



A nonprofit independent licensee of the Blue Cross Blue Shield Association

January 1 - December 31, 2025

Evidence of Coverage:

Your Medicare Health Benefits and Services as a Member of Medicare Blue Choice Freedom (HMO-POS)

This document gives you the details about your Medicare health care from January 1 – December 31, 2025. **This is an important legal document. Please keep it in a safe place.**

For questions about this document please contact Customer Care at 1-877-883-9577 for additional information. (TTY/TDD users should call 711. Hours are Monday - Friday, 8:00 a.m. - 8:00 p.m. Representatives are also available 8:00 a.m. - 8:00 p.m., Monday - Sunday, from October 1 -March 31.) This call is free.

This plan, Medicare Blue Choice Freedom (HMO-POS), is offered by Excellus BlueCross BlueShield. (When this Evidence of Coverage says "we," "us," or "our" it means Excellus BlueCross BlueShield. When it says "plan" or "our plan", it means Medicare Blue Choice Freedom (HMO-POS).)

This information is also available in braille, large print, or other alternate formats.

Benefits, premium and/or copayments/coinsurance may change on January 1, 2026.

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: August 31, 2026)

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CHAPTER 1

Getting started as a member

Chapter 1. Getting started as a member**SECTION 1 Introduction****Section 1.1 You are enrolled in Medicare Blue Choice Freedom (HMO-POS), which is a Medicare HMO Point-of-Service Plan**

You are covered by Medicare, and you have chosen to get your Medicare health care through our plan, Medicare Blue Choice Freedom (HMO-POS). 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.

Medicare Blue Choice Freedom (HMO-POS) is a Medicare Advantage HMO Plan (HMO stands for Health Maintenance Organization) with a Point-of-Service (POS) option approved by Medicare and run by a private company. Point-of-Service" means you can use providers outside the plan's network for an additional cost. (See Chapter 3, Section 2.4 for information about using the Point-of-Service option.)

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 and prescription drugs. 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 word coverage and covered services refers to the medical care and services and the prescription drugs available to you as a member of Medicare Blue Choice Freedom (HMO-POS).

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

If you are confused, concerned, or just have a question, please contact Customer Care.

Section 1.3 Legal information about the Evidence of Coverage

This Evidence of Coverage is part of our contract with you about how Medicare Blue Choice Freedom (HMO-POS) covers your care. Other parts of this contract include your enrollment form, the List of Covered Drugs (Formulary), 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 Medicare Blue Choice Freedom (HMO-POS) between January 1, 2025 and December 31, 2025.

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 Medicare Blue Choice Freedom (HMO-POS) after December 31, 2025. We can also choose to stop offering the plan in your service area, after December 31, 2025.

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Medicare (the Centers for Medicare & Medicaid Services) must approve Medicare Blue Choice Freedom (HMO-POS) 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 services 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 Medicare Blue Choice Freedom (HMO-POS)

Medicare Blue Choice Freedom (HMO-POS) 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 New York State: Livingston, Monroe, Ontario, Seneca, Yates, and Wayne.

If you plan to move out of the service area, you cannot remain a member of this plan. Please contact Customer Care 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 Medicare Blue Choice Freedom (HMO-POS) if you are not eligible to remain a member on this basis. Medicare Blue Choice Freedom (HMO-POS) 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 member card whenever you get any services covered by this plan and for prescription drugs you get at network pharmacies. You

Chapter 1. Getting started as a member

should also show the provider your Medicaid card, if applicable. Here's a sample membership card to show you what yours will look like:

		Medicare Blue Choice Freedom (HMO-POS)	
Group	00061500-XXX	Card Issued	XX/XX/XXXX
Issuer	(80840)	Benefits Effective	XX/XX/XXXX
Member ID	XXX xxxxxxxx		
Member Name	XXXXXXXX X XXXXXXXXXXX		
RxBIN	003858	PCP Copay	\$5
RxPCN	A4	Specialist Copay	\$35
RxGRP	EXLHPRX	Emergency Copay	\$110
Plan Code	302/802		
		CMS H3351-007	
		MEDICARE ADVANTAGE POS	

ExcellusMedicare.com	
Customer Care:	1-877-883-9577
TTY:	711
Prior Authorization:	1-800-926-2357
Dental Cust Care:	1-800-724-1675

Medicare limiting charges apply.

Non-Participating Provider Services are covered to the extent of your plan benefits or for urgent/emergency services.

Hospital or Physicians: File Claims with local BlueCross and/or BlueShield.

Submit Medical & Dental Claims to:
 Claims Department
 PO Box 21146
 Eagan, MN 55121

Member: If you are billed directly for services submit the claims to Excellus BlueCross BlueShield.

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

If your plan membership card is damaged, lost, or stolen, call Customer Care 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.

You must use network providers to get your medical care and services. If you go elsewhere without proper authorization, you will have to pay in full. The only exceptions are emergencies, urgently needed services when the network is not available (that is, in situations when it is unreasonable or not possible to obtain services in-network), out-of-area dialysis services, and cases in which Medicare Blue Choice Freedom (HMO-POS) authorizes use of out-of-network providers.

The Point of Service (POS) (out-of-network) benefit that comes with your plan covers medically necessary services you get from out-of-network providers. You are financially responsible for all services rendered by an out-of-network provider when plan rules are not followed. The POS benefit does not extend to all covered services. Please see the Benefit Chart for more information. There is a POS plan coverage limit. Once this limit is reached, you are responsible for 100% of the cost of out-of-network services.

The most recent list of providers is available on our website at www.ExcellusMedicare.com.

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If you would like a copy (electronically or in hardcopy form) of the Provider Directory, you can request a copy from Customer Care. Provider Directories will be mailed to you within three business days.

SECTION 4 Your monthly costs for Medicare Blue Choice Freedom (HMO-POS)

Your costs may include the following:

- Plan Premium (Section 4.1)
- Monthly Medicare Part B Premium (Section 4.2)

Medicare Part B differ for people with different incomes. If you have questions about these premiums review your copy of Medicare & You 2025 handbook, the section called "2025 Medicare Costs." If you need a copy, you can download it from the Medicare website (www.medicare.gov/medicare-and-you). 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/TDD users call 1-877-486-2048.

Section 4.1 Plan Premium

You do not pay a separate monthly plan premium for Medicare Blue Choice Freedom (HMO-POS).

Section 4.2 Monthly Medicare Part B Premium

Many members are required to pay other Medicare premiums

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.

In 2025, we will reduce the Part B premium that you pay to the Social Security Administration by \$35 per month. If you pay your Part B premium on a monthly basis, you will see this dollar amount credited in your Social Security check. If you pay your Part B premium quarterly, you will see an amount equaling three months of reductions credited on your quarterly Part B premium statement. It may take a few months to see these reductions credited to either your Social Security check or premium statement, but you will be reimbursed for any credits you did not receive during this waiting period.

SECTION 5 More information about your monthly premium

Section 5.1 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

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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 Customer Care.

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 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 insurance coverage that we know about. Please read over this information carefully. If it is correct, you don't need to do anything. If the information is incorrect, or if you have other coverage that is not listed, please call Customer Care. 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, and hospital.

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

- If you have retiree coverage, Medicare pays first.

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- 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*

Chapter 2. Important phone numbers and resources**SECTION 1 Medicare Blue Choice Freedom (HMO-POS) contacts (how to contact us, including how to reach Customer Care)****How to contact our plan's Customer Care**

For assistance with claims, billing, or member card questions, please call or write to Medicare Blue Choice Freedom (HMO-POS) Customer Care. We will be happy to help you.

Method	Customer Care – Contact Information
CALL	1-877-883-9577 Calls to this number are free. Hours are Monday - Friday, 8:00 a.m. - 8:00 p.m. Representatives are also available 8:00 a.m. - 8:00 p.m., Monday - Sunday, from October 1 -March 31. Customer Care also has free language interpreter services available for non-English speakers.
TTY/TDD	711 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free. Hours are Monday - Friday, 8:00 a.m. - 8:00 p.m. Representatives are also available 8:00 a.m. - 8:00 p.m., Monday - Sunday, from October 1 -March 31.
FAX	1-800-644-5840
WRITE	PO Box 211316, Eagan, MN 55121
WEBSITE	www.ExcellusMedicare.com

How to contact us when you are asking for a coverage decision or appeal 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. 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 9 (What to do if you have a problem or complaint (coverage decisions, appeals, complaints)).

Method	Coverage Decisions and Appeals for Medical Care– Contact Information
CALL	1-877-883-9577 Calls to this number are free. Hours are Monday - Friday, 8:00 a.m. - 8:00 p.m. Representatives are also available 8:00 a.m. - 8:00 p.m., Monday - Sunday, from October 1 -March 31. You may submit a request outside of regular weekday business hours and weekends by calling 1-877-444-5380.

Chapter 2. Important phone numbers and resources

Method	Coverage Decisions and Appeals for Medical Care– Contact Information
TTY/TDD	711 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free. Hours are Monday - Friday, 8:00 a.m. - 8:00 p.m. Representatives are also available 8:00 a.m. - 8:00 p.m., Monday - Sunday, from October 1 -March 31.
FAX	Medical Care: 1-877-203-9401
WRITE	Medical Care: Utilization Management, PO Box 21146 Eagan, MN 55121
WEBSITE	www.ExcellusMedicare.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 or network pharmacies, 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 9 (What to do if you have a problem or complaint (coverage decisions, appeals, complaints)).

Method	Complaints About Medical Care – Contact Information
CALL	1-877-883-9577 Calls to this number are free. Hours are Monday - Friday, 8:00 a.m. - 8:00 p.m. Representatives are also available 8:00 a.m. - 8:00 p.m., Monday - Sunday, from October 1 -March 31. You may submit a request outside of regular weekday business hours and weekends by calling 1-877-444-5380.
TTY/TDD	711 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free. Hours are Monday - Friday, 8:00 a.m. - 8:00 p.m. Representatives are also available 8:00 a.m. - 8:00 p.m., Monday - Sunday, from October 1 -March 31.
FAX	1-315-671-6656
WRITE	PO Box 4717, Syracuse, NY 13221
MEDICARE WEBSITE	You can submit a complaint about Medicare Blue Choice Freedom (HMO-POS) 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 7 (Asking us to pay our share of a bill you have received for covered medical services).

Chapter 2. Important phone numbers and resources

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

Method	Payment Requests for Medical Care Dental Services – Contact Information
CALL	<p>Medical: 1-877-883-9577</p> <p>Dental: 1-800-724-1675</p> <p>Calls to these numbers are free. Hours are: Monday - Friday, 8:00 a.m. - 8:00 p.m. Representatives are also available 8:00 a.m. - 8:00 p.m., Monday - Sunday, from October 1 -March 31.</p>
TTY/TDD	<p>711</p> <p>This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.</p> <p>Calls to this number are free. Hours are Monday - Friday, 8:00 a.m. - 8:00 p.m. Representatives are also available 8:00 a.m. - 8:00 p.m., Monday - Sunday, from October 1 -March 31.</p>
FAX	1-800-644-5840
WRITE	Medical and Dental: PO Box 21146, Eagan, MN 55121
WEBSITE	www.ExcellusMedicare.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	<p>1-800-MEDICARE, or 1-800-633-4227</p> <p>Calls to this number are free.</p> <p>24 hours a day, 7 days a week.</p>
TTY/TDD	<p>1-877-486-2048</p> <p>This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.</p> <p>Calls to this number are free.</p>

Chapter 2. Important phone numbers and resources

Method	Medicare – Contact Information (continued)
WEBSITE	<p data-bbox="354 254 618 285">www.Medicare.gov</p> <p data-bbox="354 306 1479 474">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.</p> <p data-bbox="354 495 1503 558">The Medicare website also has detailed information about your Medicare eligibility and enrollment options with the following tools:</p> <ul data-bbox="402 579 1511 768" style="list-style-type: none"> • Medicare Eligibility Tool: Provides Medicare eligibility status information. • Medicare Plan Finder: Provides personalized information about available Medicare health plans, and Medigap (Medicare Supplement Insurance) policies in your area. These tools provide an <i>estimate</i> of what your out-of-pocket costs might be in different Medicare plans. <p data-bbox="354 789 1438 852">You can also use the website to tell Medicare about any complaints you have about Medicare Blue Choice Freedom (HMO-POS):</p> <ul data-bbox="402 873 1520 1041" style="list-style-type: none"> • Tell Medicare about your complaint: You can submit a complaint about Medicare Blue Choice Freedom (HMO-POS) 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. <p data-bbox="354 1062 1479 1255">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/TDD users should call 1-877-486-2048.)</p>

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 New York, the SHIP is called New York State Health Insurance Information, Counseling and Assistance Program (HIICAP).

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

HIICAP 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. HIICAP 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)

Chapter 2. Important phone numbers and resources

- Select your **STATE** from the list. This will take you to a page with phone numbers and resources specific to your state.

Method	New York State Health Insurance Information, Counseling and Assistance Program (HIICAP) - Contact Information
CALL	1-800-701-0501
WRITE	New York State Office for the Aging, 2 Empire State Plaza, Albany, NY 12223-1251
WEBSITE	https://aging.ny.gov/health-insurance-information-counseling-and-assistance-program-hiicap

SECTION 4 Quality Improvement Organization

There is a designated Quality Improvement Organization for serving Medicare beneficiaries in each state. For New York, the Quality Improvement Organization is called Livanta BFCC-QIO Program.

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 BFCC-QIO Program (New York State's Quality Improvement Organization) - Contact Information
CALL	1-866-815-5440
TTY/TDD	1-866-868-2289 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.
WRITE	10820 Guilford Road, Suite 202, Annapolis Junction, MD 20701
WEBSITE	livantaqio.com/en/states/new_york

SECTION 5 Social Security

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

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

Chapter 2. Important phone numbers and resources

Method	Social Security – Contact Information
CALL	1-800-772-1213 Calls to this number are free. Available 8:00 am to 7:00 pm, 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/TDD	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 8:00 am to 7:00 pm, 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 Medicaid in New York State.

Method	Medicaid (New York State’s Medicaid program) – Contact Information
CALL	1-800-541-2831
WRITE	New York State Department of Health, Corning Tower, Empire State Plaza, Albany, NY 12237
WEBSITE	www.health.ny.gov/health_care/medicaid/

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 have questions regarding your benefits from the Railroad Retirement Board, contact the agency.

Chapter 2. Important phone numbers and resources

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.

Method	Railroad Retirement Board – Contact Information
CALL	<p>1-877-772-5772</p> <p>Calls to this number are free.</p> <p>If you press “0,” you may speak with an RRB representative from 9:00 am to 3:30 pm, Monday, Tuesday, Thursday, and Friday, and from 9:00 am to 12:00 pm on Wednesday.</p> <p>If you press “1”, you may access the automated RRB HelpLine and recorded information 24 hours a day, including weekends and holidays.</p>
TTY/TDD	<p>1-312-751-4701</p> <p>This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.</p> <p>Calls to this number are <i>not</i> free.</p>
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 Customer Care 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 Customer Care are printed on the back page of this document.) You may also call 1-800-MEDICARE (1-800-633-4227; TTY/TDD: 1-877-486-2048) with questions related to your Medicare coverage under this plan.

If you have other prescription drug coverage through your (or your spouse’s) employer or retiree group, please contact **that group’s benefits administrator**. The benefits administrator can help you determine how your current prescription drug coverage will work with our plan.

CHAPTER 3

*Using the plan's coverage
for your medical services*

Chapter 3. Using the plan's coverage for your medical services**SECTION 1 Things to know about getting your medical care as a member of our plan**

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

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

Section 1.1 What are network providers and covered services?

- **Providers** are doctors and other health care professionals licensed by the state to provide medical services and care. The term providers also includes hospitals and other health care facilities.
- **Network providers** are the doctors and other health care professionals, medical groups, hospitals, and other health care facilities that have an agreement with us to accept our payment and your cost sharing amount as payment in full. We have arranged for these providers to deliver covered services to members in our plan. The providers in our network bill us directly for care they give you. When you see a network provider, you pay only your share of the cost for their services.
- **Covered services** include all the medical care, health care services, supplies, and equipment that are covered by our plan. 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, Medicare Blue Choice Freedom (HMO-POS) must cover all services covered by Original Medicare and must follow Original Medicare's coverage rules.

Medicare Blue Choice Freedom (HMO-POS) will generally cover your medical care as long as:

- **The care you receive is included in the plan's Medical Benefits Chart** (this chart is in Chapter 4 of this document).
- **The care you receive is considered medically necessary.** Medically necessary means that the services, supplies, equipment, or drugs are needed for the prevention, diagnosis, or treatment of your medical condition and meet accepted standards of medical practice.
- **You have a network primary care provider (a PCP) who is providing and overseeing your care.** As a member of our plan, you must choose a network PCP (for more information about this, see Section 2.1 in this chapter).
- **You must receive your care from a network provider** (for more information about this, see Section 2 in this chapter). In most cases, care you receive from an out-of-network provider (a provider who is not part of our plan's network) will not be covered. This means that you will have to pay the provider in full for the services furnished. Here are four exceptions:

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- The plan covers emergency care or urgently needed services that you get from an out-of-network provider. For more information about this, and to see what emergency or urgently needed services means, see Section 2 in this chapter.
- If you need medical care that Medicare requires our plan to cover but there are no specialists in our network that provide this care, you can get this care from an out-of-network provider at the same cost sharing you normally pay in-network. Your provider would need to obtain an authorization from the plan for this. In this situation, you will pay the same as you would pay if you got the care from a network provider. For information about getting approval to see an out-of-network doctor, see Section 2.4 in this chapter.
- The plan covers kidney dialysis services that you get at a Medicare-certified dialysis facility when you are temporarily outside the plan's service area or when your provider for this service is temporarily unavailable or inaccessible. The cost sharing you pay the plan for dialysis can never exceed the cost sharing in Original Medicare. If you are outside the plan's service area and obtain the dialysis from a provider that is outside the plan's network, your cost sharing cannot exceed the cost sharing you pay in-network. However, if your usual in-network provider for dialysis is temporarily unavailable and you choose to obtain services inside the service area from a provider outside the plan's network the cost sharing for the dialysis may be higher.
- As a member of Medicare Blue Choice Freedom (HMO-POS), you may obtain services from an out-of-network provider. Doing so may result in a higher cost share and the POS benefit does not extend to all covered services. Please see the benefits chart located in Chapter 4. The plan's annual limit is \$3,000. Costs in excess of this limit are the responsibility for the member. You are financially responsible for all services rendered by an out-of-network provider when plan rules are not followed.

SECTION 2 Use providers in the plan's network to get your medical care**Section 2.1 You must choose a Primary Care Provider (PCP) to provide and oversee your medical care**

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

When you become a member of our plan, you must choose a network provider to be your PCP. Primary care providers are generally family practice, general practice, geriatric medicine or internal medicine doctors. They are trained to give you routine or basic medical care and help arrange or coordinate other covered services you get as a member of our plan (like obtaining an x-ray or lab tests).

