Evidence Of Coverage 2021

Medicare Advantage Plan

Peoples Health Patriot (PPO)

Toll-free **1-800-222-8600,** TTY **711**
8 a.m. - 8 p.m. local time, 7 days a week

www.peopleshealth.com

PEOPLES HEALTH
*Your **Medicare Health** Team*
A UnitedHealthcare Company

Y0066_EOC_H4544_002_000_2021_C

January 1 – December 31, 2021

Evidence of Coverage:

Your Medicare Health Benefits and Services as a Member of our plan

This booklet gives you the details about your Medicare health care coverage from January 1 – December 31, 2021. It explains how to get coverage for the health care services you need.

This is an important legal document. Please keep it in a safe place.

This plan, Peoples Health Patriot (PPO), is insured through UnitedHealthcare Insurance Company or one of its affiliates. (When this **Evidence of Coverage** says "we," "us," or "our," it means UnitedHealthcare. When it says "plan" or "our plan," it means Peoples Health Patriot (PPO).)

This document is available for free in other languages.

Please contact our Customer Service number at 1-800-222-8600 for additional information. (TTY users should call 711). Hours are 8 a.m. - 8 p.m. local time, 7 days a week.

Esta información está disponible sin costo en otros idiomas.

Para obtener más información, por favor comuníquese con Servicio al Cliente al 1-800-222-8600. (Usuarios TTY deben llamar 711). Horario es de 8 a.m. a 8 p.m., los 7 días de la semana, hora local.

El Servicio al Cliente también tiene disponible, de forma gratuita, servicios de interpretación para personas que no hablan inglés.

This document may be available in an alternate format such as Braille, large print or audio. Please contact our Customer Service number at 1-800-222-8600, TTY: 711, 8 a.m. - 8 p.m. local time, 7 days a week, for additional information.

Benefits and/or copayments/coinsurance may change on January 1, 2022.

The provider network may change at any time. You will receive notice when necessary.

OMB Approval 0938-1051 (Expires: December 31, 2021)

2021 Evidence of Coverage

Table of Contents

This list of chapters and page numbers is your starting point. For more help in finding information you need, go to the first page of a chapter. **You will find a detailed list of topics at the beginning of each chapter.**

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Getting started as a member

Chapter 1
Getting started as a member

SECTION 1 Introduction

Section 1.1 You are enrolled in Peoples Health Patriot (PPO), which is a Medicare PPO Plan

You are covered by Medicare, and you have chosen to get your Medicare health care coverage through our plan, Peoples Health Patriot (PPO).

There are different types of Medicare health plans. Our plan is a Medicare Advantage PPO Plan (PPO stands for Preferred Provider Organization). Peoples Health Patriot (PPO) does not include Part D prescription drug coverage. Like all Medicare health plans, this Medicare PPO is approved by Medicare and run by a private company.

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 booklet about?

This **Evidence of Coverage** booklet tells you how to get your Medicare medical care covered through our plan. This booklet explains your rights and responsibilities, what is covered, and what you pay as a member of the plan.

The words "coverage" and "covered services" refer to the medical care and services available to you as a member of the plan.

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** booklet.

If you are confused or concerned or just have a question, please contact our plan's Customer Service (phone numbers are printed on the back cover of this booklet).

Section 1.3 Legal information about the Evidence of Coverage

It's part of our contract with you

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

The contract is in effect for months in which you are enrolled in the plan between January 1, 2021 and December 31, 2021.

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 the plan after December 31, 2021. We can also choose to stop offering the plan, or to offer it in a different service area, after December 31, 2021.

Medicare must approve our plan each year

Medicare (the Centers for Medicare & Medicaid Services) must approve our plan each year. You can continue 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 (Section 2.2 tells you about Medicare Part A and Medicare Part B)
- **– and –** you live in our geographic service area (Section 2.3 below describes our service area).
- **– and –** you are a United States citizen or are lawfully present in the United States

Section 2.2 What are Medicare Part A and Medicare Part B?

When you first signed up for Medicare, you received information about what services are covered under Medicare Part A and Medicare Part B. Remember:

- Medicare Part A generally helps cover services provided by hospitals (for inpatient services, skilled nursing facilities, or home health agencies).
- Medicare Part B is for most other medical services (such as physician's services, home infusion therapy, and other outpatient services) and certain items (such as durable medical equipment (DME) and supplies).

Section 2.3 Here is the plan service area for Peoples Health Patriot (PPO)

Although Medicare is a Federal program, our plan 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 parishes in Louisiana: Acadia, Ascension, Assumption, Bossier, Caddo, Calcasieu, Cameron, East Baton Rouge, East Feliciana, Evangeline, Iberia, Iberville, Jefferson, Lafayette, Lafourche, Livingston, Orleans, Ouachita, Plaquemines, Pointe Coupee, St. Bernard, St. Charles, St. Helena, St. James, St. John the Baptist, St. Landry, St. Martin, St. Mary, St. Tammany, Tangipahoa, Terrebonne, Vermilion, Washington, West Baton Rouge, West Feliciana.

If you plan to move out of the service area, please contact Customer Service (phone numbers are printed on the back cover of this booklet).

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.

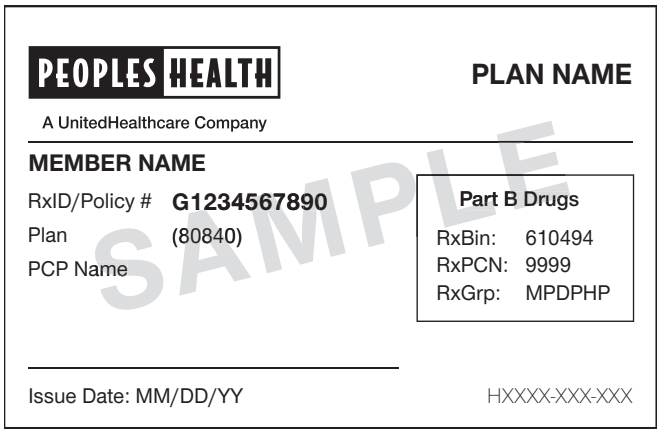
Section 2.4 U.S. Citizen or Lawful Presence

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 Peoples Health Patriot (PPO) if you are not eligible to remain a member on this basis. Peoples Health Patriot (PPO) must disenroll you if you do not meet this requirement.

SECTION 3 What other materials will you get from us?

Section 3.1 Your plan member ID card – Use it to get all covered care

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



Do NOT use your red, white, and blue Medicare card for covered medical services while you are a member of this plan. If you use your Medicare card instead of your plan member ID 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 routine research studies.

Here's why this is so important: If you get covered services using your red, white, and blue Medicare card instead of using your plan member ID card while you are a plan member, you may have to pay the full cost yourself.

If your plan member ID card is damaged, lost, or stolen, call Customer Service right away and we will send you a new card. (Phone numbers for Customer Service are printed on the back cover of this booklet.)

Section 3.2 The Provider Directory: Your guide to all providers in the plan's network

The **Provider Directory** lists our network providers and durable medical equipment suppliers.

What are "network providers"?

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. We have arranged for these providers to deliver covered services to members in our plan. The most recent list of providers and suppliers is available on our website at www.peopleshealth.com.

Why do you need to know which providers are part of our network?

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

If you don't have your copy of the **Provider Directory**, you can request a copy from Customer Service (phone numbers are printed on the cover of this booklet). You may ask Customer Service for more information about our network providers, including their qualifications. You can also search for provider information on our website. Both Customer Service and the website can give you the most up-to-date information about changes in our network providers. (You can find our website and phone information on the cover of this booklet.)

SECTION 4 Your monthly premium for the plan

Section 4.1 How much is your plan premium?

You do not pay a separate monthly plan premium for our plan. You must continue to pay your Medicare Part B premium (unless your Part B premium is paid for you by Medicaid or another third party).

Many members are required to pay other Medicare premiums

Many members are required to pay other Medicare premiums. As explained in Section 2 above, in order to be eligible for our plan, you must have both Medicare Part A and Medicare Part B. Some plan members (those who aren't eligible for premium-free Part A) pay a premium for Medicare Part A. Most plan members pay a premium for Medicare Part B. **You must continue paying your Medicare premiums to remain a member of the plan.**

As a member of Peoples Health Patriot (PPO) you receive up to a $50.00 reduction of your monthly Medicare Part B premium. The reduction is set up by Medicare and administered through the Social Security Administration (SSA). Rebates apply only to amounts you pay toward the Medicare Part B premium and are not issued on any premium amount paid by Medicaid. Depending on how you pay your Medicare Part B premium, your reduction may be credited to your Social Security check or credited on your Medicare Part B premium statement. Reductions may take several months to be issued; however, you will receive a full credit for amounts you have paid.

Your copy of **Medicare & You 2021** gives information about these premiums in the section called "2021 Medicare Costs." This explains how the Medicare Part B premium differs for people with different incomes. Everyone with Medicare receives a copy of **Medicare & You** each year in the fall. Those new to Medicare receive it within a month after first signing up. You can also download a copy of **Medicare & You 2021** from the Medicare website (www.medicare.gov). Or, you can order a printed copy by phone at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users call 1-877-486-2048.

Section 4.2 Can we change your monthly plan premium during the year?

No. We are not allowed to begin charging a 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 5 Please keep your plan membership record up to date

Section 5.1 How to help make sure that we have accurate information about you

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 medical or drug insurance coverage you have (such as from your employer, your spouse's employer, Workers' Compensation, or Medicaid).
- If you have any liability claims, such as claims from an automobile accident.
- If you have been admitted to a nursing home.
- If you receive care in an out-of-area or out-of-network hospital or emergency room.
- If your designated responsible party (such as a caregiver) changes.
- If you are participating in a clinical research study.

If any of this information changes, please let us know by calling Customer Service (phone numbers are printed on the back cover of this booklet). You can also log in to MyPeoplesHealth, our member portal, at http://www.mypeopleshealth.com to change your address or phone number or send us messages about any of these topics.

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.

Read over the information we send you about any other insurance coverage you have

Medicare requires that we collect information from you about any other medical or drug insurance coverage that you have. That's because we must coordinate any other coverage you have with your benefits under our plan. (For more information about how our coverage works when you have other insurance, see Section 7 in this chapter.)

Once each year, we will send you a letter that lists any other medical or drug insurance coverage that we know about. Please read over this information carefully. If it is correct, you don't need to do anything. If the information is incorrect, or if you have other coverage that is not listed, please call Customer Service (phone numbers are printed on the back cover of this booklet).

SECTION 6 We protect the privacy of your personal health information

Section 6.1 We make sure that your health information is protected

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.

For more information about how we protect your personal health information, please go to Chapter 6, Section 1.3 of this booklet.

SECTION 7 How other insurance works with our plan

Section 7.1 Which plan pays first when you have other insurance?

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.

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

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

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

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

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

If you have other insurance, tell your doctor, hospital, and pharmacy. If you have questions about who pays first, or you need to update your other insurance information, call Customer Service (phone numbers are printed on the back cover of this booklet). 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.

Chapter 2

Important phone numbers and resources

Chapter 2
Important phone numbers and resources

SECTION 1 Peoples Health Patriot (PPO) Contacts (how to contact us, including how to reach Customer Service at the plan)

How to contact our plan's Customer Service

For assistance with claims, billing, or member ID card questions, please call or write to our plan Customer Service. We will be happy to help you.

Method	Customer Service - Contact Information
CALL	**1-800-222-8600** Calls to this number are free. Hours of Operation: 8 a.m. - 8 p.m. local time, 7 days a week Customer Service also has free language interpreter services available for non-English speakers.
FAX	**1-504-849-6906**
TTY	**711** Calls to this number are free. Hours of Operation: 8 a.m. - 8 p.m. local time, 7 days a week
WRITE	Peoples Health Customer Service Department Three Lakeway CTR, 3838 N Causeway BLVD, STE 2200, Metairie, LA 70002 **phn.member@peopleshealth.com**
WEBSITE	**www.peopleshealth.com**

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

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

You may call us if you have questions about our coverage decision process.

Method	Coverage Decisions for Medical Care – Contact Information
CALL	**1-800-222-8600** Calls to this number are free.

Method	Coverage Decisions for Medical Care – Contact Information
	Hours of Operation: 8 a.m. - 8 p.m. local time, 7 days a week
TTY	**711** Calls to this number are free. Hours of Operation: 8 a.m. - 8 p.m. local time, 7 days a week
FAX	**1-504-849-6906**
WRITE	Peoples Health Customer Service Department (Organization Determinations) Three Lakeway CTR, 3838 N Causeway BLVD, STE 2200, Metairie, LA 70002 **phn.member@peopleshealth.com**
WEBSITE	**www.peopleshealth.com**

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

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

Method	Appeals for Medical Care – Contact Information
CALL	**1-800-222-8600** Calls to this number are free. Hours of Operation: 8 a.m. - 8 p.m. local time, 7 days a week For fast/expedited appeals for medical care: **1-800-222-8600** Calls to this number are free. Hours of Operation: 8 a.m. - 8 p.m. local time, 7 days a week
TTY	**711** Calls to this number are free. Hours of Operation: 8 a.m. - 8 p.m. local time, 7 days a week
FAX	For fast/expedited appeals only: **1-504-849-6959**
WRITE	Peoples Health Appeals and Grievances Department

Method	Appeals for Medical Care – Contact Information
	Three Lakeway CTR, 3838 N Causeway BLVD, STE 2200 Metairie, LA 70002 **phnag@peopleshealth.com**
WEBSITE	**www.peopleshealth.com**

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

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

Method	Complaints about Medical Care – Contact Information
CALL	**1-800-222-8600** Calls to this number are free. Hours of Operation: 8 a.m. - 8 p.m. local time, 7 days a week For fast/expedited complaints about medical care: **1-800-222-8600** Calls to this number are free. Hours of Operation: 8 a.m. - 8 p.m. local time, 7 days a week
TTY	**711** Calls to this number are free. Hours of Operation: 8 a.m. - 8 p.m. local time, 7 days a week
FAX	For fast/expedited complaints only: **1-504-849-6959**
WRITE	Peoples Health Appeals and Grievances Department Three Lakeway CTR, 3838 N Causeway BLVD, STE 2200 Metairie, LA 70002 **phnag@peopleshealth.com**
MEDICARE WEBSITE	You can submit a complaint about Peoples Health Patriot (PPO) 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.

For more information on situations in which you may need to ask us for reimbursement or to pay a bill you have received from a provider, see Chapter 5 **(Asking us to pay our share of a bill you have received for covered medical services)**.

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

Method	Payment Requests – Contact Information
WRITE	Peoples Health Three Lakeway CTR, 3838 N Causeway BLVD, STE 2200 Metairie, LA 70002 phn.member@peopleshealth.com
WEBSITE	**www.peopleshealth.com**

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

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

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

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

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

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

The State Health Insurance Assistance Program (SHIP) is a government program with trained counselors in every state. In your state, the SHIP is called Louisiana Senior Health Insurance Information Program (SHIIP).

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

SHIP counselors can help you with your Medicare questions or problems. They 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. SHIP counselors can also help you understand your Medicare plan choices and answer questions about switching plans.

Method	**State Health Insurance Assistance Program (SHIP) – Contact Information** **Louisiana** **Louisiana Senior Health Insurance Information Program (SHIIP)**
CALL	**1-800-259-5300**
TTY	**711**
WRITE	P.O. Box 94214, Baton Rouge, LA 70804
WEBSITE	**http://www.ldi.la.gov/SHIIP/**

SECTION 4 Quality Improvement Organization (paid by Medicare to check on the quality of care for people with Medicare)

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

Your state's Quality Improvement Organization has a group of doctors and other health care professionals who are paid by the Federal government. This organization is paid by Medicare to check on and help improve the quality of care for people with Medicare. The state's Quality Improvement Organization is an independent organization. It is not connected with our plan.

You should contact your state's Quality Improvement Organization 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	Quality Improvement Organization (QIO) – Contact Information Louisiana KEPRO
CALL	**1-888-315-0636** **9 a.m. - 5 p.m. local time, Monday - Friday; 11 a.m. - 3 p.m. local time, weekends and holidays**
TTY	**1-855-843-4776** This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.
WRITE	5201 W Kennedy BLVD, STE 900, Tampa, FL 33609
WEBSITE	**https://www.keproqio.com/providers/transition**

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. Social Security handles the enrollment process for Medicare. To apply for Medicare, you can call Social Security or visit your local Social Security office.

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

Method	Social Security – Contact Information
CALL	**1-800-772-1213** Calls to this number are free. Available 7:00 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	**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 7:00 am to 7:00 pm, Monday through Friday.

Method	Social Security – Contact Information
WEBSITE	**www.ssa.gov**

SECTION 6 Medicaid (a joint Federal and state program that helps with medical costs for some people with limited income and resources)

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.
In addition, there are programs offered through Medicaid that help people with Medicare pay their Medicare costs, such as their Medicare premiums. These "Medicare Savings Programs" help people with limited income and resources save money each year:

- **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+).)
- **Qualified 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 your state Medicaid agency.

Method	State Medicaid Program – Contact Information Louisiana Louisiana Department of Health
CALL	**1-225-342-9500** **8 a.m. - 4:30 p.m. CT, Monday - Friday**
TTY	**711** This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.
WRITE	P.O. Box 629, Baton Rouge, LA 70821-0629
WEBSITE	**http://new.dhh.louisiana.gov/**

What if you have coverage from an AIDS Drug Assistance Program (ADAP)?
What is the AIDS Drug Assistance Program (ADAP)?

The AIDS Drug Assistance Program (ADAP) helps ADAP-eligible individuals living with HIV/AIDS have access to life-saving HIV medications. Medicare Part D prescription drugs that are also covered by ADAP qualify for prescription cost-sharing assistance. Note: To be eligible for the ADAP operating in your State, individuals must meet certain criteria, including proof of State residence and HIV status, low income as defined by the State, and uninsured/under-insured status.

If you are currently enrolled in an ADAP, it can continue to provide you with Medicare Part D prescription cost-sharing assistance for drugs on the ADAP formulary. In order to be sure you continue receiving this assistance, please notify your local ADAP enrollment worker of any changes in your Medicare Part D plan name or policy number.

For information on eligibility criteria, covered drugs, or how to enroll in the program, please call your state ADAP office listed below.

Method	AIDS Drug Assistance Program (ADAP) – Contact Information Louisiana Office of Public Health
CALL	**1-504-568-7474** **8 a.m. - 5 p.m. local time, Monday - Friday**
WEBSITE	**http://new.dhh.louisiana.gov/index.cfm/page/1099**

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.

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	**1-877-772-5772** Calls to this number are free. If you press "0," you may speak with an RRB representative from 9:00 am to 3:30 pm, Monday, Tuesday, Thursday, and Friday, and from 9:00 am to 12:00 pm on Wednesday. If you press "1", you may access the automated RRB HelpLine and recorded information 24 hours a day, including weekends and holidays.
TTY	**1-312-751-4701** This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are **not** free.

Method	Railroad Retirement Board – Contact Information
WEBSITE	rrb.gov/

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

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

Chapter 3

Using the plan'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 covered 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, 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"?

Here are some definitions that can help you understand how you get the care and services that are covered for you as a member of our plan:

- **"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, Peoples Health Patriot (PPO) must cover all services covered by Original Medicare and must follow Original Medicare's coverage rules.

The plan 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 booklet).
- **The care you receive is considered medically necessary**. "Medically necessary" means that the services, supplies, or drugs are needed for the prevention, diagnosis, or treatment of your medical condition and meet accepted standards of medical practice.
- **You receive your care from a provider who is eligible to provide services under Original Medicare.** As a member of our plan, you can receive your care from either a network provider or an out-of-network provider (for more about this, see Section 2 in this chapter).

- The providers in our network are listed in the **Provider Directory.**
- If you use an out-of-network provider, your share of the costs for your covered services may be higher.
- **Please note:** While you can get your care from an out-of-network provider, the provider must be eligible to participate in Medicare. Except for emergency care, we cannot pay a provider who has opted out of or been excluded or precluded from the Medicare Program. If you go to a provider who is not eligible to participate in Medicare, you will be responsible for the full cost of the services you receive. Check with your provider before receiving services to confirm that they are eligible to participate in Medicare.

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

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

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

What is a PCP?

A Primary Care Provider (PCP) is a network physician who is selected by you to provide and coordinate your covered services.

What types of providers may act as a PCP?

PCPs are generally physicians specializing in Internal Medicine, Family Practice or General Practice.

What is the role of my PCP?

Your relationship with your PCP is an important one because your PCP is responsible for the coordination of your health care and is also responsible for your routine health care needs. You may want to ask your PCP for assistance in selecting a network specialist and follow-up with your PCP after any specialist visits. It is important for you to develop and maintain a relationship with your PCP.

How do you choose your PCP?

You must select a PCP from the **Provider Directory** at the time of your enrollment. You may, however, visit any network provider you choose.

For a copy of the most recent **Provider Directory**, or for help in selecting a PCP, call Customer Service or visit the website listed in Chapter 2 of this booklet for the most up-to-date information about our network providers.

If you do not select a PCP at the time of enrollment, we may pick one for you. You may change your PCP at any time. See "Changing your PCP" below.

Changing your PCP

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

If you want to change your PCP, call Customer Service. You can also change your PCP by logging in to MyPeoplesHealth, our member portal, at http://www.mypeopleshealth.com, or by emailing phn.member@peopleshealth.com. If the PCP is accepting additional plan members, the change will become effective on the first day of the following month. You will receive a new member ID card that shows this change.

Section 2.2 How to get care from specialists and other network providers

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

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

If you use an out-of-network provider, your share of the costs for your covered services will be as shown in the Benefits Chart in Chapter 4 under "Out-of-Network." You pay the out-of-network cost-sharing even if you received a referral for the services, or if you requested a pre-visit coverage decision from us. However, in the event that no contracted network provider is available, you can ask to access care at in-network cost-sharing from an out-of-network provider. Call Customer Service to let us know if you need to see an out-of-network provider, or to get help finding an in-network provider. (Phone numbers for Customer Service are printed on the back cover of this booklet.)

Even though your PCP is trained to handle the majority of common health care needs, there may be a time when you feel that you need to see a network specialist. **You do not need a referral from your PCP to see a network specialist or behavioral/mental health provider.** Although you do not need a referral from your PCP to see a network specialist, your PCP can recommend an appropriate network specialist for your medical condition, answer questions you have regarding a network specialist's treatment plan and provide follow-up health care as needed. For coordination of care, we recommend you notify your PCP when you see a network specialist.

Please refer to the **Provider Directory** for a listing of plan specialists available through your network, or you may consult the **Provider Directory** online at the website listed in Chapter 2 of this booklet.

What if a specialist or another network provider leaves our plan?
It is important that you know that we may make changes to the hospitals, doctors, and specialists (providers) that are part of your plan during the year. There are a number of reasons why your provider might leave your plan, but if your doctor or specialist does leave 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 make a good faith effort to provide you with at least 30 days' notice that your provider is leaving our plan so that you have time to select a new provider.
- We will assist you in selecting a new qualified provider to continue managing your health care needs.
- If you are undergoing medical treatment you have the right to request, and we will work with you to ensure that the medically necessary treatment you are receiving is not interrupted.
- If 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 an appeal of our decision.
- If you find out that 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.

You may call Customer Service for assistance at the number listed in Chapter 2 of this booklet.

Section 2.3 How to get care from out-of-network providers

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

- You can get your care from an out-of-network provider, however, in most cases that provider must be eligible to participate in Medicare. Except for emergency care, we cannot pay a provider who has opted out of or been excluded or precluded from the Medicare Program. If you receive care from a provider who is not eligible to participate in Medicare, you will be responsible for the full cost of the services you receive. Check with your provider before receiving services to confirm that they are eligible to participate in Medicare.
- When you obtain services out-of-network within the United States, we will pay for covered services using Original Medicare rules. Under Original Medicare, providers can choose whether to accept Medicare assignment. Assignment means that the doctor, provider, or supplier has signed an agreement with Medicare to accept the Medicare-approved amount as full payment for covered services. Most doctors, providers, and suppliers accept assignment, but you should always check to make sure. You may also want to find out how much you have to pay for each service or supply before you get it. To determine whether non-network doctors

or suppliers accept assignment (participate in Medicare), contact Medicare (See Chapter 2, Section 2 of this **Evidence of Coverage**).

