may have your case investigated by the Inspector General.

Where can you get more information?

If you have questions or would like more information on when we can end your membership call our Member Help Team.

Section 5.2 We cannot ask you to leave our plan for any health-related reason

Personal Choice 65 Medical-Only is not allowed to ask you to leave our plan for any health-related reason.

What should you do if this happens?

If you feel that you are being asked to leave our plan because of a health-related reason, you should call Medicare at 1-800-MEDICARE (1-800-633-4227) 24 hours a day, 7 days a week. (TTY 1-877-486-2048).

Section 5.3 You have the right to make a complaint if we end your membership in our plan

If we end your membership in our plan, we must tell you our reasons in writing for ending your membership. We must also explain how you can file a grievance or make a complaint about our decision to end your membership.

CHAPTER 9:
Legal notices

SECTION 1 Notice about governing law

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

SECTION 2 Notice about nondiscrimination

We don't discriminate based on race, ethnicity, national origin, color, religion, sex, gender, age, sexual orientation, mental or physical disability, health status, claims experience, medical history, genetic information, evidence of insurability, or geographic location within the service area. All organizations that provide Medicare Advantage plans, like our plan, must obey Federal laws against discrimination, including Title VI of the Civil Rights Act of 1964, the Rehabilitation Act of 1973, the Age Discrimination Act of 1975, the Americans with Disabilities Act, Section 1557 of the Affordable Care Act, all other laws that apply to organizations that get Federal funding, and any other laws and rules that apply for any other reason.

If you want more information or have concerns about discrimination or unfair treatment, please call the Department of Health and Human Services' **Office for Civil Rights** at 1-800-368-1019 (TTY 1-800-537-7697) or your local Office for Civil Rights. You can also review information from the Department of Health and Human Services' Office for Civil Rights at https://www.hhs.gov/ocr/index.html.

If you have a disability and need help with access to care, please call us at our Member Help Team. If you have a complaint, such as a problem with wheelchair access, our Member Help Team can help.

SECTION 3 Notice about Medicare Secondary Payer subrogation rights

We have the right and responsibility to collect for covered Medicare services for which Medicare is not the primary payer. According to CMS regulations at 42 CFR sections 422.108 and 423.462, Personal Choice 65 Medical-Only, as a Medicare Advantage Organization, will exercise the same rights of recovery that the Secretary exercises under CMS regulations in subparts B through D of part 411 of 42 CFR and the rules established in this section supersede any State laws.

SECTION 4 Notice about reporting fraud, waste, and abuse

Health care fraud, waste, and abuse are violations of state and/or Federal law. The Independence Blue Cross Corporate and Financial Investigations Department helps to protect members and providers from fraudulent and abusive practices. If you know of or suspect health insurance fraud, waste, or abuse, please report it. You are not required to provide identifying information about yourself when reporting fraud, waste, and abuse. Call the toll-free Fraud Hotline at 1-866-282-2707.

SECTION 5 Additional information about Medicare Secondary Payer subrogation rights

We have the right and responsibility to collect for covered Medicare services for which Medicare is not the primary payer. According to CMS regulations at 42 CFR sections 422.108 and 423.462, Personal Choice 65 Medical-Only, as a Medicare Advantage Organization, will exercise the same rights of recovery that the Secretary exercises under CMS regulations in subparts B through D of part 411 of 42 CFR and the rules established in this section supersede any state laws.

Personal Choice 65 Medical-Only is subrogated to all your rights against any party legally liable to pay for your injury, illness, or medical expenses. This right includes, but is not limited to, your rights under uninsured and underinsured motorist coverage, any no-fault insurance, medical payment coverage (auto, homeowners, or otherwise), workers' compensation coverage, liability insurance, umbrella insurance, or any other form or type of insurance. Personal Choice 65 Medical-Only may assert this right independently of you. However, Personal Choice 65 Medical-Only is not obligated in any way to pursue this right independently or on behalf of you but may choose to pursue its rights to reimbursement from you under the plan, at its sole discretion. Personal Choice 65 Medical-Only subrogation/reimbursement right is the first priority, and the full amount of medical expenses that were paid by Personal Choice 65 Medical-Only must be repaid in full before funds are allotted toward any other form of damages, regardless of whether you are fully compensated for other damages.