"Coordinating" your services includes checking or consulting with other plan providers about your care and how it is going. If you need certain types of covered services or supplies, you must get approval in advance from your PCP. In some cases, your PCP will need to get prior authorization (prior approval) from us. Since your PCP will provide and coordinate your medical care, you should have all your past medical records sent to your PCP's office. Chapter 6 tells you how we will protect the privacy of your medical records and personal health information.

Chapter 3. Using the plan's coverage for your medical services

You will usually see your PCP first for most of your routine health care needs. There are only a few types of covered services you may get on your own, without contacting your PCP first, as we explain below.

How do you choose your PCP?

When you completed your enrollment application, you were asked to select a network PCP. If you have not chosen a PCP, please visit our website, check your Provider/Pharmacy Directory, or call Customer Care. If there is a particular plan specialist or hospital that you want to use, check first to be sure your PCP refers patients to that specialist or uses that hospital. If you do not select a PCP, a participating network provider in your area will be assigned to your membership record.

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.

To change your PCP, call Customer Care. When you call, be sure to tell Customer Care if you are seeing specialists or getting other covered services that need your PCP's approval (such as home health services and durable medical equipment). Customer Care will help make sure that you can continue with the specialty care and other services you have been getting when you change your PCP. They will also check to be sure the PCP you want to switch to is accepting new patients. Customer Care will change your membership record to show the name of your new PCP and discuss with you when the change to your new PCP will take effect.

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

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

- Routine women's health care, which includes breast exams, screening mammograms (x-rays of the breast), Pap tests, and pelvic exams as long as you get them from a network provider.
- Flu shots (or vaccines), Covid-19 vaccinations, Hepatitis B vaccinations, and pneumonia vaccinations as long as you get them from a network provider.
- Emergency services from network providers or from out-of-network providers.
- Urgently needed plan-covered services, which are services requiring immediate medical attention that are not emergencies, provided you are temporarily outside the service area of the plan, or it is unreasonable given your time, place, and circumstances to obtain this service from network providers with whom the plan contracts. Examples of urgently needed services are unforeseen medical illnesses and injuries or unexpected flare-ups of existing conditions. However, medically necessary routine provider visits, such as annual checkups, are not considered urgently needed even if you are outside the service area of the plan or the plan network is temporarily unavailable.
- Kidney dialysis services that you get at a Medicare-certified dialysis facility when you are temporarily outside the plan's service area. If possible, please call Customer Care before you leave the service area so we can help arrange for you to have maintenance dialysis while you are away.

Chapter 3. Using the plan's coverage for your medical services

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.

What is the role (if any) of the PCP in referring members to specialists and other providers?

- Your provider may have a preference when it comes to specialists or facilities to coordinate care with. It's important to ask if they are affiliated with the hospital or facility you are seeking care at. If they are not affiliated, they may not be able to provide services to you while you are under another facilities care.
- You are not required to get referrals from your PCP to see network specialists.
- For some types of services, your PCP may need to get approval in advance from our plan (this is called getting "prior authorization"). See Chapter 4 Section 2.1 for services that require prior authorization.
- Remember you may get care from out-of-network providers without approval in advance. However, if you use out-of-network providers for care that isn't emergency care or urgently needed care, you will have to pay higher cost sharing.

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 currently 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.

Chapter 3. Using the plan's coverage for your medical services

- 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.
- 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 care grievance to the plan, or both. Please see Chapter 7.

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

The point-of-service (POS) (out-of-network) benefit that comes with your plan covers medically necessary services you receive from out-of-network providers. You will pay lower out-of-pocket costs when using network providers. You will pay more when you use out-of-network providers through your POS benefit, except in limited cases such as out-of-network dialysis, emergency care or urgently needed care, or services when our network is not available. The POS benefit for out-of-network covered services is 30% coinsurance. This 30% coinsurance is a percentage of the amount allowed by Original Medicare for the service. Please see the Benefits Chart for details.

There is a POS plan coverage limit of \$3,000 per calendar year. Once this limit is reached, you are responsible for 100% of the cost of out-of-network services. Having a POS benefit does not mean that all services are automatically covered out of the network. This POS benefit only allows the member to seek medically necessary, covered services from an out-of-network provider. All plan rules must still be followed for out-of-network services to be covered. When the plan rules are not followed, the member will be responsible for all costs. The POS benefit does not extend to all covered services. POS copayments and coinsurance do not count towards your out-of-pocket maximum costs. Please see the Benefit Chart in Chapter 4, Section 2.1 for more information.

If you need medical care that Medicare requires our plan to cover but there are no specialists in our network that provide this care, you can get this care from an out-of-network provider at the same cost-sharing you normally pay in-network. Your provider would need to obtain an authorization from the plan for this. In this situation, we will cover these services as if you got the care from a network provider.

Note: members are entitled to receive services from out-of-network providers for emergency or urgently needed services. In addition, plans must cover dialysis services for ESRD members who have traveled outside the plans service area and are not able to access contracted ESRD providers.

Chapter 3. Using the plan's coverage for your medical services**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 worldwide, and from any provider with an appropriate license even if they are not part of our network.
- **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 can be found on the back of your membership 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 be decided when your condition is stable and the medical emergency is over.

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

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

What if it wasn't a medical emergency?

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

However, after the doctor has said that it was not an emergency, we will cover additional care only if you get the additional care in one of these two ways:

- You go to a network provider to get the additional care.

Chapter 3. Using the plan's coverage for your medical services

- or – The additional care you get is considered urgently needed services and you follow the rules for getting this urgently needed services (for more information about this, see Section 3.2 below).

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

What are urgently needed services?

A plan-covered service requiring immediate medical attention that is not an emergency is an urgently needed service if either you are temporarily outside the service area of the plan, or it is unreasonable given your time, place, and circumstances to obtain this service from network providers with whom the plan contracts. Examples of urgently needed services are unforeseen medical illnesses and injuries, or unexpected flare-ups of existing conditions. However, medically necessary routine provider visits, such as annual checkups, are not considered urgently needed even if you are outside the service area of the plan or the plan network is temporarily unavailable.

If you are in the plan's service area when you have an urgent need for care you must call your primary care physician or go to an urgent care center.

Our plan covers worldwide emergency and urgent care services outside the United States under the following circumstances: the member needs emergency medical care which includes a visit to the Emergency Room or Urgent Care Facility for symptoms that require immediate medical attention. For more information, see the Medical Benefits Chart in Chapter 4 of this document.

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.health.ny.gov/environmental/emergency/ 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

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

Chapter 3. Using the plan's coverage for your medical 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. These costs will not count towards your out-of-pocket maximum.

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

Section 5.1 What is a clinical research study?

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

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

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

If you want to participate in any Medicare-approved clinical research study, you do not need to tell us or to get approval from us or your PCP. The providers that deliver your care as part of the clinical research study do not need to be part of our plan's network of providers. 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 requiring coverage with evidence development (NCSs-CED) and investigational exemption device (IDE) studies and (NCDs) 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.

Chapter 3. Using the plan's coverage for your medical services

- 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 7 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.
- Items and services customarily provided by the research sponsors free-of-charge for any enrollee in the trial.

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/TDD 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

Chapter 3. Using the plan's coverage for your medical services

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 coverage limits may apply. Refer to the benefits chart in Chapter 4 for more information on the Inpatient Hospital benefit.

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 Medicare Blue Choice Freedom (HMO-POS), 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 Customer Care for more information.

Chapter 3. Using the plan's coverage for your medical services**What happens to payments you have 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

If you qualify for Medicare oxygen equipment coverage Medicare Blue Choice Freedom (HMO-POS) 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 Medicare Blue Choice Freedom (HMO-POS) 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)*

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

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

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

Because you are enrolled in a Medicare Advantage Plan, there is a limit on the total amount you have to pay out of pocket each year for in-network medical services that are covered by our plan. This limit is called the maximum out of pocket amount for medical services. For calendar year 2025 this amount is \$4,500.

The amounts you pay for copayments and coinsurance for in-network covered services count toward this maximum out of pocket amount. The amounts you pay for your plan premiums. In addition, amounts you pay for some services do not count toward your maximum out of pocket amount. These services are marked with an asterisk in the Medical Benefits Chart. If you reach the maximum out of pocket amount of \$4,500, you will not have to pay any out of pocket costs for the rest of the year for in-network covered Part A and 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 does not allow providers to balance bill you

As a member of Medicare Blue Choice Freedom (HMO-POS), 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.

Chapter 4. Medical Benefits Chart (what is covered and what you pay)

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

SECTION 2 Use the Medical Benefits Chart to find out what is covered for you 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 Medicare Blue Choice Freedom (HMO-POS) 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, or supplies are needed for the prevention, diagnosis, or treatment of your medical condition and meet accepted standards of medical practice.
- For new enrollees, your MA coordinated care plan must provide a minimum 90-day transition period, during which time the new MA plan may not require prior authorization for any active course of treatment, even if the course of treatment was for a service that commenced with an out-of-network provider.
- You receive your care from a network provider. In most cases, care you receive from an out of network provider will not be covered, unless it is emergent or urgent care or unless your plan or a network provider has given you a referral. This means that you will have to pay the provider in full for the services furnished.

Chapter 4. Medical Benefits Chart (what is covered and what you pay)

- You have a primary care provider (a PCP) who is providing and overseeing your care.
- Some of the services listed in the Medical Benefits Chart are covered only if your doctor or other network provider gets approval in advance (sometimes called “prior authorization”) from us. Covered services that need approval in advance are marked in the Medical Benefits Chart in bold.

Other important things to know about our coverage:


- Like all Medicare health plans, we cover everything that Original Medicare covers. For some of these benefits, you pay more in our plan than you would in Original Medicare. For others, you pay less. (If you want to know more about the coverage and costs of Original Medicare, look in your Medicare & You 2025 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/TDD users should call 1-877-486-2048.)
- For all preventive services that are covered at no cost under Original Medicare, we also cover the service at no cost to you. However, if you also are treated or monitored for an existing medical condition during the visit when you receive the preventive service, a copayment will apply for the care received for the existing medical condition.
- If Medicare adds coverage for any new services during 2025, either Medicare or our plan will cover those services.



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

* You will see this symbol next to a service that does not apply to the Maximum Out of pocket amount.

Medical Benefits Chart

Services that are covered for you	What you must pay when you get these services
<p>24/7 Nurse Call Line (Remote Access Technology) You can contact a nurse by phone anytime – 24 hours a day, seven days a week by calling 1-800-348-9786 (TTY/TDD 1-800-662-1220).</p> <p>Our specially trained registered nurses can provide support and education for members with chronic or complex health conditions or answers to more general health questions.</p> <p>The information provided through the 24/7 Nurse Call Line is intended to help educate, not to replace the advice of a medical professional. If you are experiencing severe symptoms such as sharp pains, fever, or any other immediate medical concern, dial 911 or contact a physician directly.</p>	<p>There is no cost for this service.</p>
<p> Abdominal aortic aneurysm screening</p> <p>A one-time screening ultrasound for people at risk. The plan only covers this screening if you have certain risk factors and if you get a referral for it from your physician, physician assistant, nurse practitioner, or clinical nurse specialist.</p>	<p>In-network: There is no coinsurance, copayment, or deductible for beneficiaries eligible for this preventive screening.</p> <p>When services other than preventive are performed, the cost share (copayment/coinsurance) associated with the other service will apply.</p> <p>Out-of-network (POS): 30% coinsurance per visit. The plan will reimburse a maximum of \$3,000 for out-of-network (POS) services per calendar year.</p>


Chapter 4. Medical Benefits Chart (what is covered and what you pay)

Services that are covered for you	What you must pay when you get these services
<p>Acupuncture for chronic low back pain</p> <p>Covered services include:</p> <p>Up to 12 visits in 90 days are covered for Medicare beneficiaries under the following circumstances:</p> <p>For the purpose of this benefit, chronic low back pain is defined as:</p> <ul style="list-style-type: none"> • lasting 12 weeks or longer. • nonspecific, in that it has no identifiable systemic cause (i.e., not associated with metastatic, inflammatory, infectious, etc. disease); • not associated with surgery; and • not associated with pregnancy. <p>An additional 8 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.</p>	<p>In-network: 50% coinsurance per visit.</p> <p>Out-of-network (POS): Not covered.</p>



Chapter 4. Medical Benefits Chart (what is covered and what you pay)

Services that are covered for you	What you must pay when you get these services
<p>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.</p> <p>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:</p> <ul style="list-style-type: none"> • 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, • 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. <p>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.</p>	
<p>We cover an additional 10 visits per calendar year for all other diagnosis.</p>	<p>In-network: 50% coinsurance per visit.</p> <p>Out-of-network (POS): Not covered.</p>



Chapter 4. Medical Benefits Chart (what is covered and what you pay)

Services that are covered for you	What you must pay when you get these services
<p>Ambulance services</p> <ul style="list-style-type: none"> 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 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. Non-emergency transportation by ambulance is appropriate if it is documented that the member's condition is such that other means of transportation could endanger the person's health and that transportation by ambulance is medically required. 	<p>In-network and Out-of-network: \$150 copayment for each separate Medicare-covered ambulance service.</p> <p>Prior authorization is required for some services by your doctor or other network provider.</p> <p>The copayment is not waived even if you are admitted to a hospital as an inpatient immediately following the ambulance transport.</p>
<p> Annual physical exam</p> <p>Members are entitled to one annual physical exam per calendar year performed by a primary care physician. The exam will be comprehensive, focusing on key areas such as the eyes, ears, nose, and throat, cardiovascular, respiratory, gastrointestinal and musculoskeletal systems. In addition to a direct exam, the physical exam covers four areas: medication history, social history, review of symptoms and past medical history.</p>	<p>In-network: There is no coinsurance, copayment, or deductible for the annual physical exam.</p> <p>Certain services rendered during a routine exam may take a copayment/ coinsurance, for example, a diagnostic test. When services other than preventive are performed, the cost share (copayment/ coinsurance) associated with the other service will apply.</p> <p>Out-of-network (POS): Not covered.</p>



Chapter 4. Medical Benefits Chart (what is covered and what you pay)

Services that are covered for you	What you must pay when you get these services
<p> Annual wellness visit</p> <p>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.</p> <p>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.</p>	<p>In-network: There is no coinsurance, copayment, or deductible for the annual wellness visit.</p> <p>Certain services rendered during a wellness visit may take a copayment/ coinsurance, for example, a diagnostic test. When services other than preventive are performed, the cost share (copayment/ coinsurance) associated with the other service will apply.</p> <p>Out-of-network (POS): 30% coinsurance per visit. The plan will reimburse a maximum of \$3,000 for out-of-network (POS) services per calendar year.</p>
<p> Bone mass measurement</p> <p>For qualified individuals (generally, this means people at risk of losing bone mass or at risk of osteoporosis), the following services are covered every 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.</p>	<p>In-network: There is no coinsurance, copayment, or deductible for Medicare-covered bone mass measurement.</p> <p>When services other than preventive are performed, the cost share (copayment/ coinsurance) associated with the other service will apply.</p> <p>Out-of-network (POS): 30% coinsurance per visit. The plan will reimburse a maximum of \$3,000 for out-of-network (POS) services per calendar year.</p>


Chapter 4. Medical Benefits Chart (what is covered and what you pay)

Services that are covered for you	What you must pay when you get these services
<p> Breast cancer screening (mammograms)</p> <p>Covered services include:</p> <ul style="list-style-type: none"> • One baseline mammogram between the ages of 35 and 39 • One screening mammogram every 12 months for members aged 40 and older • Clinical breast exams once every 24 months 	<p>In-network: There is no coinsurance, copayment, or deductible for covered screening mammograms.</p> <p>Additional testing may require an x-ray copayment.</p> <p>When services other than preventive are performed, the cost share (copayment/coinsurance) associated with the other service will apply.</p> <p>Out-of-network (POS): 30% coinsurance per visit. The plan will reimburse a maximum of \$3,000 for out-of-network (POS) services per calendar year.</p>
<p>Cardiac rehabilitation services</p> <p>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.</p>	<p>In-Network: \$0 copayment per Medicare-covered cardiac rehabilitation visit.</p> <p>Out-of-network (POS): 30% coinsurance per visit. The plan will reimburse a maximum of \$3,000 for out-of-network (POS) services per calendar year.</p>
<p> Cardiovascular disease risk reduction visit (therapy for cardiovascular disease)</p> <p>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.</p>	<p>In-network: There is no coinsurance, copayment, or deductible for the intensive behavioral therapy cardiovascular disease preventive benefit.</p> <p>When services other than preventive are performed, the cost share (copayment/coinsurance) associated with the other service will apply.</p> <p>Out-of-network (POS): 30% coinsurance per visit. The plan will reimburse a maximum of \$3,000 for out-of-network (POS) services per calendar year.</p>

Chapter 4. Medical Benefits Chart (what is covered and what you pay)

Services that are covered for you	What you must pay when you get these services
<p> Cardiovascular disease testing</p> <p>Blood tests for the detection of cardiovascular disease (or abnormalities associated with an elevated risk of cardiovascular disease) once every 5 years (60 months).</p>	<p>In-network: There is no coinsurance, copayment, or deductible for cardiovascular disease testing that is covered once every 5 years.</p> <p>When services other than preventive are performed, the cost share (copayment/coinsurance) associated with the other service will apply.</p> <p>Out-of-network (POS): 30% coinsurance per visit. The plan will reimburse a maximum of \$3,000 for out-of-network (POS) services per calendar year.</p>
<p> Cervical and vaginal cancer screening</p> <p>Covered services include:</p> <ul style="list-style-type: none"> • 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 	<p>In-network: There is no coinsurance, copayment, or deductible for Medicare-covered preventive Pap and pelvic exams.</p> <p>When services other than preventive are performed, the cost share (copayment/coinsurance) associated with the other service will apply.</p> <p>Out-of-network (POS): 30% coinsurance per visit. The plan will reimburse a maximum of \$3,000 for out-of-network (POS) services per calendar year.</p>
<p>Chiropractic services</p> <p>Covered services include:</p> <ul style="list-style-type: none"> • We cover only manual manipulation of the spine to correct subluxation 	<p>In-network: \$15 copayment per Medicare-covered visit.</p> <p>Out-of-network (POS): 30% coinsurance per visit. The plan will reimburse a maximum of \$3,000 for out-of-network (POS) services per calendar year.</p>

Chapter 4. Medical Benefits Chart (what is covered and what you pay)

Services that are covered for you	What you must pay when you get these services
<p data-bbox="142 296 175 327"></p> <p data-bbox="207 296 652 331">Colorectal cancer screening</p> <p data-bbox="207 359 808 394">The following screening tests are covered:</p> <ul data-bbox="207 415 841 1921" style="list-style-type: none"> <li data-bbox="207 415 841 793">• 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. <li data-bbox="207 814 841 1081">• 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. <li data-bbox="207 1102 841 1207">• Screening fecal-occult blood tests for patients 45 years and older. Once every 12 months. <li data-bbox="207 1228 841 1333">• Multitarget stool DNA for patients 45 to 85 years of age and not meeting high-risk criteria. Once every 3 years. <li data-bbox="207 1354 841 1459">• Blood-based Biomarker Tests for patients 45 to 85 years of age and not meeting high-risk criteria. Once every 3 years. <li data-bbox="207 1480 841 1669">• 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 <li data-bbox="207 1690 841 1921">• 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. 	<p data-bbox="873 352 1474 472">In-network: There is no coinsurance, copayment, or deductible for a Medicare-covered colorectal cancer screening exam.</p> <p data-bbox="873 493 1490 646">Out-of-network (POS): 30% coinsurance per visit. The plan will reimburse a maximum of \$3,000 for out-of-network (POS) services per calendar year.</p> <p data-bbox="873 667 1448 823">When services other than preventive are performed, the cost share (copayment/coinsurance) associated with the other service will apply.</p>

Chapter 4. Medical Benefits Chart (what is covered and what you pay)

Services that are covered for you	What you must pay when you get these services
<p>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.</p> <ul style="list-style-type: none">• Cologuard test- covered once every 3 years for people ages 50 to 85. Must be asymptomatic and at average risk of developing colorectal cancer.	