If you obtain services from a doctor or provider within the United States who doesn't accept assignment, you will be responsible for the cost-sharing applicable to the covered service(s) under our plan, plus any difference between the amount we pay the provider and the Medicare limiting charge. The limiting charge means they can only charge you up to 15% over the Medicare-approved amount.

- Care from out-of-network providers must be medically necessary, and we may need to authorize the services in advance.
- It is best to ask an out-of-network provider to bill the plan first. But, if you have already paid for the covered services, we will reimburse you for our share of the cost for covered services. Or if an out-of-network provider sends you a bill that you think we should pay, you can send it to us for payment. See Chapter 5 **(Asking us to pay our share of a bill you have received for covered medical services)** for information about what to do if you receive a bill or if you need to ask for reimbursement.
- If you are using an out-of-network provider for emergency care, urgently needed services, or out-of-area dialysis, you may not have to pay a higher cost-sharing amount. See Section 3 for more information about these situations.

SECTION 3 How to get covered 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 loss of life, 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.

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.

What is covered if you have a medical emergency?

You may get covered emergency medical care whenever you need it, anywhere in the world. Our plan covers ambulance services in situations where getting to the emergency room in any other way could endanger your health. For more information, see the Medical Benefits Chart in Chapter 4 of this booklet.

If you receive emergency or urgently-needed services outside of the United States or its territories, you generally will be required to pay the bill at the time you receive the services. Most foreign providers are not eligible to receive reimbursement directly from Medicare, and will ask you to pay for the services directly. Ask for a written, detailed bill or receipt showing the specific services provided to you. Send a copy of the itemized bill or an itemized receipt to us to pay you back. You should be prepared to assist us in obtaining any additional information necessary to properly process your request for reimbursement, including medical records.

If you have an emergency, we will talk with the doctors who are giving you emergency care to help manage and follow up on your care. The doctors who are giving you emergency care will decide when your condition is stable and the medical emergency is over.

After the emergency is over you are entitled to follow-up care to be sure your condition continues to be stable. Your follow-up care will be covered by our plan. If you get your follow-up care from out-of-network providers, you will pay the higher out-of-network cost-sharing.

What if it wasn't a medical emergency?

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

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

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

What are "urgently needed services"?

"Urgently needed services" are non-emergency, unforeseen medical illness, injury, or condition that requires immediate medical care. Urgently needed services may be furnished by network providers or by out-of-network providers when network providers are temporarily unavailable or inaccessible. The unforeseen condition could, for example, be an unforeseen flare-up of a known condition that you have.

What if you are in the plan's service area when you have an urgent need for care?

In most situations, if you are in the plan's service area and you use an out-of-network provider, you will pay a higher share of the costs for your care. Check your **Provider Directory** for a list of network Urgent Care Centers.

You may contact your PCP's office 24 hours a day, seven days a week. Your PCP or an on-call physician your PCP designates can provide or arrange health care services for you, including after-hours and weekend care.

If you have a minor injury or illness, you can get care at an after-hours or urgent care center. These centers specialize in treating minor illnesses or injuries after provider offices have closed for the

day. Examples of minor injuries or illnesses include cuts, sprains, flu-like symptoms, earaches, fever, and minor burns. If you think you may need urgent care, you may first want to call your PCP to make sure an after-hours or urgent care center is the right place to go for treatment of your condition.

What if you are outside the plan's service area when you have an urgent need for care?

When you are outside the service area and cannot get care from a network provider, our plan will cover urgently needed services that you get from any provider at the cost-sharing amount for Urgently Needed Services as described in Chapter 4.

Our plan covers worldwide emergency and urgently needed services outside the United States under the following circumstances: emergency services, including emergency or urgently needed care and emergency ambulance transportation from the scene of an emergency to the nearest medical treatment facility. Transportation back to the United States from another country is not covered. Pre-scheduled, pre-planned treatments (including dialysis for an ongoing condition) and/or elective procedures are not covered.

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.peopleshealth.com for information on how to obtain needed care during a disaster.

Generally, 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 covered 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 share 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

Our plan covers all medical services that are medically necessary, these services are listed in the plan's Medical Benefits Chart (this chart is in Chapter 4 of this booklet), and are obtained consistent with plan rules. You are responsible for paying the full cost of services that aren't covered by our plan, either because they are not plan covered services, or plan rules were not followed.

If you have any questions about whether we will pay for any medical service or care that you are considering, you have the right to ask us whether we will cover it before you get it. You also have the right to ask for this in writing. If we say we will not cover your services, you have the right to appeal our decision not to cover your care.

Chapter 7 **(What to do if you have a problem or complaint (coverage decisions, appeals, complaints))** has more information about what to do if you want a coverage decision from us or want to appeal a decision we have already made. You may also call Customer Service to get more information (phone numbers are printed on the back cover of this booklet).

For covered services that have a benefit limitation, you pay the full cost of any services you get after you have used up your benefit for that type of covered service. For example, if your plan covers one routine physical exam per year and you receive that routine physical but choose to have a second routine physical within the same year, you pay the full cost of the second routine physical. Any amounts that you pay after you have reached the benefit limitation do not count toward your annual out-of-pocket maximum. (See Chapter 4 for more information on your plan's out-of-pocket maximum.) You can call Customer Service when you want to know how much of your benefit limit you have already used.

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

Section 5.1 What is a "clinical research study"?

A clinical research study (also called a "clinical trial") is a way that doctors and scientists test new types of medical care, like how well a new cancer drug works. They test new medical care procedures or drugs by asking for volunteers to help with the study. This kind of study is one of the final stages of a research process that helps doctors and scientists see if a new approach works and if it is safe.

Not all clinical research studies are open to members of our plan. Medicare first needs to approve the research study. 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.**

Once Medicare approves the study, 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. 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 a Medicare-approved clinical research study, you do **not** need to get approval from us or your PCP. The providers that deliver your care as part of the clinical research study do **not** need to be part of our plan's network of providers.

Although you do not need to get our plan's permission to be in a clinical research study, **you do need to tell us before you start participating in a clinical research study**.

If you plan on participating in a clinical research study, contact Customer Service (phone numbers are printed on the back cover of this booklet) to let them know that you will be participating in a clinical trial and to find out more specific details about what your plan will pay.

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

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

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

Original Medicare pays most of the cost of the covered services you receive as part of the study. After Medicare has paid its share of the cost for these services, our plan will also pay for part of the costs. We will pay the difference between the cost-sharing in Original Medicare and your 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.

> **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 we would pay another $10. This means that you would pay $10, which is the same amount you would pay under our plan's benefits.

In order for us to pay for our share of the costs, you will need to submit a request for payment. With your request, you will need to send us a copy of your Medicare Summary Notices or other documentation that shows what services you received as part of the study and how much you owe. Please see Chapter 5 for more information about submitting requests for payment.

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 and services the study gives you or any participant for free.
- Items or services provided only to collect data, and not used in your direct health care. For example, Medicare would not pay for monthly CT scans done as part of the study if your medical condition would normally require only one CT scan.

Do you want to know more?

You can get more information about joining a clinical research study by reading the publication "Medicare and Clinical Research Studies" on the Medicare website (www.medicare.gov). You can

also call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

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

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

A religious non-medical health care institution is a facility that provides care for a condition that would ordinarily be treated in a hospital or skilled nursing facility. If getting care in a hospital or a skilled nursing facility is against a member's religious beliefs, we will instead provide coverage for care in a religious non-medical health care institution. You may choose to pursue medical care at any time for any reason. This benefit is provided only for Part A inpatient services (non-medical health care services). Medicare will only pay for non-medical health care services provided by religious non-medical health care institutions.

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.

You are covered for unlimited days in the hospital, as long as your stay meets Medicare coverage guidelines. The coverage limits are described under **Inpatient Hospital Care** in the Medical Benefits Chart in Chapter 4.

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 our plan, 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. Under certain limited circumstances we will transfer ownership of the durable medical equipment item. Call Customer Service (phone numbers are printed on the back cover of this booklet) to find out about the requirements you must meet and the documentation you need to provide.

You pay a one-time copayment or coinsurance for the purchase of certain DME items—including canes, crutches, walkers and commode chairs—then you own this equipment.

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

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

If you made fewer than 13 payments for the DME item under Original Medicare **before** you joined our plan, your previous payments also do not count toward the 13 consecutive payments. You will have to make 13 new consecutive payments after you return to Original Medicare in order to own the item. There are no exceptions to this case when you return to Original Medicare.

SECTION 8 Rules for Oxygen Equipment, Supplies, and Maintenance

Section 8.1 What oxygen benefits are you entitled to?

If you qualify for Medicare oxygen equipment coverage, then for as long as you are enrolled, our plan 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 our plan or no longer medically require oxygen equipment, then the oxygen equipment must be returned to the owner.

Section 8.2 What is your cost-sharing? Will it change after 36 months?

Your cost sharing for Medicare oxygen equipment coverage is 20% coinsurance, every time you get covered equipment or supplies.

Your cost-sharing will not change after being enrolled for 36 months in our plan.

If prior to enrolling in our plan you had made 36 months of rental payment for oxygen equipment coverage, your cost sharing in our plan is 20% coinsurance.

Section 8.3 What happens if you leave your plan and return to Original Medicare?

If you return to Original Medicare, then you start a new 36-month cycle which renews every five years. For example, if you had paid rentals for oxygen equipment for 36 months prior to joining our plan, join our plan for 12 months, and then return to Original Medicare, you will pay full cost sharing for oxygen equipment coverage.

Similarly, if you made payments for 36 months while enrolled in our plan and then return to Original Medicare, you will pay full cost sharing for oxygen equipment coverage.

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 focuses on your covered services and what you pay for your medical benefits. It includes a Medical Benefits Chart that lists your covered services and shows how much you will pay for each covered service as a member of Peoples Health Patriot (PPO). 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. If you think that you are being asked to pay improperly, contact Customer Service.

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

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

- Your **in-network maximum out-of-pocket amount** is $6,700. This is the most you pay during the calendar year for covered Medicare Part A and Part B services received from network providers. The amounts you pay for copayments and coinsurance for covered services from network providers count toward this in-network maximum out-of-pocket amount. (The amounts you pay for services from out-of-network providers do not count toward your in-network maximum out-of-pocket amount. In addition, amounts you pay for some services do not count toward your in-network maximum out-of-pocket amount. These services are marked with an asterisk in the Medical Benefits Chart.) If you have paid $6,700 for covered Part A and Part B services from network providers, you will not have any out-of-pocket costs for the rest of the year when you see our network providers. However, you must continue to pay the Medicare Part B premium (unless your Part B premium is paid for you by Louisiana Department of Health (Medicaid) or another third party).

- Your **combined maximum out-of-pocket amount** is $10,000. This is the most you pay during the calendar year for covered Medicare Part A and Part B services received from both in-network and out-of-network providers. The amounts you pay for copayments and coinsurance for covered services count toward this combined maximum out-of-pocket amount. (In addition, amounts you pay for some services do not count toward your combined maximum out-of-pocket amount. These services are marked with an asterisk in the Medical Benefits Chart.) If you have paid $10,000 for covered services, you will have 100% coverage and will not have any out-of-pocket costs for the rest of the year for covered Part A and Part B services. However, you must continue to pay the Medicare Part B premium (unless your Part B premium is paid for you by Louisiana Department of Health (Medicaid) or another third party).

Section 1.3 Our plan does not allow network providers to "balance bill" you

As a member of Peoples Health Patriot (PPO), an important protection for you is that you only have to pay your cost-sharing amount when you use network providers to get services covered by our plan. We do not allow network providers to "balance bill" you. Even if we pay less than the provider charges for a service, the network provider is not allowed to bill you for the balance. The network provider is allowed to collect only the plan cost-sharing amount from you and is not allowed to charge or bill you more for covered services.

In some cases, out-of-network providers can balance bill you for covered services. If you obtain covered services from an out-of-network provider who does not accept Medicare assignment, you will be responsible for the plan cost-sharing, plus any difference between the amount we pay the provider and the Medicare limiting charge. These services are marked with a plus sign (+) in the Medical Benefits Chart.

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 Peoples Health Patriot (PPO) 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, and equipment) **must** be medically necessary. "Medically necessary" means that the services, supplies, or drugs are needed for the prevention, diagnosis, or treatment of your medical condition and meet accepted standards of medical practice.
- You 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

Peoples Health Patriot (PPO).

- Covered services that may need approval in advance to be covered as in-network services are marked in italics in the Medical Benefits Chart.
- Network providers agree by contract to obtain prior authorization from the plan and agree not to balance bill you.
- You never need approval in advance for out-of-network services from out-of-network providers.
- While you don't need approval in advance for out-of-network services, you or your doctor can ask us to make a coverage decision in advance.

Other important things to know about our coverage:

- For benefits where your cost-sharing is a coinsurance percentage, the amount you pay depends on what type of provider you receive the services from:
  - If you receive the covered services from a network provider, you pay the coinsurance percentage multiplied by the plan's reimbursement rate (as determined in the contract between the provider and the plan).
  - If you receive the covered services from an out-of-network provider who participates with Medicare, you pay the coinsurance percentage multiplied by the Medicare payment rate for participating providers.
  - If you receive the covered services from an out-of-network provider who does not participate with Medicare, you pay the coinsurance percentage multiplied by the Medicare Allowable Charge, plus the difference between the Medicare Allowable Charge and the Original Medicare Limiting Charge.
- 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 2021** Handbook. View it online at www.medicare.gov or ask for a copy by calling 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.)
- For all preventive services that are covered at no cost under Original Medicare, we also cover the service at no cost to you when you use a network provider. 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. See the Medical Benefits Chart for information about your share of the **out-of-network** costs for these services.
- Sometimes, Medicare adds coverage under Original Medicare for new services during the year. If Medicare adds coverage for any services during 2021, either Medicare or our plan will cover those services.

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

Medically Necessary - means health care services, supplies, or drugs needed for the prevention, diagnosis, or treatment of your sickness, injury or illness that are all of the following as determined by us or our designee, within our sole discretion:

- In accordance with **Generally Accepted Standards of Medical Practice**.
- Most appropriate, in terms of type, frequency, extent, site and duration, and considered effective for your sickness, injury, or illness.
- Not mainly for your convenience or that of your doctor or other health care provider.
- Meet, but do not exceed your medical need, are at least as beneficial as an existing and available medically appropriate alternative, and are furnished in the most cost-effective manner that may be provided safely and effectively.

Generally Accepted Standards of Medical Practice are standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, relying primarily on controlled clinical trials, or, if not available, observational studies from more than one institution that suggest a causal relationship between the service or treatment and health outcomes.

If no credible scientific evidence is available, then standards that are based on Physician specialty society recommendations or professional standards of care may be considered. We reserve the right to consult expert opinion in determining whether health care services are Medically Necessary. The decision to apply Physician specialty society recommendations, the choice of expert and the determination of when to use any such expert opinion, shall be within our sole discretion.

Medical Benefits Chart

Services that are covered for you	**What you must pay** when you get these services In-Network	**What you must pay** when you get these services Out-of-Network
Providers may ask you for more than one cost share payment if you get more than one service at an appointment. For example: □ Your doctor will ask for a copayment for the office visit and additional copayments for each x-ray that is performed while you are there. □ Your hospital may ask for separate cost sharing for certain outpatient hospital medical services for example but not limited to; radiological tests or Medicare Part B drugs administered while you are there. □ The specific cost sharing that will apply depends on which services you receive. The Medical Benefits Chart below lists the cost sharing that applies for each specific service.		
Abdominal Aortic Aneurysm Screening A one-time (once per lifetime) 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.	There is no coinsurance, copayment, or deductible for members eligible for this preventive screening.	40% coinsurance for members eligible for this preventive screening.+ You pay these amounts until you reach the out-of-pocket maximum.

If you are a Qualified Medicare Beneficiary (QMB) or have full Medicaid benefits then your deductible, coinsurance and/or copayment may be less for services that are covered under Original Medicare.

Services that are covered for you	What you must pay when you get these services In-Network	What you must pay when you get these services Out-of-Network
Acupuncture for chronic low back pain Covered services include: Up to 12 visits in 90 days are covered for Medicare beneficiaries under the following circumstances: For the purpose of this benefit, chronic low back pain is defined as: • Lasting 12 weeks or longer; • nonspecific, in that it has no identifiable systemic cause (i.e., not associated with metastatic, inflammatory, infectious, etc. disease); • not associated with surgery; and • not associated with pregnancy. An additional eight sessions will be covered for those patients demonstrating an improvement. No more than 20 acupuncture treatments may be administered annually. Treatment must be discontinued if the patient is not improving or is regressing.	You will pay the cost-sharing that applies to primary care services or specialist physician services (as described under "Physician/ Practitioner Services, Including Doctor's Office Visits") depending on if you receive services from a primary care physician or specialist. You pay these amounts until you reach the out-of-pocket maximum.	You will pay the cost-sharing that applies to primary care services or specialist physician services (as described under "Physician/ Practitioner Services, Including Doctor's Office Visits") depending on if you receive services from a primary care physician or specialist.+ You pay these amounts until you reach the out-of-pocket maximum.
Ambulance Services □ Covered ambulance services include fixed wing, rotary wing, and ground ambulance services, to the nearest appropriate facility that can provide care only if they	$250 copayment for each one-way Medicare-covered ground trip. $250 copayment for each one-way Medicare-covered air trip.	

If you are a Qualified Medicare Beneficiary (QMB) or have full Medicaid benefits then your deductible, coinsurance and/or copayment may be less for services that are covered under Original Medicare.

Services that are covered for you	What you must pay when you get these services In-Network	What you must pay when you get these services Out-of-Network
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.	You pay these amounts until you reach the out-of-pocket maximum. *Your provider may need to obtain prior authorization for Non-emergency transportation.*	
Annual Routine Physical Exam Includes comprehensive physical examination and evaluation of status of chronic diseases. Doesn't include lab tests, radiological diagnostic tests or non-radiological diagnostic tests. Additional cost share may apply to any lab or diagnostic testing performed during your visit, as described for each separate service in this Medical Benefits Chart. Annual Routine Physical Exam visits do not need to be scheduled 12 months apart but are limited to one each calendar year. Benefit is combined in and out-of-network.	$0 copayment for a routine physical exam each year.	40% coinsurance for a routine physical exam each year.*

If you are a Qualified Medicare Beneficiary (QMB) or have full Medicaid benefits then your deductible, coinsurance and/or copayment may be less for services that are covered under Original Medicare.

Services that are covered for you	**What you must pay** when you get these services In-Network	**What you must pay** when you get these services Out-of-Network
Annual Wellness Visit If you've had Part B for longer than 12 months, you can get an annual wellness visit to develop or update a personalized prevention plan based on your current health and risk factors. This is covered once every 12 months. Doesn't include lab tests, radiological diagnostic tests or non-radiological diagnostic tests. Additional cost share may apply to any lab or diagnostic testing performed during your visit, as described for each separate service in this Medical Benefits Chart. **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.	There is no coinsurance, copayment, or deductible for the annual wellness visit.	40% coinsurance for the annual wellness visit.+ You pay these amounts until you reach the out-of-pocket maximum.

If you are a Qualified Medicare Beneficiary (QMB) or have full Medicaid benefits then your deductible, coinsurance and/or copayment may be less for services that are covered under Original Medicare.

Services that are covered for you	**What you must pay** when you get these services In-Network	**What you must pay** when you get these services Out-of-Network
Bone Mass Measurement For qualified individuals (generally, this means people at risk of losing bone mass or at risk of osteoporosis), the following services are covered every 24 months or more frequently if medically necessary: procedures to identify bone mass, detect bone loss, or determine bone quality, including a physician's interpretation of the results.	There is no coinsurance, copayment, or deductible for Medicare-covered bone mass measurement.	40% coinsurance for Medicare-covered bone mass measurement.+ You pay these amounts until you reach the out-of-pocket maximum.
Breast Cancer Screening (Mammograms) Covered services include: □ One baseline mammogram between the ages of 35 and 39 □ One screening mammogram every 12 months for women age 40 and older □ Clinical breast exams once every 24 months	There is no coinsurance, copayment, or deductible for covered screening mammograms.	40% coinsurance for covered screening mammograms.+ You pay these amounts until you reach the out-of-pocket maximum.
Cardiac Rehabilitation Services Comprehensive programs of cardiac rehabilitation services that include exercise, education, and counseling are covered for members who meet certain conditions with a doctor's order. The plan also covers intensive cardiac rehabilitation programs that are typically more rigorous or more	$0 copayment for each Medicare-covered cardiac rehabilitative visit. *Your provider may need to obtain prior authorization.*	$55 copayment for each Medicare-covered cardiac rehabilitative visit.+ You pay these amounts until you reach the out-of-pocket maximum.

Services that are covered for you	**What you must pay** when you get these services In-Network	**What you must pay** when you get these services Out-of-Network
intense than cardiac rehabilitation programs.		
Cardiovascular disease risk reduction visit (therapy for cardiovascular disease) We cover one visit per year with your primary care doctor to help lower your risk for cardiovascular disease. During this visit, your doctor may discuss aspirin use (if appropriate), check your blood pressure, and give you tips to make sure you're eating healthy.	There is no coinsurance, copayment, or deductible for the cardiovascular disease preventive benefit.	40% coinsurance for the cardiovascular disease preventive benefit.+ You pay these amounts until you reach the out-of-pocket maximum.
Cardiovascular Disease Testing Blood tests for the detection of cardiovascular disease (or abnormalities associated with an elevated risk of cardiovascular disease) covered once every five years (60 months).	There is no coinsurance, copayment, or deductible for cardiovascular disease testing that is covered once every five years.	40% coinsurance for cardiovascular disease testing that is covered once every five years.+ You pay these amounts until you reach the out-of-pocket maximum.

If you are a Qualified Medicare Beneficiary (QMB) or have full Medicaid benefits then your deductible, coinsurance and/or copayment may be less for services that are covered under Original Medicare.

Services that are covered for you	**What you must pay** when you get these services In-Network	**What you must pay** when you get these services Out-of-Network
Cervical and Vaginal Cancer Screening Covered services include: □ For all women: Pap tests and pelvic exams are covered once every 24 months □ If you are at high risk of cervical or vaginal cancer or you are of childbearing age and have had an abnormal Pap test within the past 3 years: one Pap test every 12 months □ For asymptomatic women between the ages of 30 and 65: HPV Testing once every 5 years, in conjunction with the Pap test	There is no coinsurance, copayment, or deductible for Medicare-covered preventive Pap and pelvic exams.	40% coinsurance for Medicare-covered preventive Pap and pelvic exams.+ You pay these amounts until you reach the out-of-pocket maximum.
Chiropractic Services Covered services include: □ Manual manipulation of the spine to correct subluxation (when one or more of the bones of your spine move out of position). □ Excluded from Medicare coverage is any service other than manual manipulation for the treatment of subluxation.	$20 copayment for each Medicare-covered visit. You pay these amounts until you reach the out-of-pocket maximum.	$55 copayment for each Medicare-covered visit.+ You pay these amounts until you reach the out-of-pocket maximum.
Colorectal Cancer Screening	There is no coinsurance, copayment, or	40% coinsurance for a Medicare-covered

If you are a Qualified Medicare Beneficiary (QMB) or have full Medicaid benefits then your deductible, coinsurance and/or copayment may be less for services that are covered under Original Medicare.

Services that are covered for you	**What you must pay** when you get these services In-Network	**What you must pay** when you get these services Out-of-Network
For people 50 and older, the following are covered: □ Flexible sigmoidoscopy (or screening barium enema as an alternative) every 48 months One of the following every 12 months : □ Guaiac-based fecal occult blood test (gFOBT) □ Fecal immunochemical test (FIT) DNA based colorectal screening every 3 years For people at high risk of colorectal cancer, we cover: □ Screening colonoscopy (or screening barium enema as an alternative) every 24 months For people not at high risk of colorectal cancer, we cover: □ Screening colonoscopy every 10 years (120 months), but not within 48 months of a screening sigmoidoscopy	deductible for a Medicare-covered colorectal cancer screening exam. There is no coinsurance, copayment, or deductible for each Medicare-covered barium enema.	colorectal cancer screening exam.+ You pay these amounts until you reach the out-of-pocket maximum. 40% coinsurance for each Medicare-covered barium enema.+ You pay these amounts until you reach the out-of-pocket maximum.

If you are a Qualified Medicare Beneficiary (QMB) or have full Medicaid benefits then your deductible, coinsurance and/or copayment may be less for services that are covered under Original Medicare.