In cases of occupational illness or injury, Personal Choice 65 Medical-Only's recovery rights shall apply to all sums recovered, regardless of whether the illness or injury is deemed compensable under any workers' compensation or other coverage. Any award or compromise settlement, including any lump-sum settlement, shall be deemed to include Personal Choice 65 Medical-Only's interest and Personal Choice 65 Medical-Only shall be reimbursed in first priority from any such award or settlement.

You or anyone acting legally on your behalf must:

- Fully cooperate with Personal Choice 65 Medical-Only to protect Personal Choice 65 Medical-Only's subrogation/reimbursement rights;
- Give notice of Personal Choice 65 Medical-Only's claim to third parties and their insurers who may be legally responsible;
- Provide Personal Choice 65 Medical-Only with relevant information, and sign and deliver such documents as Personal Choice 65 Medical-Only reasonably requests to secure Personal Choice 65 Medical-Only's subrogation/reimbursement claim; and
- Request Personal Choice 65 Medical-Only's consent before releasing any party from liability for medical expenses or services paid or provided.
- Fully reimburse Personal Choice 65 Medical-Only or its designated representative immediately upon receiving compensation from a third party, regardless of how the compensation is described or designated.

If you enter into litigation or settlement negotiations regarding the obligations of other parties, you must not prejudice, in any way, Personal Choice 65 Medical-Only's subrogation/reimbursement rights. In other words, you must not do anything or take any steps to jeopardize the recovery rights of Personal Choice 65 Medical-Only.

SECTION 6 Notice of Privacy Practices

Independence is committed to protecting the privacy of our members' personal health information. Part of that commitment is complying with the Privacy Rule of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), which requires us to take additional measures to protect personal information and to inform our members about those measures. The Notice of Privacy Practices describes how Independence may use and disclose a member's personal health information and how a member of an Independence health plan can get access to this information. For details on our practices, available privacy forms, and HIPAA requirements, please visit www.ibxmedicare.com/privacy. You can also call to request a copy of the Notice of Privacy Practices by contacting our Member Help Team.

CHAPTER 10:

Definitions of important words

Allowed Amount – The allowed amount is the maximum amount a plan will pay for a covered health care service. If your provider charges more than the plan's allowed amount, you may have to pay the difference.

Ambulatory Surgical Center – An Ambulatory Surgical Center is an entity that operates exclusively for the purpose of furnishing outpatient surgical services to patients not requiring hospitalization and whose expected stay in the center does not exceed 24 hours.

Annual Enrollment Period – The time period of October 15 until December 7 of each year when members can change their health or drug plans or switch to Original Medicare.

Appeal – An appeal is something you do if you disagree with our decision to deny a request for coverage of health care services or payment for services you already received. You may also make an appeal if you disagree with our decision to stop services that you are receiving.

Balance Billing – When a provider (such as a doctor or hospital) bills a patient more than the plan's allowed cost-sharing amount. As a member of Personal Choice 65 Medical-Only, you only have to pay our plan's cost-sharing amounts when you get services covered by our plan. We do not allow providers to *balance bill* or otherwise charge you more than the amount of cost-sharing your plan says you must pay.

Benefit Period – The way that both our plan and Original Medicare measures your use of hospital and skilled nursing facility (SNF) services. Our plan uses benefit periods for skilled nursing facility stays, but we do not use benefit periods to measure inpatient hospital stays. A benefit period begins the day you go into a hospital or skilled nursing facility. The benefit period ends when you have not received any inpatient hospital care (or skilled care in an SNF) for 60 days in a row. If you go into a hospital or a skilled nursing facility after one benefit period has ended, a new benefit period begins. There is no limit to the number of benefit periods.

Centers for Medicare & Medicaid Services (CMS) – The Federal agency that administers Medicare.