Chapter 4. Medical Benefits Chart (what is covered and what you pay)

Services that are covered for you	What you must pay when you get these services
<p>Dental services</p> <p>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:</p> <p>Routine Preventive Dental:</p> <ul style="list-style-type: none"> • Oral Exams – twice per calendar year. • Routine Cleanings - twice per calendar year. • X-rays (bitewings) – twice per calendar year (not to exceed maximum of four per year). • X-rays (full mouth or panorax) – once every 36 months. <p>Coverage for routine preventive dental care is limited to these procedure codes: D1110, D0120, D0140, D0150, D9110, D0270, D0272, D0273, D0274, D0210, D0330, D0220, D0230, D0240, D0250, D0251, D0277, D0310, D0350</p> <p>Comprehensive Dental: We will pay costs for covered dental services for the calendar year until you reach the maximum plan benefit coverage amount of \$1,000 for in & out-of-network covered dental services.</p> <p>Once this maximum benefit amount is reached, you are responsible for 100% of the cost of in & out-of-network dental services and dental providers may balance bill you if charges are above the allowed</p>	<p>In-network: \$0 copayment for each visit for covered routine dental services when provided by an in-network provider.</p> <p>Out-of-Network: When services are received from an out-of-network provider, your plan will pay 100% of the allowance or dentist's charges, whichever is less. You are responsible for balances up to the dentist's charge. When you receive preventive dental services, you are responsible for making payment to your dentist and filing a claim with us to be reimbursed for these costs. If you have any questions about what to pay a provider or where to send a paper claim you may call Customer Care (phone number for Dental Customer Care is in Chapter 2, Section 1)</p> <p>In and Out of network: \$1,000 annual allowance for covered dental services per calendar year.</p>

Chapter 4. Medical Benefits Chart (what is covered and what you pay)

Services that are covered for you	What you must pay when you get these services
<p>amount. The maximum plan benefit coverage amount does not apply to routine preventive dental services.</p> <p>Limited to specific dental codes (exclusions apply) and limitations may apply on the number of covered services within a service category. Limitations to services may apply. We do not reimburse dentists for charges above the allowed amount. An in-network dentist will not charge you for any balances for covered services. Out-of-network dentists, however, may bill you for any balances over the allowed amount. When you receive services from an out-of-network provider, you are responsible for making payment to your dentist and filing a claim with us. You must submit your dental claim to us within 12 months from the date of service.</p> <p>Restorative</p> <ul style="list-style-type: none"> • Amalgam Restorations (once per tooth every 12 months) • Resin Filling (once per tooth every 12 months) • Composite Restorations (once per tooth every 12 months) <p>Coverage for restorative care is limited to these procedure codes: D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394, D2940, D2951, D2990</p> <p>Periodontics</p> <ul style="list-style-type: none"> • Scaling and root planning (once per quadrant per 24 months) • Periodontal Maintenance (twice every calendar year) • Osseous Surgery • Gingivectomy or Gingivoplasty • Gingival Flap Procedure <p>Coverage for periodontics is limited to these procedure codes: D4210, D4211, D4240,</p>	

Chapter 4. Medical Benefits Chart (what is covered and what you pay)

Services that are covered for you	What you must pay when you get these services
<p>D4241, D4249, D4260, D4261, D4341, D4342, D4910</p> <p>Extractions/Oral Surgery</p> <ul style="list-style-type: none"> • Surgical Extractions • Partial and Full Bony Extractions • Simple Extractions • Incisional Biopsy of Oral Tissue- hard or soft. This benefit covers biopsies of oral tissue that are not covered under the medical benefit. • Alveoloplasty- without or without extractions. Only covered when preparing mouth for dentures • Incision and Drainage of Abscess <p>Coverage for extractions/oral surgery is limited to these procedure codes: D7111, D7140, D7210, D7220, D7230, D7240, D7241, D7250, D7285, D7286, D7310, D7311, D7320, D7321, D7510, D7511</p> <p>Endodontics</p> <ul style="list-style-type: none"> • Root Canal • Endodontics Therapy (once per tooth per lifetime) • Apicoectomy • Pulp Vitality Test <p>Coverage for endodontics is limited to these procedure codes: D0460, D3110, D3120, D3220, D3221, D3222, D3230, D3240, D3310, D3320, D3330, D3332, D3346, D3347, D3348, D3351, D3352, D3353, D3355, D3356, D3357, D3410, D3421, D3425, D3426, D3430, D3450, D3920, D3921</p> <p>Prosthodontics</p> <ul style="list-style-type: none"> • Select Crowns (once per tooth every 5 years) • Complete Dentures (once every 5 years) • Partial Dentures (once every 5 years) 	

Chapter 4. Medical Benefits Chart (what is covered and what you pay)

Services that are covered for you	What you must pay when you get these services
<ul style="list-style-type: none"> • Interim Partial Dentures Maxillary and Mandibular (Only covered for anterior teeth) • Inlays/Onlays - Single (once per tooth every 5 years) • Fixed Bridges (once per tooth every 5 years) <p>Prosthetic Maintenance</p> <ul style="list-style-type: none"> • Recement for Select Crowns (once every 36 months) • Denture Adjustments • Denture Repairs • Denture Recline & Rebase (once every 36 months) • Bridge Repairs • Bridge Recementation (once every 36 months) • Inlays/Onlays – Recementation (once every 36 months) 	
<p>Coverage for prosthodontics and prosthodontic maintenance is limited to these procedure codes: D2390, D2510, D2520, D2530, D2542, D2543, D2544, D2610, D2620, D2630, D2642, D2643, D2644, D2650, D2651, D2652, D2662, D2663, D2664, D2710, D2712, D2720, D2721, D2722, D2740, D2750, D2751, D2752, D2753, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2794, D2910, D2915, D2920, D2928, D2929, D2930, D2931, D2932, D2933, D2934, D2950, D2952, D2954, D2975, D5110, D5120, D5130, D5140, D5211, D5212, D5213, D5214, D5221, D5222, D5223, D5224, D5225, D5226, D5227, D5228, D5282, D5283, D5284, D5286, D5410, D5411, D5421, D5422, D5511, D5512, D5520, D5611, D5612, D5621, D5622, D5630, D5640, D5650, D5660, D5710, D5711, D5720, D5721, D5730, D5731, D5740, D5741, D5750, D5751, D5760, D5761, D5765, D5820, D5821, D5850,</p>	



Chapter 4. Medical Benefits Chart (what is covered and what you pay)

Services that are covered for you	What you must pay when you get these services
<p>D5851, D5863, D5864, D5865, D5866, D5876, D6205, D6210, D6211, D6212, D6214, D6240, D6241, D6242, D6243, D6245, D6250, D6251, D6252, D6545, D6548, D6549, D6600, D6601, D6602, D6603, D6604, D6605, D6606, D6607, D6608, D6609, D6610, D6611, D6612, D6613, D6614, D6615, D6624, D6634, D6710, D6720, D6721, D6722, D6740, D6750, D6751, D6752, D6753, D6780, D6781, D6782, D6783, D6784, D6790, D6791, D6792, D6794, D6930, D6980</p> <p>Other Coverage is limited to these procedure codes: D9222, D9223, D9239, D9243, D9410, D9420</p> <p>In addition to the exclusions in the General Exclusions listed in Chapter 4, Section 3.1, we will not provide benefits for any of the following conditions, treatments, services, supplies or accommodations, including any direct complications or consequences that arise from them:</p> <ul style="list-style-type: none"> • Dental procedure codes not listed in the benefit grid. • Bonding & Splinting • Consults • Cosmetic Services - We will not provide coverage for dental services and supplies that are primarily for cosmetic or aesthetic purposes and are not medically necessary, including bleaching of teeth and labial veneers. • Fluoride • Grafting Procedures • Medications and Supplies - Charges in connection with medication, including take home drugs, pre-medications, therapeutic drug injections and 	


Chapter 4. Medical Benefits Chart (what is covered and what you pay)

Services that are covered for you	What you must pay when you get these services
<p>supplies associated with dental services are not covered.</p> <ul style="list-style-type: none"> • Oral Hygiene Programs - We will not provide coverage for training or supplies used for: dietary counseling; tobacco counseling; oral hygiene; or plaque control programs. • Orthodontic Services • Procedures to Increase Vertical Dimension - We will not provide coverage for procedures, restorations and appliances to increase vertical dimension or to restore occlusion. • Replacement of Prosthetic Devices - We will not provide coverage for replacement of a lost, missing or stolen prosthetic device. We will not provide coverage for replacement of a prosthetic device for which benefits were provided under this benefit unless the existing prosthetic was placed more than five years ago and cannot be made serviceable. • Tooth Implants and Transplants including select crowns and any associated care for implant placement. • Sealants • Separate Charges - Services and supplies that may be billed as separate charges (these are considered inclusive of the billed procedure), including the following: any supplies and sterilization. • Space Maintainers • Special Charges - We will not provide coverage for charges billed to you for telephone consultations, missed appointments, new patient processing, interest, copies of provider records, or completion of claim forms. 	

Chapter 4. Medical Benefits Chart (what is covered and what you pay)

<p>Services that are covered for you</p>	<p>What you must pay when you get these services</p>
<ul style="list-style-type: none"> • Temporomandibular Joint - We will not provide coverage for appliances, therapy, surgery or any services rendered for what we determine in our sole judgment is for the medical treatment of the temporomandibular joint. • Veneers 	
<p> Depression screening</p> <p>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.</p>	<p>In-network: There is no coinsurance, copayment, or deductible for an annual depression screening visit.</p> <p>When services other than preventive are performed, the cost share (copayment/coinsurance) associated with the other service will apply.</p> <p>Out-of-network (POS): 30% coinsurance per visit. The plan will reimburse a maximum of \$3,000 for out-of-network (POS) services per calendar year.</p>
<p> Diabetes screening</p> <p>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.</p> <p>You may be eligible for up to two diabetes screenings every 12 months following the date of your most recent diabetes screening test.</p>	<p>In-network: There is no coinsurance, copayment, or deductible for the Medicare covered diabetes screening tests.</p> <p>When services other than preventive are performed, the cost share (copayment/coinsurance) associated with the other service will apply.</p> <p>Out-of-network (POS): 30% coinsurance per visit. The plan will reimburse a maximum of \$3,000 for out-of-network (POS) services per calendar year.</p>

Chapter 4. Medical Benefits Chart (what is covered and what you pay)

Services that are covered for you	What you must pay when you get these services
<p> Diabetes self-management training, diabetic services, and supplies For all people who have diabetes (insulin and non-insulin users). Covered services include:</p> <ul style="list-style-type: none"> • Diabetes self-management training is covered under certain conditions. 	<p>In-network: There is no coinsurance, copayment, or deductible for beneficiaries eligible for the diabetes self-management training preventive benefit. When services other than preventive are performed, the cost share (copayment/coinsurance) associated with the other service will apply.</p> <p>Out-of-network (POS): 30% coinsurance per visit. The plan will reimburse a maximum of \$3,000 for out-of-network (POS) services per calendar year.</p>

Chapter 4. Medical Benefits Chart (what is covered and what you pay)

Services that are covered for you	What you must pay when you get these services
<p>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.</p> <p>Members are eligible to receive the following diabetic meters, and the associated test strips:</p> <ul style="list-style-type: none"> - FreeStyle test strips - FreeStyle Lite meters and test strips - FreeStyle Freedom Lite meters - Precision Xtra meters and test strips - Precision Xtra Beta Ketone test strips - FreeStyle Precision Neo test strips - FreeStyle Precision Neo meter <p>Continuous Glucose Monitoring (CGM) supplies can be purchased at a participating retail pharmacy, participating mail order pharmacy or a participating DME provider. We cover:</p> <ul style="list-style-type: none"> - FreeStyle Libre 14-Day - FreeStyle Libre 2 - FreeStyle Libre 3 - Dexcom G6 - Dexcom G7 <p>Prior Authorization is required. Quantity Limits may apply.</p>	<p>In-network: \$5 copayment per item for each 30-day supply when received from the preferred manufacturer, Abbott. Diabetic monitors and test strips received from a non-preferred manufacturer are not covered.</p> <p>Members will pay a maximum \$35 copay for a 30-day supply of insulin that is used in a traditional insulin pump* (e.g., Medtronic Minimed system).</p> <p>* Insulin used in Omnipod™ and V-Go™ systems are not covered under Part B.</p> <p>Please Note: Our plan requires you to try one of the listed Abbott products before we will cover other manufacturer test strips or meter products that are not listed. Prior authorization required for coverage of a non-preferred manufacturer's meters and test strips.</p> <p>Prior authorization is required for some services by your doctor or other network provider.</p> <p>Out-of-network (POS): 30% coinsurance per 30-day supply when received from a preferred manufacturer. Diabetic monitors and test strips received from a non-preferred manufacturer are not covered. The plan will reimburse a maximum of \$3,000 for out-of-network (POS) services per calendar year.</p> <p>Members will pay a maximum \$35 copay for a 30-day supply of insulin that is used in a traditional insulin pump* (e.g., Medtronic Minimed system).</p>

Chapter 4. Medical Benefits Chart (what is covered and what you pay)

Services that are covered for you	What you must pay when you get these services
<ul style="list-style-type: none"> 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. <p>Two Ways We Help Members Manage diabetes.</p> <ol style="list-style-type: none"> Long-term support from Care Managers. We can help you understand diabetes and stay as healthy and well as you can. Call 1-800-860-2619 (TTY/TDD: 711) Mon. – Fri., 8 a.m. to 4:30 p.m. Medicare Customer Care Advocates are available to help members understand their coverage. 	<p>In-network: 20% coinsurance for each pair of Medicare-covered therapeutic shoes.</p> <p>Out-of-network (POS): 30% coinsurance for each pair of Medicare – covered therapeutic shoes. The plan will reimburse a maximum of \$3,000 for out-of-network (POS) services per calendar year.</p>
<p>Durable medical equipment (DME) and related supplies (For a definition of durable medical equipment, see Chapter 12 as well as Chapter 3, Section 7 of this document.) Covered items include, but are not limited to wheelchairs, crutches, powered mattress systems, diabetic supplies, hospital beds ordered by a provider for use in the home, IV infusion pumps, speech generating devices, oxygen equipment, nebulizers, and walkers.</p> <p>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.ExcellusMedicare.com.</p>	<p>In-network: 20% coinsurance for each Medicare-covered durable medical equipment item.</p> <p>Prior authorization is required for some services by your doctor or other network provider.</p> <p>Out-of-network (POS): 30% coinsurance per item. The plan will reimburse a maximum of \$3,000 for out-of-network (POS) services per calendar year. Your cost sharing for Medicare oxygen equipment coverage is 20% coinsurance. Your cost sharing will not change after being enrolled for 36 months.</p>


Chapter 4. Medical Benefits Chart (what is covered and what you pay)

Services that are covered for you	What you must pay when you get these services
<p>Emergency care</p> <p>Emergency care refers to services that are:</p> <ul style="list-style-type: none"> • Furnished by a provider qualified to furnish emergency services, and • Needed to evaluate or stabilize an emergency medical condition. <p>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.</p> <p>Cost sharing for necessary emergency services furnished out-of-network is the same as for such services furnished in-network.</p> <p>You are covered for emergency care anywhere in the world.</p>	<p>In-network and Out-of-network: \$110 copayment per visit.</p> <p>Copayment is waived if admitted to the hospital within 24 hour(s) for the same condition.</p> <p>If you receive emergency care at an out-of-network hospital and need inpatient care after your emergency condition is stabilized, you must have your inpatient care at the out-of-network hospital authorized by the plan and your cost is the cost sharing you would pay at a network hospital.</p>

Chapter 4. Medical Benefits Chart (what is covered and what you pay)

<p>Services that are covered for you</p>	<p>What you must pay when you get these services</p>
<p>Enhanced Disease Management</p> <p>This benefit is for members who have a muscular skeleton disease. If you qualify for this program we will reach out to you. The member will be evaluated by an orthopedic focused physician for appropriateness for the program and will be assigned a care management team which will perform physical therapy/coaching/physician reviews/dietary visits through a digital tool on a smart device or web-based platform, as well as having access to exercises, care plan goals, and asynchronous text messaging with caregivers. The management program is designed to limit pain and member frustration, eliminate unnecessary opioid usage, unnecessary procedures and surgeries, re-operations, and surgical complications by using a whole person, personalized care approach.</p>	<p>In network:</p> <p>There is no coinsurance, copayment, or deductible.</p> <p>Out of network:</p> <p>Not covered</p>
<p>Health Education</p> <p>This benefit is for members who have stage 4 or 5 chronic kidney disease. If you qualify for this program we will reach out to you. Once you enter the program, you will be assigned a multi-disciplinary care team who will focus on evidence-based, guideline-driven patient education, patient engagement, self-management, management of comorbidities, coordination of care, as well as behavior change counseling and patient navigation services. The goal of the education program is to prolong kidney function, decrease the progression of chronic kidney disease and enable engaged members requiring and selecting renal replacement therapy to experience an optimal transition. The program is offered virtually and in-person.</p>	<p>In network:</p> <p>There is no coinsurance, copayment, or deductible.</p> <p>Out of network:</p> <p>Not covered</p>


Chapter 4. Medical Benefits Chart (what is covered and what you pay)

Services that are covered for you	What you must pay when you get these services
<p> Health and wellness education programs</p> <p>Your plan includes a membership to FitOn Health, a fitness and health platform that provides access to a nationwide network of gyms, local fitness studios, and community centers.</p> <p>Members are provided 36 credits each month to use within the FitOn Health network. Monthly credits can be used to cover a variety of options - monthly gym membership with unlimited visits, fitness studio classes, and at-home fitness accessories and equipment.</p> <p>Any unused credits from the monthly allotment do not carry over to the next month.</p> <p>FitOn Health also includes unlimited access to a digital library of at-home workouts, nutrition and meal planning guidance, lifestyle advice, condition management courses, challenges and more.</p> <p>Access your FitOn Health account on desktop, tablet or mobile app.</p> <p>For more information regarding FitOn Health, please logon to our website at www.ExcellusMedicare.com.</p> <p>You can also email help@fitonhealth.com or call the FitOn Health Customer Service department at 1-855-952-6423 (TTY/TDD 711) Monday through Friday, from 8:00am to 9:00pm. An interactive voice response system is available after hours and on Saturdays, Sundays and Federal Holidays.</p>	<ul style="list-style-type: none"> • There is no fee for the FitOn Health benefit. • Members are provided 36 credits each month to use within the FitOn Health network. • You can access nonparticipating fitness facilities if needed (limitations and restrictions apply).