Services that are covered for you	What you must pay when you get these services In-Network	What you must pay when you get these services Out-of-Network
Dental Services In general, preventive dental services (such as cleaning, routine dental exams, and dental x-rays) are not covered by Original Medicare. We cover: **Additional Dental Benefits** You can view the Vendor Information Sheet at www.peopleshealth.com, or call Customer Service to have a paper copy sent to you.	You are covered for additional dental benefits. See the additional dental benefit description at the end of this chart for details.*	
Depression Screening We cover one screening for depression per year. The screening must be done in a primary care setting that can provide follow-up treatment and/or referrals.	There is no coinsurance, copayment, or deductible for an annual depression screening visit.	40% coinsurance for an annual depression screening visit.+ You pay these amounts until you reach the out-of-pocket maximum.
Diabetes Screening We cover this screening (includes fasting glucose tests) if you have any of the following risk factors: high blood pressure (hypertension), history of abnormal cholesterol and triglyceride levels (dyslipidemia), obesity, or a history of high blood sugar (glucose). Tests may also be covered if you meet other requirements, like being	There is no coinsurance, copayment, or deductible for the Medicare-covered diabetes screening tests.	40% coinsurance for the Medicare-covered diabetes screening tests. + You pay these amounts until you reach the out-of-pocket maximum.

If you are a Qualified Medicare Beneficiary (QMB) or have full Medicaid benefits then your deductible, coinsurance and/or copayment may be less for services that are covered under Original Medicare.

Services that are covered for you	**What you must pay** when you get these services In-Network	**What you must pay** when you get these services Out-of-Network
overweight and having a family history of diabetes. Based on the results of these tests, you may be eligible for up to two diabetes screenings every 12 months.		
Diabetes Self-Management Training, Diabetic Services and Supplies For all people who have diabetes (insulin and non-insulin users). Covered services include:		
□ Supplies to monitor your blood glucose: Blood glucose monitor, blood glucose test strips, lancet devices and lancets, and glucose-control solutions for checking the accuracy of test strips and monitors. The blood glucose monitors and blood glucose monitor test strip brands we cover are either preferred brands or non-preferred brands. The preferred brands we cover can be found on our website at www.peopleshealth.com or by calling member services.	$0 copayment for each Medicare-covered diabetes monitoring supply. Diabetes monitoring supplies must be purchased from a durable medical equipment provider. *Your provider may need to obtain prior authorization*. Insulin and syringes are not covered.	40% coinsurance for each Medicare-covered diabetes monitoring supply. Diabetes monitoring supplies must be purchased from a durable medical equipment provider. You pay these amounts until you reach the out-of-pocket maximum. Insulin and syringes are not covered.
□ For people with diabetes who have severe diabetic foot disease: One	20% coinsurance for each pair of Medicare-	40% coinsurance for each pair of Medicare-

Services that are covered for you	**What you must pay** when you get these services In-Network	**What you must pay** when you get these services Out-of-Network
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.	covered therapeutic shoes. You pay these amounts until you reach the out-of-pocket maximum. *Your provider may need to obtain prior authorization.*	covered therapeutic shoes. You pay these amounts until you reach the out-of-pocket maximum.
□ Diabetes self-management training is covered under certain conditions. Limited to 20 visits of 30 minutes per year for a maximum of 10 hours the initial year. Follow-up training subsequent years after, limited to 4 visits of 30 minutes for a maximum of 2 hours per year.	$0 copayment for Medicare-covered benefits.	40% coinsurance for Medicare-covered benefits.+ You pay these amounts until you reach the out-of-pocket maximum.
Durable Medical Equipment (DME) and Related Supplies (For a definition of "durable medical equipment," see Chapter 10 of this booklet.) 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	20% coinsurance for Medicare-covered benefits. 20% coinsurance for each Medicare-covered Continuous Glucose Monitor and supplies in accordance with Medicare guidelines. There are no brand limitations for	50% coinsurance for Medicare-covered benefits. 50% coinsurance for each Medicare-covered Continuous Glucose Monitor and supplies in accordance with Medicare guidelines.

If you are a Qualified Medicare Beneficiary (QMB) or have full Medicaid benefits then your deductible, coinsurance and/or copayment may be less for services that are covered under Original Medicare.

Services that are covered for you	**What you must pay** when you get these services In-Network	**What you must pay** when you get these services Out-of-Network
devices, oxygen equipment, nebulizers, and walkers. We cover all medically necessary DME covered by Original Medicare. If our supplier in your area does not carry a particular brand or manufacturer, you may ask them if they can special order it for you. Please speak with your doctor to obtain a product medically appropriate for you through our preferred vendor.	Continuous Glucose Monitors. You pay these amounts until you reach the out-of-pocket maximum. *Your provider may need to obtain prior authorization.*	You pay these amounts until you reach the out-of-pocket maximum.
Emergency Care Emergency care refers to services that are: □ Furnished by a provider qualified to furnish emergency services, and □ Needed to evaluate or stabilize an emergency medical condition. A medical emergency is when you, or any other prudent layperson with an average knowledge of health and medicine, believe that you have medical symptoms that require immediate medical attention to prevent loss of life, 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.	$90 copayment for each emergency room visit. You do not pay this amount if you are admitted to the hospital within 24 hours for the same condition. If you are admitted to a hospital, you will pay cost sharing as described in the “Inpatient Hospital Care” section in this benefit chart. You pay these amounts until you reach the out-of-pocket maximum.	

If you are a Qualified Medicare Beneficiary (QMB) or have full Medicaid benefits then your deductible, coinsurance and/or copayment may be less for services that are covered under Original Medicare.

Services that are covered for you	**What you must pay** when you get these services In-Network	**What you must pay** when you get these services Out-of-Network
Cost sharing for necessary emergency services furnished out-of-network is the same as for such services furnished in-network. Worldwide coverage for emergency department services. • This includes emergency or urgently needed care and emergency ambulance transportation from the scene of an emergency to the nearest medical treatment facility. • Transportation back to the United States from another country is not covered. • Pre-scheduled, pre-planned treatments (including dialysis for an ongoing condition) and/or elective procedures are not covered. • Services provided by a dentist are not covered.	$0 copayment for worldwide coverage for emergency services. Please see Chapter 5 Section 1.1 for expense reimbursement for worldwide services. If you receive emergency care at an out-of-network hospital and need inpatient care after your emergency condition is stabilized, you must move to a network hospital in order to pay the in-network cost-sharing amount for the part of your stay after you are stabilized. If you stay at the out-of-network hospital, your stay will be covered but you will pay the out-of-network cost-sharing amount for the part of your stay after you are stabilized.	
Fitness Program Peoples Health offers members a membership to their choice of a network fitness center. Membership includes orientation to the facility, as well as access to cardiovascular and	$0 copayment	$0 copayment for an at-home fitness kit: Available for members living 15 miles or more from a participating fitness center location. There are no out-of-

If you are a Qualified Medicare Beneficiary (QMB) or have full Medicaid benefits then your deductible, coinsurance and/or copayment may be less for services that are covered under Original Medicare.

Services that are covered for you	**What you must pay** when you get these services In-Network	**What you must pay** when you get these services Out-of-Network
weight-training equipment, some classes, pools, and saunas.		network facilities available for this benefit.
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.	$0 copayment for each Medicare-covered exam.	$55 copayment for each Medicare-covered exam.+ You pay these amounts until you reach the out-of-pocket maximum.
Additional Routine Hearing Exams: □ Limited to 1 exam(s) every year. **Hearing Aids**: We also cover the following services: • Two hearing aids (one hearing aid per ear) up to a maximum of $500 per ear, per year. Hearing aid purchase includes: o Three follow-up visits for hearing aid fitting and adjustments o 45-day trial period o Three-year warranty o 48 batteries per aid, for non-rechargeable hearing aids • One hearing exam for evaluation and fitting of hearing aids per year	**Hearing Exam**: $20 copayment* **Hearing Aids**: $0 copayment Hearing aid credit is $500 per ear up to a maximum benefit of $1,000 per year $0 copayment for hearing exam for evaluation and fitting of hearing aids	**Hearing Exam**: $55 copayment* **Hearing Aids**: Benefits combined in and out-of-network. Home delivered hearing aids available nationwide through TruHearing.

If you are a Qualified Medicare Beneficiary (QMB) or have full Medicaid benefits then your deductible, coinsurance and/or copayment may be less for services that are covered under Original Medicare.

Services that are covered for you	**What you must pay** when you get these services In-Network	**What you must pay** when you get these services Out-of-Network
Note: There is a network of audiologists and hearing instrument specialists that you must use for hearing aids and for hearing exams for evaluation and fitting of hearing aids to be covered. Call Customer Service (see the back cover) or refer to the Provider Directory in the Audiologists and Hearing Instrument Specialists section for more information about these providers. You can access our online directory at http://www.peopleshealth.com/providers, or call Customer Service if you need help finding a network provider. You can view the Vendor Information Sheet at www.peopleshealth.com, or call Customer Service to have a paper copy sent to you.		
HIV Screening For people who ask for an HIV screening test or who are at increased risk for HIV infection, we cover: □ One screening exam every 12 months For women who are pregnant, we cover:	There is no coinsurance, copayment, or deductible for members eligible for Medicare-covered preventive HIV screening.	40% coinsurance for members eligible for Medicare-covered preventive HIV screening.+ You pay these amounts until you reach the out-of-pocket maximum.

If you are a Qualified Medicare Beneficiary (QMB) or have full Medicaid benefits then your deductible, coinsurance and/or copayment may be less for services that are covered under Original Medicare.

Services that are covered for you	**What you must pay** when you get these services In-Network	**What you must pay** when you get these services Out-of-Network
□ Up to three screening exams during a pregnancy		
Home Health Agency Care Prior to receiving home health services, a doctor must certify that you are confined to your home. Confined to the home means that: □ Because of illness or injury, aid of supportive devices such as crutches, canes, wheelchairs, and walkers; the use of special transportation; or the assistance of another person is needed in order to leave your place of residence; or □ You have a condition such that leaving your home is not medically recommended There must also exist a normal inability for you to leave the home, and when you do leave the home it must require a considerable and taxing effort. You also need to have a qualifying need for skilled care. A signed order must come from the doctor with the request for home health services. You will need to see the doctor either within 90 days prior to starting home health services or within 30 days after services have started.	$0 copayment for all home health visits provided by a network home health agency when Medicare criteria are met. Other copayments or coinsurance may apply (Please see Durable Medical Equipment and Related Supplies for applicable copayments or coinsurance). *Your provider may need to obtain prior authorization*.	50% coinsurance for all home health visits provided by a home health agency when Medicare criteria are met. Other copayments or coinsurance may apply (Please see Durable Medical Equipment and Related Supplies for applicable copayments or coinsurance). You pay these amounts until you reach the out-of-pocket maximum.

If you are a Qualified Medicare Beneficiary (QMB) or have full Medicaid benefits then your deductible, coinsurance and/or copayment may be less for services that are covered under Original Medicare.

Services that are covered for you	**What you must pay** when you get these services In-Network	**What you must pay** when you get these services Out-of-Network
Covered services include, but are not limited to: □ Part-time or intermittent skilled nursing and home health aide services (To be covered under the home health care benefit, your skilled nursing and home health aide services combined must total fewer than 8 hours per day and 35 hours per week) □ Physical therapy, occupational therapy, and speech therapy □ Medical and social services □ Medical equipment and supplies		
Home Infusion Therapy Home infusion therapy involves the intravenous or subcutaneous administration of drugs or biologicals to an individual at home. The components needed to perform home infusion include the drug (for example, antivirals, immune globulin), equipment (for example, a pump), and supplies (for example, tubing and catheters). Covered services include, but are not limited to: □ Professional services, including nursing services, furnished in accordance with the plan of care	You will pay the cost-sharing that applies to primary care services, specialist physician services, or Home Health (as described under “Physician/Practitioner Services, Including Doctor’s Office Visits” or "Home Health Agency Care") depending on where you received administration or monitoring services. You pay these amounts until you reach the out-of-pocket maximum.	You will pay the cost-sharing that applies to primary care services, specialist physician services, or Home Health (as described under “Physician/Practitioner Services, Including Doctor’s Office Visits” or "Home Health Agency Care") depending on where you received administration or monitoring services.+ You pay these amounts until you reach the out-of-pocket maximum.

If you are a Qualified Medicare Beneficiary (QMB) or have full Medicaid benefits then your deductible, coinsurance and/or copayment may be less for services that are covered under Original Medicare.

Services that are covered for you	**What you must pay** when you get these services In-Network	**What you must pay** when you get these services Out-of-Network
□ 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	*Your provider may need to obtain prior authorization*. See "Durable Medical Equipment" earlier in this chart for any applicable cost-sharing for equipment and supplies related to Home Infusion Therapy. You pay these amounts until you reach the out-of-pocket maximum. *Your provider may need to obtain prior authorization*. See "Medicare Part B Prescription Drugs" later in this chart for any applicable cost-sharing for drugs related to Home Infusion Therapy. You pay these amounts until you reach the out-of-pocket maximum. *Your provider may need to obtain prior authorization*.	See "Durable Medical Equipment" earlier in this chart for any applicable cost-sharing for equipment and supplies related to Home Infusion Therapy. You pay these amounts until you reach the out-of-pocket maximum. See "Medicare Part B Prescription Drugs" later in this chart for any applicable cost-sharing for drugs related to Home Infusion Therapy. You pay these amounts until you reach the out-of-pocket maximum.

If you are a Qualified Medicare Beneficiary (QMB) or have full Medicaid benefits then your deductible, coinsurance and/or copayment may be less for services that are covered under Original Medicare.

Services that are covered for you	**What you must pay** when you get these services In-Network	**What you must pay** when you get these services Out-of-Network
Hospice Care You may receive care from any Medicare-certified hospice program. 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. Your hospice doctor can be a network provider or an out-of-network provider. Covered services include: □ Drugs for symptom control and pain relief □ Short-term respite care □ Home care **For hospice services and for services that are covered by Medicare Part A or B and are related to your terminal prognosis:** Original Medicare (rather than our plan) will pay 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. **For services that are covered by Medicare Part A or B and are not**	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 Peoples Health Patriot (PPO).	

If you are a Qualified Medicare Beneficiary (QMB) or have full Medicaid benefits then your deductible, coinsurance and/or copayment may be less for services that are covered under Original Medicare.

Services that are covered for you	**What you must pay** when you get these services In-Network	**What you must pay** when you get these services Out-of-Network
related to your terminal prognosis: If you need non-emergency, non-urgently needed services that are covered under Medicare Part A or B and that are not related to your terminal prognosis, your cost for these services depends on whether you use a provider in our plan's network: □ If you obtain the covered services from a network provider, you only pay the plan cost-sharing amount for in-network services □ If you obtain the covered services from an out-of-network provider, you pay the plan cost-sharing for out-of-network services For services that are covered by Peoples Health Patriot (PPO) but are not covered by Medicare Part A or B: Peoples Health Patriot (PPO) will continue to cover plan-covered services that are not covered under Part A or B whether or not they are related to your terminal prognosis. You pay your plan cost-sharing amount for these services. **Note:** If you need non-hospice care (care that is not related to your terminal prognosis), you should contact us to arrange the services. Getting your non-hospice care through our network providers will lower your share of the costs for the services.		

If you are a Qualified Medicare Beneficiary (QMB) or have full Medicaid benefits then your deductible, coinsurance and/or copayment may be less for services that are covered under Original Medicare.

Services that are covered for you	**What you must pay** when you get these services In-Network	**What you must pay** when you get these services Out-of-Network
Our plan covers hospice consultation services (one time only) for a terminally ill person who hasn't elected the hospice benefit.		
Immunizations Covered Medicare Part B services include: □ Pneumonia vaccine □ Flu shots, each flu season in the fall and winter, with additional flu shots if medically necessary □ Hepatitis B vaccine if you are at high or intermediate risk of getting Hepatitis B □ Other vaccines if you are at risk and they meet Medicare Part B coverage rules	There is no coinsurance, copayment, or deductible for the pneumonia, influenza, and Hepatitis B vaccines. There is no coinsurance, copayment, or deductible for all other Medicare-covered Immunizations.	There is no coinsurance, copayment, or deductible for the pneumonia, influenza, and Hepatitis B vaccines.+ There is no coinsurance, copayment, or deductible for all other Medicare-covered Immunizations.+
Inpatient Hospital Care Includes inpatient acute, inpatient rehabilitation, long-term care hospitals, and other types of inpatient hospital services. Inpatient hospital care starts the day you are formally admitted to the hospital with a doctor's order. The day before you are discharged is your last inpatient day. Covered services include, but are not limited to:	$225 copayment each day for days 1 to 7 for Medicare-covered hospital care. $0 copayment for additional Medicare-covered days. You pay these amounts until you reach the out-of-pocket maximum.	40% coinsurance for each Medicare-covered hospital stay for unlimited days. You pay these amounts until you reach the out-of-pocket maximum. Medicare hospital benefit periods do not apply. (See definition of benefit periods in the

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Services that are covered for you	**What you must pay** when you get these services In-Network	**What you must pay** when you get these services Out-of-Network
□ 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. □ 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. The plan has a network of facilities that perform organ transplants. The plan's hospital network for organ transplant services is different than the network shown in the 'Hospitals' section of your provider directory. Some hospitals in the	*Your provider may need to obtain prior authorization*. If you get authorized inpatient care at an out-of-network hospital after your emergency condition is stabilized, your cost is the cost-sharing you would pay at a network hospital. Medicare hospital benefit periods do not apply. (See definition of benefit periods in the chapter titled Definitions of important words.) For inpatient hospital care, the cost-sharing described above applies each time you are admitted to the hospital. A transfer to a separate facility type (such as an Inpatient Rehabilitation Hospital or Long Term Care Hospital) is considered a new admission. For each inpatient hospital stay, you are covered for unlimited days as long as the hospital stay is	chapter titled Definitions of important words.) For inpatient hospital care, the cost-sharing described above applies each time you are admitted to the hospital. A transfer to a separate facility type (such as an Inpatient Rehabilitation Hospital or Long Term Care Hospital) is considered a new admission. For each inpatient hospital stay, you are covered for unlimited days as long as the hospital stay is covered in accordance with plan rules.

If you are a Qualified Medicare Beneficiary (QMB) or have full Medicaid benefits then your deductible, coinsurance and/or copayment may be less for services that are covered under Original Medicare.

Services that are covered for you	**What you must pay** when you get these services In-Network	**What you must pay** when you get these services Out-of-Network
plan's network for other medical services are not in the plan's network for transplant services. For information on network facilities for transplant services, please call Peoples Health Patriot (PPO) Customer Service at 1-800-222-8600 TTY 711. 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. 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 Peoples Health Patriot (PPO) provides transplant services at a location outside of the pattern of care for transplants in your community and you chose to obtain transplants at this distant location, we will arrange or pay for appropriate lodging and transportation costs for you and a companion. While you are receiving care at the distant location, we will also reimburse transportation costs to and from	covered in accordance with plan rules.	

If you are a Qualified Medicare Beneficiary (QMB) or have full Medicaid benefits then your deductible, coinsurance and/or copayment may be less for services that are covered under Original Medicare.

Services that are covered for you	**What you must pay** when you get these services In-Network	**What you must pay** when you get these services Out-of-Network
the hospital or doctor's office for evaluations, transplant services and follow-up care. (Transportation in the distant location includes, but is not limited to: vehicle mileage, economy/coach airfare, taxi fares, or rideshare services.) Costs for lodging or places to stay such as hotels, motels or short-term housing as a result of travel for a covered organ transplant may also be covered. You can be reimbursed for eligible costs up to $125 per day total. Transportation services are not subject to the daily limit amount. □ Blood - including storage and administration. Coverage begins with the first pint of blood that you need. □ Physician services **Note:** To be an inpatient, your provider must write an order to admit you formally as an inpatient of the hospital. Even if you stay in the hospital overnight, you might still be considered an "outpatient." This is called an "Outpatient Observation" stay. If you are not sure if you are an	Outpatient observation cost-sharing is explained in Outpatient Surgery and Other Medical Services Provided at Hospital Outpatient Facilities and Ambulatory Surgical Centers.	Outpatient observation cost-sharing is explained in Outpatient Surgery and Other Medical Services Provided at Hospital Outpatient Facilities and Ambulatory Surgical Centers.

If you are a Qualified Medicare Beneficiary (QMB) or have full Medicaid benefits then your deductible, coinsurance and/or copayment may be less for services that are covered under Original Medicare.

Services that are covered for you	What you must pay when you get these services In-Network	What you must pay when you get these services Out-of-Network
inpatient or an outpatient, you should ask the hospital staff. You can also find more information in a Medicare fact sheet called "Are You a Hospital Inpatient or Outpatient? If You Have Medicare – Ask!" This fact sheet is available on the Web at https://www.medicare.gov/sites/default/files/2018-09/11435-Are-You-an-Inpatient-or-Outpatient.pdf or by calling 1-800-MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048. You can call these numbers for free, 24 hours a day, 7 days a week.		
Inpatient Mental Health Care 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 Mental Health services provided in a psychiatric unit of a general hospital. □ Inpatient substance abuse services	$225 copayment each day for days 1 to 7 each time you are admitted. $0 copayment for additional Medicare-covered days, up to 90 days. Plus an additional 60 lifetime reserve days. You pay these amounts until you reach the out-of-pocket maximum. *Your provider may need to obtain prior authorization.* Medicare hospital benefit periods are used to determine the total	40% coinsurance each time you are admitted, up to 90 days. Plus an additional 60 lifetime reserve days. You pay these amounts until you reach the out-of-pocket maximum. Medicare hospital benefit periods are used to determine the total number of days covered for inpatient mental health care. (See definition of benefit periods in the chapter titled Definitions of important words.)

If you are a Qualified Medicare Beneficiary (QMB) or have full Medicaid benefits then your deductible, coinsurance and/or copayment may be less for services that are covered under Original Medicare.

Services that are covered for you	**What you must pay** when you get these services In-Network	**What you must pay** when you get these services Out-of-Network
	number of days covered for inpatient mental health care. (See definition of benefit periods in the chapter titled Definitions of important words.) However, the cost-sharing described above applies each time you are admitted to the hospital, even if you are admitted multiple times within a benefit period.	However, the cost-sharing described above applies each time you are admitted to the hospital, even if you are admitted multiple times within a benefit period.
Inpatient Stay: Covered services received in a hospital or Skilled Nursing Facility (SNF) during a non-covered inpatient stay If you have exhausted your inpatient benefits or if the inpatient stay is not reasonable and necessary, we will not cover your inpatient stay. However, in some cases, we will cover certain services you receive while you are in the hospital or the skilled nursing facility (SNF). Covered services include, but are not limited to:	When your stay is no longer covered, these services will be covered as described in the following sections:	When your stay is no longer covered, these services will be covered as described in the following sections:
□ Physician services	Please refer below to Physician/Practitioner Services, Including Doctor's Office Visits.	Please refer below to Physician/Practitioner Services, Including Doctor's Office Visits.

If you are a Qualified Medicare Beneficiary (QMB) or have full Medicaid benefits then your deductible, coinsurance and/or copayment may be less for services that are covered under Original Medicare.

Services that are covered for you	**What you must pay** when you get these services In-Network	**What you must pay** when you get these services Out-of-Network
□ Diagnostic tests (like lab tests)	Please refer below to Outpatient Diagnostic Tests and Therapeutic Services and Supplies.	Please refer below to Outpatient Diagnostic Tests and Therapeutic Services and Supplies.
□ X-ray, radium, and isotope therapy including technician materials and services	Please refer below to Outpatient Diagnostic Tests and Therapeutic Services and Supplies.	Please refer below to Outpatient Diagnostic Tests and Therapeutic Services and Supplies.
□ Surgical dressings □ Splints, casts and other devices used to reduce fractures and dislocations	Please refer below to Outpatient Diagnostic Tests and Therapeutic Services and Supplies.	Please refer below to Outpatient Diagnostic Tests and Therapeutic Services and Supplies.
□ 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	Please refer below to Prosthetic Devices and Related Supplies.	Please refer below to Prosthetic Devices and Related Supplies.
□ 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	Please refer below to Prosthetic Devices and Related Supplies.	Please refer below to Prosthetic Devices and Related Supplies.