Coinsurance – An amount you may be required to pay, expressed as a percentage (for example 20%) as your share of the cost for services.

Colorectal screening – A series of cancer screening tests to help find precancerous growths or find cancer early when treatment is most effective.

Combined Maximum Out-of-Pocket Amount – This is the most you will pay in a year for all Part A and Part B services from both network (preferred) providers and out-of-network (non-preferred) providers. In addition to the maximum out-of-pocket amount for covered Part A and Part B medical services, we also have a maximum out-of-pocket amount for certain types of services. See Chapter 4, Section 1.2 for information about your combined maximum out-of-pocket amount.

Complaint – The formal name for *making a complaint* is *filing a grievance*. The complaint process is used *only* for certain types of problems. This includes problems related to quality of care, waiting times, and the customer service you receive. It also includes complaints if your plan does not follow the time periods in the appeal process.

Comprehensive Outpatient Rehabilitation Facility (CORF) – A facility that mainly provides rehabilitation services after an illness or injury, including physical therapy, social or psychological services, respiratory therapy, occupational therapy and speech-language pathology services, and home environment evaluation services.

Copayment (or copay) – An amount you may be required to pay as your share of the cost for a medical service or supply, like a doctor's visit, hospital outpatient visit, or a prescription. A copayment is a set amount (for example $10), rather than a percentage.

Cost-Sharing – Cost-sharing refers to amounts that a member has to pay when services are received. (This is in addition to the plan's monthly premium.) Cost-sharing includes any combination of the following three types of payments: (1) any deductible amount a plan may impose before services are covered; (2) any fixed *copayment* amount that a plan requires when a specific service is received; or (3) any *coinsurance* amount, a percentage of the total amount paid for a service, that a plan requires when a specific service is received.

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

Creditable Prescription Drug Coverage – Prescription drug coverage (for example, from an employer or union) that is expected to pay, on average, at least as much as Medicare's standard prescription drug coverage. People who have this kind of coverage when they become eligible for Medicare can generally keep that coverage without paying a penalty if they decide to enroll in Medicare prescription drug coverage later.

Custodial Care – Custodial care is personal care provided in a nursing home, hospice, in a home setting, other facility setting when you do not need skilled medical care or skilled nursing care. Custodial care provided by people who do not have professional skills or training includes help with activities of daily living like bathing, dressing, eating, getting in or out of a bed or chair, moving around, and using the bathroom. It may also include the kind of health-related care that most people do themselves, like using eye drops. Medicare doesn't pay for custodial care.

Deductible – The amount you must pay for health care before our plan pays.

Diagnostic Colonoscopy – If a colorectal screening test results in the biopsy or removal of a lesion or growth during the same visit, according to Medicare, the procedure is now considered diagnostic. There will be no copayment for that diagnostic test.

Disenroll or **Disenrollment** – The process of ending your membership in our plan.

Durable Medical Equipment (DME) – Certain medical equipment that is ordered by your doctor for medical reasons. Examples include: walkers, wheelchairs, crutches, powered mattress systems, diabetic supplies, IV infusion pumps, speech generating devices, oxygen equipment, nebulizers, or hospital beds ordered by a provider for use in the home.

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

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

Evidence of Coverage (EOC) and Disclosure Information – This document, along with your enrollment form and any other attachments, riders, or other optional coverage selected, which explains your coverage, what we must do, your rights, and what you have to do as a member of our plan.

"Extra Help" – A Medicare or a state program to help people with limited income and resources pay Medicare prescription drug program costs, such as premiums, deductibles, and coinsurance.

Grievance – A type of complaint you make about our plan or providers including a complaint concerning the quality of your care. This type of complaint does not involve coverage or payment disputes.

Home Health Aide – A person who provides services that do not need the skills of a licensed nurse or therapist, such as help with personal care (e.g., bathing, using the toilet, dressing, or carrying out the prescribed exercises).