Chapter 4. Medical Benefits Chart (what is covered and what you pay)

Services that are covered for you	What you must pay when you get these services
<p>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.</p> <p>Routine hearing exam covered once per calendar year.</p> <p>To schedule an appointment call 1-855-205-5519 (TTY/TDD users call 711) Monday through Friday, from 8 a.m. to 9 p.m.</p> <p>*The routine hearing exam copayment does not count towards your maximum out-of-pocket amount.</p>	<p>In-network: \$35 copayment for each Medicare-covered diagnostic hearing exam.</p> <p>Out-of-network (POS): 30% coinsurance for each Medicare-covered diagnostic hearing exam. The plan will reimburse a maximum of \$3,000 for out-of-network (POS) services per calendar year.</p> <p>In-network: *\$0 copayment for one routine hearing exam per calendar year by a TruHearing provider.</p> <p>Out-of-network (POS): Not covered. For routine hearing exams and hearing aids, you must contact TruHearing to schedule an appointment prior to visiting the provider.</p>
<p>Hearing Aids</p> <p>Up to two TruHearing-branded hearing aids every year (one per ear per year). Benefit is limited to the TruHearing's Advanced and Premium hearing aids, which come in various styles and colors and are available in rechargeable style options for an additional \$50 per aid. You must see a TruHearing provider to use this benefit.</p> <p>Hearing aid purchases includes:</p> <ul style="list-style-type: none"> • First year of follow-up provider visits • 60-day trial period • 3-year extended warranty • 80 batteries per aid for non-rechargeable models 	<p>*\$499 copayment per aid for Advanced Aids</p> <p>*\$799 copayment per aid for Premium Aids</p> <p>* \$50 additional cost per aid for optional hearing aid rechargeability</p>

Chapter 4. Medical Benefits Chart (what is covered and what you pay)

<p>Services that are covered for you</p>	<p>What you must pay when you get these services</p>
<p>To schedule an appointment call 1-855-205-5519 (TTY/TDD users call 711) Monday through Friday, from 8 a.m. to 9 p.m.</p> <p>Benefit does not include or cover any of the following:</p> <ul style="list-style-type: none"> • Additional cost for optional hearing aid rechargeability • Ear molds • Hearing aid accessories • Additional provider visits • Additional batteries: batteries when a rechargeable hearing aid is purchased • Hearing aids that are not the TruHearing- branded hearing aids • Costs associated with loss & damage warranty claims <p>Costs associated with excluded items are the responsibility of the member and not covered by the plan.</p>	<p>For routine hearing exams and hearing aids, you must contact TruHearing to schedule an appointment prior to visiting the provider.</p> <p>*Hearing Aid copayments do not count towards your maximum out-of-pocket amount.</p>
<p> HIV screening</p> <p>For people who ask for an HIV screening test or who are at increased risk for HIV infection, we cover:</p> <ul style="list-style-type: none"> • One screening exam every 12 months <p>For members who are pregnant, we cover:</p> <ul style="list-style-type: none"> • Up to three screening exams during a pregnancy 	<p>In-network: There is no coinsurance, copayment, or deductible for beneficiaries eligible for Medicare-covered preventive HIV screening.</p> <p>When services other than preventive are performed, the cost share (copayment/coinsurance) associated with the other service will apply.</p> <p>Out-of-network (POS): 30% coinsurance per visit. The plan will reimburse a maximum of \$3,000 for out-of-network (POS) services per calendar year.</p>

Chapter 4. Medical Benefits Chart (what is covered and what you pay)

Services that are covered for you	What you must pay when you get these services
<p>Home health agency care</p> <p>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.</p> <p>Covered services include, but are not limited to:</p> <ul style="list-style-type: none"> • 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 	<p>In-network: \$0 copayment per Medicare-covered home health visit.</p> <p>20% coinsurance for each Medicare-covered Durable Medical equipment item.</p> <p>Supplies are covered in full when medically necessary and provided by a Home Health Care Agency.</p> <p>Prior authorization is required for some services by your doctor or other network provider.</p> <p>Out-of-network (POS): 30% coinsurance per Medicare-covered home health visit. The plan will reimburse a maximum of \$3,000 for out-of-network (POS) services per calendar year.</p>

Chapter 4. Medical Benefits Chart (what is covered and what you pay)

Services that are covered for you	What you must pay when you get these services
<p>Home infusion therapy</p> <p>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, immunoglobulin), equipment (for example, a pump), and supplies (for example, tubing and catheters. Covered services include, but are not limited to:</p> <ul style="list-style-type: none"> • 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 	<p>In-network: \$0 copayment per Medicare-covered home health visit.</p> <p>20% coinsurance for each Medicare-covered Durable Medical equipment item.</p> <p>20% coinsurance for each Medicare-covered Part B drug.</p> <p>Supplies are covered in full when medically necessary and provided by a Home Health Care Agency.</p> <p>Prior authorization and Step Therapy may be required for some services by your doctor or other network provider.</p> <p>Out-of-network (POS): 30% coinsurance per Medicare-covered home health visit. The plan will reimburse a maximum of \$3,000 for out-of-network (POS) services per calendar year.</p> <p>30% coinsurance for each Medicare-covered Durable Medical equipment item. The plan will reimburse a maximum of \$3,000 for out-of-network (POS) services per calendar year.</p> <p>30% coinsurance for each Medicare-covered Part B drug. The plan will reimburse a maximum of \$3,000 for out-of-network (POS) services per calendar year.</p>


Chapter 4. Medical Benefits Chart (what is covered and what you pay)

Services that are covered for you	What you must pay when you get these services
<p>Hospice care</p> <p>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 services 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.</p> <p>Covered services include:</p> <ul style="list-style-type: none"> • Drugs for symptom control and pain relief • Short-term respite care • Home care <p>When you are admitted to a hospice you have the right to remain in your plan; if you choose to remain in your plan you must continue to pay plan premiums.</p> <p><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.</p>	<p>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 Medicare Blue Choice Freedom (HMO-POS).</p>

Chapter 4. Medical Benefits Chart (what is covered and what you pay)

Services that are covered for you	What you must pay when you get these services
<p><u>For services that are covered by Medicare Part A or B and are not related to your terminal prognosis:</u></p> <p>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).</p> <ul style="list-style-type: none"> • 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 cost sharing under Fee-for-Service Medicare (Original Medicare) <p><u>For services that are covered by Medicare Blue Choice Freedom (HMO-POS) but are not covered by Medicare Part A or B:</u> Medicare Blue Choice Freedom (HMO-POS) 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.</p> <p>Note: If you need non-hospice care (care that is not related to your terminal prognosis), you should contact us to arrange the services.</p> <p>Our plan covers hospice consultation services (one time only) for a terminally ill person who hasn't elected the hospice benefit.</p>	<p>In-network: \$0 copayment for a one-time hospice consultation.</p> <p>Out-of-network (POS): 30% coinsurance per visit. The plan will reimburse a maximum of \$3,000 for out-of-network (POS) services per calendar year.</p>

Chapter 4. Medical Benefits Chart (what is covered and what you pay)

Services that are covered for you	What you must pay when you get these services
<p> Immunizations</p> <p>Covered Medicare Part B services include:</p> <ul style="list-style-type: none"> • Pneumonia vaccines • Flu/influenza shots (or vaccines), once each flu/influenza season in the fall and winter, with additional flu/influenza shots (or vaccines) if medically necessary • Hepatitis B vaccines if you are at high or intermediate risk of getting Hepatitis B • COVID-19 vaccines • Other vaccines if you are at risk and they meet Medicare Part B coverage rules 	<p>In-network: There is no coinsurance, copayment, or deductible for the pneumonia, flu/influenza, Hepatitis B, and COVID-19 vaccines</p> <p>20% coinsurance for all other Medicare-Part B covered immunizations.</p> <p>When services other than preventive are performed, the cost share (copayment/coinsurance) associated with the other service will apply.</p> <p>Out-of-network (POS): There is no coinsurance or copayment for pneumonia vaccines, COVID-19 vaccines and flu shots. 30% coinsurance for Hepatitis B and all other Medicare Part B-covered immunizations. The plan will reimburse a maximum of \$3,000 for out-of-network (POS) services per calendar</p>

Chapter 4. Medical Benefits Chart (what is covered and what you pay)

Services that are covered for you	What you must pay when you get these services
<p>Inpatient hospital care</p> <p>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.</p> <p>Covered services include but are not limited to:</p> <ul style="list-style-type: none"> • 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 use disorder services <p>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.</p>	<p>In-network: \$260 copayment per day for days 1 through 5. Thereafter, you pay a \$0 copayment for additional Medicare-covered days during your hospital admission.</p> <p>Copayment applies on the date of hospital admission.</p> <p>Out-of-network (POS): 30% coinsurance per visit. The plan will reimburse a maximum of \$3,000 for out-of-network (POS) services per calendar year.</p> <p>For inpatient hospital care, the cost sharing described above applies each time you are admitted to the hospital. This applies each time you move from acute to rehabilitation care, even if you are in the same physical facility.</p> <p>Prior authorization is required by your doctor or other network provider.</p> <p>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 an in-network hospital. This applies when moving from acute to rehabilitation care, even if you are in the same physical facility.</p>

Chapter 4. Medical Benefits Chart (what is covered and what you pay)

Services that are covered for you	What you must pay when you get these services
<p>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 Medicare Blue Choice Freedom (HMO-POS) 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 up to the IRS medical mile approved rate in effect on the date of travel and up to the per diem rate for lodging specified by the U.S. General Service or the actual cost of lodging whichever is less. The maximum amount payable for all travel and lodging services is ten-thousand dollars (\$10,000.00) per transplant in accordance with plan guidelines. The travel and lodging benefit period begins five days prior to the initial transplant and extends through the patient's discharge date from the transplant facility. These expenses will not count towards the Member Out-of-Pocket Maximum amount.</p> <ul style="list-style-type: none"> • Physician services • Blood-including storage and administration. Coverage begins with the first pint used. 	

Chapter 4. Medical Benefits Chart (what is covered and what you pay)

<p>Services that are covered for you</p>	<p>What you must pay when you get these services</p>
<p>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.</p> <p>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/publications/11435-Inpatient-or-Outpatient.pdf or by calling 1-800-MEDICARE (1-800-633-4227). TTY/ TDD users call 1-877-486-2048. You can call these numbers for free, 24 hours a day, 7 days a week.</p>	
<p>Inpatient services in a psychiatric hospital and substance abuse services</p> <ul style="list-style-type: none"> • Covered services include mental health care services that require a hospital stay. There is a 190-day lifetime limit for inpatient services in a psychiatric hospital. The 190-day limit does not apply to inpatient mental health services provided in a psychiatric unit of a general hospital. • Inpatient substance abuse services 	<p>Prior authorization is required for by your doctor or other network provider.</p> <p>In-network: \$260 copayment per day for days 1 through 5. Thereafter, you pay a \$0 copayment for additional Medicare-covered days during your hospital admission.</p> <p>Copayment applies on the date of hospital admission.</p> <p>Out-of-network (POS): 30% coinsurance per visit. The plan will reimburse a maximum of \$3,000 for out-of-network (POS) services per calendar year.</p> <p>For inpatient mental health hospital care, the cost sharing described above applies each time you are admitted to the hospital.</p>

Chapter 4. Medical Benefits Chart (what is covered and what you pay)

Services that are covered for you	What you must pay when you get these services
<ul style="list-style-type: none"> • X-ray. • Diagnostic Imaging (CT scan, MRI/MRA, Myocardial Nuclear Perfusion Imaging and PET scans). • Radiation Therapy: radium and isotope therapy including technician materials and services. • Surgical dressings, splints, casts, and other devices used to reduce fractures and dislocations. • Physical therapy, speech therapy, and occupational therapy. 	<p>In-network: \$40 copayment for each Medicare-covered standard x-ray.</p> <p>Out-of-network (POS): 30% coinsurance. The plan will reimburse a maximum of \$3,000 for out-of-network (POS) services per calendar year.</p> <p>In-network: \$150 copayment for each Medicare-covered service. This includes the cost of the imaging and any associated provider services.</p> <p>Out-of-network (POS): 30% coinsurance. The plan will reimburse a maximum of \$3,000 for out-of-network (POS) services per calendar year.</p> <p>In-network: 20% coinsurance for each Medicare-covered radiation therapy.</p> <p>Out-of-network (POS): 30% coinsurance. The plan will reimburse a maximum of \$3,000 for out-of-network (POS) services per calendar year.</p> <p>In-network: 20% coinsurance for each Medicare-covered item.</p> <p>Out-of-network (POS): 30% coinsurance. The plan will reimburse a maximum of \$3,000 for out-of-network (POS) services per calendar year.</p> <p>In-network: \$35 copayment per treatment.</p> <p>Out-of-network (POS): 30% coinsurance. The plan will reimburse a maximum of \$3,000 for out-of-network (POS) services per calendar year.</p>
<ul style="list-style-type: none"> • 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. 	<p>In-network: 20% coinsurance for each Medicare-covered item.</p> <p>Out-of-network (POS): 30% coinsurance. The plan will reimburse a maximum of \$3,000 for out-of-network (POS) services per calendar year.</p>



Chapter 4. Medical Benefits Chart (what is covered and what you pay)

Services that are covered for you	What you must pay when you get these services
<ul style="list-style-type: none">• 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.	<p>In-network: 20% coinsurance for each Medicare-covered item.</p> <p>Out-of-network (POS): 30% coinsurance. The plan will reimburse a maximum of \$3,000 for out-of-network (POS) services per calendar year.</p>

Chapter 4. Medical Benefits Chart (what is covered and what you pay)

Services that are covered for you	What you must pay when you get these services
<p>Meals – Post Discharge</p> <p>Your post discharge meal benefit provides access to two meals per day for 7-days following an Inpatient hospital, hospital observation, or Skilled Nursing Facility stay.</p> <p>These nutritious, fully prepared, refrigerated entrees will be shipped to your home by Mom’s Meals® at no additional cost. Health-specific menus are tailored to your dietary needs and offer nutritional support while you recuperate.</p> <p>To request your delivery of meals once you have been discharged, please contact our Care Management team within 30 days of discharge by calling 1-800-860-2619 (TTY/ TDD 1-800-662-1220). Representatives are available Monday through Friday, 8:30 a.m. – 4:30 p.m.</p> <p>Our healthcare representatives will coordinate your delivery of meals to support any of your dietary or allergy restrictions. Important benefit details:</p> <ul style="list-style-type: none"> • Meal requests must be made within 30-days of discharge. • There are no limits on the number of qualifying inpatient hospital or skilled nursing facility discharges. • Discharges from Inpatient Mental Health facilities are not eligible for the meals benefit. • Meal requests that are not coordinated by our Healthcare Services team directly with Mom’s Meals will not be covered. • Meal requests prepared or delivered from any other meal provider are not covered. <p>Anything you pay out-of-pocket for meal requests that are not coordinated by our healthcare services team will also not count towards your out-of-pocket maximum.</p>	<p>\$0 copay for coordinated meal requests with Mom’s Meals.</p>

Chapter 4. Medical Benefits Chart (what is covered and what you pay)

Services that are covered for you	What you must pay when you get these services
<p> Medical nutrition therapy</p> <p>This benefit is for people with diabetes, renal (kidney) disease (but not on dialysis), or after a kidney transplant when ordered by your doctor.</p> <p>We cover 3 hours of one-on-one counseling services during your first year that you receive medical nutrition therapy services under Medicare (this includes our plan, any other Medicare Advantage plan, or Original Medicare), and 2 hours each year after that. If your condition, treatment, or diagnosis changes, you may be able to receive more hours of treatment with a physician's order. A physician must prescribe these services and renew their order yearly if your treatment is needed into the next calendar year.</p>	<p>In-network: There is no coinsurance, copayment, or deductible for beneficiaries eligible for Medicare-covered medical nutrition therapy services.</p> <p>When services other than preventive are performed, the cost share (copayment/coinsurance) associated with the other service will apply.</p> <p>Out-of-network (POS): 30% coinsurance. The plan will reimburse a maximum of \$3,000 for out-of-network (POS) services per calendar year.</p>
<p> Medicare Diabetes Prevention Program (MDPP)</p> <p>MDPP services will be covered for eligible Medicare beneficiaries under all Medicare health plans.</p> <p>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.</p>	<p>In-network: There is no coinsurance, copayment, or deductible for the MDPP benefit.</p> <p>When services other than preventive are performed, the cost share (copayment/coinsurance) associated with the other service will apply.</p> <p>Out-of-network (POS): 30% coinsurance. The plan will reimburse a maximum of \$3,000 for out-of-network (POS) services per calendar year.</p>


Chapter 4. Medical Benefits Chart (what is covered and what you pay)

Services that are covered for you	What you must pay when you get these services
<p>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.</p> <p>Covered drugs include:</p> <ul style="list-style-type: none"> • 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 • The Alzheimer's drug, Leqembi, (generic name lecanemab), which is administered intravenously. In addition to medication costs, you may need additional scans and tests before and/or during treatment that could add to your overall costs. Talk to your doctor about what scans and tests you may need as part of your treatment • Clotting factors, you give yourself by injection if you have hemophilia • Transplant/Immunosuppressive Drugs: Medicare covers transplant drug therapy if Medicare paid for your organ transplant. You must have Part A at the time of the covered transplant, and you must have Part B at the time you get immunosuppressive drugs. Keep in mind, Medicare drug coverage (Part D) covers immunosuppressive drugs if Part B doesn't cover them • Injectable osteoporosis drugs, if you are homebound, have a bone fracture that a doctor certifies was related to 	<p>In-network: 20% coinsurance for each covered Medicare Part B drug.</p> <p>Select Part B drugs may cost less than a 20% coinsurance.</p> <p>Prior authorization and Step Therapy may be required for some services by your doctor or other network provider.</p> <p>Out-of-network (POS): 30% coinsurance. The plan will reimburse a maximum of \$3,000 for out-of-network (POS) services per calendar year.</p> <p>If services are received during a doctor's office visit or at an outpatient facility visit, you will pay your share of the cost for the services in addition to your copayment for the office/facility visit.</p>

Chapter 4. Medical Benefits Chart (what is covered and what you pay)

Services that are covered for you	What you must pay when you get these services
<p>post-menopausal osteoporosis, and cannot self-administer the drug</p> <ul style="list-style-type: none"> • Some Antigens: Medicare covers antigens if a doctor prepares them and a properly instructed person (who could be you, the patient) gives them under appropriate supervision • Certain oral anti-cancer drugs: Medicare covers some oral cancer drugs you take by mouth if the same drug is available in injectable form or the drug is a prodrug (an oral form of a drug that, when ingested, breaks down into the same active ingredient found in the injectable drug) of the injectable drug. As new oral cancer drugs become available, Part B may cover them. If Part B doesn't cover them, Part D does • Oral anti-nausea drugs: Medicare covers oral anti-nausea drugs you use as part of an anti-cancer chemotherapeutic regimen if they're administered before, at, or within 48 hours of chemotherapy or are used as a full therapeutic replacement for an intravenous anti-nausea drug • Certain oral End-Stage Renal Disease (ESRD) drugs if the same drug is available in injectable form and the Part B ESRD benefit covers it • Calcimimetic medications under the ESRD payment system, including the intravenous medication Parsabiv, and the oral medication Sensipar • Certain drugs for home dialysis, including heparin, the antidote for heparin, when medically necessary, and topical anesthetics • Erythropoiesis-stimulating agents: Medicare covers erythropoietin by injection if you have End-Stage Renal Disease (ESRD) or you need this drug to treat anemia related to certain other 	