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Services that are covered for you	**What you must pay** when you get these services In-Network	**What you must pay** when you get these services Out-of-Network
□ Physical therapy, speech language therapy, and occupational therapy	Please refer below to Outpatient Rehabilitation Services.	Please refer below to Outpatient Rehabilitation Services.
Meal Benefit We cover up to 2 prepared meals per day for 5 days (up to 10 meals total) for members who are being discharged from an inpatient hospital stay, an inpatient rehabilitation stay, or a long-term acute care facility stay to their home or another household in Louisiana. Meals are not covered following a discharge from an inpatient mental health stay, a skilled nursing facility stay, or an observation stay. Meals are prepared and delivered by the network meal provider. We will work with you at the time of your discharge to set up meals based on your health needs. If you don't order meals at the time of discharge, you have up to seven calendar days after your discharge date to set up meals.	$0 copayment; delivered by the network meal provider Prior authorization is required.	
Medical Nutrition Therapy This benefit is for people with diabetes, renal (kidney) disease (but not on dialysis), or after a kidney transplant when ordered by your doctor.	There is no coinsurance, copayment, or deductible for members eligible for Medicare-covered medical nutrition therapy services.	40% coinsurance for members eligible for Medicare-covered medical nutrition therapy services.+

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Services that are covered for you	**What you must pay** when you get these services In-Network	**What you must pay** when you get these services Out-of-Network
We cover three hours of one-on-one counseling services during your first year that you receive medical nutrition therapy services under Medicare (this includes our plan, any other Medicare Advantage plan, or Original Medicare), and two hours each year after that. If your condition, treatment, or diagnosis changes, you may be able to receive more hours of treatment with a physician's order. A physician must prescribe these services and renew their order yearly if your treatment is needed into the next calendar year.		You pay these amounts until you reach the out-of-pocket maximum.
Medicare Diabetes Prevention Program (MDPP) MDPP services will be covered for eligible Medicare beneficiaries under all Medicare health plans. MDPP is a structured health behavior change intervention that provides practical training in long-term dietary change, increased physical activity, and problem-solving strategies for overcoming challenges to sustaining weight loss and a healthy lifestyle.	There is no coinsurance, copayment, or deductible for the MDPP benefit.	40% coinsurance for the MDPP benefit.+ You pay these amounts until you reach the out-of-pocket maximum.
Medicare Part B Prescription Drugs These drugs are covered under Part B of Original Medicare. Members of our plan receive coverage for these drugs	20% coinsurance for each Medicare-covered Part B drug. Additionally, for the administration of	40% coinsurance for each Medicare-covered Part B drug. Additionally, for the administration of that drug, you will pay

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Services that are covered for you	**What you must pay** when you get these services In-Network	**What you must pay** when you get these services Out-of-Network
through our plan. Covered drugs include: □ Drugs that usually aren't self-administered by the patient and are injected or infused while you are getting physician, hospital outpatient, or ambulatory surgical center services □ Drugs you take using durable medical equipment (such as nebulizers) that were authorized by the plan □ Clotting factors you give yourself by injection if you have hemophilia □ Immunosuppressive drugs, if you were enrolled in Medicare Part A at the time of the organ transplant □ Injectable osteoporosis drugs, if you are homebound, have a bone fracture that a doctor certifies was related to post-menopausal osteoporosis, and cannot self-administer the drug □ Antigens (for allergy shots) □ Certain oral anti-cancer drugs and anti-nausea drugs □ Certain drugs for home dialysis, including heparin, the antidote for heparin when medically necessary, topical anesthetics, and erythropoiesis-stimulating agents (such as Epogen®, Procrit®,	that drug, you will pay the cost-sharing that applies to primary care provider services, specialist services, or outpatient hospital services (as described under "Physician/ Practitioner Services, Including Doctor's Office Visits" or "Outpatient Hospital Services" in this benefit chart) depending on where you received drug administration or infusion services. You pay these amounts until you reach the out-of-pocket maximum. *Your provider may need to obtain prior authorization.*	the cost-sharing that applies to primary care provider services, specialist services, or outpatient hospital services (as described under "Physician/ Practitioner Services, Including Doctor's Office Visits" or "Outpatient Hospital Services" in this benefit chart) depending on where you received drug administration or infusion services. You pay these amounts until you reach the out-of-pocket maximum.

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Services that are covered for you	What you must pay when you get these services In-Network	What you must pay when you get these services Out-of-Network
Epoetin Alfa, Aranesp®, or Darbepoetin Alfa) □ Intravenous Immune Globulin for the home treatment of primary immune deficiency diseases □ Chemotherapy Drugs, and the Administration of chemotherapy drugs	20% coinsurance for each Medicare-covered chemotherapy drug and the administration of that drug. You pay these amounts until you reach the out-of-pocket maximum. *Your provider may need to obtain prior authorization.*	40% coinsurance for each Medicare-covered chemotherapy drug and the administration of that drug. You pay these amounts until you reach the out-of-pocket maximum.
NurseLine NurseLine services available, 24 hours a day, seven days a week. Speak to a registered nurse (RN) about your medical concerns and questions. You can view the Vendor Information Sheet at www.peopleshealth.com, or call Customer Service to have a paper copy sent to you.	Provided by: NurseLine $0 copayment	
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	There is no coinsurance, copayment, or deductible for preventive	40% coinsurance for preventive obesity screening and therapy.+

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Services that are covered for you	**What you must pay** when you get these services In-Network	**What you must pay** when you get these services Out-of-Network
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.	obesity screening and therapy.	You pay these amounts until you reach the out-of-pocket maximum.
Opioid Treatment Program Services Opioid use disorder treatment services are covered under Part B of Original Medicare. Members of our plan receive coverage for these services through our plan. Covered services include: □ FDA-approved opioid agonist and antagonist treatment medications and the dispensing and administration of such medications, if applicable □ Substance use counseling □ Individual and group therapy □ Toxicology testing	$0 copayment for Medicare-covered opioid treatment program services. *Your provider may need to obtain prior authorization*.	$0 copayment for Medicare-covered opioid treatment program services.
Outpatient Diagnostic Tests and Therapeutic Services and Supplies Covered services include, but are not limited to:		

Services that are covered for you	**What you must pay** when you get these services In-Network	**What you must pay** when you get these services Out-of-Network
□ X-rays	$15 copayment for each Medicare-covered standard X-ray service. You pay these amounts until you reach the out-of-pocket maximum. *Your provider may need to obtain prior authorization.*	$20 copayment for each Medicare-covered standard X-ray service.+ You pay these amounts until you reach the out-of-pocket maximum.
□ Radiation (radium and isotope) therapy including technician materials and supplies	$50 copayment for each Medicare-covered radiation therapy service. You pay these amounts until you reach the out-of-pocket maximum. *Your provider may need to obtain prior authorization.*	40% coinsurance for each Medicare-covered radiation therapy service.+ You pay these amounts until you reach the out-of-pocket maximum.

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Services that are covered for you	**What you must pay** when you get these services In-Network	**What you must pay** when you get these services Out-of-Network
□ Surgical supplies, such as dressings □ Splints, casts, and other devices used to reduce fractures and dislocations Note: There is no separate charge for medical supplies routinely used in the course of an office visit and included in the provider's charges for that visit (such as bandages, cotton swabs, and other routine supplies.) However, supplies for which an appropriate separate charge is made by providers (such as, chemical agents used in certain diagnostic procedures) are subject to cost-sharing as shown.	20% coinsurance for each Medicare-covered medical supply. You pay these amounts until you reach the out-of-pocket maximum. *Your provider may need to obtain prior authorization*.	40% coinsurance for each Medicare-covered medical supply. You pay these amounts until you reach the out-of-pocket maximum.
□ Laboratory tests	$0 copayment for Medicare-covered lab services. *Your provider may need to obtain prior authorization*.	$0 copayment for Medicare-covered lab services.

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Services that are covered for you	**What you must pay** when you get these services In-Network	**What you must pay** when you get these services Out-of-Network
□ Blood - including storage and administration (this means processing and handling of blood). Coverage begins with the first pint of blood that you need. □ In addition, for the administration of blood infusion, you will pay the cost sharing as described under the following sections of this chart, depending on where you received infusion services: o Physician/Practitioner Services, Including Doctor's Office Visits o Outpatient Surgery and Other Medical Services Provided at Hospital Outpatient Facilities and Ambulatory Surgical Centers	$0 copayment for Medicare-covered blood services. *Your provider may need to obtain prior authorization*.	$0 copayment for Medicare-covered blood services.

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Services that are covered for you	**What you must pay** when you get these services In-Network	**What you must pay** when you get these services Out-of-Network
□ Other outpatient diagnostic tests - Non-radiological diagnostic services	$20 copayment for Medicare-covered non-radiological diagnostic services. Examples include, but are not limited to EKG's, pulmonary function tests, home or lab-based sleep studies, and treadmill stress tests. You pay these amounts until you reach the out-of-pocket maximum. *Your provider may need to obtain prior authorization.*	40% coinsurance for Medicare-covered non-radiological diagnostic services.+ Examples include, but are not limited to EKG's, pulmonary function tests, home or lab-based sleep studies, and treadmill stress tests. You pay these amounts until you reach the out-of-pocket maximum.

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Services that are covered for you	**What you must pay** when you get these services In-Network	**What you must pay** when you get these services Out-of-Network
□ Other outpatient diagnostic tests - Radiological diagnostic services, not including x-rays.	$0 copayment for each diagnostic mammogram. $110 copayment for Medicare-covered radiological diagnostic services, not including X-rays, performed in a physician's office or at a free-standing facility (such as a radiology center or medical clinic). You pay these amounts until you reach the out-of-pocket maximum. *Your provider may need to obtain prior authorization*. The diagnostic radiology services require specialized equipment beyond standard X-ray equipment and must be performed by specially trained or certified personnel. Examples include, but are not limited to, specialized scans, CT, SPECT, PET, MRI, MRA, nuclear studies, ultrasounds, diagnostic mammograms and interventional	40% coinsurance for Medicare-covered radiological diagnostic services, not including X-rays, performed in a physician's office or at a free-standing facility (such as a radiology center or medical clinic).+ You pay these amounts until you reach the out-of-pocket maximum. The diagnostic radiology services require specialized equipment beyond standard X-ray equipment and must be performed by specially trained or certified personnel. Examples include, but are not limited to, specialized scans, CT, SPECT, PET, MRI, MRA, nuclear studies, ultrasounds, diagnostic mammograms and interventional radiological procedures (myelogram, cystogram, angiogram, and barium studies).

If you are a Qualified Medicare Beneficiary (QMB) or have full Medicaid benefits then your deductible, coinsurance and/or copayment may be less for services that are covered under Original Medicare.

Services that are covered for you	**What you must pay** when you get these services In-Network	**What you must pay** when you get these services Out-of-Network
	radiological procedures (myelogram, cystogram, angiogram, and barium studies).	

If you are a Qualified Medicare Beneficiary (QMB) or have full Medicaid benefits then your deductible, coinsurance and/or copayment may be less for services that are covered under Original Medicare.

Services that are covered for you	**What you must pay** when you get these services In-Network	**What you must pay** when you get these services Out-of-Network
Outpatient Hospital Observation Observation services are hospital outpatient services given to determine if you need to be admitted as an inpatient or can be discharged. For outpatient hospital observation services to be covered, they must meet the Medicare criteria and be considered reasonable and necessary. Observation services are covered only when provided by the order of a physician or another individual authorized by state licensure law and hospital staff bylaws to admit patients to the hospital or order outpatient tests. **Note:** Unless the provider has written an order to admit you as an inpatient to the hospital, you are an outpatient and pay the cost-sharing amounts for outpatient hospital services. Even if you stay in the hospital overnight, you might still be considered an "outpatient." If you are not sure if you are an outpatient, you should ask the hospital staff. You can also find more information in a Medicare fact sheet called "Are You a Hospital Inpatient or Outpatient? If You Have Medicare – Ask!" This fact sheet is available on the Web at https://www.medicare.gov/sites/default/files/2018-09/11435-Are-You-an-Inpatient-or-Outpatient.pdf or by calling 1-800-MEDICARE	Outpatient observation cost-sharing is explained in Outpatient Surgery and Other Medical Services Provided at Hospital Outpatient Facilities and Ambulatory Surgical Centers.	Outpatient observation cost-sharing is explained in Outpatient Surgery and Other Medical Services Provided at Hospital Outpatient Facilities and Ambulatory Surgical Centers.

If you are a Qualified Medicare Beneficiary (QMB) or have full Medicaid benefits then your deductible, coinsurance and/or copayment may be less for services that are covered under Original Medicare.

Services that are covered for you	**What you must pay** when you get these services In-Network	**What you must pay** when you get these services Out-of-Network
(1-800-633-4227). TTY users call 1-877-486-2048. You can call these numbers for free, 24 hours a day, 7days a week.		
Outpatient Hospital Services We cover medically-necessary services you get in the outpatient department of a hospital for diagnosis or treatment of an illness or injury. Covered services include, but are not limited to:		
□ Services in an emergency department	Please refer to Emergency Care.	Please refer to Emergency Care.
□ Laboratory and diagnostic tests billed by the hospital	Please refer to Outpatient Diagnostic Tests and Therapeutic Services and Supplies.	Please refer to Outpatient Diagnostic Tests and Therapeutic Services and Supplies.
□ Mental health care, including care in a partial-hospitalization program, if a doctor certifies that inpatient treatment would be required without it	Please refer to Outpatient Mental Health Care.	Please refer to Outpatient Mental Health Care.
□ X-rays and other radiology services billed by the hospital	Please refer to Outpatient Diagnostic Tests and Therapeutic Services and Supplies.	Please refer to Outpatient Diagnostic Tests and Therapeutic Services and Supplies

If you are a Qualified Medicare Beneficiary (QMB) or have full Medicaid benefits then your deductible, coinsurance and/or copayment may be less for services that are covered under Original Medicare.

Services that are covered for you	**What you must pay** when you get these services In-Network	**What you must pay** when you get these services Out-of-Network
□ Medical supplies such as splints and casts	Please refer to Outpatient Diagnostic Tests and Therapeutic Services and Supplies.	Please refer to Outpatient Diagnostic Tests and Therapeutic Services and Supplies.
□ Certain screenings and preventive services	Please refer to the benefits preceded by the “Apple” icon.	Please refer to the benefits preceded by the “Apple” icon.
□ Certain drugs and biologicals that you can’t give yourself	Please refer to Medicare Part B Prescription Drugs.	Please refer to Medicare Part B Prescription Drugs.
□ Services performed at an outpatient clinic	Please refer to Physician/Practitioner Services, Including Doctor's Office Visits.	Please refer to Physician/Practitioner Services, Including Doctor's Office Visits.
□ Outpatient surgery or observation	Please refer to Outpatient Surgery and Other Medical Services Provided at Hospital Outpatient Facilities and Ambulatory Surgical Centers.	Please refer to Outpatient Surgery and Other Medical Services Provided at Hospital Outpatient Facilities and Ambulatory Surgical Centers.
□ Outpatient infusion therapy For the drug that is infused, you will pay the cost-sharing as described in "Medicare Part B Prescription Drugs"	Please refer to Medicare Part B Prescription Drugs and Physician/ Practitioner Services, Including Doctor’s Office	Please refer to Medicare Part B Prescription Drugs and Physician/ Practitioner Services, Including Doctor’s Office

If you are a Qualified Medicare Beneficiary (QMB) or have full Medicaid benefits then your deductible, coinsurance and/or copayment may be less for services that are covered under Original Medicare.

Services that are covered for you	**What you must pay** when you get these services In-Network	**What you must pay** when you get these services Out-of-Network
in this benefit chart. In addition, for the administration of infusion therapy drugs, you will pay the cost-sharing that applies to primary care provider services, specialist services, or outpatient hospital services (as described under "Physician/ Practitioner Services, Including Doctor's Office Visits" or "Outpatient Surgery and Other Medical Services Provided at Hospital Outpatient Facilities and Ambulatory Surgical Centers" in this benefit chart) depending on where you received drug administration or infusion services.	Visits or Outpatient Surgery and Other Medical Services Provided at Hospital Outpatient Facilities and Ambulatory Surgical Centers.	Visits or Outpatient Surgery and Other Medical Services Provided at Hospital Outpatient Facilities and Ambulatory Surgical Centers.
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." This is called an "Outpatient Observation" stay. If you are not sure if you are an outpatient, you should ask the hospital staff. You can also find more information in a Medicare fact sheet called "Are You a Hospital Inpatient or Outpatient? If You Have Medicare – Ask!" This fact sheet is available on the Web at https:// www.medicare.gov/sites/default/files/	Outpatient observation cost-sharing is explained in Outpatient Surgery and Other Medical Services Provided at Hospital Outpatient Facilities and Ambulatory Surgical Centers.	Outpatient observation cost-sharing is explained in Outpatient Surgery and Other Medical Services Provided at Hospital Outpatient Facilities and Ambulatory Surgical Centers.

If you are a Qualified Medicare Beneficiary (QMB) or have full Medicaid benefits then your deductible, coinsurance and/or copayment may be less for services that are covered under Original Medicare.

Services that are covered for you	**What you must pay** when you get these services In-Network	**What you must pay** when you get these services Out-of-Network
2018-09/11435-Are-You-an-Inpatient-or-Outpatient.pdf or by calling 1-800-MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048. You can call these numbers for free, 24 hours a day, 7 days a week.		
Outpatient Mental Health Care Covered services include: Mental health services provided by a state-licensed psychiatrist or doctor, clinical psychologist, clinical social worker, clinical nurse specialist, nurse practitioner, physician assistant, or other Medicare-qualified mental health care professional as allowed under applicable state laws.	$25 copayment for each Medicare-covered **individual** therapy session $15 copayment for each Medicare-covered **group** therapy session You pay these amounts until you reach the out-of-pocket maximum. *Your provider may need to obtain prior authorization.*	$40 copayment for each Medicare-covered **individual** therapy session.+ $30 copayment for each Medicare-covered **group** therapy session.+ You pay these amounts until you reach the out-of-pocket maximum.
Outpatient Rehabilitation Services Covered services include: physical therapy, occupational therapy, and speech language therapy. Outpatient rehabilitation services are provided in various outpatient settings, such as hospital outpatient departments, independent therapist	$35 copayment for each Medicare-covered physical therapy and speech-language therapy visit. You pay these amounts until you reach the out-of-pocket maximum.	$55 copayment for each Medicare-covered physical therapy and speech-language therapy visit.+ You pay these amounts until you reach the out-of-pocket maximum.

If you are a Qualified Medicare Beneficiary (QMB) or have full Medicaid benefits then your deductible, coinsurance and/or copayment may be less for services that are covered under Original Medicare.

Services that are covered for you	**What you must pay** when you get these services In-Network	**What you must pay** when you get these services Out-of-Network
offices, physician offices, and Comprehensive Outpatient Rehabilitation Facilities (CORFs).	*Your provider may need to obtain prior authorization*. $35 copayment for each Medicare-covered occupational therapy visit. You pay these amounts until you reach the out-of-pocket maximum. *Your provider may need to obtain prior authorization*.	$55 copayment for each Medicare-covered occupational therapy visit.+ You pay these amounts until you reach the out-of-pocket maximum.
Outpatient Substance Abuse Services Outpatient treatment and counseling for substance abuse.	$25 copayment for each Medicare-covered **individual** therapy session. $15 copayment for each Medicare-covered **group** therapy session. You pay these amounts until you reach the out-of-pocket maximum. *Your provider may need to obtain prior authorization*.	$40 copayment for each Medicare-covered **individual** therapy session.+ $30 copayment for each Medicare-covered **group** therapy session.+ You pay these amounts until you reach the out-of-pocket maximum.
Outpatient Surgery and Other Medical Services Provided at	$0 copayment for a diagnostic colonoscopy at an ambulatory	40% coinsurance for Medicare-covered surgery or other services

If you are a Qualified Medicare Beneficiary (QMB) or have full Medicaid benefits then your deductible, coinsurance and/or copayment may be less for services that are covered under Original Medicare.

Services that are covered for you	What you must pay when you get these services In-Network	What you must pay when you get these services Out-of-Network
Hospital Outpatient Facilities and Ambulatory Surgical Centers **Note**: If you are having surgery in a hospital facility, you should check with your provider about whether you will be an inpatient or outpatient. Unless the provider writes an order to admit you as an inpatient to the hospital, you are an outpatient and pay the cost-sharing amounts for outpatient surgery. Even if you stay in the hospital overnight, you might still be considered an "outpatient." This is called an "Outpatient Observation" stay. If you are not sure if you are an outpatient, you should ask your doctor or the hospital staff. If you receive any services or items other than surgery, including but not limited to diagnostic tests, therapeutic services, prosthetics, orthotics, supplies or Part B drugs, there may be additional cost sharing for those services or items. Please refer to the appropriate section in this chart for the additional service or item you received for the specific cost sharing required.	surgical center. $225 copayment for Medicare-covered surgery or other services provided to you at an ambulatory surgical center, including but not limited to hospital or other facility charges and physician or surgical charges. You pay these amounts until you reach the out-of-pocket maximum. *Your provider may need to obtain prior authorization*. $0 copayment for a diagnostic colonoscopy at an outpatient hospital. $225 copayment for Medicare-covered surgery or other services provided to you at an outpatient hospital, including but not limited to hospital or other facility charges and physician or surgical charges.	provided to you at an ambulatory surgical center, including but not limited to hospital or other facility charges and physician or surgical charges.+ You pay these amounts until you reach the out-of-pocket maximum. 40% coinsurance for Medicare-covered surgery or other services provided to you at an outpatient hospital, including but not limited to hospital or other facility charges and physician or surgical charges.+ You pay these amounts until you reach the out-of-pocket maximum.

If you are a Qualified Medicare Beneficiary (QMB) or have full Medicaid benefits then your deductible, coinsurance and/or copayment may be less for services that are covered under Original Medicare.

Services that are covered for you	**What you must pay** when you get these services In-Network	**What you must pay** when you get these services Out-of-Network
	You pay these amounts until you reach the out-of-pocket maximum. *Your provider may need to obtain prior authorization*. Outpatient surgical services that can be delivered in an available ambulatory surgery center must be delivered in an ambulatory surgery center unless a hospital outpatient department is medically necessary. $225 copayment for each day of Medicare-covered observation services provided to you at an outpatient hospital, including but not limited to hospital or other facility charges and physician or surgical charges. You pay these amounts until you reach the out-of-pocket maximum.	40% coinsurance for each day of Medicare-covered observation services provided to you at an outpatient hospital, including but not limited to hospital or other facility charges and physician or surgical charges.+ You pay these amounts until you reach the out-of-pocket maximum.

If you are a Qualified Medicare Beneficiary (QMB) or have full Medicaid benefits then your deductible, coinsurance and/or copayment may be less for services that are covered under Original Medicare.

Services that are covered for you	**What you must pay** when you get these services In-Network	**What you must pay** when you get these services Out-of-Network
	Your provider may need to obtain prior authorization.	
Over-the-Counter (OTC) Products Catalog This benefit gives you a quarterly credit (in January, April, July, and October) to buy over-the-counter items from a list of eligible products. Credits expire at the end of each quarter (March 31st, June 30th, September 30th, and December 31st). You can place your order online, over the phone, or by mail through your Health & Wellness Products Catalog. $35 minimum per order is required. To receive a paper catalog, contact Customer Service or call the number on the Vendor Information Sheet. You can view the Vendor Information Sheet at www.peopleshealth.com, or call Customer Service to have a paper copy sent to you.	Provided by: Solutran Quarterly Credit is $125.	

If you are a Qualified Medicare Beneficiary (QMB) or have full Medicaid benefits then your deductible, coinsurance and/or copayment may be less for services that are covered under Original Medicare.

Services that are covered for you	**What you must pay** when you get these services In-Network	**What you must pay** when you get these services Out-of-Network
Partial Hospitalization Services "Partial hospitalization" is a structured program of active psychiatric treatment provided as a hospital outpatient service, or by a community mental health center, that is more intense than the care received in your doctor's or therapist's office and is an alternative to inpatient hospitalization.	$55 copayment each day for Medicare-covered benefits. You pay these amounts until you reach the out-of-pocket maximum. *Your provider may need to obtain prior authorization*.	$75 copayment each day for Medicare-covered benefits.+ You pay these amounts until you reach the out-of-pocket maximum.
Physician/Practitioner Services, Including Doctor's Office Visits Covered services include: □ Medically-necessary medical or surgical services furnished in a physician's office	$5 copayment for services obtained from a primary care provider or under certain circumstances, treatment by a nurse practitioner or physician's assistant or other non-physician health care professionals in a primary care provider's office (as permitted under Medicare rules). You pay these amounts until you reach the out-of-pocket maximum.	$25 copayment for services obtained from a primary care provider or under certain circumstances, treatment by a nurse practitioner or physician's assistant or other non-physician health care professionals in a primary care provider's office (as permitted under Medicare rules).+ You pay these amounts until you reach the out-of-pocket maximum.