Home Setting – A home setting is a location at which you primarily reside and receive certain health care services. Health care provided in a home setting can include care given by skilled medical professionals, including skilled nursing care, physical therapy, occupational therapy, and speech therapy. Custodial care, as defined in this document, can also be received in a home setting. Medicare does not cover custodial care provided in a home health care setting.

Homebound – To be homebound means that leaving your home is not recommended because of your condition; or, your condition keeps you from leaving home without help (such as using a wheelchair or walker, needing special transportation, or getting help from another person); or, leaving home takes a considerable and taxing effort. A person may leave home for medical treatment or short, infrequent absences for non-medical reasons, such as attending religious services. You can still get home health care if you attend adult day care, but you would get the home care services in your home.

Hospice – A benefit that provides special treatment for a member who has been medically certified as terminally ill, meaning having a life expectancy of 6 months or less. We, your plan, must provide you with a list of hospices in your geographic area. If you elect hospice and continue to pay premiums, you are still a member of our plan. You can still obtain all medically necessary services as well as the supplemental benefits we offer.

Hospital Inpatient Stay – A hospital stay when you have been formally admitted to the hospital for skilled medical services. Even if you stay in the hospital overnight, you might still be considered an *outpatient*.

Initial Enrollment Period – When you are first eligible for Medicare, the period of time when you can sign up for Medicare Part A and Part B. If you're eligible for Medicare when you turn 65, your Initial Enrollment Period is the 7-month period that begins 3 months before the month you turn 65, includes the month you turn 65, and ends 3 months after the month you turn 65.

In-Network Maximum Out-of-Pocket Amount – The most you will pay for covered Part A and Part B services received from network (preferred) providers. After you have reached this limit, you will not have to pay anything when you get covered services from network providers for the rest of the contract year. However, until you reach your combined out-of-pocket amount, you must continue to pay your share of the costs when you seek care from an out-of-network (non-preferred) provider. In addition to the maximum out-of-pocket amount for covered Part A and Part B medical services, we also have a maximum out-of-pocket amount for certain types of services.

Low Income Subsidy (LIS) – See "Extra Help."

Medicaid (or Medical Assistance) – A joint Federal and state program that helps with medical costs for some people with low incomes and limited resources. State Medicaid programs vary, but most health care costs are covered if you qualify for both Medicare and Medicaid.

Medically Necessary – Services, supplies, or drugs that are needed for the prevention, diagnosis, or treatment of your medical condition and meet accepted standards of medical practice.

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

Medicare Advantage Open Enrollment Period – The time period from January 1 until March 31 when members in a Medicare Advantage plan can cancel their plan enrollment and switch to another Medicare Advantage plan, or obtain coverage through Original Medicare. If you choose to switch to Original Medicare during this period, you can also join a separate Medicare prescription drug plan at that time. The Medicare Advantage Open Enrollment Period is also available for a 3-month period after an individual is first eligible for Medicare.

Medicare Advantage (MA) Plan – Sometimes called Medicare Part C. A plan offered by a private company that contracts with Medicare to provide you with all your Medicare Part A and Part B benefits. A Medicare Advantage Plan can be an i) HMO, a ii) PPO, a iii) Private Fee-for-Service (PFFS) plan, or a iv) Medicare Medical Savings Account (MSA) plan. Besides choosing from these types of plans, a Medicare Advantage HMO or PPO plan can also be a Special Needs Plan (SNP). In most cases, Medicare Advantage Plans also offer Medicare Part D (prescription drug coverage). These plans are called **Medicare Advantage Plans with Prescription Drug Coverage**.

Medicare-Covered Services – Services covered by Medicare Part A and Part B. All Medicare health plans must cover all of the services that are covered by Medicare Part A and B. The term Medicare-Covered Services does not include the extra benefits, such as vision, dental or hearing, that a Medicare Advantage plan may offer.

Medicare Health Plan – A Medicare health plan is offered by a private company that contracts with Medicare to provide Part A and Part B benefits to people with Medicare who enroll in the plan. This term includes all Medicare Advantage Plans, Medicare Cost Plans, Special Needs Plans, Demonstration/Pilot Programs, and Programs of All-inclusive Care for the Elderly (PACE).