Chapter 4. Medical Benefits Chart (what is covered and what you pay)

<p>Services that are covered for you</p>	<p>What you must pay when you get these services</p>
<p>conditions [plans may delete any of the following drugs that are not covered under the plan] (such as Epogen, Procrit, Retacrit, Epoetin Alfa, Aranesp, Darbepoetin Alfa, Mircera, or Methoxy polyethylene glycol-epoetin beta)</p> <ul style="list-style-type: none"> • Intravenous Immune Globulin for the home treatment of primary immune deficiency diseases • Parenteral and enteral nutrition (intravenous and tube feeding) <p>The following link will take you to a list of Part B Drugs that may be subject to Step Therapy: MyExcellusMedicare.com/Formulary</p>	
<p> 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.</p>	<p>In-network: There is no coinsurance, copayment, or deductible for preventive obesity screening and therapy.</p> <p>When services other than preventive are performed, the cost share (copayment/coinsurance) associated with the other service will apply.</p> <p>Out-of-network (POS): 30% coinsurance. The plan will reimburse a maximum of \$3,000 for out-of-network (POS) services per calendar year.</p>

Chapter 4. Medical Benefits Chart (what is covered and what you pay)

<p>Services that are covered for you</p>	<p>What you must pay when you get these services</p>
<p>Opioid Treatment Program Services Members of our plan with opioid use disorder (OUD) can received coverage of services to treat OUD through an Opioid Treatment program (OTP) which includes the following services:</p> <ul style="list-style-type: none"> • 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 disorder counseling • Individual and group therapy • Toxicology testing • Intake activities • Periodic assessments 	<p>In-network: 20% coinsurance for each Opioid Treatment Program visit. Out-of-Network (POS): 30% coinsurance for each Opioid Treatment Program visit. The plan will reimburse a maximum of \$3,000 for out-of-network (POS) services per calendar year.</p>
<p>Outpatient diagnostic tests and therapeutic services and supplies Covered services include, but are not limited to:</p> <ul style="list-style-type: none"> • X-rays and Ultrasounds. • Diagnostic Imaging (CT scan, MRI/ MRA, Myocardial Nuclear Perfusion Imaging and PET scans). 	<p>Prior authorization is required for some services by your doctor or other network provider.</p> <p>In-network: \$40 copayment for each Medicare-covered standard x-ray and ultrasound. Out-of-network (POS): 30% coinsurance. The plan will reimburse a maximum of \$3,000 for out-of-network (POS) services per calendar year.</p> <p>In-network: \$150 copayment for each Medicare-covered service. This includes the cost of the imaging and any associated provider services. Out-of-network (POS): 30% coinsurance. The plan will reimburse a maximum of \$3,000 for out-of-network (POS) services per calendar year. This includes the cost of the imaging and any associated provider services.</p>

Chapter 4. Medical Benefits Chart (what is covered and what you pay)

Services that are covered for you	What you must pay when you get these services
<ul style="list-style-type: none"> • Radiation Therapy: radium and isotope therapy including technician materials and supplies. 	<p>In-network: 20% coinsurance for Medicare-covered radiation therapy. Out-of-network (POS): 30% coinsurance. The plan will reimburse a maximum of \$3,000 for out-of-network (POS) services per calendar year.</p>
<ul style="list-style-type: none"> • Surgical supplies, such as dressings, splints, casts, and other devices used to reduce fractures and dislocations. 	<p>In-network: 20% coinsurance for each Medicare-covered item. Out-of-network (POS): 30% coinsurance. The plan will reimburse a maximum of \$3,000 for out-of-network (POS) services per calendar year.</p>
<ul style="list-style-type: none"> • Laboratory tests (outpatient). 	<p>In-network: \$10 copayment for Medicare-covered lab tests. Out-of-network (POS): 30% coinsurance. The plan will reimburse a maximum of \$3,000 for out-of-network (POS) services per calendar year.</p>
<ul style="list-style-type: none"> • Blood - including storage and administration. Coverage of whole blood and packed red cells begins with the first pint used. 	<p>In-network: \$0 copayment for blood service. Out-of-network (POS): 30% coinsurance. The plan will reimburse a maximum of \$3,000 for out-of-network (POS) services per calendar year.</p>
<ul style="list-style-type: none"> • Other outpatient diagnostic tests (EKG's, pulmonary function tests, treadmill stress tests, etc.). 	<p>In-network: \$10 copayment for Medicare-covered non-radiological diagnostic tests. When services in addition to the diagnostic test are done during the visit, a \$5 copayment for PCP or \$35 copayment for Specialist will apply. Out-of-network (POS): 30% coinsurance. The plan will reimburse a maximum of \$3,000 for out-of-network (POS) services per calendar year.</p>

Chapter 4. Medical Benefits Chart (what is covered and what you pay)

Services that are covered for you	What you must pay when you get these services
<p>Outpatient Hospital Observation</p> <p>Observation services are hospital outpatient services given to determine if you need to be admitted as an inpatient or can be discharged.</p> <p>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.</p> <p>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 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. If you are not sure if you are an outpatient, you should ask the hospital staff.</p> <p>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/publications/11435-Inpatient-or-Outpatient.pdf or by calling 1-800-MEDICARE (1-800-633-4227). TTY/TDD users call 1-877-486-2048. You can call these numbers for free, 24 hours a day, 7 days a week.</p>	<p>In-network: \$250 copayment for each outpatient hospital observation visit.</p> <p>Out-of-Network (POS): 30% coinsurance for each outpatient hospital observation visit. \$3,000 for out-of-network (POS) services per calendar year.</p>
<p>Outpatient hospital services</p> <p>We cover medically necessary services you get in the outpatient department of a hospital for diagnosis or treatment of an illness or injury.</p>	<p>Prior authorization is required for some services by your doctor or other network provider.</p>

Chapter 4. Medical Benefits Chart (what is covered and what you pay)

Services that are covered for you	What you must pay when you get these services
<p>Covered services include, but are not limited to:</p> <ul style="list-style-type: none"> • 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. 	<p>In-network: \$110 copayment for each emergency care service. \$5 copayment for PCP and/or \$35 copayment for Specialist for each outpatient clinic visit. \$250 copayment for each outpatient hospital and observation service.</p> <p>Out-of-network (POS): \$110 copayment for each emergency service. 30% coinsurance for each outpatient clinic visit, outpatient hospital and observation service. The plan will reimburse a maximum of \$3,000 for out-of-network (POS) services per calendar year.</p> <p>In-network: \$10 copayment for Medicare-covered labs and non-radiological diagnostic tests.</p> <p>When additional services are done during the visit, a cost share (copayment/coinsurance) associated with the other service will apply.</p> <p>Out-of-network (POS): 30% coinsurance per visit. The plan will reimburse a maximum of \$3,000 for out-of-network (POS) services per calendar year.</p> <p>In-network: \$0 copayment per Medicare-covered visit.</p> <p>Out-of-network (POS): 30% coinsurance per mental health visit. 30% coinsurance per partial hospitalization visit. The plan will reimburse a maximum of \$3,000 for out-of-network (POS) services per calendar year.</p> <p>In-network: \$40 copayment for each Medicare-covered standard x-ray.</p> <p>Out-of-network (POS): 30% coinsurance. The plan will reimburse a maximum of \$3,000 for out-of-network (POS) services per calendar year.</p>

Chapter 4. Medical Benefits Chart (what is covered and what you pay)

Services that are covered for you	What you must pay when you get these services
<ul style="list-style-type: none"> Diagnostic Imaging (CT scan, MRI/MRA, Myocardial Nuclear Perfusion Imaging and PET scans). 	<p>In-network: \$150 copayment for each Medicare-covered service. This includes the cost of the imaging and any associated provider services.</p> <p>Out-of-network (POS): 30% coinsurance. The plan will reimburse a maximum of \$3,000 for out-of-network (POS) services per calendar year.</p>
<ul style="list-style-type: none"> Radiation Therapy: radium and isotope therapy, including technician materials and services. 	<p>In-network: 20% coinsurance for each Medicare-covered radiation therapy.</p> <p>Out-of-network (POS): 30% coinsurance. The plan will reimburse a maximum of \$3,000 for out-of-network (POS) services per calendar year.</p>
<ul style="list-style-type: none"> Medical supplies such as splints and casts. 	<p>In-network: 20% coinsurance for Medicare-covered supplies.</p> <p>Out-of-network (POS): 30% coinsurance. The plan will reimburse a maximum of \$3,000 for out-of-network (POS) services per calendar year.</p>
<ul style="list-style-type: none"> Certain screenings and preventive services. 	<p>In-network: \$0 copayment.</p> <p>When services other than preventive are performed, the cost share (copayment/coinsurance) associated with the other service will apply.</p> <p>Out-of-network (POS): 30% coinsurance. The plan will reimburse a maximum of \$3,000 for out-of-network (POS) services per calendar year.</p>
<ul style="list-style-type: none"> Certain drugs and biologicals that you can't give yourself. 	<p>In-network: 20% coinsurance for each Medicare-covered Part B drug.</p> <p>If a Part B drug is administered in the office or outpatient hospital setting, it is subject to 20% coinsurance in addition to the office/outpatient member liability.</p> <p>Out-of-network (POS): 30% coinsurance. The plan will reimburse a maximum of \$3,000 for out-of-network (POS) services per calendar year.</p>

Chapter 4. Medical Benefits Chart (what is covered and what you pay)

<p>Services that are covered for you</p>	<p>What you must pay when you get these services</p>
<p>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.</p> <p>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/publications/11435-Inpatient-or-Outpatient.pdf or by calling 1-800-MEDICARE (1-800-633-4227). TTY/TDD users call 1-877-486-2048. You can call these numbers for free, 24 hours a day, 7 days a week.</p>	
<p>Outpatient mental health care</p> <p>Covered services include:</p> <p>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.</p>	<p>Prior authorization is required for some services by your doctor or other network provider.</p> <p>In-network: \$0 copayment per Medicare-covered visit.</p> <p>Out-of-network (POS): 30% coinsurance per visit. The plan will reimburse a maximum of \$3,000 for out-of-network (POS) services per calendar year.</p>

Chapter 4. Medical Benefits Chart (what is covered and what you pay)

Services that are covered for you	What you must pay when you get these services
<p>Outpatient rehabilitation services</p> <p>Covered services include physical therapy, occupational therapy, and speech language therapy.</p> <p>Outpatient rehabilitation services are provided in various outpatient settings, such as hospital outpatient departments, independent therapist offices, and Comprehensive Outpatient Rehabilitation Facilities (CORFs).</p>	<p>In-network: \$35 copayment for each Medicare-covered therapy visit.</p> <p>Prior authorization is required for some services by your doctor or other network provider.</p> <p>Out-of-network (POS): 30% coinsurance. The plan will reimburse a maximum of \$3,000 for out-of-network (POS) services per calendar year.</p>
<p>Outpatient substance abuse services</p> <p>Covered services include diagnosis, establishment of a treatment plan, and follow-up care from a physician for substance abuse.</p>	<p>In-network: \$0 copayment per Medicare-covered visit.</p> <p>Out-of-network (POS): 30% coinsurance per visit. The plan will reimburse a maximum of \$3,000 for out-of-network (POS) services per calendar year.</p>
<p>Outpatient surgery, including services provided at hospital outpatient facilities and ambulatory surgical centers</p> <p>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.</p>	<p>In-network: \$250 copayment per visit.</p> <p>Prior authorization is required for some services by your doctor or other network provider.</p> <p>Out-of-network (POS): 30% coinsurance per visit. The plan will reimburse a maximum of \$3,000 for out-of-network (POS) services per calendar year.</p>

Chapter 4. Medical Benefits Chart (what is covered and what you pay)

Services that are covered for you	What you must pay when you get these services
<p>Over-the-counter (OTC) Items:</p> <p>Your coverage includes non-prescription OTC (Over the Counter) health related items like vitamins, pain relievers, cough and cold medicines, first aid supplies, and Covid-19 testing kits.</p> <p>Quarterly OTC benefit periods are January – March, April – June, July – September, and October – December</p> <p>Quarterly allowances must be used within the quarter. The entire allowance must be used within 1 transaction.</p> <p>Unused benefit amounts will NOT carry over to the next quarter</p> <p>OTC Items must be purchased through a catalog that will be provided and is NOT available for purchase at retail stores</p> <p>You will receive a catalog and ordering guidance in the mail.</p> <p>You will be allowed to self-pay for anything above your allowance. Only 1 purchase per quarter.</p> <p>* The OTC benefit does not apply to the Maximum Out-of-Pocket Amount</p>	<p>* You have a \$50 allowance every quarter (3 months) to spend on plan-approved OTC items.</p>

Chapter 4. Medical Benefits Chart (what is covered and what you pay)

Services that are covered for you	What you must pay when you get these services
<p>Partial hospitalization services and Intensive outpatient services</p> <p>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, therapist's, licensed marriage and family therapist's (LMFT), or licensed professional counselor's office and is an alternative to inpatient hospitalization.</p> <p>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, therapist's, licensed marriage and family therapist's (LMFT), or licensed professional counselor's office but less intense than partial hospitalization.</p>	<p>In-network: 20% coinsurance per Medicare-covered visit.</p> <p>Prior authorization is required for some services by your doctor or other network provider.</p> <p>Out-of-network (POS): 30% coinsurance per visit. The plan will reimburse a maximum of \$3,000 for out-of-network (POS) services per calendar year.</p>

Chapter 4. Medical Benefits Chart (what is covered and what you pay)**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 PCP or specialist, if your doctor orders it to see if you need medical treatment.

In-network:

\$5 copayment per visit for PCP and \$35 copayment per visit for a Specialist office visit. \$0 copayment for physician services in a certified ambulatory surgery center or hospital outpatient department.

Out-of-network (POS): 30% coinsurance per other visits. The plan will reimburse a maximum of \$3,000 for out-of-network (POS) services per calendar year.

In-network: \$5 copayment per visit for a PCP and \$35 copayment per visit for a Specialist.

Out-of-network (POS): 30% coinsurance per visit. The plan will reimburse a maximum of \$3,000 for out-of-network (POS) services per calendar year.

Chapter 4. Medical Benefits Chart (what is covered and what you pay)

- Certain telehealth services, including Primary Care Physician services, Physician Specialist services, individual sessions for Mental Health Specialist and Psychiatric services, individual sessions for Outpatient Substance Abuse, Kidney Disease Education services and Diabetes Self-Management Training.
 - You have the option of getting these services either through an in-person visit or by telehealth. If you choose to receive one of these services by telehealth, then you must use a network provider who offers the service by telehealth.
 - Electronic exchange can be by smartphone, regular telephone, computer, or tablet and can include video. Please check with your provider for their preferred method.

In-Network:

\$5 copayment for each PCP telehealth visit.

\$35 copayment for each Specialist telehealth visit.

\$0 copayment for each Individual Session for Mental Health Specialty.

\$0 copayment for each Individual Session for Outpatient Substance Abuse.

\$0 copayment for each Kidney Disease Education Service.

\$0 copayment for each Diabetes Self-Management Training session.

Excellus BlueCross BlueShield is also partnering with MDLIVE[®] to offer this service. MDLIVE[®] can connect you with a network doctor regardless of time or location. Please contact Customer Care for additional benefit details or visit www.ExcellusMedicare.com to register with MDLIVE[®].

\$5 copayment for each MDLive visit.

\$35 copayment for each MDLive mental health visit.

Out-of-network (POS): Not covered out-of-network.

- Some telehealth services including consultation, diagnosis, and treatment by a physician or practitioner for patients in certain rural areas or other locations approved by Medicare.

In-Network:

\$5 copayment for a PCP and \$35 copayment for a Specialist per Medicare-covered visit for consultation, diagnosis and treatment. \$0 copayment for Medicare qualified mental health consultations.

Out-of-network (POS): 30% coinsurance per visit for a consultation, diagnosis and treatment by a specialist. The plan will reimburse a maximum of \$3,000 for out-of-network (POS) services per calendar year.

Chapter 4. Medical Benefits Chart (what is covered and what you pay)

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| <ul style="list-style-type: none"> • 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. | <p>In-network: \$5 copayment per visit for a PCP and \$35 copayment per visit for a Specialist.</p> <p>Out-of-network (POS): 30% coinsurance per visit. The plan will reimburse a maximum of \$3,000 for out-of-network (POS) services per calendar year.</p> <p>In-network: \$5 copayment per visit for a PCP and \$35 copayment per visit for a Specialist.</p> <p>Out-of-network (POS): 30% coinsurance per visit. The plan will reimburse a maximum of \$3,000 for out-of-network (POS) services per calendar year.</p> |
| <ul style="list-style-type: none"> • Telehealth services for diagnosis, evaluation, and treatment of mental health disorders if: <ul style="list-style-type: none"> ○ You have an in-person visit within 6 months prior to your first telehealth visit ○ You have an in-person visit every 12 months while receiving these telehealth services ○ 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: <ul style="list-style-type: none"> ○ You're not a new patient and ○ The check-in isn't related to an office visit in the past 7 days and ○ The check-in doesn't lead to an office visit within 24 hours or the soonest available appointment. | <p>In-network: \$0 copayment per Medicare-covered visit.</p> <p>Out-of-network (POS): 30% coinsurance per visit. The plan will reimburse a maximum of \$3,000 for out-of-network (POS) services per calendar year.</p> <p>In-network: \$5 copayment per visit for a PCP and \$35 copayment per visit for a Specialist.</p> <p>Out-of-network (POS): 30% coinsurance per visit. The plan will reimburse a maximum of \$3,000 for out-of-network (POS) services per calendar year.</p> |

Chapter 4. Medical Benefits Chart (what is covered and what you pay)

- Evaluation of video and/or images you send to your doctor, and interpretation and follow-up by your doctor within 24 hours **if**:
 - You're not a new patient **and**
 - The evaluation isn't related to an office visit in the past 7 days **and**
 - 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

In-network: \$5 copayment per visit for a PCP and \$35 copayment per visit for a Specialist.

Out-of-network (POS): 30% coinsurance per visit. The plan will reimburse a maximum of \$3,000 for out-of-network (POS) services per calendar year.

In-network: \$5 copayment per consultation for a PCP and \$35 copayment per consultation for a Specialist.

Out-of-network (POS): 30% coinsurance per consultation. The plan will reimburse a maximum of \$3,000 for out-of-network (POS) services per calendar year.

- Second opinion by another network provider prior to surgery.

In-network: \$5 copayment per visit for a PCP and \$35 copayment per visit for a Specialist.