If you are a Qualified Medicare Beneficiary (QMB) or have full Medicaid benefits then your deductible, coinsurance and/or copayment may be less for services that are covered under Original Medicare.

Services that are covered for you	**What you must pay** when you get these services In-Network	**What you must pay** when you get these services Out-of-Network
□ Medically-necessary medical or surgical services furnished in a certified ambulatory surgical center or hospital outpatient department	See "Outpatient Surgery" earlier in this chart for any applicable copayments or coinsurance amounts for ambulatory surgical center visits or in a hospital outpatient setting.	See "Outpatient Surgery" earlier in this chart for any applicable copayments or coinsurance amounts for ambulatory surgical center visits or in a hospital outpatient setting.
□ Consultation, diagnosis, and treatment by a specialist	$35 copayment for services obtained from a specialist, or under certain circumstances, treatment by a nurse practitioner or physician's assistant or other non-physician health care professionals in a specialist's office (as permitted under Medicare rules). You pay these amounts until you reach the out-of-pocket maximum.	$55 copayment for services obtained from a specialist, or under certain circumstances, treatment by a nurse practitioner or physician's assistant or other non-physician health care professionals in a specialist's office (as permitted under Medicare rules).+ You pay these amounts until you reach the out-of-pocket maximum.
□ Basic hearing and balance exams performed by your specialist, if your doctor orders it to see if you need medical treatment	$0 copayment for each Medicare-covered exam.	$55 copayment for each Medicare-covered exam.+ You pay these amounts until you reach the out-of-pocket maximum.

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Services that are covered for you	**What you must pay** when you get these services In-Network	**What you must pay** when you get these services Out-of-Network
□ Second opinion prior to surgery □ Some telehealth services including consultation, diagnosis, and treatment by a physician or practitioner, for patients in certain rural areas or other places approved by Medicare. □ 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.	You will pay the cost-sharing that applies to specialist services (as described under "Physician/Practitioner Services, Including Doctor's Office Visits" above). You pay these amounts until you reach the out-of-pocket maximum.	You will pay the cost-sharing that applies to specialist services (as described under "Physician/Practitioner Services, Including Doctor's Office Visits" above).+ You pay these amounts until you reach the out-of-pocket maximum.
□ Telehealth services to diagnose, evaluate, or treat symptoms of a stroke. □ Virtual check-ins (for example, by phone or video chat) with your doctor for 5-10 minutes if: o You're not a new patient and o The evaluation isn't related to an office visit in the past 7 days and o The evaluation doesn't lead to an office visit within 24 hours or the soonest available appointment □ Evaluation of video and/or images you send to your doctor, and interpretation and follow-up by your doctor within 24 hours if: o You're not a new patient and	You will pay the cost-sharing that applies to primary care services or specialist physician services (as described under "Physician/Practitioner Services, Including Doctor's Office Visits" above). You pay these amounts until you reach the out-of-pocket maximum.	You will pay the cost-sharing that applies to primary care services or specialist physician services (as described under "Physician/Practitioner Services, Including Doctor's Office Visits" above).+ You pay these amounts until you reach the out-of-pocket maximum.

If you are a Qualified Medicare Beneficiary (QMB) or have full Medicaid benefits then your deductible, coinsurance and/or copayment may be less for services that are covered under Original Medicare.

Services that are covered for you	**What you must pay** when you get these services In-Network	**What you must pay** when you get these services Out-of-Network
○ 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 if you're not a new patient		
□ 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). Dental services provided by a dentist in connection with care, treatment, filling, removal, or replacement of teeth or structures directly supporting the teeth are not Medicare-covered benefits and not covered under this benefit.	20% coinsurance for each Medicare-covered visit. You pay these amounts until you reach the out-of-pocket maximum.	40% coinsurance for each Medicare-covered visit.+ You pay these amounts until you reach the out-of-pocket maximum.
□ Monitoring services in a physician's office or outpatient hospital setting if you are taking anticoagulation medications, such as Coumadin, Heparin or Warfarin	You will pay the cost-sharing that applies to primary care provider services, specialist services, or outpatient	You will pay the cost-sharing that applies to primary care provider services, specialist services, or outpatient

If you are a Qualified Medicare Beneficiary (QMB) or have full Medicaid benefits then your deductible, coinsurance and/or copayment may be less for services that are covered under Original Medicare.

Services that are covered for you	**What you must pay** when you get these services In-Network	**What you must pay** when you get these services Out-of-Network
(these services may also be referred to as 'Coumadin Clinic' services)	hospital services (as described under "Physician/Practitioner Services, Including Doctor's Office Visits" or "Outpatient Hospital Services" in this benefit chart) depending on where you receive services. You pay these amounts until you reach the out-of-pocket maximum. *Your provider may need to obtain prior authorization*.	hospital services (as described under "Physician/Practitioner Services, Including Doctor's Office Visits" or "Outpatient Hospital Services" in this benefit chart) depending on where you receive services.+ You pay these amounts until you reach the out-of-pocket maximum.
□ Medically-necessary medical or surgical services that are covered benefits and are furnished by a physician in your home or a nursing home in which you reside.	You will pay the cost sharing that applies to primary care provider services or specialist physician services (as applied in an office setting, described above in this section of the benefit chart) depending on the type of physician that provides the services. You pay these amounts until you reach the out-of-pocket maximum.	You will pay the cost sharing that applies to primary care provider services or specialist physician services (as applied in an office setting, described above in this section of the benefit chart) depending on the type of physician that provides the services.+ You pay these amounts until you reach the out-of-pocket maximum.

If you are a Qualified Medicare Beneficiary (QMB) or have full Medicaid benefits then your deductible, coinsurance and/or copayment may be less for services that are covered under Original Medicare.

Services that are covered for you	**What you must pay** when you get these services In-Network	**What you must pay** when you get these services Out-of-Network
□ Certain telehealth services, including:		
○ Covered services included in Virtual Medical Visits: □ Primary Care Provider □ Urgently Needed Services ○ Telehealth or virtual medical visits are medical visits delivered to you outside of medical facilities by network providers that have appropriate online technology and live audio/video capabilities to conduct the visit. ○ Not all medical conditions can be treated through virtual visits. The virtual visit doctor will identify if you need to see an in-person doctor for treatment.	$0 copayment The in-network provider must be used for the out-of-network benefit.	Not covered out-of-network
○ Virtual Mental Health Visits are mental health visits delivered to you outside of medical facilities by virtual providers that use online technology and live audio/video capabilities. Visit virtualvisitsmentalhealth.uhc.com to learn more and schedule a virtual appointment. □ Covered services include individual mental health services	$0 copayment The in-network provider must be used for the out-of-network benefit.	Not covered out-of-network

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Services that are covered for you	**What you must pay** when you get these services In-Network	**What you must pay** when you get these services Out-of-Network
□ Not all conditions can be treated through virtual visits. The virtual visit provider will identify if you need to see an in-person provider for treatment. □ You have the option of receiving these services either through an in-person visit or via telehealth. If you choose to receive one of these services via telehealth, then you must use a network provider that currently offers the service via telehealth.		
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.	$35 copayment for each Medicare-covered visit in an office or home setting. For services rendered in an outpatient hospital setting, such as surgery, please refer to Outpatient Surgery and Other Medical Services Provided at Hospital Outpatient Facilities and Ambulatory Surgical Centers.	$55 copayment for each Medicare-covered visit in an office or home setting.+ For services rendered in an outpatient hospital setting, such as surgery, please refer to Outpatient Surgery and Other Medical Services Provided at Hospital Outpatient Facilities and Ambulatory Surgical Centers.

If you are a Qualified Medicare Beneficiary (QMB) or have full Medicaid benefits then your deductible, coinsurance and/or copayment may be less for services that are covered under Original Medicare.

Services that are covered for you	**What you must pay** when you get these services In-Network	**What you must pay** when you get these services Out-of-Network
	You pay these amounts until you reach the out-of-pocket maximum.	You pay these amounts until you reach the out-of-pocket maximum.
Additional Routine Foot Care Treatment of the foot which is generally considered preventive, i.e., cutting or removal of corns, warts, calluses or nails. Benefit is combined in and out-of-network.	$35 copayment for each routine visit up to 6 visits every year.*	$55 copayment for each routine visit up to 6 visits every year.*
Prostate Cancer Screening Exams For men age 50 and older, covered services include the following - once every 12 months: □ Digital rectal exam □ Prostate Specific Antigen (PSA) test	There is no coinsurance, copayment, or deductible for each Medicare-covered digital rectal exam. There is no coinsurance, copayment, or deductible for an annual PSA test. Diagnostic PSA exams are subject to cost sharing as described under Outpatient Diagnostic Tests and Therapeutic Services and Supplies in this chart.	40% coinsurance for each Medicare-covered digital rectal exam.+ You pay these amounts until you reach the out-of-pocket maximum. 40% coinsurance for an annual PSA test.+ You pay these amounts until you reach the out-of-pocket maximum.

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Services that are covered for you	What you must pay when you get these services In-Network	What you must pay when you get these services Out-of-Network
Prosthetic Devices and Related Supplies Devices (other than dental) that replace all or part of a body part or function. These include, but are not limited to: colostomy bags and supplies directly related to colostomy care, pacemakers, braces, prosthetic shoes, artificial limbs, and breast prostheses (including a surgical brassiere after a mastectomy). Includes certain supplies related to prosthetic devices, and repair and/or replacement of prosthetic devices. Also includes some coverage following cataract removal or cataract surgery – see "Vision Care" later in this section for more detail.	20% coinsurance for each Medicare-covered prosthetic or orthotic device, including replacement or repairs of such devices, and related supplies. You pay these amounts until you reach the out-of-pocket maximum. *Your provider may need to obtain prior authorization.*	40% coinsurance for each Medicare-covered prosthetic or orthotic device, including replacement or repairs of such devices, and related supplies. You pay these amounts until you reach the out-of-pocket maximum.
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. Medicare covers up to two (2) one-hour sessions per day, for up to 36 lifetime sessions (in some cases, up to 72 lifetime sessions) of pulmonary rehabilitation services.	$20 copayment for each Medicare-covered pulmonary rehabilitative visit You pay these amounts until you reach the out-of-pocket maximum. *Your provider may need to obtain prior authorization.*	$55 copayment for each Medicare-covered pulmonary rehabilitative visit.+ You pay these amounts until you reach the out-of-pocket maximum.

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Services that are covered for you	What you must pay when you get these services In-Network	What you must pay when you get these services Out-of-Network
Screening and Counseling to Reduce Alcohol Misuse We cover one alcohol misuse screening for adults with Medicare (including pregnant women) who misuse alcohol, but aren't alcohol dependent. If you screen positive for alcohol misuse, you can get up to four brief face-to-face counseling sessions per year (if you're competent and alert during counseling) provided by a qualified primary care doctor or practitioner in a primary care setting.	There is no coinsurance, copayment, or deductible for the Medicare-covered screening and counseling to reduce alcohol misuse preventive benefit.	40% coinsurance for the Medicare-covered screening and counseling to reduce alcohol misuse preventive benefit.+ You pay these amounts until you reach the out-of-pocket maximum.
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 55 – 77 years who have no signs or symptoms of lung cancer, but who have a history of tobacco smoking of at least 30 pack-years and who currently smoke or have quit smoking within the last 15 years, who receive a written order for LDCT during a lung cancer screening counseling and shared decision making visit that meets the Medicare criteria for such visits and be	There is no coinsurance, copayment, or deductible for the Medicare-covered counseling and shared decision making visit or for the LDCT.	40% coinsurance for the Medicare-covered counseling and shared decision making visit or for the LDCT.+ You pay these amounts until you reach the out-of-pocket maximum.

Services that are covered for you	**What you must pay** when you get these services In-Network	**What you must pay** when you get these services Out-of-Network
furnished by a physician or qualified non-physician practitioner. **For LDCT lung cancer screenings after the initial LDCT screening:** the member must receive a written order for LDCT lung cancer screening, which may be furnished during any appropriate visit with a physician or qualified non-physician practitioner. If a physician or qualified non-physician practitioner elects to provide a lung cancer screening counseling and shared decision making visit for subsequent lung cancer screenings with LDCT, the visit must meet the Medicare criteria for such visits.		
Screening for Sexually Transmitted Infections (STIs) and Counseling to Prevent STIs We cover sexually transmitted infection (STI) screenings for chlamydia, gonorrhea, syphilis, and Hepatitis B. These screenings are covered for pregnant women and for certain people who are at increased risk for an STI when the tests are ordered by a primary care provider. We cover these tests once every 12 months or at certain times during pregnancy. We also cover up to two individual 20 to 30 minute, face-to-face high-intensity	There is no coinsurance, copayment, or deductible for the Medicare-covered screening for STIs and counseling for STIs preventive benefit.	40% coinsurance for the Medicare-covered screening for STIs and counseling for STIs preventive benefit.+ You pay these amounts until you reach the out-of-pocket maximum.

Services that are covered for you	**What you must pay** when you get these services In-Network	**What you must pay** when you get these services Out-of-Network
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.		
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.	$0 copayment for Medicare-covered benefits.	40% coinsurance for Medicare-covered benefits.+ You pay these amounts until you reach the out-of-pocket maximum.
□ Outpatient dialysis treatments (including dialysis treatments when temporarily out of the service area, as explained in Chapter 3)	20% coinsurance for Medicare-covered benefits. You pay these amounts until you reach the out-of-pocket maximum. *Your provider may need to obtain prior authorization.*	20% coinsurance for Medicare-covered benefits.+ You pay these amounts until you reach the out-of-pocket maximum.

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Services that are covered for you	**What you must pay** when you get these services In-Network	**What you must pay** when you get these services Out-of-Network
□ Self-dialysis training (includes training for you and anyone helping you with your home dialysis treatments)	$0 copayment for Medicare-covered benefits.	40% coinsurance for Medicare-covered benefits.+ You pay these amounts until you reach the out-of-pocket maximum.
□ Inpatient dialysis treatments (if you are admitted as an inpatient to a hospital for special care)	These services will be covered as described in the following sections: Please refer to Inpatient Hospital Care.	These services will be covered as described in the following sections: Please refer to Inpatient Hospital Care.
□ Home dialysis equipment and supplies	Please refer to Durable Medical Equipment and Related Supplies.	Please refer to Durable Medical Equipment and Related Supplies.
□ Certain home support services (such as, when necessary, visits by trained dialysis workers to check on your home dialysis, to help in emergencies, and check your dialysis equipment and water supply)	Please refer to Home Health Agency Care.	Please refer to Home Health Agency Care.
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.”		

If you are a Qualified Medicare Beneficiary (QMB) or have full Medicaid benefits then your deductible, coinsurance and/or copayment may be less for services that are covered under Original Medicare.

Services that are covered for you	**What you must pay** when you get these services In-Network	**What you must pay** when you get these services Out-of-Network
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 services include, but are not limited to: □ Semiprivate room (or a private room if medically necessary) □ Meals, including special diets □ Skilled nursing services □ Physical therapy, occupational therapy, and speech language 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 begins with the first pint of blood that you need. □ Medical and surgical supplies ordinarily provided by SNFs □ Laboratory tests ordinarily provided by SNFs □ X-rays and other radiology services ordinarily provided by SNFs	$0 copayment each day for days 1 to 20. $184 copayment each day for days 21 to 57. $0 copayment for additional Medicare-covered days, up to 100 days. You pay these amounts until you reach the out-of-pocket maximum. *Your provider may need to obtain prior authorization*. You are covered for up to 100 days each benefit period for inpatient services in a SNF, in accordance with Medicare guidelines. A benefit period begins on the first day you go to a Medicare-covered inpatient hospital or a skilled nursing facility. The benefit period ends when you haven't been an inpatient at any hospital or SNF for 60 days in a row. If you go to the hospital (or SNF) after one benefit period	$225 copayment each day for days 1 to 45. $0 copayment for additional Medicare-covered days, up to 100 days. You pay these amounts until you reach the out-of-pocket maximum. You are covered for up to 100 days each benefit period for inpatient services in a SNF, in accordance with Medicare guidelines. A benefit period begins on the first day you go to a Medicare-covered inpatient hospital or a skilled nursing facility. The benefit period ends when you haven't been an inpatient at any hospital or SNF for 60 days in a row. If you go to the hospital (or SNF) after one benefit period has ended, a new benefit period begins. There is no limit to the number of benefit periods you can have.

If you are a Qualified Medicare Beneficiary (QMB) or have full Medicaid benefits then your deductible, coinsurance and/or copayment may be less for services that are covered under Original Medicare.

Services that are covered for you	**What you must pay** when you get these services In-Network	**What you must pay** when you get these services Out-of-Network
□ Use of appliances such as wheelchairs ordinarily provided by SNFs □ Physician/Practitioner services A 3-day prior hospital stay is not required. 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 is living at the time you leave the hospital.	has ended, a new benefit period begins. There is no limit to the number of benefit periods you can have.	
Smoking and Tobacco Use Cessation (Counseling to Stop Smoking or Tobacco Use) If you use tobacco, we cover two counseling quit attempts within a 12-month period as a preventive service. Each counseling attempt includes up to four face-to-face visits.	There is no coinsurance, copayment, or deductible for the Medicare-covered smoking and tobacco use cessation preventive benefits.	40% coinsurance for the Medicare-covered smoking and tobacco use cessation preventive benefits.+ You pay these amounts until you reach the out-of-pocket maximum.

If you are a Qualified Medicare Beneficiary (QMB) or have full Medicaid benefits then your deductible, coinsurance and/or copayment may be less for services that are covered under Original Medicare.

Services that are covered for you	**What you must pay** when you get these services In-Network	**What you must pay** when you get these services Out-of-Network
Supervised Exercise Therapy (SET) SET is covered for members who have symptomatic peripheral artery disease (PAD) and have a referral 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 of 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	$20 copayment for each Medicare-covered supervised exercise therapy (SET) visit. You pay these amounts until you reach the out-of-pocket maximum. *Your provider may need to obtain prior authorization.*	$55 copayment for each Medicare-covered supervised exercise therapy (SET) visit.+ You pay these amounts until you reach the out-of-pocket maximum.

If you are a Qualified Medicare Beneficiary (QMB) or have full Medicaid benefits then your deductible, coinsurance and/or copayment may be less for services that are covered under Original Medicare.

Services that are covered for you	**What you must pay** when you get these services In-Network	**What you must pay** when you get these services Out-of-Network
additional 36 sessions over an extended period of time if deemed medically necessary by a health care provider.		
Urgently Needed Services Urgently needed services are provided to treat a non-emergency, unforeseen medical illness, injury, or condition that requires immediate medical care. Urgently needed services may be furnished by network providers or by out-of-network providers when network providers are temporarily unavailable or inaccessible. Covered services include urgently needed services obtained at a retail walk-in clinic or an urgent care center. Worldwide coverage for 'urgently needed services' when medical services are needed right away because of an illness, injury, or condition that you did not expect or anticipate, and you can't wait until you are back in our plan's service area to obtain services. Services provided by a dentist are not covered.	\$30 copayment for each visit in a contracted Urgent Care Center or walk-in clinic. \$40 copayment for each urgently needed visit in a non-contracted Urgent Care Center or walk-in clinic in the United States. \$0 copayment for Worldwide coverage of urgently needed services received outside of the United States. Please see Chapter 5 Section 1.1 for expense reimbursement for worldwide services. You pay these amounts until you reach the out-of-pocket maximum.	
Vision Care Covered services include:		

If you are a Qualified Medicare Beneficiary (QMB) or have full Medicaid benefits then your deductible, coinsurance and/or copayment may be less for services that are covered under Original Medicare.

Services that are covered for you	**What you must pay** when you get these services In-Network	**What you must pay** when you get these services Out-of-Network
□ Outpatient physician services provided by an ophthalmologist or optometrist for the diagnosis and treatment of diseases and injuries of the eye, including diagnosis or treatment for age-related macular degeneration or cataracts. Original Medicare doesn't cover routine eye exams (eye refractions) for eyeglasses/contacts.	$0 copayment for each Medicare-covered exam.	$55 copayment for each Medicare-covered exam.+ You pay these amounts until you reach the out-of-pocket maximum.
□ 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.	$0 copayment for Medicare-covered glaucoma screening.	$55 copayment for Medicare-covered glaucoma screening.+ You pay these amounts until you reach the out-of-pocket maximum.
□ For people with diabetes or signs and symptoms of eye disease, eye exams to evaluate for eye disease are covered per Medicare guidelines. Annual examinations by an ophthalmologist or optometrist are recommended for asymptomatic diabetics. □ For people with diabetes, screening for diabetic retinopathy is covered once per year.	$0 copayment for Medicare-covered eye exams to evaluate for eye disease.	$55 copayment for Medicare-covered eye exams to evaluate for eye disease.+ You pay these amounts until you reach the out-of-pocket maximum.

If you are a Qualified Medicare Beneficiary (QMB) or have full Medicaid benefits then your deductible, coinsurance and/or copayment may be less for services that are covered under Original Medicare.

Services that are covered for you	**What you must pay** when you get these services In-Network	**What you must pay** when you get these services Out-of-Network
□ One pair of eyeglasses or contact lenses after each cataract surgery that includes insertion of an intraocular lens (additional pairs of eyeglasses or contacts are not covered by Medicare). If you have two separate cataract operations, you cannot reserve the benefit after the first surgery and purchase two eyeglasses after the second surgery. Covered eyeglasses after cataract surgery includes standard frames and lenses as defined by Medicare; any upgrades are not covered (including, but not limited to, deluxe frames, tinting, progressive lenses or anti-reflective coating).	$0 copayment for one pair of Medicare-covered standard glasses or contact lenses after cataract surgery.	$55 copayment for one pair of Medicare-covered standard glasses or contact lenses after cataract surgery.+ You pay these amounts until you reach the out-of-pocket maximum.
Additional Routine Eye Exam: Your plan covers one supplemental routine eye exam for eyeglasses or contact lenses each year. Note: There is a special network of vision providers that you must use for a routine eye exam to be covered. Call Customer Service (see the back cover) or refer to the Provider Directory in the Routine Vision Care Providers section for more information about these providers. You can access our online directory at http://www.peopleshealth.com/providers, or call Customer Service if	**Additional Routine Eye Exam:** $0 copayment for one routine eye exam each year; see note at left about network vision providers **Additional Routine Eye Wear:** $0 copayment; receive a total credit of $200 toward your purchase of	**Additional Routine Eye Exam:** $55 copayment, benefits combined in and out-of-network.* **Additional Routine Eye Wear:** $0 copayment; plan pays up to a $200 credit for covered eyewear, benefits combined in and out-of-network.

If you are a Qualified Medicare Beneficiary (QMB) or have full Medicaid benefits then your deductible, coinsurance and/or copayment may be less for services that are covered under Original Medicare.

Services that are covered for you	**What you must pay** when you get these services In-Network	**What you must pay** when you get these services Out-of-Network
you need help finding a network provider. **Additional Routine Eye Wear:** Benefit is combined in and out-of-network The plan covers one pair of eyeglasses or contact lenses for vision correction each year. Certain types of eyeglass lenses and eyeglass frames are covered. You may incur additional costs for some lens features and frames. After plan paid benefits for eye glasses (lenses and frames) or contact lenses, you are responsible.	lenses/frames and contact lenses	Home-delivered eyewear available only through Vision Benefits Network (select products only). You are responsible for all costs for eyewear not purchased from a Vision Benefits Network network provider.
 **"Welcome to Medicare" Preventive Visit** The plan covers the one-time "Welcome to Medicare" preventive visit. The visit includes a review of your health, as well as education and counseling about the preventive services you need (including certain screenings and shots), and referrals for other care if needed. Doesn't include lab tests, radiological diagnostic tests or non-radiological diagnostic tests or diagnostic tests. Additional cost share may apply to any lab or diagnostic	There is no coinsurance, copayment, or deductible for the "Welcome to Medicare" preventive visit. There is no coinsurance, copayment, or deductible for a one-time Medicare-covered EKG screening if ordered as a result of your "Welcome to Medicare" preventive visit. Please refer to Outpatient Diagnostic Tests and Therapeutic	40% coinsurance for the "Welcome to Medicare" preventive visit.+ You pay these amounts until you reach the out-of-pocket maximum. 40% coinsurance for a one-time Medicare-covered EKG screening if ordered as a result of your "Welcome to Medicare" preventive visit.+ Please refer to Outpatient Diagnostic

If you are a Qualified Medicare Beneficiary (QMB) or have full Medicaid benefits then your deductible, coinsurance and/or copayment may be less for services that are covered under Original Medicare.