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

Medigap (Medicare Supplement Insurance) Policy – Medicare supplement insurance sold by private insurance companies to fill **gaps** in Original Medicare. Medigap policies only work with Original Medicare. (A Medicare Advantage Plan is not a Medigap policy.)

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

Member Help Team – A department within our plan responsible for answering your questions about your membership, benefits, grievances, and appeals.

Network Provider – Provider is the general term for doctors, other health care professionals, hospitals, and other health care facilities that are licensed or certified by Medicare and by the State to provide health care services. **Network providers** have an agreement with our plan to accept our payment as payment in full, and in some cases to coordinate as well as provide covered services to members of our plan. Network providers are also called *plan providers*.

Organization Determination – A decision our plan makes about whether items or services are covered or how much you have to pay for covered items or services. Organization determinations are called *coverage decisions* in this document.

Original Medicare (Traditional Medicare or Fee-for-service Medicare) – Original Medicare is offered by the government, and not a private health plan like Medicare Advantage Plans and prescription drug plans. Under Original Medicare, Medicare services are covered by paying doctors, hospitals, and other health care providers payment amounts established by Congress. You can see any doctor, hospital, or other health care provider that accepts Medicare. You must pay the deductible. Medicare pays its share of the Medicare-approved amount, and you pay your share. Original Medicare has two parts: Part A (Hospital Insurance) and Part B (Medical Insurance) and is available everywhere in the United States.

Out-of-Network Provider or Out-of-Network Facility – A provider or facility that does not have a contract with our plan to coordinate or provide covered services to members of our plan. Out-of-network providers are providers that are not employed, owned, or operated by our plan.

Out-of-Pocket Costs – See the definition for *cost-sharing* above. A member's cost-sharing requirement to pay for a portion of services received is also referred to as the member's *out-of-pocket* cost requirement.

PACE plan – A PACE (Program of All-inclusive Care for the Elderly) plan combines medical, social, and long-term services and supports (LTSS) for frail people to help them stay independent and living in their community (instead of moving to a nursing home) as long as possible. People enrolled in PACE plans receive both their Medicare and Medicaid benefits through the plan.

Palliative Care – Palliative Care is care for adults with serious illness that focuses on relieving suffering and improving quality of life for patients and their families but is not intended to cure the disease itself.

Part C – see Medicare Advantage (MA) Plan.

Part D – The voluntary Medicare Prescription Drug Benefit Program.

Per Year – The term "per year" as used in this document refers to the period in which you have health care coverage and can obtain services covered under your plan. This period is between January 1, 2024, and December 31, 2024. This is also known as the "plan year," "contract year," "benefit year," or "coverage year."

Preferred Provider Organization (PPO) Plan – A Preferred Provider Organization plan is a Medicare Advantage Plan that has a network of contracted providers that have agreed to treat plan members for a specified payment amount. A PPO plan must cover all plan benefits whether they are received from network or out-of-network providers. Member cost-sharing will generally be higher when plan benefits are received from out-of-network providers. PPO plans have an annual limit on your out-of-pocket costs for services received from network (preferred) providers and a higher limit on your total combined out-of-pocket costs for services from both in-network (preferred) and out-of-network (non-preferred) providers.

Premium – The periodic payment to Medicare, an insurance company, or a health care plan for health or prescription drug coverage.

Primary Care Provider (PCP) – The doctor or other provider you see first for most health problems. In many Medicare health plans, you must see your primary care provider before you see any other health care provider.

Prior Authorization – Approval in advance to get covered services. In the network portion of a PPO, some in-network medical services are covered only if your doctor or other network provider gets *prior authorization* from our plan. In a PPO, you do not need prior authorization to obtain out-of-network services. However, you may want to check with the plan before obtaining services from out-of-network providers to confirm that the service is covered by your plan and what your cost-sharing responsibility is. Covered services that need prior authorization are marked in the Benefits Chart in Chapter 4.