Out-of-network (POS): 30% coinsurance per visit. The plan will reimburse a maximum of \$3,000 for out-of-network (POS) services per calendar year.

- 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).

In-network: \$35 copayment per Medicare-covered visit.

Out-of-network (POS): 30% coinsurance per Medicare-covered visit. The plan will reimburse a maximum of \$3,000 for out-of-network (POS) services per calendar year.

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.

In-network: \$35 copayment per Medicare-covered visit.

Out-of-network (POS): 30% coinsurance per visit. The plan will reimburse a maximum of \$3,000 for out-of-network (POS) services per calendar year.

Chapter 4. Medical Benefits Chart (what is covered and what you pay)**Prostate cancer screening exams**

For members 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, copayment, or deductible for an annual PSA test or Digital rectal exam.

When services other than preventive are performed, the cost share (copayment/coinsurance) associated with the other service will apply.

Out-of-network (POS): 30% coinsurance per visit. The plan will reimburse a maximum of \$3,000 for out-of-network (POS) services per calendar year.

Prosthetic and orthotic 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 testing, fitting, or training in the use of prosthetic and orthotic devices; as well as: 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 and orthotic devices, and repair and/or replacement of prosthetic and orthotic 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 each Medicare-covered prosthetic device and related supplies.

Prior authorization is required for some services by your doctor or other network provider.

Out-of-network (POS): 30% coinsurance. The plan will reimburse a maximum of \$3,000 for out-of-network (POS) services per calendar year..

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: \$15 copayment per Medicare-covered visit.

Out-of-network (POS): 30% coinsurance. The plan will reimburse a maximum of \$3,000 for out-of-network (POS) services per calendar year.

Chapter 4. Medical Benefits Chart (what is covered and what you pay)**Screening and counseling to reduce alcohol misuse**

We cover one alcohol misuse screening for adults with Medicare (including pregnant members) who misuse alcohol but aren't alcohol dependent.

If you screen positive for alcohol misuse, you can get up to 4 brief face-to-face counseling sessions per year (if you're competent and alert during counseling) provided by a qualified primary care doctor or practitioner in a primary care setting.

In-network: There is no coinsurance, copayment, or deductible for the Medicare-covered screening and counseling to reduce alcohol misuse preventive benefit.

When services other than preventive are performed, the cost share (copayment/coinsurance) associated with the other service will apply.

Out-of-network (POS): 30% coinsurance. The plan will reimburse a maximum of \$3,000 for out-of-network (POS) services per calendar year.

**Screening for lung cancer with low dose computed tomography (LDCT)**

For qualified individuals, a LDCT is covered every 12 months. **Eligible members are** people aged 50 – 77 years who have no signs or symptoms of lung cancer, but who have a history of tobacco smoking of at least 20 pack-years and who currently smoke or have quit smoking within the last 15 years, who receive an order for LDCT during a lung cancer screening counseling and shared decision making visit that meets the Medicare criteria for such visits and be furnished by a physician or qualified non-physician practitioner.

For LDCT lung cancer screenings after the initial LDCT screening: the members must receive an 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, copayment, or deductible for the Medicare-covered counseling and shared decision-making visit or for the LDCT.

When services other than preventive are performed, the cost share (copayment/coinsurance) associated with the other service will apply.

Prior authorization is required by your doctor or other network provider.

Out-of-network (POS): 30% coinsurance. The plan will reimburse a maximum of \$3,000 for out-of-network (POS) services per calendar year.

Chapter 4. Medical Benefits Chart (what is covered and what you pay)



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 members 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, copayment, or deductible for the Medicare-covered screening for STIs and counseling to prevent STIs preventive benefit.

When services other than preventive are performed, the cost share (copayment/coinsurance) associated with the other service will apply.

Out-of-network (POS): 30% coinsurance. The plan will reimburse a maximum of \$3,000 for out-of-network (POS) services per calendar year.

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.

Prior authorization is required for some services by your doctor or other network provider.

In-network: There is no copayment, coinsurance, or deductible for kidney disease education.

When services other than preventive are performed, the cost share (copayment/coinsurance) associated with the other service will apply.

Out-of-network: 30% coinsurance for kidney disease education. The plan will reimburse a maximum of \$3,000 for out-of-network (POS) services per calendar year.

- Outpatient dialysis treatments (including dialysis treatments when temporarily out of the service area, as explained in Chapter 3)

In-network & Out-of-network: 20% coinsurance for each Medicare-covered dialysis treatment performed as an outpatient service.

Chapter 4. Medical Benefits Chart (what is covered and what you pay)

- | | |
|--|--|
| <ul style="list-style-type: none"> Inpatient dialysis treatments (if you are admitted as an inpatient to a hospital for special care) | <p>In-network: \$260 copayment per day for days 1 through 5. Thereafter, you pay a \$0 copayment for additional Medicare-covered days during your hospital admission</p> <p>Copayment applies on the date of hospital admission. Cost share is applied per hospital admission.</p> |
| <ul style="list-style-type: none"> Self-dialysis training (includes training for you and anyone helping you with your home dialysis treatments) | <p>Out-of-network (POS): 30% coinsurance for inpatient dialysis treatment. The plan will reimburse a maximum of \$3,000 for out-of-network (POS) services per calendar year.</p> <p>In-network: \$5 copayment per visit for a PCP and \$35 copayment per visit for a Specialist.</p> <p>Out-of-network (POS): 30% coinsurance for self-dialysis training. The plan will reimburse a maximum of \$3,000 for out-of-network (POS) services per calendar year.</p> |
| <ul style="list-style-type: none"> Home dialysis equipment and supplies | <p>In-network: 20% coinsurance for home dialysis equipment and supplies.</p> <p>Out-of-network (POS): 30% coinsurance. The plan will reimburse a maximum of \$3,000 for out-of-network (POS) services per calendar year.</p> |
| <ul style="list-style-type: none"> 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) | <p>In-network: \$0 copayment for Medicare-covered home support services.</p> <p>When services other than those listed under home support services are performed, the cost share (copayment/coinsurance) associated with the other service will apply.</p> <p>Out-of-network (POS): 30% coinsurance for home support services. The plan will reimburse a maximum of \$3,000 for out-of-network (POS) services per calendar year.</p> |

Chapter 4. Medical Benefits Chart (what is covered and what you pay)

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.

Skilled nursing facility (SNF) care

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

Covered for up to 100 days when admitted by your doctor or other network provider. Covered services include but are not limited to:

- Semiprivate room (or a private room if medically necessary)
- Meals, including special diets
- Skilled nursing services

In-network: Days 1-20: \$0 copayment per day.

Days 21-100: \$214 Copayment per day.

Prior authorization is required for some services by your doctor or other network provider.

Out-of-network (POS): 30% coinsurance. The plan will reimburse a maximum of \$3,000 for out-of-network (POS) services per calendar year.

Covered up to 100 days per benefit period. A benefit period begins the day you go into a skilled nursing facility. The benefit period ends when you haven't received any inpatient hospital care (or skilled care in a SNF) for 60 days in a row. If you go into a skilled nursing facility after one benefit period has ended, a new benefit period begins. There is no limit to the number of benefit periods.

Chapter 4. Medical Benefits Chart (what is covered and what you pay)

- Physical therapy, occupational therapy, and speech therapy
- Drugs administered to you as part of your plan of care (This includes substances that are naturally present in the body, such as blood clotting factors.)
- Blood - including storage and administration. Coverage of whole blood and packed red cells begins with the first pint 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

Copayment is not waived when member is discharged from acute hospital and admitted to a SNF. This includes SNF to SNF.

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).
- A SNF where your spouse or domestic partner is living at the time you leave the hospital.

Chapter 4. Medical Benefits Chart (what is covered and what you pay)**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, copayment, or deductible for the Medicare-covered smoking and tobacco use cessation preventive benefits.

When services other than preventive are performed, the cost share (copayment/coinsurance) associated with the other service will apply.

Out-of-network (POS): 30% coinsurance. The plan will reimburse a maximum of \$3,000 for out-of-network (POS) services per calendar year.

Chapter 4. Medical Benefits Chart (what is covered and what you pay)**Supervised Exercise Therapy (SET)**

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

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

The SET program must:

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

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

In-network: \$15 copayment per Medicare-covered visit.

Out-of-network (POS): 30% coinsurance. The plan will reimburse a maximum of \$3,000 for out-of-network (POS) services per calendar year.

Chapter 4. Medical Benefits Chart (what is covered and what you pay)**Routine Transportation**

We cover up to 12 one-way trips per calendar year to take you to and from health-related locations such as in-patient facilities and medical centers provided by our designated transportation provider.

Rides may be provided by rideshare services, vans, and non-emergency medical transport as determined by our transportation partner, SafeRide Health.

To schedule a ride or find out how many rides you have left for the year (ride balance), please call 1-888-617-0270 (TTY/TDD 711), Monday-Saturday 8a.m.-8p.m. There is a voicemail messaging system for members to leave messages outside of business hours.

Rides must be scheduled at least two hours before your pick-up time. You must cancel rides at least 3 hours before the scheduled pick-up time. If not, the ride will be deducted from your annual ride balance.

In-network:

\$0 copayment

The transportation benefit includes 12 one-way trips per year up to 50 miles maximum per trip.

Out-of-network (POS):

Not covered.

Chapter 4. Medical Benefits Chart (what is covered and what you pay)**Urgently needed services**

A plan-covered service requiring immediate medical attention that is not an emergency is an urgently needed service if either you are temporarily outside the service area of the plan, or even if you are inside the service area of the plan, it is unreasonable given your time, place, and circumstances to obtain this service from network providers with whom the plan contracts. Your plan must cover urgently needed services and only charge you in-network cost sharing. Examples of urgently needed services are unforeseen medical illnesses and injuries, or unexpected flare-ups of existing conditions. However, medically necessary routine provider visits, such as annual checkups, are not considered urgently needed even if you are outside the service area of the plan or the plan network is temporarily unavailable.

In-network and Out-of-network: \$50 copayment per visit for covered services to a medical facility or urgent care center.

Services received in an emergency department of a hospital are subject to a \$110 copayment per emergency room visit.

You are covered worldwide for urgently needed care.

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

Chapter 4. Medical Benefits Chart (what is covered and what you pay)**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.)
- Routine eye examinations covered once per calendar year.

In-network: \$40 copayment per Medicare-covered visit.

If a Part B drug is administered during your visit, it may be subject to a 20% coinsurance.

Out-of-network (POS): 30% coinsurance. The plan will reimburse a maximum of \$3,000 for out-of-network (POS) services per calendar year.

In-network: \$0 copayment per Medicare-covered glaucoma screening.

When services other than preventive are performed, the cost share (copayment/coinsurance) associated with the other service will apply.

Out-of-network (POS): 30% coinsurance. The plan will reimburse a maximum of \$3,000 for out-of-network (POS) services per calendar year.

In-network: \$0 copayment for Medicare-covered diabetic retinopathy screening.

Out-of-network (POS): 30% coinsurance. The plan will reimburse a maximum of \$3,000 for out-of-network (POS) services per calendar year.

In-network: \$35 copayment for one pair of Medicare-covered standard glasses or contacts after each cataract surgery.

Out-of-network (POS): 30% coinsurance for one pair of Medicare-covered standard glasses or contacts after each cataract surgery. The plan will reimburse a maximum of \$3,000 for out-of-network (POS) services per calendar year.

In-network: \$40 copayment per visit.

Out-of-network (POS): Not covered.

Chapter 4. Medical Benefits Chart (what is covered and what you pay)

- Reimbursement towards the purchase of eyeglasses or contact lenses. You may choose to see any provider licensed to perform these services.

In-network and Out-of-network: We will provide reimbursement for up to \$250 allowance every calendar year.

 **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 (or vaccines)), 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, copayment, or deductible for the Welcome to Medicare preventive visit.

When services other than preventive are performed, the cost share (copayment/coinsurance) associated with the other service will apply.

Out-of-network (POS): 30% coinsurance. The plan will reimburse a maximum of \$3,000 for out-of-network (POS) services per calendar year.

SECTION 3 What benefits are not covered by the plan?

Section 3.1 Benefits we do not cover (exclusions)

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

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

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

All exclusions or limitations on services are described in the Benefits Chart or in the chart below.

Services not covered by Medicare	Not covered under any condition	Covered only under specific conditions
Auditory Osseointegrated Implant (AOI) / Bone Conduction Hearing Device	Not covered under any condition	

Chapter 4. Medical Benefits Chart (what is covered and what you pay)

Services not covered by Medicare	Not covered under any condition	Covered only under specific conditions
Residential Treatment- treatment to prevent the reoccurrence of a condition such as, but not limited to eating disorder, alcohol addiction etc.	Not covered under any condition	
Concierge Care	Not covered under any condition	
Naturopath and homeopath services (uses natural or alternative treatments)	Not covered under any condition	
Massage Therapy when performed by a Licensed Massage Therapist (LMT)	Not covered under any condition	
Biofeedback, including psychiatric therapy with biofeedback		Except when it is-covered under Original Medicare
Alternative and experimental services including but not limited to: thermogenic therapy, electrosleep therapy, transcendental meditation, intravenous histamine therapy, transillumination light scanning, diaphanography	Not covered under any condition	
Cellular therapy	Not covered under any condition	
Initial evaluations, X-rays, labs, evaluation and management codes, maintenance and therapeutic therapy, and other services at the chiropractor's office	Not covered under any condition	

Chapter 4. Medical Benefits Chart (what is covered and what you pay)

Services not covered by Medicare	Not covered under any condition	Covered only under specific conditions
Chiropractic therapy		Other than manual manipulation of the spine consistent with Medicare coverage guidelines
Experimental or investigational medical and surgical procedures, equipment and medications. Experimental procedures and items are those items and procedures determined by our plan and Original Medicare to not be generally accepted by the medical community		<p>May be covered by Original Medicare under a Medicare-approved clinical research study (See Chapter 3, Section 5 for more information on clinical research studies.)</p> <p>We have a department of physicians and nurses who, along with a committee of regional board-certified physicians, determine medical policy and coverage of new technology and medical procedures. We use a variety of sources, such as the Food and Drug Administration (FDA), clinical practice guidelines, and peer-reviewed professional journals, in researching new technologies. Our medical policy department will only allow new technology to become a part of our benefit package after it has been thoroughly investigated and determined to be safe and effective.</p>
Emergency Communication Systems, such as Personal Emergency Response System (PERS), in-home device to notify appropriate personnel of an emergency (e.g., a fall), or telephone alert systems	Not covered under any condition	

Chapter 4. Medical Benefits Chart (what is covered and what you pay)

Services not covered by Medicare	Not covered under any condition	Covered only under specific conditions
Convenience items including but not limited to, air or water purifiers, refrigerators, HEPA filters, humidifiers, portable room heaters, air conditioners, bathtub lifts, bathtub seats, bed-lounges (power or manual), carafes, emesis basins, massage devices, over-bed tables, whirlpool pumps (standard and portable), sauna baths, standing tables, toilet lifts, and raised toilet seats	Not covered under any condition	
Adaptive equipment, structural modifications such as ramps, doorways, stair lifts, and elevators including stairway elevators	Not covered under any condition	
Vision aids such as handheld low vision aids and other non-spectacle mounted aids	Not covered under any condition	
Personal items in your room at the hospital or a skilled nursing facility, including but not limited to a telephone or a television	Not covered under any condition	
Vaccinations or inoculations that are not covered under Part B Medicare		Not all vaccinations or inoculations are covered, see Chapter 4 Medical Benefit Chart, under Immunizations.
Over-the-counter (OTC) items		See "Over-the-counter (OTC) Items" section of the Medical Benefits Chart in Chapter 4, Section 2.1 for information. OTC items not included in the catalog are not covered under any condition.

Chapter 4. Medical Benefits Chart (what is covered and what you pay)

Services not covered by Medicare	Not covered under any condition	Covered only under specific conditions
Non-routine dental care and routine dental care, such as cleanings, filings or dentures.		Please see the benefit chart in chapter 4 for coverage details and exclusions.
Durable medical equipment items including but not limited to: bed baths (home type), bed lifters, bed boards, blood glucose analyzers (Reflectance Colorimeter), braille Teaching Texts, catheters, crutch substitute- lower leg platform with or without wheels, diathermy machines (standard pulses wave types), disposable sheets and bags, electrical stimulation for wounds, esophageal dilators, fabric support or support hose, face masks (surgical), grab bars, heat and massage foam cushion pads, heating and cooling plants, incontinent pads, oscillating beds, paraffin bath units (standard), parallel bars, preset portable oxygen units, pulse tachometers, speech teaching machines, surgical stockings, elastic (Jobst) stockings, white canes and wigs.	Not covered under any condition	
Gradient Compression Stockings and Garments		<p>Compression Sleeves/Stockings are covered with a diagnosis for Venous Stasis Ulcers (dx I87.2, I87.303), procedure codes A6531, A6532 or A6545. Members are allowed 2 pair/year or if condition changes.</p> <p>Compression garments are also covered with a diagnosis of Lymphedema (dx 189.0), procedure codes A6552, A6554 and A6583. Members are allowed</p>

Chapter 4. Medical Benefits Chart (what is covered and what you pay)

Services not covered by Medicare	Not covered under any condition	Covered only under specific conditions
		<p>3 daytime garments per affected body part every 6 months, 2 nighttime garments per affected body part every 2 years.</p> <p>See Surgical Supplies under "Outpatient diagnostic tests and therapeutic services and supplies" section of the Medical Benefits Chart in Chapter 4, Section 2.1 for information.</p>
<p>Services not approved by the Federal Food and Drug Administration (FDA). Drugs, supplements, tests, vaccines, devices, radioactive material, and any other items/services that by law requires FDA approval in order to be sold in the U.S. but are not approved by the FDA. This exclusion applies to services provided anywhere, even outside of the U.S. It does not apply to Medicare-covered clinical trials or emergency/urgent care you receive outside the U.S.</p>	Not covered under any condition	
<p>Personal trainers or exercise coaches for in-home sessions.</p>	Not covered under any condition	
<p>Exercise Equipment</p>	Not covered under any condition	
<p>Routine foot care - The cutting or removal of corns and calluses; -The trimming, cutting, clipping, or debriding of nails; and</p>		<p>Some limited coverage provided according to Medicare guidelines, e.g., if you have diabetes</p>

Chapter 4. Medical Benefits Chart (what is covered and what you pay)

Services not covered by Medicare	Not covered under any condition	Covered only under specific conditions
- Other hygienic and preventive maintenance care, such as cleaning and soaking the feet, and any other service performed in the absence of localized illness, injury, or symptoms involving the foot		
Orthopedic shoes or supportive devices for the feet		Shoes 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
Supportive devices for the feet, such as custom-molded orthotics or removable shoe inserts		Except for orthopedic or therapeutic shoes for people with diabetic foot disease
Routine hearing exams, hearing aids, or exams to fit hearing aids.		See "Hearing Services" section of the Medical Benefits Chart in Chapter 4, Section 2.1 for more information.
Hearing aids and provider visits to service hearing aids (except as specifically described in the Covered Benefits), ear molds, hearing aid accessories, warranty claim fees, and hearing aid batteries (beyond the 80 free batteries per non-rechargeable aid purchased). Over-the-counter hearing aids are not covered under your hearing benefit.		See "Hearing Services" section of the Medical Benefits Chart in Chapter 4, Section 2.1 for information on what is covered.
Assistive listening devices such as telephone amplifiers, alerting devices etc.	Not covered under any condition	
Private duty nurses	Not covered under any condition	