Services that are covered for you	**What you must pay** when you get these services In-Network	**What you must pay** when you get these services Out-of-Network
testing performed during your visit, as described for each separate service in this Medical Benefits Chart. **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.	Services and Supplies for other EKG's.	Tests and Therapeutic Services and Supplies for other EKG's. You pay these amounts until you reach the out-of-pocket maximum.
+ If you obtain covered services from an out-of-network physician or provider who does not accept Medicare assignment, you will be responsible for the cost sharing shown above, plus any difference between the amount we pay the provider and the Medicare limiting charge. If you obtain durable medical equipment from an out-of-network supplier who does not accept Medicare assignment, the plan will pay based on the billed amount and you will be responsible for the cost sharing shown above. You can get your care from an out-of-network provider. However, that provider must be eligible to participate in Medicare. We cannot pay a provider who is not eligible to participate in Medicare. You will be responsible for the full cost of the services you receive. Check with your provider before receiving services to confirm that they participate in Medicare.		
* Covered services that do not count toward your maximum out-of-pocket amount.		

If you are a Qualified Medicare Beneficiary (QMB) or have full Medicaid benefits then your deductible, coinsurance and/or copayment may be less for services that are covered under Original Medicare.

Your plan covers the services listed in the following chart. There is an annual plan coverage maximum of $2,500 for the services listed; this is a combined plan coverage maximum for services received from network providers or out-of-network providers. Endodontics and periodontics are not covered. Dental lab fees are not covered, so you may be responsible for the costs of any dental lab services you need. Speak to your provider for more information.

Providers are paid based on Maximum Allowable Charge (MAC). For services covered under the plan, you may still be billed by an out-of-network provider for any amount greater than the MAC payment made by the plan to the provider.

For more information about the providers in our dental network, call Customer Service (phone numbers are printed on the back cover of this booklet).

Procedure Code	**Procedure Description**	**You pay at a network provider or an out-of-network provider (you may be billed more by an out-of-network provider if the charge is greater than MAC):**
Preventive and Diagnostic Services		
D1110	Prophylaxis (cleaning)	$0
D0120	Periodic oral evaluation	$0
D0140	Limited oral evaluation	$0
D0150	Comprehensive oral evaluation – new or established	$0
D0210	X-rays, intraoral – complete series (including bitewings)	$0
D0220	X-rays, intraoral – periapical first film	$0
D0230	X-rays, intraoral – periapical each additional film	$0
D0240	X-rays, Intraoral – occlusal film	$0
D0270	X-rays, bitewings, single film	$0
D0272	X-rays, bitewings, two films	$0

If you are a Qualified Medicare Beneficiary (QMB) or have full Medicaid benefits then your deductible, coinsurance and/or copayment may be less for services that are covered under Original Medicare.

D0274	X-rays, bitewings, four films	$0
D0330	X-rays, panoramic film	$0
Comprehensive Services		
D2140	Amalgam, one surface, primary or permanent	$0
D2150	Amalgam, two surfaces, primary or permanent	$0
D2160	Amalgam, three surfaces, primary or permanent	$0
D2161	Amalgam, four surfaces or more	$0
D2330	Resin – one surface, anterior	$0
D2331	Resin – two surfaces, anterior	$0
D2332	Resin – three surfaces, anterior	$0
D2335	Resin – four or more surfaces, anterior	$0
D2391	Resin – one surface, posterior	$0
D2392	Resin – two surfaces, posterior	$0
D2393	Resin – three surfaces, posterior	$0
D2394	Resin – four or more surfaces, posterior	$0
D2740	Crown – porcelain/ceramic substrate	$0
D2750	Crown – porcelain fused to high noble metal	$0
D2751	Crown – porcelain fused predominantly base metal	$0
D2752	Crown – porcelain fused to noble metal	$0
D2783	Crown – 3/4 porcelain/ceramic substrate	$0
D2790	Crown – full cast high noble metal	$0
D2791	Crown – full cast predominantly base metal	$0
D2792	Crown – full cast noble metal	$0
D2930	Prefabricated stainless steel crown – primary tooth	$0
D2931	Prefabricated stainless steel crown – permanent tooth	$0
D4341	Periodontal scaling and root	$0
D4342	Periodontal scaling, 1-3 teeth	$0
D4346	Scaling, presence of generalized moderate/ severe gingivitis inflammation	$0
D4355	Full mouth debridement	$0
D5110	Complete denture – maxillary	$0

If you are a Qualified Medicare Beneficiary (QMB) or have full Medicaid benefits then your deductible, coinsurance and/or copayment may be less for services that are covered under Original Medicare.

D5120	Complete denture – mandibular	$0
D5130	Immediate denture – maxillary (in lieu of D5110)	$0
D5140	Immediate denture – mandibular (in lieu of D5120)	$0
D5213	Maxillary partial denture – cast metal framework	$0
D5214	Mandibular partial denture – cast metal framework	$0
D5410	Adjust complete denture – maxillary	$0
D5411	Adjust complete denture – mandibular	$0
D5421	Adjust partial denture – maxillary	$0
D5422	Adjust partial denture – mandibular	$0
D5511	Repair broken complete denture base, mandibular	$0
D5512	Repair broken complete denture base, maxillary	$0
D5520	Replace missing or broken teeth – complete denture	$0
D5611	Repair resin denture base, mandibular (for a partial denture)	$0
D5612	Repair resin denture base, maxillary (for a partial denture)	$0
D5640	Replace broken teeth – per tooth (for a partial denture)	$0
D7140	Extraction – erupted tooth or exposed root (elevation or removal)	$0
D7210	Extraction – erupted tooth requiring removal of bone and/or sectioning of tooth	$0
D9110	Palliative (emergency) treatment of dental pain	$0

SECTION 3 What services are not covered by the plan?

Section 3.1 Services we do not cover (exclusions)

This section tells you what services are "excluded" from Medicare coverage and therefore, are not covered by this plan. If a service is "excluded," it means that this plan doesn't cover the service.

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. We won't pay for the excluded medical services listed in the chart below except under the specific conditions listed. The only exception: we will pay if a service in the chart below is found upon appeal to be a medical service that we should have paid for or covered because of your specific situation. (For information about appealing a decision we have made to not cover a medical service, go to Chapter 7, Section 5.3 in this booklet.)

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

Services not covered by Medicare	Not covered under any condition	Covered only under specific conditions
Services considered not reasonable and necessary, according to the standards of Original Medicare.	✓	
Experimental 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.		✓ May be covered by Original Medicare under a Medicare-approved clinical research study or by our plan. (See Chapter 3, Section 5 for more information on clinical research studies.)
Private room in a hospital.		✓ Covered only when medically necessary.
Personal items in your room at a hospital or a skilled nursing	✓	

Services not covered by Medicare	Not covered under any condition	Covered only under specific conditions
facility, such as a telephone or a television.		
Full-time nursing care in your home.	✓	
Custodial care is care provided in a nursing home, hospice, or other facility setting when you do not require skilled medical care or skilled nursing care. Custodial care is personal care that does not require the continuing attention of trained medical or paramedical personnel, such as care that helps you with activities of daily living, such as bathing or dressing.	✓	
Homemaker services include basic household assistance, including light housekeeping or light meal preparation.	✓	
Fees charged for care by your immediate relatives or members of your household.	✓	
Cosmetic surgery or procedures.		✓ □ Covered in cases of an accidental injury or for improvement of the functioning of a malformed body member. □ Covered for all stages of reconstruction for a breast after a mastectomy, as well as for the unaffected breast to produce a symmetrical appearance.

Services not covered by Medicare	Not covered under any condition	Covered only under specific conditions
Chiropractic Services (Medicare-covered)		✓ Manual manipulation of the spine to correct a subluxation is covered. Excluded from Medicare coverage is any service other than manual manipulation of the spine for the treatment of subluxation.
Orthopedic shoes.		✓ If shoes are part of a leg brace and are included in the cost of the brace, or the shoes are for a person with diabetic foot disease. (As specifically described in the Medical Benefits Chart in this chapter.)
Supportive devices for the feet.		✓ Orthopedic or therapeutic shoes for people with diabetic foot disease.
Outpatient prescription drugs.		✓ Some coverage provided according to Medicare guidelines. (As specifically described in the Medical Benefits Chart in this chapter.)
Elective hysterectomy, tubal ligation, or vasectomy, if the primary indication for these procedures is sterilization. Reversal of sterilization procedures, penile vacuum erection devices, or non-prescription contraceptive supplies.	✓	
Acupuncture.		✓

Services not covered by Medicare	Not covered under any condition	Covered only under specific conditions
		(As specifically described in the Medical Benefits Chart in this chapter.)
Naturopath services (uses natural or alternative treatments).	✓	
Paramedic intercept service (advanced life support provided by an emergency service entity, such as a paramedic services unit, which do not provide ambulance transport)		✓ Services are only covered when the ambulance pick-up address is located in rural New York and applicable conditions are met. Members are responsible for all paramedic intercept service costs that occur outside of rural New York.
Optional, additional, or deluxe features or accessories to durable medical equipment, corrective appliances or prosthetics which are primarily for the comfort or convenience of the member, or for ambulation primarily in the community, including but not limited to home and car remodeling or modification, and exercise equipment.	✓	
Immunizations for foreign travel purposes.	✓	
Equipment or supplies that condition the air, heating pads, hot water bottles, wigs, and their care, support stockings and other primarily non-medical equipment.	✓	
Any non-emergency care received outside of the United	✓	

Services not covered by Medicare	Not covered under any condition	Covered only under specific conditions
States and the U.S. Territories.		
For transplants: items not covered include, but are not limited to the below. For transportation: □ Vehicle rental, purchase, or maintenance/repairs □ Auto clubs (roadside assistance) □ Gas □ Travel by air or ground ambulance (may be covered under your medical benefit). □ Air or ground travel not related to medical appointments □ Parking fees incurred other than at lodging or hospital For lodging: □ Deposits □ Utilities (if billed separate from the rent payment) □ Phone calls, newspapers, movie rentals and gift cards □ Expenses for lodging when staying with a relative or friend □ Meals	✓	

We regularly review new procedures, devices and drugs to determine whether or not they are safe and effective for members. New procedures and technology that are safe and effective are eligible to become covered services. If the technology becomes a covered service, it will be subject to all other terms and conditions of the plan, including medical necessity and any applicable member copayments, coinsurance, deductibles or other payment contributions.

In determining whether to cover a service, we use proprietary technology guidelines to review new devices, procedures and drugs, including those related to behavioral/mental health. When clinical necessity requires a rapid determination of the safe and effective use of a new technology or new

application of an existing technology for an individual member, one of our medical directors makes a medical necessity determination based on individual member medical documentation, review of published scientific evidence, and, when appropriate, relevant specialty or professional opinion from an individual who has expertise in the technology.

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

Section 1.1 If you pay our plan's share of the cost of your covered services, or if you receive a bill, you can ask us for payment

Sometimes when you get medical care, you may need to pay the full cost right away. Other times, you may find that you have paid more than you expected under the coverage rules of the plan. In either case, 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 also be times when you get a bill from a provider for the full cost of medical care you have received. In many cases, you should send this 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.

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

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

When you received services from a provider in the United States who is not part of our network, you are only responsible for paying your share of the cost, not for the entire cost. (Your share of the cost may be higher for an out-of-network provider than for a network provider).You should ask the provider to bill the plan for our share of the cost.

- If you pay the entire amount yourself at the time you receive the care, you need to 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.
- At times you may get a bill from the provider asking for payment that you think you do not owe. Send us this bill, along with documentation of any payments you have already made.
  - If the provider is owed anything, we will pay the provider directly.
  - If you have already paid more than your share of the cost of the service, we will determine how much you owed and pay you back for our share of the cost.
- **Please note:** While you can get your care from an out-of-network provider, the provider must be eligible to participate in Medicare. Except for emergency care, we cannot pay a provider who has opted out of or been excluded or precluded from the Medicare Program. If the provider is not eligible to participate in Medicare, you will be responsible for the full cost of the services you receive.
- You can also receive emergency or urgently needed services from a provider outside the United States. If you receive emergency or urgently-needed services outside of the United States, the provider may require that you pay for the cost of the services in full. Ask for a written, detailed bill or receipt showing the specific services provided to you. Send a copy of the itemized bill or an itemized receipt to us to pay you back. You should be prepared to

assist us in obtaining all of the information necessary to properly process your request for reimbursement, including medical records.

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 services covered by our plan. We do not allow network providers to add additional separate charges, called "balance billing." This protection (that you never pay more than your cost-sharing amount) applies even if we pay the provider less than the provider charges for a service and even if there is a dispute and we don't pay certain provider charges. For more information about "balance billing," go to Chapter 4, Section 1.3.
- Whenever you get a bill from a network provider that you think is more than you should pay, send us the bill. We will contact the provider directly and resolve the billing problem.
- If you have already paid a bill to a network provider, but you feel that you paid too much, send us the bill along with documentation of any payment you have made and ask us to pay you back the difference between the amount you paid and the amount you owed under the plan.

3. If you are retroactively enrolled in our plan

Sometimes a person's enrollment in the plan is retroactive. (Retroactive 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 for us to handle the reimbursement.

Please call Customer Service for additional information about how to ask us to pay you back and deadlines for making your request. (Phone numbers for Customer Service are printed on the back cover of this booklet.)

4. When you utilize your Worldwide Emergency Coverage, Worldwide Urgently Needed Services, or Worldwide Emergency Transportation benefits

You will pay the full cost of emergency services received outside of the United States at the time you receive services. To receive reimbursement from us, you must do the following:

- Pay your bill at the time it is received. We will reimburse you for the difference between the amount of your bill and your cost share for the services as outlined in Chapter 4 of this document.
- Save all of your receipts and send us copies when you ask us to pay you back. In some situations, we may need to get more information from you or the provider who rendered services to you in order to pay you back for our share of the cost. Please see Chapter 5 Section 2.1 for expense reimbursement for worldwide services.

- If you are being asked to pay your bill for worldwide emergency services and are unable to make the payment, please call Customer Service for additional assistance and we may be able to help coordinate payment for covered services on your behalf.

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 booklet **(What to do if you have a problem or complaint (coverage decisions, appeals, complaints))** has information about how to make an appeal.

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

Section 2.1 How and where to send us your request for payment

Send us your request for payment, along with 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.
- Either download a copy of the form from our website (**www.peopleshealth.com**) or call Customer Service and ask for the form. (Phone numbers for Customer Service are printed on the back cover of this booklet.)

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

Medical Claims payment requests
Peoples Health
Three Lakeway CTR, 3838 N Causeway BLVD, STE 2200
Metairie, LA 70002

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.

Contact Customer Service if you have any questions (phone numbers are printed on the back cover of this booklet). If you don't know what you should have paid, or you receive bills and you don't know what to do about those bills, we can help. You can also call if you want to give us more information about a request for payment you have already sent to us.

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

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

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

- If we decide that the medical care is covered and you followed all the rules for getting the care, 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. (Chapter 3 explains the rules you need to follow for getting your medical services covered.)
- 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. Instead, we will send you a letter that explains the reasons why we are not sending the payment you have requested 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 you don't agree with 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.

For the details on how to make this appeal, go to Chapter 7 of this booklet **(What to do if you have a problem or complaint (coverage decisions, appeals, complaints))**. The appeals process is a formal process with detailed procedures and important deadlines. If making an appeal is new to you, you will find it helpful to start by reading Section 4 of Chapter 7. Section 4 is an introductory section that explains the process for coverage decisions and appeals and gives definitions of terms such as "appeal." Then after you have read Section 4, you can go to Section 5.3 in Chapter 7 that tells what to do if you want to make an appeal about getting paid back for a medical service.

Chapter 6

Your rights and responsibilities

Chapter 6
Your rights and responsibilities

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

Section 1.1 You have a right to receive information about the organization, its services, its practitioners and providers and member rights and responsibilities. We must provide information in a way that works for you (in languages other than English, in Braille, in large print, or other alternate formats, etc.)

To get information from us in a way that works for you, please call Customer Service (phone numbers are printed on the back cover of this booklet).

Our plan has people and free interpreter services available to answer questions from disabled and non-English speaking members. This information is available for free in other languages. We can also give you information in Braille, in large print, or other alternate formats at no cost if you need it. We are required to give you information about the plan's benefits in a format that is accessible and appropriate for you. To get information from us in a way that works for you, please call Customer Service (phone numbers are printed on the back cover of this booklet) or contact our Civil Rights Coordinator.

If you have any trouble getting information from our plan in a format that is accessible and appropriate for you, please call to file a grievance with Customer Service (phone numbers are printed on the cover of this booklet). 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. Contact information is included in this **Evidence of Coverage** or with this mailing, or you may contact Customer Service for additional information.

Sección 1.1 Usted tiene derecho a recibir información sobre la organización, sus servicios, sus profesionales del cuidado de la salud y proveedores, además de los derechos y las responsabilidades de los miembros. Debemos brindarle información útil y en otros idiomas aparte del inglés, en braille, en letras grandes o en otros formatos alternativos

Para obtener información nuestra de una forma que le resulte conveniente, llame al Servicio al Cliente (los teléfonos aparecen en la portada posterior de esta guía). Nuestro plan cuenta con personal y con servicios de interpretación gratuitos para responder a las preguntas de los miembros que no hablan inglés o que tienen alguna discapacidad. Esta información está disponible sin costo en otros idiomas. También podemos proporcionarle la información en braille, en formato de letras grandes o en otros formatos, sin costo alguno, si es necesario. Se nos exige que le brindemos la información de los beneficios del plan en un formato que sea accesible y apropiado para usted. Para obtener información de una forma que le resulte conveniente, llame a Servicio al Cliente (los teléfonos están impresos en la portada posterior de esta guía) o comuníquese con nuestro Coordinador de Derechos Civiles.

Si tiene algún problema para obtener la información de nuestro plan en un formato accesible y apropiado para usted, por favor llame a Servicio al Cliente y solicite presentar una queja formal (los números de teléfono están impresos en la portada de esta guía). También puede presentar una queja con Medicare llamando al 1-800-MEDICARE (1-800-633-4227) o directamente en la Oficina de Derechos Civiles. La información de contacto se encuentra en la **Evidencia de Cobertura** o en este comunicado. Si desea obtener más información puede comunicarse con Servicio al Cliente.

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

You have the right to choose a provider in the plan's network. Call Customer Service to learn which doctors are accepting new patients (phone numbers are printed on the back cover of this booklet). You also have the right to go to a women's health specialist (such as a gynecologist) without a referral and still pay the in-network cost-sharing amount.

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

How to Receive Care After Hours

If you need to talk or see your Primary Care Provider after the office has closed for the day, call your Primary Care Provider's office. When the on call physician returns your call he or she will advise you on how to proceed.

If you think that you are not getting your medical care within a reasonable amount of time, Chapter 7, Section 9 of this booklet tells what you can do. (If we have denied coverage for your medical care and you don't agree with our decision, Chapter 7, Section 4 tells what you can do.)

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

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

- Your "personal health information" includes the personal information you gave us when you enrolled in this plan as well as your medical records and other medical and health information.
- The laws that protect your privacy give you rights related to getting 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.
- In most situations, if we 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 first**. Written permission can be given by you or by someone you have given legal power to make decisions for you.

- There are certain exceptions that do not require us to get your written permission first. These exceptions are allowed or required by law.
  - For example, 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.

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 Service (phone numbers are printed on the back cover of this booklet).

Notice of Privacy Practices

(administered by Peoples Health)

Effective January 1, 2021

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please read it carefully.

At Peoples Health, we respect the confidentiality of your health information and will protect your information in a responsible and professional manner. We are required by law to maintain the privacy of your health information, to send you this notice, and to abide by the terms of this notice. We maintain physical, electronic and procedural safeguards that comply with state and federal regulations to guard non-public personal information from unauthorized access, use and disclosure. We are also required by law to notify affected individuals following a breach of unsecured protected health information.

This notice explains how we use information about you and when we can share that information with others. It also informs you of your rights with respect to your health information and how you can exercise those rights.

When we talk about “information” or “health information” in this notice we mean the following: Any information about you that Peoples Health creates or receives that reasonably can be used to identify you and that relates to your physical or mental health condition, the provision of health care to you, or the payment for such health care.

How We May Use and Disclose Your Health Information

Under the law, we may use or disclose your health information in certain circumstances without your permission. The following categories describe the different ways that we may use and disclose your health information. For each category of uses or disclosures we will explain what we mean and present some examples. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted to use and disclose information will fall within one of the categories.

For Treatment. We may use or disclose your health information to facilitate medical treatment or services by providers. We may disclose information about you to providers, including doctors, nurses, technicians, medical students, or other health care professionals who are involved in taking care of you. For example, we might disclose information about your prior prescriptions to a pharmacist to determine if prior prescriptions contraindicate a pending prescription.

For Payment. We may use or disclose your health information to determine your eligibility for Plan benefits, to facilitate payment for the treatment and services you receive from health care providers, to determine benefit responsibility under the Plan, or to coordinate Plan coverage. For example, we may tell your health care provider about your medical history to determine whether a particular treatment is experimental, investigational, or medically necessary, or to determine whether the Plan will cover the treatment. We may also share your health information with a utilization review or precertification service provider. Likewise, we may share your health information with another entity to assist with the adjudication or subrogation of health claims or to another health plan to coordinate benefit payments.

For Health Care Operations. We may use or disclose your health information for other Plan operations. These uses and disclosures are necessary to run the Plan. For example, we may use medical information in connection with conducting quality assessment and improvement activities; submitting claims for stop-loss (or excess-loss) coverage; conducting or arranging for medical review, legal services, audit services, and fraud and abuse detection programs; business planning and development such as cost management; and business management and general Plan administrative activities. We may use or share your information for underwriting purposes; however, we are prohibited from using or disclosing genetic information for underwriting purposes.

Treatment Alternatives or Health-Related Benefits and Services. We may use and disclose your health information to send you information about treatment alternatives or other health-related benefits and services that might be of interest to you.

To Business Associates. We may contract with individuals or entities known as business associates to perform various functions on our behalf or to provide certain types of services. In order to perform these functions or to provide these services, business associates will receive, create, maintain, transmit, use, and/or disclose your health information, but only after they agree in writing with us to implement appropriate safeguards regarding your health information. For

example, we may disclose your health information to a business associate to process your claims for Plan benefits or to provide support services, such as utilization management, pharmacy benefit management, or subrogation, but only after the business associate enters into a business associate agreement with us.

As Required by Law. We will disclose your health information when required to do so by federal, state, or local law. For example, we may disclose your health information when required by national security laws or public health disclosure laws.

To Avert a Serious Threat to Health or Safety. We may use and disclose your health information when necessary to prevent a serious threat to your health and safety, or the health and safety of the public or another person. Any disclosure, however, would only be to someone able to help prevent the threat. For example, we may disclose your health information in a proceeding regarding the licensure of a physician.

To Plan Sponsors. If your coverage is through an employer sponsored group health plan, we may share summary health information and enrollment and disenrollment information with the plan sponsor. In addition, we may share other health information with the plan sponsor for plan administration purposes if the plan sponsor agrees to special restrictions on its use and disclosure of the information in accordance with federal law.

To Persons Involved With Your Care. We may use or disclose your health information to a person involved in your care or who helps pay for your care, such as a family member, when you are incapacitated or in an emergency, or when you agree or fail to object when given the opportunity. If you are unavailable or unable to object, we will use our best judgment to decide if the disclosure is in your best interests. Special rules apply regarding when we may disclose health information to family members and others involved in a deceased individual's care. We may disclose health information to any persons involved, prior to the death, in the care or payment for care of a deceased individual, unless we are aware that doing so would be inconsistent with a preference previously expressed by the deceased.

For Reminders. We may use or disclose health information to send you reminders about your benefits or care, such as appointment reminders with providers who provide medical care to you.