Prosthetics and Orthotics – Medical devices including, but are not limited to: arm, back and neck braces; artificial limbs; artificial eyes; and devices needed to replace an internal body part or function, including ostomy supplies and enteral and parenteral nutrition therapy.

Quality Improvement Organization (QIO) – A group of practicing doctors and other health care experts paid by the Federal government to check and improve the care given to Medicare patients.

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

Respite Care – Temporary institutional care of a dependent elderly, ill, or handicapped person, which provides relief for their usual caregivers.

Retail Clinic – A type of walk-in clinic located in a supermarket, pharmacy, or retail store where members can receive preventive care or treatment for uncomplicated minor illnesses in a nonemergency setting.

Service Area – A geographic area where you must live to join a particular health plan. For plans that limit which doctors and hospitals you may use, it's also generally the area where you can get routine (non-emergency) services. The plan must disenroll you if you permanently move out of the plan's service area.

Skilled Nursing Facility (SNF) Care – Skilled nursing care and rehabilitation services provided on a continuous, daily basis, in a skilled nursing facility. Examples of care include physical therapy or intravenous injections that can only be given by a registered nurse or doctor.

Special Enrollment Period – A set time when members can change their health or drug plans or return to Original Medicare. Situations in which you may be eligible for a Special Enrollment Period include: if you move outside the service area, if you move into a nursing home, or if we violate our contract with you.

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

Urgently Needed Services – Covered services that are not emergency services, provided when the network providers are temporarily unavailable or inaccessible or when the enrollee is out of the service area. For example, you need immediate care during the weekend. Services must be immediately needed and medically necessary.

Website URL – The address of a resource (such as a document or website) on the Internet. URL stands for "uniform resource locator" or a "universal resource locator."

Form Approved
OMB# 0938-1421

Multi-Language Insert

Multi-language Interpreter Services

English: We have free interpreter services to answer any questions you may have about our health or drug plan. To get an interpreter, just call us at 1-800-275-2583. Someone who speaks English/Language can help you. This is a free service.

Spanish: Tenemos servicios de intérprete sin costo alguno para responder cualquier pregunta que pueda tener sobre nuestro plan de salud o medicamentos. Para hablar con un intérprete, por favor llame al 1-800-275-2583. Alguien que hable español le podrá ayudar. Este es un servicio gratuito.

Chinese Mandarin: 我们提供免费的翻译服务，帮助您解答关于健康或药物保险的任何疑 问。如果您需要此翻译服务，请致电 1-800-275-2583。我们的中文工作人员很乐意帮助您。 这是一项免费服务。

Chinese Cantonese: 您對我們的健康或藥物保險可能存有疑問，為此我們提供免費的翻譯 服務。如需翻譯服務，請致電 1-800-275-2583。我們講中文的人員將樂意為您提供幫助。這 是一項免費服務。

Tagalog: Mayroon kaming libreng serbisyo sa pagsasaling-wika upang masagot ang anumang mga katanungan ninyo hinggil sa aming planong pangkalusugan o panggamot. Upang makakuha ng tagasaling-wika, tawagan lamang kami sa 1-800-275-2583. Maaari kayong tulungan ng isang nakakapagsalita ng Tagalog. Ito ay libreng serbisyo.

French: Nous proposons des services gratuits d'interprétation pour répondre à toutes vos questions relatives à notre régime de santé ou d'assurance-médicaments. Pour accéder au service d'interprétation, il vous suffit de nous appeler au 1-800-275-2583. Un interlocuteur parlant Français pourra vous aider. Ce service est gratuit.

Vietnamese: Chúng tôi có dịch vụ thông dịch miễn phí để trả lời các câu hỏi về chương sức khỏe và chương trình thuốc men. Nếu quí vị cần thông dịch viên xin gọi 1-800-275-2583 sẽ có nhân viên nói tiếng Việt giúp đỡ quí vị. Đây là dịch vụ miễn phí .