Chapter 4. Medical Benefits Chart (what is covered and what you pay)

Services not covered by Medicare	Not covered under any condition	Covered only under specific conditions
Full-time nursing care in your home	Not covered under any condition	
<p>Custodial Care. (Care that helps with activities of daily living that does not require professional skills or training e.g., bathing and dressing.)</p> <p>Custodial care is personal care that does not require the continuing attention of trained medical or paramedical personnel. This is provided in a nursing home, hospice, or other facility setting and includes care that helps you with activities of daily living, such as bathing and dressing.</p>	Not covered under any condition	
Homemaker services include household assistance, including light housekeeping or light meal preparation	Not covered under any condition	
Fees charged for care by immediate relatives or members of your household.	Not covered under any condition	
Home-delivered meals		See "Meals – Post Discharge" section of the Medical Benefits Chart in Chapter 4, Section 2.1 for information on what is covered
Physical exams and other services, such as sleep studies or drug testing (1) only required for obtaining or maintaining employment or participation in employee programs, (2) only	Not covered under any condition	

Chapter 4. Medical Benefits Chart (what is covered and what you pay)

Services not covered by Medicare	Not covered under any condition	Covered only under specific conditions
required for insurance or licensing, (3) requested sports physicals, or (4) on court order or required for parole or probation.		
A LifeLine Screening (as named and marketed by Lifeline Screening at its website lifelinescreening.com) and any similar service. No exception will be made for the Abdominal Aortic Aneurysm screening. Please refer to the Medical Benefit Chart in this chapter for the preventive service that Medicare covers, which are noted with an apple	Not covered under any condition	
Private room in a hospital		Covered only when medically necessary
Any treatment or services rendered by, or at the direction, of a provider of health care services who is not licensed to provide the services, or who is not operating within the scope of the license	Not covered under any condition	
Sanctioned or excluded providers: Items or services furnished, ordered, or prescribed by any provider listed or identified on any of the following lists or databases: The U.S. Department of Health & Human Services Office of Inspector List of Excluded Individuals and Entities (LEIE), the U.S General Services Administration Excluded Parties List System (EPLS), the U.S Department of Treasury Office of Foreign Assets Control Specially Designated Nationals (SDN) List, or	Not covered under any condition	

Chapter 4. Medical Benefits Chart (what is covered and what you pay)

Services not covered by Medicare	Not covered under any condition	Covered only under specific conditions
on any individual state provider exclusion or sanction list or database including, but not limited to, state Office of Medicaid Inspector exclusion lists.		
Items or services furnished by a provider who has opted-out of participation with Medicare. An opt-out provider cannot bill us, nor can we pay you for these services		Except in services provided in an emergency/urgent care situation or for preventive and comprehensive supplement dental services
Services considered not reasonable and necessary, according to Original Medicare standards	Not covered under any condition	
Third Party insurance coverage: Services provided under another plan for which other coverage is required by federal, state or local law to be purchased or provided through other arrangements. Examples include but not limited to Workers' Compensation, medical payment coverage under no-fault or underinsured automobile insurance, or coverage required under similar legislation.	Not covered under any condition	
Items and services furnished by a nongovernmental provider, physician or supplier if the charges have been paid for by a government program other than Medicare. Examples of this governmental entity exclusion includes but not limited to State Veterans Homes, state and local psychiatric hospitals for individuals committed under penal statute, prisoners (since generally a state	Not covered under any condition	

Chapter 4. Medical Benefits Chart (what is covered and what you pay)

Services not covered by Medicare	Not covered under any condition	Covered only under specific conditions
or local government has custody of a Medicare beneficiary under a penal statute has a financial obligation to pay for the cost of healthcare items and services), and vocational rehabilitation (VR) agencies.		
Group Health Plan: Items or services for which payment can reasonably be made under a group health plan under which the beneficiary may have coverage	Not covered under any condition	
Elective or voluntary enhancement procedures or services (including but not limited to, hair growth, sexual performance, athletic performance, and anti-aging)	Not covered under any condition	
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 symmetrical appearance.
Surgery that is performed to alter or reshape normal structures of the body in order to improve appearance	Not covered under any condition	
Reversal of sterilization procedures and/or non-prescription contraceptive supplies	Not covered under any condition	

Chapter 4. Medical Benefits Chart (what is covered and what you pay)

Services not covered by Medicare	Not covered under any condition	Covered only under specific conditions
Treatment for the sole purpose of inducing pregnancy including, but not limited to in vitro fertilization, gamete intrafallopian transfers, zygote intrafallopian transfers, collection; transportation; or preservation of sperm, sperm banking, pharmaceuticals related to treatment of infertility. Cloning or any service incident to cloning	Not covered under any condition	
Hormone replacement therapy including but not limited to pellet implantation and bioidenticals for purposes of combating aging and/or improving sexual function	Not covered under any condition	
Any item purchased outside of the U.S. including but not limited to prescription drugs, durable medical equipment, prosthetics and orthotics.	Not covered under any condition	
Food Allergy testing and treatment	Not covered under any condition	
Transportation by commercial or private air transport, car, bus, gurney van, wheelchair van, and any other type of transportation, even if it is the only way to travel to a network provider. If you choose to use an ambulance when it is not a Medicare-covered service, you will be responsible for the entire cost. Wheelchair van (chair car) transportation is not covered even if provided by an ambulance company		See the "Routine Transportation" section of the Medical Benefits Chart in Chapter 4, Section 2.1 for information on what is covered

Chapter 4. Medical Benefits Chart (what is covered and what you pay)

Services not covered by Medicare	Not covered under any condition	Covered only under specific conditions
Mileage for ambulance transport beyond nearest facility or to/from facility preferred by member and/or family	Not covered under any condition	
Care provided in conjunction with an ambulance call when no transport is provided. Ambulance service is a transport benefit, and it is only payable when you're transported to a hospital. If an ambulance is called and you received care, but decide not to be transported to a hospital, we do not cover those services	Not covered under any condition	
Paramedic Intercept-advanced life support (ALS) services billed separately from the transporting ambulance provider		Except for rural areas where paramedic intercept services are allowed by law when a voluntary ambulance service cannot bill for transportation
Services provided to veterans in Veterans Affairs (VA) facilities		When emergency services are received at VA hospital and the VA cost sharing is more than the cost sharing under our plan, we will reimburse veterans for the difference. Members are still responsible for our cost sharing amounts.
Items or services which are required as a result of war, or of an act of war, occurring after the effective date of the patient's current entitlement date are not covered	Not covered under any condition	
Routine eye examinations, eyeglasses, radial keratotomy, LASIK surgery, refractive		Eye exam and one pair of eyeglasses (or contact lenses)

Chapter 4. Medical Benefits Chart (what is covered and what you pay)

Services not covered by Medicare	Not covered under any condition	Covered only under specific conditions
keratoplasty and other low vision aids. Also, in most cases polarized lenses are excluded		are covered for people after cataract surgery. One routine eye exam is covered per year. You receive a \$250 allowance every calendar year towards routine eyewear or contact lenses.
Nonconventional intraocular lenses (IOLs) following cataract surgery (lenses which correct your vision and replace your need to wear glasses)		Except for the portion of the hospital outpatient or physician charges equal to the charge for insertion of a conventional intraocular lens (standard, non-vision correcting lenses).
Surgical treatment for morbid obesity		Except when it is considered medically necessary and covered under Original Medicare
Weight-loss treatment, including but not limited to medications, self-help groups, non-Medicare covered weight loss programs, meal programs and dietary supplements	Not covered under any condition	
Autopsy and Necropsy, including but not limited to gross, complete, limited, forensic, and coroner's autopsy	Not covered under any condition	

CHAPTER 5

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

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 this document. First try to resolve the bill with the provider. If that does not work, send the bill to us instead of paying it. We will look at the bill and decide whether the services should be covered. If we decide they should be covered, we will pay the provider directly. If we decide not to pay it, we will notify the provider. You should never pay more than plan-allowed cost-sharing. If this provider is contracted, you still have the right to treatment.

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

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

Outside the service area, you can receive emergency or urgently needed services from any provider, whether or not the provider is a part of our network. In these cases,

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

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

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

- You only have to pay your cost-sharing amount when you get covered services. We do not allow providers to add additional separate charges, called balance billing. This protection (that you never pay more than your cost-sharing amount) applies even if we pay the provider less than the 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.

Chapter 5. Asking us to pay our share of a bill you have received for covered medical services

- 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 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.

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. **You must submit your Part C (medical) claim to us within 12 months** of the date you received the service, item, or Part B drug.
- Either download a copy of the form from our website (www.ExcellusMedicare.com) or call Customer Care and ask for the form.

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

**For Medical and Dental Services
claims**

Excellus BlueCross BlueShield
PO Box 21146, 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.

Chapter 5. Asking us to pay our share of a bill you have received for covered medical services

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

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

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

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

CHAPTER 6

Your rights and responsibilities

Chapter 6. Your rights and responsibilities**SECTION 1 Our plan must honor your rights and cultural sensitivities as a member of the plan****Section 1.1 We must provide information in a way that works for you and consistent with your cultural sensitivities (in languages other than English, in braille, in large print, or other alternate formats, etc.)**

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

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

Our plan is required to give female enrollees the option of direct access to a women's health specialist within the network for women's routine and preventive health care services. If providers in the plan's network for a specialty are not available, it is the plan's responsibility to locate specialty providers outside the network who will provide you with the necessary care. In this case, you will only pay in-network cost sharing. If you find yourself in a situation where there are no specialists in the plan's network that cover a service you need, call the plan for information on where to go to obtain this service at in-network cost sharing.

If you have any trouble getting information from our plan in a format that is accessible and appropriate for you, seeing a women's health specialists or finding a network specialist, please call to file a grievance with Customer Care. 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/TDD 1-800-537-7697.

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

You have the right to choose a primary care provider (PCP) in the plan's network to provide and arrange for your covered services. We do not require you to get referrals to go to network providers.

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

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

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

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

Chapter 6. Your rights and responsibilities

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

How do we protect the privacy of your health information?

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

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

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

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

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

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

As a member of Medicare Blue Choice Freedom (HMO-POS), you have the right to get several kinds of information from us.

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

- **Information about our plan.** This includes, for example, information about the plan's financial condition.

Chapter 6. Your rights and responsibilities

- **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 services 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. It also includes being told about programs our plan offers to help members manage their medications and use drugs safely.
- **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. You also have the right to stop taking your medication. Of course, if you refuse treatment or stop taking medication, you accept full responsibility for what happens to your body as a result.
- **The right to participate in developing your care plan.** You have the right to work with your provider and health care team to develop mutually agreed-upon treatment goals, to the degree possible. Tell your provider what you are, or are not, willing or able to do as part of your plan of care.

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.

Chapter 6. Your rights and responsibilities

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

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

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

- **Get the form.** You can get an advance directive form from your lawyer, from a social worker, or from some office supply stores. You can sometimes get advance directive forms from organizations that give people information about Medicare. You can also contact Customer Care 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 State of New York, Department of Health.

Advance Care Planning process is a process of planning for future medical care in case you are unable to make your own decisions.

Advance Care Planning assists you in preparing for a sudden unexpected illness, from which you expect to recover, as well as the dying process and ultimately death. Advance care planning is a gift to you and your family. It allows you to maintain control over your treatment and to ensure that you experience the type of care you deserve at the end-of-life.

The Community-wide End-of-life/Palliative Care Initiative developed an evidence-based, successful two-step approach to advance care planning that includes:

Community Conversations on Compassionate Care (CCCC) is an award-winning, nationally recognized program developed to help individuals over 18 years of age complete health care proxies. The CCCC Program focuses on Five Easy Steps to complete a health care proxy. Use the Five Easy Steps:

Chapter 6. Your rights and responsibilities

1. Learn about Advance Directives
2. Remove Barriers
3. Motivate Yourself
4. Complete Your Health Care Proxy and Living Will
 - Have Conversations with Your Family and Health Care Provider
 - Choose the Right Health Care Agent
 - Discuss Your Values, Beliefs and What is Important to You
 - Understand Life-Sustaining Treatment
 - Share Copies of Your Completed Advance Directives
5. Review and Update

Medical Orders for Life-Sustaining Treatment (MOLST) is a program designed to improve the quality of care seriously ill patients receive at the end of life, based on effective communication of patient wishes, documentation of medical orders on a brightly colored pink form and a promise by health care professionals to honor these wishes.

Get Started - It's Free!

View further information on www.CompassionAndSupport.org.

Each state has its own laws governing Advance Care Planning and the use of Health Care Proxy forms and Living Wills. Advance directives from each state can be found at your State's Department of Health website or www.caringinfo.org.

Where do I obtain additional information?

Go to www.CompassionAndSupport.org our main tool and resource. This website aims to educate and empower patients, families, health care and other professionals to accomplish the goal of treating individuals facing serious illness or death with dignity, respect and compassion. If you have a question after viewing this site, just click "Contact" found in the top tool bar to email us.

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?

You have the right to be treated with respect and dignity, and the right to privacy.

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

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

Chapter 6. Your rights and responsibilities

Is it about something else?

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

- You can call Customer Care.
- 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/TDD (1-877-486-2048).

Section 1.8 How to get more information about your rights

You have a right to make recommendations regarding the plan's member rights and responsibilities.

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

- You can call Customer Care.
- 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/TDD (1-877-486-2048).

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

Section 2.1 What are your responsibilities?

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

- **Get familiar with your covered services and the rules you must follow to get these covered services.** Use this Evidence of Coverage to learn what is covered for you and the rules you need to follow to get your covered services.
 - Chapters 3 and 4 give the details about your medical services.
- If you have any other health insurance coverage in addition to our plan, you are required to tell us. Chapter 1 tells you about coordinating these benefits.
- **Tell your doctor and other health care providers that you are enrolled in our plan.** Show your plan membership card whenever you get your medical care.
- Help your doctors and other providers help you by giving them information, asking questions, and following through on your care.
 - To help get the best care, tell your doctors and other health providers about your health problems. Follow the treatment plans and instructions that you and your doctors agree upon.

Chapter 6. Your rights and responsibilities

- 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 continue to pay a premium for your Medicare Part B to remain a member of the plan.
 - For most of your medical services covered by the plan, you must pay your share of the cost when you get the service.
 - **If you move within our service area, we need to know** so we can keep your membership record up to date and know how to contact you.
 - If you move outside of our plan service area, you cannot remain a member of our plan.
 - If you move, it is also important to tell Social Security (or the Railroad Retirement Board).

CHAPTER 7

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

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 technical 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," or "coverage determination," or "at-risk 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 Care 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:

Chapter 7. What to do if you have a problem or complaint (coverage decisions, appeals, complaints)

- You can call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY/TDD 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 is 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 10** 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 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 services

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 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 a 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.

Chapter 7. What to do if you have a problem or complaint (coverage decisions, appeals, complaints)

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

Making an appeal

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

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 for medical care.

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 9 in this chapter explains the Level 3, 4, and 5 appeals processes).

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

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

- You **can call us at Customer Care**.
- 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 Member Services and ask for the “Appointment of Representative” form. (The form is also available on Medicare’s website at <https://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/Downloads/cms1696.pdf>)
 - For medical care or Part B prescription drugs, your doctor can request a coverage decision or a Level 1 appeal on your behalf. If your appeal is denied at Level 1, it will be automatically forwarded to Level 2.
- **You can ask someone to act on your behalf.** If you want to, you can name another person to act for you as your “representative” to ask for a coverage decision or make an appeal.
 - If you want a friend, relative, or other person to be your representative, call Customer Care and ask for the “Appointment of Representative” form. (The form is

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also available on Medicare's website at

<https://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/Downloads/cms1696.pdf>

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 before our deadline for making a decision on our 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 four 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 to only these services: home health care, skilled nursing facility care, and Comprehensive Outpatient Rehabilitation Facility (CORF) services)

If you're not sure which section you should be using, please call Customer Care. 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

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

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

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

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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	<p>When a coverage decision involves your medical care, it is called an organization determination.</p> <p>A fast coverage decision is called an expedited determination.</p>
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Step 1: Decide if you need a standard coverage decision or a fast coverage decision.

A standard coverage decision is usually made within 14 calendar 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 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.

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- 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 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. 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 10 of this chapter for information on complaints.)

For fast coverage decisions we use an expedited timeframe.

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

- However, if you ask for more time, or if we need more that may benefit you we can take up to 14 more calendar 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 10 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.

Chapter 7. What to do if you have a problem or complaint (coverage decisions, appeals, complaints)

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

Legal Terms	<p>An appeal to the plan about a medical care coverage decision is called a plan reconsideration.</p> <p>A fast appeal is also called an expedited reconsideration.</p>
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Step 1: Decide if you need a standard appeal or a fast appeal.

A standard appeal is usually made within 30 calendar days or 7 calendar 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. 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 65 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

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item or service. If we take extra days, we will tell you in writing. We can't take extra time if your request is for a Medicare Part B prescription drug.

- If we do not give you an answer within 72 hours (or by the end of the extended time period if we took extra days), we are required to automatically send your request on to Level 2 of the appeals process, where it will be reviewed by an independent review organization. Section 5.4 explains the Level 2 appeal process.
- **If our answer is yes to part or all of what you requested**, we must authorize or provide the coverage we have agreed to provide within 72 hours after we receive your appeal.
- **If our answer is no to part or all of what you requested**, we will send you our decision in writing and automatically forward your appeal to the independent review organization for a Level 2 appeal. The independent review organization will notify you in writing when it receives your appeal.

Deadlines for a standard appeal

- For standard appeals, we must give you our answer **within 30 calendar days** after we receive your appeal. If your request is for a Medicare Part B prescription drug you have not yet received, we will give you our answer **within 7 calendar days** after we receive your appeal. We will give you our decision sooner if your health condition requires us to.
 - However, if you ask for more time, or if we need more information that may benefit you, **we can take up to 14 more calendar days** if your request is for medical item or service. If we take extra days, we will tell you in writing. We can't take extra time to make a decision if your request is for a Medicare Part B prescription drug.
 - If you believe we should not take extra days, you can file a fast complaint. When you file a fast complaint, we will give you an answer to your complaint within 24 hours. (See Section 10 of this chapter for information on complaints.)
 - If we do not give you an answer by the deadline (or by the end of the extended time period), we will send your request to a Level 2 appeal, where an independent review organization will review the appeal. Section 5.4 explains the Level 2 appeal process.
- **If our answer is yes to part or all of what you requested**, we must authorize or provide the coverage within 30 calendar days if your request is for a medical item or service, or **within 7 calendar days** if your request is for a Medicare Part B prescription drug.
- **If our plan says no to part or all of your appeal**, we will automatically send your appeal to the independent review organization for a Level 2 appeal.