Special Situations

In addition to the above, the following categories describe other possible ways that we may use and disclose your health information without your specific authorization. For each category of uses or disclosures, we will explain what we mean and present some examples. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted to use and disclose information will fall within one of the categories.

Organ and Tissue Donation. If you are an organ donor, we may release your health information after your death to organizations that handle organ procurement or organ, eye, or tissue

transplantation or to an organ donation bank, as necessary to facilitate organ or tissue donation and transplantation.

Military. If you are a member of the armed forces, we may release your health information as required by military command authorities. We may also release health information about foreign military personnel to the appropriate foreign military authority.

Workers' Compensation. We may release your health information for workers' compensation or similar programs, but only as authorized by, and to the extent necessary to comply with, laws relating to workers' compensation and similar programs that provide benefits for work- related injuries or illness.

Public Health Risks. We may disclose your health information for public health activities. These activities generally include the following:

- to prevent or control disease, injury, or disability;
- to report births and deaths;
- to report child abuse or neglect;
- to report reactions to medications or problems with products;
- to notify people of recalls of products they may be using;
- to notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition;
- to notify the appropriate government authority if we believe that a patient has been the victim of abuse, neglect, or domestic violence. We will only make this disclosure if you agree, or when required or authorized by law.

Health Oversight Activities. We may disclose your health information to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.

Lawsuits and Disputes. If you are involved in a lawsuit or a dispute, we may disclose your health information in response to a court or administrative order. We may also disclose your health information in response to a subpoena, discovery request, or other lawful process by someone involved in a legal dispute, but only if efforts have been made to tell you about the request or to obtain a court or administrative order protecting the information requested.

Law Enforcement. We may disclose your health information if asked to do so by a law-enforcement official:

- in response to a court order, subpoena, warrant, summons, or similar process;
- to identify or locate a suspect, fugitive, material witness, or missing person;
- about the victim of a crime if, under certain limited circumstances, we are unable to obtain the victim's agreement;

- about a death that we believe may be the result of criminal conduct; and
- about criminal conduct.

Coroners, Medical Examiners, and Funeral Directors. We may release health information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We may also release medical information about patients to funeral directors, as necessary to carry out their duties.

National Security and Intelligence Activities. We may release your health information to authorized federal officials for intelligence, counterintelligence, and other national security activities authorized by law.

Inmates. If you are an inmate of a correctional institution or are in the custody of a law-enforcement official, we may disclose your health information to the correctional institution or law-enforcement official if necessary (1) for the institution to provide you with health care; (2) to protect your health and safety or the health and safety of others; or (3) for the safety and security of the correctional institution.

Research. We may disclose your health information to researchers when:

1) the individual identifiers have been removed; or
2) when an institutional review board or privacy board has reviewed the research proposal and established protocols to ensure the privacy of the requested information, and approves the research.

Required Disclosures

The following is a description of disclosures of your health information we are required to make.

Government Audits. We are required to disclose your health information to the Secretary of the United States Department of Health and Human Services when the Secretary is investigating or determining our compliance with the HIPAA privacy rule.

Disclosures to You. When you request, we are required to disclose to you the portion of your health information that contains medical records, billing records, and any other records used to make decisions regarding your health care benefits. We are also required, when requested, to provide you with an accounting of most disclosures of your health information if the disclosure was for reasons other than for payment, treatment, or health care operations, and if the health information was not disclosed pursuant to your individual authorization.

Other Disclosures

Personal Representatives. We will disclose your health information to individuals authorized by you, or to an individual designated as your personal representative, attorney-in-fact, etc., so long as you provide us with a written notice/authorization and any supporting documents (i.e., power of

attorney). Note: Under the HIPAA privacy rule, we do not have to disclose information to a personal representative if we have a reasonable belief that:

1) you have been, or may be, subjected to domestic violence, abuse, or neglect by such person; or
2) treating such person as your personal representative could endanger you; and
3) in the exercise of professional judgment, it is not in your best interest to treat the person as your personal representative.

Authorizations. Other uses or disclosures of your health information not described above will only be made with your written authorization. For example, in general and subject to specific conditions, we will not use or disclose your psychotherapy notes; we will not use or disclose your health information for marketing purposes; and we will not sell your health information, unless you give us a written authorization. You may revoke written authorizations at any time, so long as the revocation is in writing. Once we receive your written revocation, it will only be effective for future uses and disclosures. It will not be effective for any information that may have been used or disclosed in reliance upon the written authorization and prior to receiving your written revocation.

Additional Restrictions on Use and Disclosure. Certain federal and state laws may require special privacy protections that restrict the use and disclosure of certain health information, including highly confidential information about you. Such laws may protect the following types of information:

1) Alcohol and Substance Abuse
2) Biometric Information
3) Child or Adult Abuse or Neglect, including Sexual Assault.
4) Communicable Diseases
5) Genetic Information
6) HIV/AIDS
7) Mental Health
8) Minors' Information
9) Prescriptions
10) Reproductive Health
11) Sexually Transmitted Diseases

What Are Your Rights?

The following are your rights with respect to your health information. If you would like to exercise the following rights, please write the Privacy Officer at the Peoples Health address listed at the end of this statement.

You have the right to ask us to restrict how we use or disclose your information for treatment, payment, or healthcare operations. You also have the right to ask us to restrict information that we have been asked to give to family members or to others who are involved in your healthcare or payment for your healthcare. *However, we are not required under law to agree to these restrictions except when the protected health information pertains solely to a health care item or service for which the individual or person other than the health plan has paid in full*.

You have the right to ask to receive confidential communications of information. For example, if you believe that you would be harmed if we send your information to your current mailing address (for example, in situations involving domestic disputes or violence), you can ask us to send the information by alternative means (for example, by fax) or to an alternative address. We will accommodate your reasonable requests as explained above.

You have the right to inspect and obtain a copy of information that we maintain about you in your designated record set. A "designated record set" is comprised of both (1) your medical records and billing records, and (2) your enrollment, payment, claims adjudication, and case or medical management record systems maintained by us; or for a health plan, which are used, in whole or in part, by or for the covered entity to make decisions about your healthcare.

However, **you do not have the right to access certain types of information** and we may decide not to provide you with copies of the following information:

- contained in psychotherapy notes;
- compiled in reasonable anticipation of, or for use in, a civil, criminal or administrative action or proceeding; and
- subject to certain federal laws governing biological products and clinical laboratories.

In certain other situations, we may deny your request to inspect or obtain a copy of your information. If we deny your request, we will notify you in writing and may provide you with a right to have the denial reviewed.

You have the right to ask us to make changes to information we maintain about you in your designated record set. These changes are known as amendments. Your request must be in writing and you must provide a reason for your request. We will respond to your request no later than 60 days after we receive it. If we are unable to act within 60 days, we may extend that time by no more than an additional 30 days. If we need to extend this time, we will notify you of the delay in writing and the date by which we will complete action on your request.

If we make the amendment, we will notify you in writing that it was made. In addition, we will provide the amendment to any person that we know has received your health information. We will also provide the amendment to other persons identified by you.

If we deny your request to amend, we will notify you in writing of the reason for the denial. The denial will explain your right to file a written statement of disagreement. We have a right to respond to your statement. However, you have the right to request that your written request, our written

denial and your statement of disagreement be included with your information for any future disclosures.

You have the right to receive an accounting of certain disclosures of your information made by us during the six years prior to your request. Please note that we are not required to provide you with an accounting of the following information:

- Any information collected or disclosed prior to April 14, 2003;
- Information disclosed or used for treatment, payment, and healthcare operations purposes;
- Information disclosed to you or pursuant to your authorization;
- Information that is incident to a use or disclosure otherwise permitted;
- Information disclosed for a facility's directory or to persons involved in your care or other notification purposes;
- Information disclosed for national security or intelligence purposes;
- Information disclosed to correctional institutions or law enforcement officials;
- Information that was disclosed or used as part of a limited data set for research, public health, or healthcare operations purposes.

Your request must be in writing. We will act on your request for an accounting within 60 days. We may need additional time to act on your request. If so, we may take up to an additional 30 days. Your first accounting will be free. We will continue to provide you with one free accounting upon request every 12 months. If you request an additional accounting within 12 months of receiving your free accounting, we may charge you a fee. We will inform you in advance of the fee and provide you with an opportunity to withdraw or modify your request.

Exercising Your Rights

You have the right to a paper copy of this notice. You may ask for a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice. You may also obtain a copy of this notice at www.peopleshealth.com.

Should any of our privacy practices change, we reserve the right to change the terms of this notice and to make the new notice effective for all protected health information we maintain. When we make significant changes in our privacy practices, we will change this notice and post it on our website; we will also send the notice to our current health plan subscribers.

If you have any questions about this notice or about how we use or share information, please contact the Privacy Officer at 1-800-455-4521. This is a 24-hour voice-activated hotline. Your call will be responded to within 72 business hours. Our office is open to receive written complaints Monday through Friday from 8:00 a.m. to 5:00 p.m. You can also send us questions by e-mail at PHNTClprivacy@peopleshealth.com.

If you believe your privacy rights have been violated, you may file a complaint with us by calling 1-800-455-4521, or by email to PHNTCIprivacy@peopleshealth.com or writing to the Privacy Officer at the Peoples Health address below. You may also notify the Secretary of the U.S. Department of Health and Human Services of your complaint. **We will not retaliate in any way if you elect to file a complaint with us or with the U.S. Department of Health and Human Services.**

Peoples Health
Three Lakeway Center
3838 N. Causeway Blvd., Suite 2200
Metairie, LA 70002
www.peopleshealth.com

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

As a member of our plan, you have the right to get several kinds of information from us. (As explained above in Section 1.1, you have the right to get information from us in a way that works for you. This includes getting the information in languages other than English and in large print or other alternate formats.)

If you want any of the following kinds of information, please call Customer Service (phone numbers are printed on the back cover of this booklet):

- **Information about our plan**. This includes, for example, information about the plan's financial condition. It also includes information about the number of appeals made by members and the plan's performance ratings, including how it has been rated by plan members and how it compares to other Medicare health plans.
- **Information about our network providers**.
  - For example, you have the right to get information from us about the qualifications of the providers in our network and how we pay the providers in our network.
  - For a list of the providers in the plan's network, see the **Provider Directory**.
  - For more detailed information about our providers, you can call Customer Service (phone numbers are printed on the back cover of this booklet) or visit our website at www.peopleshealth.com.
- **Information about your coverage and the rules you must follow when using your coverage.**
  - In Chapters 3 and 4 of this booklet, we explain what medical services are covered for you, any restrictions to your coverage, and what rules you must follow to get your covered medical services.
  - If you have questions about the rules or restrictions, please call Customer Service (phone numbers are printed on the back cover of this booklet).
- **Information about why something is not covered and what you can do about it.**
  - If a medical service is not covered for you, or if your coverage is restricted in some way, you can ask us for a written explanation. You have the right to this explanation even if you received the medical service from an out-of-network provider.

- If you are not happy or if you disagree with a decision we make about what medical care is covered for you, you have the right to ask us to change the decision. You can ask us to change the decision by making an appeal. For details on what to do if something is not covered for you in the way you think it should be covered, see Chapter 7 of this booklet. It gives you the details about how to make an appeal if you want us to change our decision. (Chapter 7 also tells about how to make a complaint about quality of care, waiting times, and other concerns.)
- If you want to ask our plan to pay our share of a bill you have received for medical care, see Chapter 5 of this booklet.

Section 1.5 You have a right to participate with practitioners in making decisions about your health care. We must support your right to make decisions about your care and a candid discussion of appropriate or medically necessary treatment options for your conditions, regardless of cost or benefit coverage.

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 when you go for medical care. 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**. This means that you have the right to be told about all of the treatment options that are recommended for your condition, no matter what they cost or whether they are covered by our plan.
- **To know about the risks**. You have the right to be told about any risks involved in your care. You must be told in advance if any proposed medical care or treatment is part of a research experiment. You always have the choice to refuse any experimental treatments.
- **The right to say "no."** You have the right to refuse any recommended treatment. This includes the right to leave a hospital or other medical facility, even if your doctor advises you not to leave. Of course, if you refuse treatment, you accept full responsibility for what happens to your body as a result.
- **To receive an explanation if you are denied coverage for care**. You have the right to receive an explanation from us if a provider has denied care that you believe you should receive. To receive this explanation, you will need to ask us for a coverage decision. Chapter 7 of this booklet tells how to ask the plan for a coverage decision.

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

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

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

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

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

- **Get the form**. If you want to have an advance directive, you can get a form from your lawyer, from a social worker, or from some office supply stores. You can sometimes get advance directive forms from organizations that give people information about Medicare. You can also contact Customer Service for assistance in locating an advanced directive form.
- **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 as the one to make decisions for you if you can't. You may want to give copies to close friends or family members as well. Be sure to 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**.

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

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

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 appropriate state-specific agency, for example, your State Department of Health. See Chapter 2, Section 3 for contact information regarding your state-specific agency.

Section 1.6 You have a right to voice complaints or appeals about the organization or the care it provides. You have the right to make complaints and to ask us to reconsider decisions we have made

If you have any problems or concerns about your covered services or care, Chapter 7 of this booklet tells what you can do. It gives the details about how to deal with all types of problems and complaints. What you need to do to follow up on a problem or concern depends on the situation. You might need to ask our plan to make a coverage decision for you, make an appeal to us to change a coverage decision, or make a complaint. Whatever you do – ask for a coverage decision, make an appeal, or make a complaint – **we are required to treat you fairly.**

You have the right to get a summary of information about the appeals and complaints that other members have filed against our plan in the past. To get this information, please call Customer Service (phone numbers are printed on the back cover of this booklet).

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

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

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

Is it about something else?

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

- You can **call Customer Service** (phone numbers are printed on the back cover of this booklet).
- You can **call the State Health Insurance Assistance Program.** For details about this organization and how to contact it, 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 users should call 1-877-486-2048.

Section 1.8 You have a right to make recommendations regarding the organization's member rights and responsibilities policy. How to get more information about your rights

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

- You can **call Customer Service** (phone numbers are printed on the back cover of this booklet).
- For information on the Quality Improvement Program for your specific health plan, call the Customer Service number on the back of your member ID card. You may also access this

information via the website (https://www.uhcmedicaresolutions.com/health-plans/medicare-advantage-plans/resources-plan-material/ma-medicare-forms). Select, “Commitment to Quality.”

- You can **call the State Health Insurance Assistance Program.** For details about this organization and how to contact it, 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 users should call 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 Service (phone numbers are printed on the back cover of this booklet). We’re here to help.

- **Get familiar with your covered services and the rules you must follow to get these covered services**. Use this **Evidence of Coverage** booklet 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, including what is covered, what is not covered, rules to follow, and what you pay.
- **If you have any other health insurance coverage in addition to our plan, you are required to tell us.** Please call Customer Service to let us know (phone numbers are printed on the back cover of this booklet).
  - We are required to follow rules set by Medicare to make sure that you are using all of your coverage in combination when you get your covered services from our plan. This is called “**coordination of benefits**” because it involves coordinating the health benefits you get from our plan with any other health benefits available to you. We’ll help you coordinate your benefits. (For more information about coordination of benefits, go to Chapter 1, Section 7.)
- **Tell your doctor and other health care providers that you are enrolled in our plan.** Show your plan member ID 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 your doctors and other health providers give you the best care, learn as much as you are able to about your health problems and give them the information they need about you and your health. Follow the treatment plans and instructions that you and your doctors agree upon.

- Make sure your doctors know all of the drugs you are taking, including over-the-counter drugs, vitamins, and supplements.
- If you have any questions, be sure to ask. Your doctors and other health care providers are supposed to explain things in a way you can understand. If you ask a question and you don't understand the answer you are given, ask again.

- **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:
  - In order to be eligible for our plan, you must have Medicare Part A and Medicare Part B. Some plan members must pay a premium for Medicare Part A. Most plan members must pay a premium for Medicare Part B to remain a member of the plan.
  - For some of your medical services covered by the plan, you must pay your share of the cost when you get the service. This will be a copayment (a fixed amount) or coinsurance (a percentage of the total cost). Chapter 4 tells what you must pay for your medical services.
  - If you get any medical services that are not covered by our plan or by other insurance you may have, you must pay the full cost.
  - If you disagree with our decision to deny coverage for a service, you can make an appeal. Please see Chapter 7 of this booklet for information about how to make an appeal.
- **Tell us if you move**. If you are going to move, it's important to tell us right away. Call Customer Service (phone numbers are printed on the back cover of this booklet).
  - **If you move outside of our plan service area, you cannot remain a member of our plan**. (Chapter 1 tells about our service area.) We can help you figure out whether you are moving outside our service area. If you are leaving our service area, you will have a Special Enrollment Period when you can join any Medicare plan available in your new area. We can let you know if we have a plan in your new area.
  - **If you move within our service area, we still need to know** so we can keep your membership record up to date and know how to contact you.
  - **If** you move, it is also important to tell Social Security (or the Railroad Retirement Board) . You can find phone numbers and contact information for these organizations in Chapter 2.
- **Call Customer Service for help if you have questions or concerns**. We also welcome any suggestions you may have for improving our plan.
  - Phone numbers and calling hours for Customer Service are printed on the back cover of this booklet.
  - For more information on how to reach us, including our mailing address, please see Chapter 2.

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)

COVERAGE DECISIONS AND APPEALS

MAKING 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 types of problems, you need to use the **process for coverage decisions and appeals**.
- For other types of problems, you need to use the **process for making complaints**.

Both of these processes have been approved by Medicare. To ensure fairness and prompt handling of your problems, each process has a set of rules, procedures, and deadlines that must be followed by us and by you.

Which one do you use? That depends on the type of problem you are having. The guide in Section 3 will help you identify the right process to use.

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 keep things simple, this chapter explains the legal rules and procedures using simpler words in place of certain legal terms. For example, this chapter generally says “making a complaint” rather than “filing a grievance,” “coverage decision” rather than “organization determination,” and “Independent Review Organization” instead of “Independent Review Entity.” It also uses abbreviations as little as possible.

However, it can be helpful – and sometimes quite important – for you to know the correct legal terms for the situation you are in. Knowing which terms to use will help you communicate more clearly and accurately when you are dealing with your problem and 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 You can get help from government organizations that are not connected with us

Section 2.1 Where to get more information and personalized assistance

Sometimes it can be confusing to start or follow through the process for dealing with a problem. This can be especially true if you do not feel well or have limited energy. Other times, you may not have the knowledge you need to take the next step.

Get help from an independent government organization

We are always available to help you. But in some situations you may also want help or guidance from someone who is not connected with us. You can always contact your **State Health Insurance Assistance Program (SHIP)**. This government program has trained counselors in every state. 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 in Chapter 2, Section 3 of this booklet.

You can also get help and information from Medicare

For more information and help in handling a problem, you can also contact Medicare. Here are two ways to get information directly from Medicare:

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

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

Section 3.1 Should you use the process for coverage decisions and appeals? Or should you use the process for making complaints?

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.

To figure out which part of this chapter will help with your specific problem or concern, **START HERE**

Is your problem or concern about your benefits or coverage?	
(This includes problems about whether particular medical care or prescription drugs are covered or not, the way in which they are covered, and problems related to payment for medical care or prescription drugs.)	
Yes. My problem is about benefits or coverage.	**No.** My problem is not about benefits or coverage.
Go on to the next section of this chapter, **Section 4, "A guide to the basics of coverage decisions and appeals."**	Skip ahead to **Section 9** at the end of this chapter: **"How to make a complaint about**

	quality of care, waiting times, customer service or other concerns."

COVERAGE DECISIONS AND APPEALS

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

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

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

Asking for coverage decisions

A coverage decision is a decision we make about your benefits and coverage or about the amount we will pay for your medical services. For example, your plan network doctor makes a (favorable) coverage decision for you whenever you receive medical care from him or her or if your network doctor refers you to a medical specialist. You or your doctor can also contact us and ask for a coverage decision if your doctor is unsure whether we will cover a particular medical service or refuses to provide medical care you think that you need. In other words, if you want to know if we will cover a medical service before you receive it, you can ask us to make a coverage decision for you.

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 and you are not satisfied with this decision, you can "appeal" the decision. An appeal is a formal way of asking us to review and change a coverage decision we have made.

When you appeal a decision for the first time, this is called a Level 1 Appeal. In this appeal, we review the coverage decision we made to check to see if we were following all of the rules properly. Your appeal is handled by different reviewers than those who made the original unfavorable decision. When we have completed the review, we give you our decision. Under certain circumstances, which we discuss later, you can request an expedited or "fast coverage decision" or fast appeal of a coverage decision.

If we say no to all or part of your Level 1 Appeal, you can go on to a Level 2 Appeal. The Level 2 Appeal is conducted by an Independent Review Organization that is not connected to us. (In some

situations, your case will be automatically sent to the Independent Review Organization for a Level 2 Appeal. In other situations, you will need to ask for a Level 2 Appeal.) 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 4.2 How to get help when you are asking for a coverage decision or making an appeal

Would you like some help? Here are resources you may wish to use if you decide to ask for any kind of coverage decision or appeal a decision:

- You **can call us at Customer Service** (phone numbers are printed on the back cover of this booklet).
- You can get free help from your State Health Insurance Assistance Program (see Section 2 of this chapter).
- **Your doctor can make a request for you.**
  - 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. To request any appeal after Level 2, your doctor must be appointed as your representative.
- **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.
  - There may be someone who is already legally authorized to act as your representative under State law.
  - If you want a friend, relative, your doctor or other provider, or other person to be your representative, call Customer Service (phone numbers are printed on the back cover of this booklet) and ask for the "Appointment of Representative" form. (The form is also available on Medicare's website at www.cms.gov/Medicare/CMS-Forms/CMS-Forms/downloads/cms1696.pdf) 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.
- **You also have the right to hire a lawyer to act for you.** You may contact your own lawyer, or get the name of a lawyer from your local bar association or other referral service. There are also groups that will give you free legal services if you qualify. However, **you are not required to hire a lawyer** to ask for any kind of coverage decision or appeal a decision.

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

There are three different types of 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 these services only:** home health care, skilled nursing facility care, and Comprehensive Outpatient Rehabilitation Facility (CORF) services)

If you’re not sure which section you should be using, please call Customer Service (phone numbers are printed on the back cover of this booklet). You can also get help or information from government organizations such as your State Health Insurance Assistance Program (Chapter 2, Section 3, of this booklet has the phone numbers for this program).

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

Have you read Section 4 of this chapter (A guide to “the basics” of coverage decisions and appeals)? If not, you may want to read it before you start this section.

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

This section is about your benefits for medical care and services. These benefits are described in Chapter 4 of this booklet: **Medical Benefits Chart (what is covered and what you pay)**. To keep things simple, we generally refer to “medical care coverage” or “medical care” in the rest of this section, instead of repeating “medical care or treatment or services” every time. The term “medical care” 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:

1. You are not getting certain medical care you want, and you believe that this care is covered by our plan.
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.
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.

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.
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.

- 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 a separate section of this chapter because special rules apply to these types of care. Here's what to read in those situations:
  - Chapter 7, Section 6: **How to ask us to cover a longer inpatient hospital stay if you think the doctor is discharging you too soon.**
  - Chapter 7, Section 7: **How to ask us to keep covering certain medical services if you think your coverage is ending too soon.** This section is about three services only: home health care, skilled nursing facility care, and Comprehensive Outpatient Rehabilitation Facility (CORF) services.
- For **all other** situations that involve being told that medical care you have been getting will be stopped, use this section (Section 5) as your guide for what to do.

Which of these situations are you in?

If you are in this situation:	This is what you can do:
To find out whether we will cover the medical care you want.	You can ask us to make a coverage decision for you. Go to the next section of this chapter, **Section 5.2**.
If we already told you that we will not cover or pay for a medical service in the way that you want it to be covered or paid for.	You can make an **appeal**. (This means you are asking us to reconsider.) Skip ahead to **Section 5.3** of this chapter.
If you want to ask us to pay you back for medical care you have already received and paid for.	You can send us the bill. Skip ahead to **Section 5.5** of this chapter.

Section 5.2 Step-by-step: How to ask for a coverage decision (how to ask our plan to authorize or provide the medical care coverage you want)

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

1 **Step 1: You ask our plan to make a coverage decision on the medical care you are requesting.** If your health requires a quick response, you should ask us to make a **"fast coverage decision."**

Legal Terms	A "fast coverage decision" is called an **"expedited determination."**

How to request coverage for the medical care you want

- 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.
- For the details on how to contact us, go to Chapter 2, Section 1 and look for the section called, **How to contact us when you are asking for a coverage decision about your medical care**.