German: Unser kostenloser Dolmetscherservice beantwortet Ihren Fragen zu unserem Gesundheits- und Arzneimittelplan. Unsere Dolmetscher erreichen Sie unter 1-800-275-2583. Man wird Ihnen dort auf Deutsch weiterhelfen. Dieser Service ist kostenlos.

Korean: 당사는 의료 보험 또는 약품 보험에 관한 질문에 답해 드리고자 무료 통역 서비스를 제공하고 있습니다. 통역 서비스를 이용하려면 전화 1-800-275-2583 번으로 문의해 주십시오. 한국어를 하는 담당자가 도와 드릴 것입니다. 이 서비스는 무료로 운영됩니다.

Russian: Если у вас возникнут вопросы относительно страхового или медикаментного плана, вы можете воспользоваться нашими бесплатными услугами переводчиков. Чтобы воспользоваться услугами переводчика, позвоните нам по телефону 1-800-275-2583. Вам окажет помощь сотрудник, который говорит по-русски. Данная услуга бесплатная.

Arabic: إننا نقدم خدمات المترجم الفوري المجانية للإجابة عن أي أسئلة تتعلق بالصحة أو جدول الأدوية لدينا. للحصول على مترجم فوري، ليس عليك سوى الاتصال بنا على 1-800-275-2583 . سيقوم شخص ما يتحدث العربية بمساعدتك. هذه خدمة مجانية.

Hindi: हमारे स्वास्थ्य या दवा की योजना के बारे में आपके किसी भी प्रश्न के जवाब देने के लिए हमारे पास मुफ्त दुभाषिया सेवाएँ उपलब्ध हैं. एक दुभाषिया प्राप्त करने के लिए, बस हमें 1-800-275-2583 पर फोन करें. कोई व्यक्ति जो हिन्दी बोलता है आपकी मदद कर सकता है. यह एक मुफ्त सेवा है.

Italian: È disponibile un servizio di interpretariato gratuito per rispondere a eventuali domande sul nostro piano sanitario e farmaceutico. Per un interprete, contattare il numero 1-800-275-2583. Un nostro incaricato che parla Italianovi fornirà l'assistenza necessaria. È un servizio gratuito.

Portuguese: Dispomos de serviços de interpretação gratuitos para responder a qualquer questão que tenha acerca do nosso plano de saúde ou de medicação. Para obter um intérprete, contacte-nos através do número 1-800-275-2583. Irá encontrar alguém que fale o idioma Português para o ajudar. Este serviço é gratuito.

French Creole: Nou genyen sèvis entèprèt gratis pou reponn tout kesyon ou ta genyen konsènan plan medikal oswa dwòg nou an. Pou jwenn yon entèprèt, jis rele nou nan 1-800-275-2583. Yon moun ki pale Kreyòl kapab ede w. Sa a se yon sèvis ki gratis.

Polish: Umożliwiamy bezpłatne skorzystanie z usług tłumacza ustnego, który pomoże w uzyskaniu odpowiedzi na temat planu zdrowotnego lub dawkowania leków. Aby skorzystać z pomocy tłumacza znającego język polski, należy zadzwonić pod numer 1-800-275-2583. Ta usługa jest bezpłatna.

Japanese: 当社の健康 健康保険と薬品 処方薬プランに関するご質問にお答えするために、無料の通訳サービスがありますございます。通訳をご用命になるには、1-800-275-2583 にお電話ください。日本語を話す人 者 が支援いたします。これは無料のサー ビスです。

Gujarati: અમારી આરોગ્ય અથવા દવા યોજના વિશે તમને હોય શકે તેવા કોઈપણ પ્રશ્નોના જવાબ આપવા માટે અમારી પાસે નિ:શુલ્ક દુભાષિયા સેવાઓ છે. દુભાષિયા મેળવવા માટે, અમને ફક્ત 1-800-275-2583 પર કૉલ કરો. ગુજરાતી બોલતી વ્યક્તિ તમને મદદ કરી શકે છે. આ એક નિ:શુલ્ક સેવા છે.