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

Chapter 7. What to do if you have a problem or complaint (coverage decisions, appeals, complaints)

Legal Term	The formal name for the independent review organization is the Independent Review Entity . It is sometimes called the IRE .
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The independent review organization is an independent organization hired by Medicare. It is not connected with us and is not a government agency. This organization decides whether the decision we make 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 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

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under dispute within **72 hours** after we receive the decision from the review organization for **standard requests**. For **expedited requests** we have **24 hours** from the date, we receive the decision from the review organization.

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

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

- There are three additional levels in the appeals process after Level 2 (for a total of five levels of appeal). If you want to go to a Level 3 appeal the details on how to do this are in the written notice you get after your Level 2 appeal.
- The Level 3 appeal is handled by an Administrative Law Judge or attorney adjudicator. Section 8 in this chapter explains the Levels 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 7 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 typically within 30 calendar days, but no later than 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:

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

SECTION 6 How to ask us to cover a longer inpatient hospital stay if you think the doctor is discharging you too soon

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

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

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

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

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

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

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

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

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

- **Follow the process.**
- **Meet the deadlines.**
- **Ask for help if you need it.** If you have questions or need help at any time, please call Customer Care. 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.**

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- 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, contact us. If 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.

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

You can get a sample of the **Detailed Notice of Discharge** by calling Customer Care or 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week (TTY/TDD 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.

Chapter 7. What to do if you have a problem or complaint (coverage decisions, appeals, complaints)

- 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. This is called “upholding the decision.”
- The notice you get will tell you in writing what you can do if you wish to continue with the review process.

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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 9 in this chapter tells more about Levels 3, 4, and 5 of the appeals processes.

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 covered services for that type of care for as long as the care is needed to diagnose and treat your illness or injury.

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

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

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

Legal Term	"Notice of Medicare Non-Coverage." It tells you how you can request a fast-track appeal . Requesting a fast-track appeal is a formal, legal way to request a change to our coverage decision about when to stop your care.
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- 1. You receive a notice in writing** at least two calendar 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.

Chapter 7. What to do if you have a problem or complaint (coverage decisions, appeals, complaints)**Section 7.3 Step-by-step: How to make a Level 1 appeal to have our plan cover your care for a longer time**

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

- **Follow the process.**
- **Meet the deadlines.**
- **Ask for help if you need it.** If you have questions or need help at any time, please call Customer Care. 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.

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

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

How can you contact this organization?

- The written notice you received (Notice of Medicare Non-Coverage) tells you how to reach this organization. Or find the name, address, and phone number of the Quality Improvement Organization for your state in Chapter 2.
- If you miss the deadline, and you wish to file an appeal, you still have appeal rights. Contact your Quality Improvement Organization.

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.

Chapter 7. What to do if you have a problem or complaint (coverage decisions, appeals, complaints)

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.
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What happens during this review?

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

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

What happens if the reviewers say yes?

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

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.

Chapter 7. What to do if you have a problem or complaint (coverage decisions, appeals, complaints)

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 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 calendar 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 appeal is handled by an Administrative Law Judge or attorney adjudicator. Section 9 in this chapter tells more about Levels 3, 4, and 5 of the appeals processes.

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.

Chapter 7. What to do if you have a problem or complaint (coverage decisions, appeals, complaints)

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.

Chapter 7. What to do if you have a problem or complaint (coverage decisions, appeals, complaints)

- 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.

If you have any of these kinds of problems, you can “make a complaint”

Chapter 7. What to do if you have a problem or complaint (coverage decisions, appeals, complaints)

Complaint	Example
Quality of your medical care	<ul style="list-style-type: none"> • Are you unhappy with the quality of the care you have received (including care in the hospital)?
Respecting your privacy	<ul style="list-style-type: none"> • Did someone not respect your right to privacy or shared confidential information?
Disrespect, poor customer service, or other negative behaviors	<ul style="list-style-type: none"> • Has someone been rude or disrespectful to you? • Are you unhappy with our Customer Care? • Do you feel you are being encouraged to leave the plan?
Waiting times	<ul style="list-style-type: none"> • Are you having trouble getting an appointment, or waiting too long to get it? • Have you been kept waiting too long by doctors, pharmacists, or other health professionals? Or by our Customer Care or other staff at the plan? <ul style="list-style-type: none"> ○ Examples include waiting too long on the phone or in the waiting or exam room.
Cleanliness	<ul style="list-style-type: none"> • Are you unhappy with the cleanliness or condition of a clinic, hospital, or doctor's office?
Information you get from us	<ul style="list-style-type: none"> • 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)	<p>If you have asked for a coverage decision or made an appeal, and you think that we are not responding quickly enough, you can make a complaint about our slowness. Here are examples:</p> <ul style="list-style-type: none"> • 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

Chapter 7. What to do if you have a problem or complaint (coverage decisions, appeals, complaints)

Legal Terms

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

Section 9.3 Step-by-step: Making a complaint

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

- **Usually, calling Customer Care is the first step.** If there is anything else you need to do, Customer Care 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's how it works:

- If you have a complaint, you or your representative may call Customer Care. We will try to resolve your complaint over the phone. If you ask for a written response, file a written complaint, or if your complaint is related to quality of care, we will respond in writing to you. If we cannot resolve your complaint over the phone, we have a formal procedure to review your complaints. We call this a Grievance Process.
- If we are not able to resolve your complaint over the phone, we will coordinate an investigation of the grievance and in most cases a decision will be rendered within the thirty (30) day regulatory standard.
- If we deny your grievance in whole or in part, our written decision will explain the reasons and will tell you about any dispute resolution options you may have.

Option for Filing an Expedited Grievance

You may request an expedited grievance for any of the following reasons:

- Excellus BlueCross BlueShield chooses to extend the time frame to make an organization determination or reconsideration.
- Excellus BlueCross BlueShield chooses to extend the time frame to make an initial decision or appeal.
- Excellus BlueCross BlueShield refuses to grant a request for an expedited organization determination or reconsideration.
- Excellus BlueCross BlueShield refuses to grant a request for an expedited initial decision or expedited appeal.

How to file an Expedited Grievance

Chapter 7. What to do if you have a problem or complaint (coverage decisions, appeals, complaints)

As a member of Excellus BlueCross BlueShield, you or your representative may make a verbal request for an expedited grievance to a representative of the Customer Care department.

- You may contact the Customer Care department at 1-877-883-9577, (TTY/TDD only, 711). The hours are Monday - Friday, 8:00 a.m. - 8:00 p.m. Representatives are also available 8:00 a.m. - 8:00 p.m., Monday - Sunday, from October 1 -March 31.
- **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 Medicare Blue Choice Freedom (HMO-POS) 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

Chapter 8. Ending your membership in the plan

SECTION 1 Introduction to ending your membership in our plan

Ending your membership in Medicare Blue Choice Freedom (HMO-POS) 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 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 annual Medicare Advantage Open Enrollment Period.

- **The annual Medicare Advantage Open Enrollment Period** is from January 1 to March 31 and also for new Medicare beneficiaries who are enrolled in an MA plan, from the month of entitlement to Part A and Part B until the last day of the 3rd month of entitlement.
- **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.

Chapter 8. Ending your membership in the plan

- **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 Medicare Blue Choice Freedom (HMO-POS) 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/TDD 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.

Note: If you disenroll from Medicare prescription drug coverage and go without creditable prescription drug coverage for 63 days or more in a row, you may have to pay a Part D late enrollment penalty if you join a Medicare drug plan later.

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

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

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

- **Call Customer Care.**
- You can find the information in the **Medicare & You 2025** handbook.

Chapter 8. Ending your membership in the plan

- Contact **Medicare** at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY/TDD 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:
<ul style="list-style-type: none"> • Another Medicare health plan. 	<ul style="list-style-type: none"> • Enroll in the new Medicare health plan. You will automatically be disenrolled from Medicare Blue Choice Freedom (HMO-POS) when your new plan's coverage begins.
<ul style="list-style-type: none"> • Original Medicare with a separate Medicare prescription drug plan. 	<ul style="list-style-type: none"> • Enroll in the new Medicare prescription drug plan. You will automatically be disenrolled from Medicare Blue Choice Freedom (HMO-POS) when your new plan's coverage begins.
<ul style="list-style-type: none"> • Original Medicare without a separate Medicare prescription drug plan. 	<ul style="list-style-type: none"> • Send us a written request to disenroll. Contact Customer Care 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/TDD users should call 1-877-486-2048. • You will be disenrolled from Medicare Blue Choice Freedom (HMO-POS) when your coverage in Original Medicare begins.

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

Until your membership ends, and your new Medicare coverage begins, you must continue to get your medical items and 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).

Chapter 8. Ending your membership in the plan**SECTION 5 Medicare Blue Choice Freedom (HMO-POS) must end your membership in the plan in certain situations****Section 5.1 When must we end your membership in the plan?****Medicare Blue Choice Freedom (HMO-POS) must end your membership in the plan if any of the following happen:**

- If you no longer have Medicare Part A and Part B.
- If you move out of our service area.
- If you are away from our service area for more than six months.
 - If you move or take a long trip, call Customer Care to find out if the place you are moving or traveling to is in our plan's area.
- If you become incarcerated (go to prison).
- If you are no longer a United States citizen or lawfully present in the United States.
- If you intentionally give us incorrect information when you are enrolling in our plan and that information affects your eligibility for our plan. (We cannot make you leave our plan for this reason unless we get permission from Medicare first.)
- If you continuously behave in a way that is disruptive and makes it difficult for us to provide medical care for you and other members of our plan. (We cannot make you leave our plan for this reason unless we get permission from Medicare first.)
- If you let someone else use your membership card to get medical care. (We cannot make you leave our plan for this reason unless we get permission from Medicare first.)
 - If we end your membership because of this reason, Medicare may have your case investigated by the Inspector General.
- If you do not pay the plan premiums for 2 calendar months.
 - We must notify you in writing that you have 2 calendar months to pay the plan premium before we end your membership.

Where can you get more information?

If you have questions or would like more information on when we can end your membership, call Customer Care.

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

Medicare Blue Choice Freedom (HMO-POS) 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/TDD 1-877-486-2048).

Chapter 8. Ending your membership in the plan

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

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/TDD 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 <http://www.hhs.gov/ocr/index>.

If you have a disability and need help with access to care, please call us at Customer Care. If you have a complaint, such as a problem with wheelchair access, Customer Care 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, Medicare Blue Choice Freedom (HMO-POS), 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.

CHAPTER 10

Definitions of important words

Chapter 10. Definitions of important words

Allowed Amount – The dollar amount typically considered payment-in-full by The Centers for Medicare and Medicaid Services (CMS). The Allowed Amount is typically a discounted rate rather than the actual charge. Your health insurance company will pay all or a portion of the remaining allowed amount, minus any co-payment or deductible that you may owe.

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 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 Medicare Blue Choice Freedom (HMO-POS), 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 skilled nursing facility (SNF) services. A benefit period begins the day you go into a skilled nursing facility. The benefit period ends when you have not received any skilled care in a SNF for 60 days in a row. If you go into a skilled nursing facility after one benefit period has ended, a new benefit period begins. There is no limit to the number of benefit periods.

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

Chronic-Care Special Needs Plan – C-SNPs are SNPs that restrict enrollment MA eligible individuals who have one or more severe or disabling chronic conditions, as defined under 42 CFR 422.2, including restricting enrollment based on the multiple commonly co-morbid and clinically linked condition groupings specified in 42 CFR 422.4(a)(1)(iv).

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

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

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

Chapter 10. Definitions of important words

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

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

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

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

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

Customer Care – A department within our plan responsible for answering your questions about your membership, benefits, grievances, and appeals. See Chapter 2 for information about how to contact Customer Care.

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

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

Dual Eligible Special Needs Plans (D-SNP) – D-SNPs enroll individuals who are entitled to both Medicare (Title XVIII of the Social Security Act) and medical assistance from a state plan under Medicaid (Title XIX). States cover some Medicare costs, depending on the state and the individual’s eligibility.

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

Emergency – A medical emergency is when you, or any other prudent layperson with an average knowledge of health and medicine, believe that you have medical symptoms that require immediate medical attention to prevent loss of life (and, if you are a pregnant woman, loss of an 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.

Chapter 10. Definitions of important words

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 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, providers, or pharmacies, including a complaint concerning the quality of your care. This does not involve coverage or payment disputes.

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

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

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

Income Related Monthly Adjustment Amount (IRMAA) – If your modified adjusted gross income as reported on your IRS tax return from 2 years ago is above a certain amount, you'll pay the standard premium amount and an Income Related Monthly Adjustment Amount, also known as IRMAA. IRMAA is an extra charge added to your premium. Less than 5% of people with Medicare are affected, so most people will not pay a higher premium.

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.

Institutional Special Needs Plan (SNP) – A plan that enrolls eligible individuals who continuously reside or are expected to continuously reside for 90 days or longer in a long-term care (LTC) facility. These facilities may include a skilled nursing facility (SNF), nursing facility (NF), (SNF/NF), Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID), an inpatient psychiatric facility, and/or facilities approved by CMS that furnishes similar long-term, health care services that are covered under Medicare Part A, Medicare Part B, or Medicaid; and whose residents have similar needs and health care status to the other named facility types. An institutional Special Needs Plan must have a contractual arrangement with (or own and operate) the specific LTC facility(ies).

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Institutional Equivalent Special Needs Plan (SNP) – A plan that enrolls eligible individuals living in the community but requiring an institutional level of care based on the State assessment. The assessment must be performed using the same respective State level of care assessment tool and administered by an entity other than the organization offering the plan. This type of Special Needs Plan may restrict enrollment to individuals that reside in a contracted assisted living facility (ALF) if necessary to ensure uniform delivery of specialized care.

Low Income Subsidy (LIS) – See “Extra Help.”

Maximum Out-of-Pocket Amount – The most that you pay out-of-pocket during the calendar year for in-network covered Part A and Part B services. Amounts you pay for your plan premiums and Medicare Part A and Part B premiums do not count toward the maximum out-of-pocket amount. See Chapter 4, Section 1.2 for information about your maximum out-of-pocket amount.

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

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

Medically Necessary – Services or supplies 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) an HMO, ii) a PPO, a iii) a Private Fee-for-Service (PFFS) plan, or a iv) a 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 Cost Plan – A Medicare Cost Plan is a plan operated by a Health Maintenance Organization (HMO-POS) or Competitive Medical Plan (CMP) in accordance with a cost-reimbursed contract under section 1876(h) of the Act.

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.

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

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

Medigap (Medicare Supplement Insurance) Policy – Medicare supplement insurance sold by private insurance companies to fill gaps in Original Medicare. Medigap policies only work with Original Medicare. (A Medicare Advantage Plan is not a Medigap policy.)

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

Network Provider – Provider is the general term for doctors, other health care professionals, hospitals, and other health care facilities that are licensed or certified by Medicare and by the State to provide health care services. Network providers have an agreement with our plan to accept our payment as payment in full, and in some cases to coordinate as well as provide covered services to members of our plan. Network providers are also called plan providers.

Organization Determination – A decision our plan makes about whether items or services are covered or how much you have to pay for covered items or services. Organization determinations are called coverage decisions in this document.

Original Medicare (Traditional Medicare or Fee-for-service Medicare) – Original Medicare is offered by the government, and not a private health plan like Medicare Advantage Plans and prescription drug plans. Under Original Medicare, Medicare services are covered by paying doctors, hospitals, and other health care providers payment amounts established by Congress. You can see any doctor, hospital, or other health care provider that accepts Medicare. You must pay the deductible. Medicare pays its share of the Medicare-approved amount, and you pay your share. Original Medicare has two parts: Part A (Hospital Insurance) and Part B (Medical Insurance) and is available everywhere in the United States.

Out-of-Network Provider or Out-of-Network Facility – A provider or facility that does not have a contract with our plan to coordinate or provide covered services to members of our plan. Out-of-network providers are providers that are not employed, owned, or operated by our plan.

Out-of-Pocket Costs – See the definition for cost-sharing above. A member's cost-sharing requirement to pay for a portion of services received is also referred to as the member's out-of-pocket cost requirement.

PACE plan – A PACE (Program of All-Inclusive Care for the Elderly) plan combines medical, social, and long-term care (LTC) services for frail people to help people stay independent and living in their community (instead of moving to a nursing home) as long as possible. People enrolled in PACE plans receive both their Medicare and Medicaid benefits through the plan.

Part C – see Medicare Advantage (MA) Plan.

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

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Point of Service – Is a benefit that covers medically necessary services received from out-of-network providers. The POS benefit for out-of-network covered services is 30% coinsurance. This 30% coinsurance is a percentage of the amount allowed by Original Medicare for the service. Please see Ch. 3 Section 2.4 details.

Preferred Provider Organization (PPO) Plan – A Preferred Provider Organization plan is a Medicare Advantage Plan that has a network of contracted providers that have agreed to treat plan members for a specified payment amount. A PPO plan must cover all plan benefits whether they are received from network or out-of-network providers. Member cost-sharing will generally be higher when plan benefits are received from out-of-network providers. PPO plans have an annual limit on your out-of-pocket costs for services received from network (preferred) providers and a higher limit on your total combined out-of-pocket costs for services from both network (preferred) and out-of-network (non-preferred) providers.

Premium – The periodic payment to Medicare, an insurance company, or a health care plan for health coverage.

Primary Care Provider (PCP) – The doctor or other provider you see first for most health problems. In many Medicare health plans, you must see your primary care provider before you see any other health care provider.

Prior Authorization – Approval in advance to get services. Covered services that need prior authorization are marked in the Benefits Chart in Chapter 4.

Prosthetics and Orthotics – Medical devices including, but are not limited to, arm, back and neck braces; artificial limbs; artificial eyes; and devices needed to replace an internal body part or function, including ostomy supplies and enteral and parenteral nutrition therapy.

Quality Improvement Organization (QIO) – A group of practicing doctors and other health care experts paid by the Federal Government to check and improve the care given to Medicare patients.

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

Service Area – A geographic area where you must live to join a particular health plan. For plans that limit which doctors and hospitals you may use, it's also generally the area where you can get routine (non-emergency) services. The plan must disenroll you if you permanently move out of the plan's service area.

Skilled Nursing Facility (SNF) Care – Skilled nursing care and rehabilitation services provided on a continuous, daily basis, in a skilled nursing facility. Examples of care include physical therapy or intravenous injections that can only be given by a registered nurse or doctor.

Special Enrollment Period – A set time when members can change their health plan 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 are getting "Extra Help" with your prescription drug costs, if you move into a nursing home, or if we violate our contract with you.

Special Needs Plan – A special type of Medicare Advantage Plan that provides more focused health care for specific groups of people, such as those who have both Medicare and Medicaid, who reside in a nursing home, or who have certain chronic medical conditions.

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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 – A plan-covered service requiring immediate medical attention that is not an emergency is an urgently needed service if either you are temporarily outside the service area of the plan, or it is unreasonable given your time, place, and circumstances to obtain this service from network providers with whom the plan contracts. Examples of urgently needed services are unforeseen medical illnesses and injuries, or unexpected flare-ups of existing conditions. However, medically necessary routine provider visits, such as annual checkups, are not considered urgently needed even if you are outside the service area of the plan or the plan network is temporarily unavailable.