Urdu: آپ کی صحت یا دوا کے متعلق کسی بھی سوال کا جواب دینے کے لیے ہمارے پاس مفت ترجمانی کی خدمات دستیاب ہیں۔ مترجم کی سہولت کے لیے، 1-800-275-2583 پر کال کریں۔ اردو بولنے والا کوئی شخص آپ کی مدد کر سکتا ہے۔ یہ مفت سروس ہے۔

Khmer: យើងមានផ្តល់សេវាកម្មអ្នកបកប្រែផ្ទាល់មាត់ឥតគិតថ្លៃ ដើម្បីឆ្លើយសំណួរណា
មួយដែលអ្នកប្រហែលជាមានអំពីគម្រោងសុខភាព ឬឱសថរបស់យើង។ ដើម្បីទទួលបានអ្នកបកប្រែផ្ទាល់មាត់
គ្រាន់តែហៅទូរសព្ទមកយើងតាមលេខ 1-800-275-2583 ។
អ្នកណាម្នាក់ដែលនិយាយភាសាអ៊ូឌូអាចជួយអ្នកបាន។ នេះគឺជាសេវាកម្មឥតគិតថ្លៃ។

Telugu: మా ఆరోగ్యం లేదా ఔషధ ప్రణాళిక గురించి మీకు ఏవైనా ప్రశ్నలకు సమాధానం ఇవ్వడానికి మాకు ఉచిత ఇంటర్‌ప్రెటర్ సర్వీస్‌లు అందుబాటులో ఉన్నాయి. అనువాదకుడిని పొందడానికి, 1-800-275-2583 ద్వారా మాకు కాల్ చేయండి. తెలుగు మాట్లాడగలిగే ఎవరైనా మీకు సహాయం చేయగలరు. ఇది ఉచిత సర్వీస్.

Discrimination is Against the Law

This Plan complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. This Plan does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

This Plan provides:

- Free aids and services to people with disabilities to communicate effectively with us, such as: qualified sign language interpreters, and written information in other formats (large print, audio, accessible electronic formats, other formats).
- Free language services to people whose primary language is not English, such as: qualified interpreters and information written in other languages.

If you need these services, contact our Civil Rights Coordinator. If you believe that This Plan has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with our Civil Rights Coordinator.

You can file a grievance in the following ways:

- In person or by mail: ATTN: Civil Rights Coordinator, 1901 Market Street, Philadelphia, PA 19103
- By phone: 1-888-377-3933 (TTY: 711)
- By fax: 215-761-0245
- By email: civilrightscoordinator@1901market.com

If you need help filing a grievance, our Civil Rights Coordinator is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at *https://ocrportal.hhs.gov/ocr/portal/lobby.jsf* or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, 1-800-368-1019, 800-537-7697 (TDD). Complaint forms are available at *http://www.hhs.gov/ocr/office/file/index.html.*

Personal Choice 65 Medical-Only Member Help Team

Method	Member Help Team – Contact Information
CALL	1-888-718-3333 Calls to this number are free. 7 days a week, 8 a.m. to 8 p.m. Please note that on weekends and holidays from April 1 through September 30, your call may be sent to voicemail. Our Member Help Team also has free language interpreter services available for non-English speakers.
TTY/TDD	711 Calls to this number are free. Same hours as the phone number above.
FAX	1-888-289-3029 215-238-7960
WRITE	Personal Choice 65 Medical-Only PO Box 7799 Philadelphia, PA 19101-7799
WEBSITE	www.ibxmedicare.com

PA MEDI (Pennsylvania's SHIP)

PA MEDI is a state program that gets money from the Federal government to give free local health insurance counseling to people with Medicare.

Method	Contact Information
CALL	1-800-783-7067
WRITE	PA MEDI Commonwealth of Pennsylvania Department of Aging 555 Walnut Street, 5th Floor Harrisburg, PA 17101-1919
WEBSITE	www.aging.pa.gov/aging-services/medicare-counseling/Pages/default.aspx

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