Generally we use the standard deadlines for giving you our decision

When we give you our decision, we will use the "standard" deadlines unless we have agreed to use the "fast" deadlines. **A standard coverage decision 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, for a request for a medical item or service, we can take up to 14 more calendar days** if you ask for more time, or if we need information (such as medical records from out-of-network providers) that may benefit you. If we decide to take extra days to make the decision, 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" about our decision to take extra days. When you file a fast complaint, we will give you an answer to your complaint within 24 hours. (The process for making a complaint is different from the process for coverage decisions and appeals. For more information about the process for making complaints, including fast complaints, see Section 9 of this chapter.)

If your health requires it, ask us to give you a "fast coverage decision"

- **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,** for a request **for a medical item or service, we can take up to 14 more calendar days** if we find that some information that may benefit you is missing (such as medical records from out-of-network providers), or if you need time to get information to us for the review. If we decide to 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" about our decision to take extra days. (For more information about the process for making complaints, including fast complaints, see Section 9 of this chapter.) We will call you as soon as we make the decision.

- **To get a fast coverage decision, you must meet two requirements:**
  - You can get a fast coverage decision **only** if you are asking for coverage for medical care **you have not yet received**. (You cannot ask for a fast coverage decision if your request is about payment for medical care you have 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 decide that your medical condition does not meet the requirements for a fast coverage decision, we will send you a letter that says so (and we will use the standard deadlines instead).
  - This letter will tell you that if your doctor asks for the fast coverage decision, we will automatically give a fast coverage decision.
  - The letter will also tell how you can file a "fast complaint" about our decision to give you a standard coverage decision instead of the fast coverage decision you requested. (For more information about the process for making complaints, including fast complaints, see Section 9 of this chapter.)

2 Step 2: We consider your request for medical care coverage and give you our answer.

Deadlines for a "fast" coverage decision

- Generally, for a fast coverage decision on a request for a medical item or service, we will give you our answer **within 72 hours**. If your request is for a Medicare Part B prescription drug, we will answer **within 24 hours.**
  - As explained above, we can take up to 14 more calendar days under certain circumstances. If we decide to take extra days to make the coverage decision, 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" about our decision to take extra days. When you file a fast complaint, we will give you an answer to your complaint within 24 hours. (For more information about the process for making complaints, including fast complaints, see Section 9 of this chapter.)
  - If we do not give you our answer within 72 hours (or if there is an extended time period, by the end of that period), or 24 hours if your request is for a Medicare Part B prescription drug, you have the right to appeal. Section 5.3 below tells how to make an appeal.
- **If our answer is no to part or all of what you requested,** we will send you a detailed written explanation as to why we said no.

Deadlines for a "standard" coverage decision

- Generally, for a standard coverage decision on a request for a medical item or service, we will give you our answer **within 14 calendar days of receiving your request**. If your request is for a Medicare Part B prescription drug, we will give you an answer **within 72 hours** of receiving your request.
  - For a request for a medical item or service, we can take up to 14 more calendar days ("an extended time period") under certain circumstances. If we decide to take extra days to make the coverage decision, 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" about our decision to take extra days. When you file a fast complaint, we will give you an answer to your complaint within 24 hours. (For more information about the process for making complaints, including fast complaints, see Section 9 of this chapter.)
  - If we do not give you our answer within 14 calendar days (or if there is an extended time period, by the end of that period), or 72 hours if your request is for a Part B prescription drug, you have the right to appeal. Section 5.3 below tells how to make an appeal.
- **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.

3 **Step 3: If we say no to your request for coverage for medical care, you decide if you want to make an appeal.**

- If we say no, you have the right to ask us to reconsider – and perhaps change – this decision by making an appeal. Making an appeal means making another try to get the medical care coverage you want.
- If you decide to make an appeal, it means you are going on to Level 1 of the appeals process (see Section 5.3 below).

Section 5.3 Step-by-step: How to make a Level 1 Appeal (how to ask for a review of a medical care coverage decision made by our plan)

Legal Terms	An appeal to the plan about a medical care coverage decision is called a plan **"reconsideration."**

1 **Step 1: You contact us and make your appeal.** If your health requires a quick response, you must ask for a **"fast appeal."**

What to do

- **To start an appeal, you, your doctor, or your representative, must contact us.** For details on how to reach us for any purpose related to your appeal, go to Chapter 2, Section 1 and look for the section called, **How to contact us when you are making an appeal about your medical care**.
- **If you are asking for a standard appeal, make your standard appeal in writing by submitting a request.**
  - If you have someone appealing our decision for you other than your doctor, your appeal must include an Appointment of Representative form authorizing this person to represent you. (To get the form, call Customer Service (phone numbers are printed on the back cover of this booklet) and ask for the "Appointment of Representative" form. It is also available on Medicare's website at www.cms.gov/Medicare/CMS-Forms/CMS-Forms/downloads/cms1696.pdf). While we can accept an appeal request without the form, we cannot begin or complete our review until we receive it. If we do not receive the form within 44 calendar days after receiving your appeal request (our deadline for making a decision on your appeal), your appeal request will be dismissed. If this happens, we will send you a written notice explaining your right to ask the Independent Review Organization to review our decision to dismiss your appeal.
- **If you are asking for a fast appeal, make your appeal in writing or call us** at the phone number shown in Chapter 2, Section 1 **(How to contact us when you are making an appeal about your medical care)**.
  - **You must make your appeal request within 60 calendar days** from the date on the written notice we sent to tell you our answer to your request for a 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 for missing the deadline may include if you had 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 and add more information to support your appeal.**
  - You have the right to ask us for a copy of the information regarding your appeal.
  - If you wish, you and your doctor may give us additional information to support your appeal.

If your health requires it, ask for a "fast appeal" (you can make a request by calling us)

Legal Terms	A "fast appeal" is also called an **"expedited reconsideration."**

- 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."

- The requirements and procedures for getting a "fast appeal" are the same as those for getting a "fast coverage decision." To ask for a fast appeal, follow the instructions for asking for a fast coverage decision. (These instructions are given earlier in this section.)
- If your doctor tells us that your health requires a "fast appeal," we will give you a fast appeal.

2 Step 2: We consider your appeal and we give you our answer.

- When our plan is reviewing your appeal, we take another careful look at all of the information about your request for coverage of medical care. We check to see if we were following all the rules when we said no to your request.
- We will gather more information if we need it. We may contact you or your doctor to get more information.

Deadlines for a "fast" appeal

- When we are using the fast deadlines, 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 do so.
  - However, if you ask for more time, or if we need to gather 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 decide to take extra days to make the decision, 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 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. Later in this section, we talk about this review organization and explain what happens at Appeal Level 2 of the appeals 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 automatically send your appeal to the Independent Review Organization for a Level 2 Appeal.

Deadlines for a "standard" appeal

- If we are using the standard deadlines, we must give you our answer on a request for a medical item or service **within 30 calendar days** after we receive your appeal if your appeal is about coverage for services you have not yet received. 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 to gather 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 decide to take extra days to make the decision, 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" about our decision to take extra days. When you file a fast complaint, we will give you an answer to your complaint within 24 hours. (For more information about the process for making complaints, including fast complaints, see Section 9 of this chapter.)
- If we do not give you an answer by the applicable deadline above (or by the end of the extended time period if we took extra days on your request for a medical item or service), we are required to send your request on to Level 2 of the appeals process, where it will be reviewed by an Independent Review Organization. Later in this section, we talk about this review organization and explain what happens at Level 2 of the appeals 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 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 answer is no to part or all of what you requested,** we will automatically send your appeal to the Independent Review Organization for a Level 2 Appeal.

3 Step 3: If our plan says no to part or all of your appeal, your case will automatically be sent on to the next level of the appeals process.

- To make sure we were following all the rules when we said no to your appeal, **our plan is required to send your appeal to the "Independent Review Organization."** When we do this, it means that your appeal is going on to the next level of the appeals process, which is Level 2.

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

If our plan says no to your Level 1 Appeal, your case will **automatically** be sent on to the next level of the appeals process. During the Level 2 Appeal, the **Independent Review Organization** reviews our decision for your first appeal. This organization decides whether the decision we made should be changed.

Legal Terms	The formal name for the "Independent Review Organization" is the **"Independent Review Entity."** It is sometimes called the **"IRE."**

1 Step 1: The Independent Review Organization reviews your appeal.

- **The Independent Review Organization is an independent organization that is hired by Medicare.** This organization is not connected with us and it is not a government agency. This

organization is a company chosen by Medicare to handle the job of being the Independent Review Organization. Medicare oversees its work.

- 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

- If you had a fast appeal to our plan at Level 1, you will automatically receive a fast appeal at Level 2. 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

- If you had a standard appeal to our plan at Level 1, you will automatically receive a standard appeal at Level 2. 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.

2 Step 2: The Independent Review Organization gives you their answer.

The Independent Review Organization will tell you its decision in writing and explain the reasons for it.

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

- **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 under dispute within **72 hours** after we receive the decision from the review organization for **standard requests** or within **24 hours** from the date we receive the decision from the review organization for **expedited requests.**
- **If this organization says no to part or all of your appeal,** it means they agree with us that your request (or part of your request) for coverage for medical care should not be approved. (This is called "upholding the decision." It is also called "turning down your appeal.")
  - If the Independent Review Organization "upholds the decision" you have the right to a Level 3 Appeal. However, to make another appeal at Level 3, the dollar value of the medical care coverage you are requesting must meet a certain minimum. If the dollar value of the coverage you are requesting is too low, you cannot make another appeal, which means that the decision at Level 2 is final. The written notice you get from the Independent Review Organization will tell you how to find out the dollar amount to continue the appeals process.

3 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 your Level 2 Appeal is turned down and you meet the requirements to continue with the appeals process, you must decide whether you want to go on to Level 3 and make a third 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 tells more about Levels 3, 4, and 5 of the appeals process.

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

If you want to ask us for payment for medical care, start by reading Chapter 5 of this booklet: **Asking us to pay our share of a bill you have received for covered medical services**. Chapter 5 describes the situations in which 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 that asks for reimbursement, you are asking us to make a coverage decision (for more information about coverage decisions, see Section 4.1 of this chapter). To make this coverage decision, we will check to see if the medical care you paid for is a covered service (see Chapter 4: **Medical Benefits Chart (what is covered and what you pay)**). We will also check to see if you followed all the rules for using your coverage for medical care (these rules are given in Chapter 3 of this booklet: **Using the plan's coverage for your medical services**).

We will say yes or no to your request

- If the medical care you paid for is covered and you followed all the rules, we will send you the payment for our share of the cost of your medical care within 60 calendar days after we receive your request. Or, if you haven't paid for the services, we will send the payment directly to the provider. (When we send the payment, it's the same as saying **yes** to your request for a coverage decision.)
- If the medical care is **not** covered, or you did **not** follow all the rules, we will not send payment. Instead, we will send you a letter that says we will not pay for the services and the reasons why in detail. (When we turn down your request for payment, it's the same as saying **no** to your request for a coverage decision.)

What if you ask for payment and we say that we will not pay?

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. Go to this section for step-by-step instructions. When you are following these instructions, please note:

- If you make an appeal for reimbursement, 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 yourself, you are not allowed to ask for a fast appeal.)
- If the Independent Review Organization reverses our decision to deny payment, we must send the payment you have requested to you or to the provider 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. For more information about our coverage for your hospital care, including any limitations on this coverage, see Chapter 4 of this booklet: **Medical Benefits Chart (what is covered and what you pay).**

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 also 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 has been decided, your doctor or the hospital staff will let you know.
- 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. This section tells you how to ask.

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

During your covered hospital stay, 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 whenever they are admitted to a hospital. Someone at the hospital (for example, a caseworker or nurse) must give it to you within two days after you are admitted. If you do not get the notice, ask any hospital employee for it. If you need help, please call Customer Service (phone numbers are printed on the back cover of this booklet). You can also call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

1. **Read this notice carefully and ask questions if you don't understand it.** It tells you about your rights as a hospital patient, including:
   - 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, and your right to know who will pay for it.
   - Where to report any concerns you have about quality of your hospital care.
   - Your right to appeal your discharge decision if you think you are being discharged from the hospital too soon.

Legal Terms	The written notice from Medicare tells you how you can **"request an immediate review."** Requesting an immediate review 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. (Section 6.2 below tells you how you can request an immediate review.)

2. **You will be asked to sign the written notice to show that you received it and understand your rights.**
   - You or someone who is acting on your behalf will be asked to sign the notice. (Section 4 of this chapter tells how you can give written permission to someone else to act as your representative.)
   - Signing the notice shows **only** that you have received the information about your rights. The notice does not give your discharge date (your doctor or hospital staff will tell you your discharge date). Signing the notice **does not mean** you are agreeing on a discharge date.
3. **Keep your copy** of the notice so you will have the information about making an appeal (or reporting a concern about quality of care) handy if you need it.
   - If you sign the notice more than two days before the day you leave the hospital, you will get another copy before you are scheduled to be discharged.
   - To look at a copy of this notice in advance, you can call Customer Service (phone numbers are printed on the back cover of this booklet) or 1-800 MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048. You can also see the

notice online at www.cms.gov/Medicare/Medicare-General-Information/BNI/HospitalDischargeAppealNotices.html.

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 our plan 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.** Each step in the first two levels of the appeals process is explained below.
- **Meet the deadlines.** The deadlines are important. Be sure that you understand and follow the deadlines that apply to things you must do.
- **Ask for help if you need it.** If you have questions or need help at any time, please call Customer Service (phone numbers are printed on the back cover of this booklet). Or, call your State Health Insurance Assistance Program, a government organization that provides personalized assistance (see Section 2, of this chapter).

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.

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

What is the Quality Improvement Organization?

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

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, Section 4, of this booklet.)

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.** (Your "planned discharge date" is the date that has been set for you to leave the hospital.)
  - If you meet this deadline, you are allowed to stay in the hospital **after** your discharge date **without paying for it** while you wait to get the decision on your appeal from the Quality Improvement Organization.

- If you do **not** meet this deadline, and you decide to stay in the hospital after your planned discharge date, **you may have to pay all of the costs** for hospital care you receive after your planned discharge date.

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

Ask for a "fast review":

- You must ask the Quality Improvement Organization for a **"fast review"** of your discharge. Asking for a "fast review" means you are asking for the organization to use the "fast" deadlines for an appeal instead of using the standard deadlines.

Legal Terms	A "**fast review**" is also called an "**immediate review**" or an "**expedited review**."

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

What happens during this review?

- Health professionals at the Quality Improvement Organization (we will call them "the reviewers" for short) 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 informed our plan of your appeal, you will also get a written notice that 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.

Legal Terms	This written explanation is called the **"Detailed Notice of Discharge."** You can get a sample of this notice by calling Customer Service (phone numbers are printed on the back cover of this booklet) or 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048. Or you can see a sample notice online at www.cms.gov/Medicare/Medicare-General-Information/BNI/HospitalDischargeAppealNotices.html

3 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** to your appeal, **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. (See Chapter 4 of this booklet).

What happens if the answer is no?

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

4 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 turned down 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

If the Quality Improvement Organization has turned down your appeal, **and** you stay in the hospital after your planned discharge date, then you can make a Level 2 Appeal. During a Level 2 Appeal, you ask the Quality Improvement Organization to take another look at the decision they made 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.

Here are the steps for Level 2 of the appeal process:

1 Step 1: You 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.

2 **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.

3 **Step 3: Within 14 calendar days of receipt of your request for a second review, the Quality Improvement Organization 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 and will not change it.
- 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.

4 **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 the review organization turns down your Level 2 Appeal, you can choose whether to accept that decision or whether to go on to Level 3 and make another appeal. At Level 3, your appeal is reviewed by an Administrative Law Judge or attorney adjudicator.
- Section 8 in this chapter tells more about Levels 3, 4, and 5 of the appeals process.

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

You can appeal to us instead

As explained above in Section 6.2, you must act quickly to contact the Quality Improvement Organization to start your first appeal of your hospital discharge. (“Quickly” means before you leave the hospital and no later than your planned discharge date, whichever comes first.) If you miss the deadline for contacting this organization, there is another way to make your appeal.

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

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

If you miss the deadline for contacting the Quality Improvement Organization, you can make an appeal to our plan, asking for a "fast review." A fast review is an appeal that uses the fast deadlines instead of the standard deadlines.

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

1 **Step 1: Contact our plan and ask for a "fast review."**

- For details on how to contact us, go to Chapter 2, Section 1 and look for the section called, **How to contact us when you are making an appeal about your medical care**.
- **Be sure to ask for a "fast review."** This means you are asking us to give you an answer using the "fast" deadlines rather than the "standard" deadlines.

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

- During this review, we take a look at all of the information about your hospital stay. We check to see if your planned discharge date was medically appropriate. We will check to see if the decision about when you should leave the hospital was fair and followed all the rules.
- In this situation, we will use the "fast" deadlines rather than the standard deadlines for giving you the answer to this review.

3 **Step 3: We give you our decision within 72 hours after you ask for a "fast review" ("fast appeal").**

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

4 Step 4: If our plan says no to your fast appeal, your case will automatically be sent on to the next level of the appeals process.

- To make sure we were following all the rules when we said no to your fast appeal, **our plan is required to send your appeal to the "Independent Review Organization."** When we do this, it means that you are **automatically** going on to Level 2 of the appeals process.

Step-by-Step: Level 2 Alternate Appeal Process

During the Level 2 Appeal, an **Independent Review Organization** reviews the decision we made when we said no to your "fast appeal." This organization decides whether the decision we made should be changed.

Legal Terms	The formal name for the "Independent Review Organization" is the **"Independent Review Entity."** It is sometimes called the **"IRE."**

1 Step 1: We will automatically forward your case to the Independent Review Organization.

- We are required to send the information for your Level 2 Appeal to the Independent Review Organization within 24 hours of when we tell you that we are saying no to your first appeal. (If you think we are not meeting this deadline or other deadlines, you can make a complaint. The complaint process is different from the appeal process. Section 9 of this chapter tells how to make a complaint.)

2 Step 2: The Independent Review Organization does a "fast review" of your appeal. The reviewers give you an answer within 72 hours.

- **The Independent Review Organization is an independent organization that is hired by Medicare**. This organization is not connected with our plan and it is not a government agency. This organization is a company chosen by Medicare to handle the job of being the Independent Review Organization. Medicare oversees its work.
- Reviewers at the Independent Review Organization will take a careful look at all of the information related to your appeal of your hospital discharge.
- **If this organization says yes to your appeal,** then we must reimburse you (pay you back) for our share of the costs of hospital care you have received since the date of your planned discharge. We must also continue the plan's coverage of your inpatient hospital services for as long as it is medically necessary. You must continue to pay your share of the costs. If there are coverage limitations, these could limit how much we would reimburse or how long we would continue to cover your services.

- **If this organization says no to your appeal,** it means they agree with us that your planned hospital discharge date was medically appropriate.
  - The notice you get from the Independent Review Organization 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 a Level 3 Appeal, which is handled by an Administrative Law Judge or attorney adjudicator.

3 Step 3: If the Independent Review Organization turns down your appeal, you choose whether you want to take your appeal further.

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

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

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

This section is about the following types of care **only**:

- **Home health care services** you are getting.
- **Skilled nursing care** you are getting as a patient in a skilled nursing facility. (To learn about requirements for being considered a "skilled nursing facility," see Chapter 10, **Definitions of important words**.)
- **Rehabilitation care** you are getting as an outpatient at a Medicare-approved Comprehensive Outpatient Rehabilitation Facility (CORF). Usually, this means you are getting treatment for an illness or accident, or you are recovering from a major operation. (For more information about this type of facility, see Chapter 10, **Definitions of important words**.)

When you are getting any of these types of care, 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. For more information on your covered services, including your share of the cost and any limitations to coverage that may apply, see Chapter 4 of this booklet: **Medical Benefits Chart (what is covered and what you pay)**.

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

1. **You receive a notice in writing.** At least two days before our plan is going to stop covering your care, you will receive a notice.
   - The written notice tells you the date when we will stop covering the care for you.
   - The written notice also tells what you can do if you want to ask us to change this decision about when to end your care, and keep covering it for a longer period of time.

Legal Terms	In telling you what you can do, the written notice is telling 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. (Section 7.3 below tells how you can request a fast-track appeal.) The written notice is called the **"Notice of Medicare Non-Coverage."**

2. **You will be asked to sign the written notice to show that you received it.**
   - You or someone who is acting on your behalf will be asked to sign the notice. (Section 4 tells how you can give written permission to someone else to act as your representative.)
   - Signing the notice shows **only** that you have received the information about when your coverage will stop. **Signing it does <u>not</u> mean you agree** with the plan that it's time to stop getting the care.

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

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

- **Follow the process.** Each step in the first two levels of the appeals process is explained below.
- **Meet the deadlines.** The deadlines are important. Be sure that you understand and follow the deadlines that apply to things you must do. There are also deadlines our plan must follow. (If you think we are not meeting our deadlines, you can file a complaint. Section 9 of this chapter tells you how to file a complaint.)

- **Ask for help if you need it.** If you have questions or need help at any time, please call Customer Service (phone numbers are printed on the back cover of this booklet). Or call your State Health Insurance Assistance Program, a government organization that provides personalized assistance (see Section 2 of this chapter).

During a Level 1 Appeal, the Quality Improvement Organization reviews your appeal and decides whether to change the decision made by our plan.

1 Step 1: Make your Level 1 Appeal: contact the Quality Improvement Organization for your state and ask for a review. You must act quickly.

What is the Quality Improvement Organization?

- This organization is a group of doctors and other health care experts who are paid by the Federal government. These experts are not part of our plan. They check on the quality of care received by people with Medicare and review plan decisions about when it's time to stop covering certain kinds of medical care.

How can you contact this organization?

- The written notice you received 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, Section 4, of this booklet.)

What should you ask for?

- Ask this organization for a "fast-track appeal" (to do an independent review) of whether it is medically appropriate for us to end coverage for your medical services.

Your deadline for contacting this organization.

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

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

What happens during this review?

- Health professionals at the Quality Improvement Organization (we will call them "the reviewers" for short) 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 informed us of your appeal, and you will also get a written notice from us that explains in detail our reasons for ending our coverage for your services.

Legal Terms	This notice of explanation is called the **"Detailed Explanation of Non-Coverage."**

3 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 to your appeal?

- 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). In addition, there may be limitations on your covered services (see Chapter 4 of this booklet).

What happens if the reviewers say no to your appeal?

- If the reviewers say **no** to your appeal, then **your coverage will end on the date we have told you.** We will stop paying our share of the costs of this care on the date listed on the notice.
- 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.

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

- This first appeal you make is "Level 1" of the appeals process. 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 another appeal.
- Making another appeal means you are going on to "Level 2" of the appeals process.

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

If the Quality Improvement Organization has turned down your appeal and you choose to continue getting care after your coverage for the care has ended, then you can make a Level 2 Appeal. During a Level 2 Appeal, you ask the Quality Improvement Organization to take another look at the decision they made 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.

Here are the steps for Level 2 of the appeal process:

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

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

2 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.

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

What happens if the review organization says yes to your appeal?

- **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 we made to your Level 1 Appeal and will not change it.
- 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.

4 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 reviewers turn down your Level 2 Appeal, you can choose whether to accept that decision or to

go on to Level 3 and make another appeal. At Level 3, your appeal is reviewed by an Administrative Law Judge or attorney adjudicator.

- Section 8 in this chapter tells more about Levels 3, 4, and 5 of the appeals process.

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

You can appeal to us instead

As explained above in Section 7.3, you must act quickly to contact the Quality Improvement Organization to start your first appeal (within a day or two, at the most). If you miss the deadline for contacting this organization, there is another way to make your appeal. If you use this other way of making your appeal, **the first two levels of appeal are different**.

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

If you miss the deadline for contacting the Quality Improvement Organization, you can make an appeal to our plan, asking for a "fast review." A fast review is an appeal that uses the fast deadlines instead of the standard deadlines.

Here are the steps for a Level 1 Alternate Appeal:

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

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

- For details on how to contact us, go to Chapter 2, Section 1 and look for the section called, **How to contact us when you are making an appeal about your medical care**.
- **Be sure to ask for a "fast review."** This means you are asking us to give you an answer using the "fast" deadlines rather than the "standard" deadlines.

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

- During this review, we take another look at all of the information about your case. We check to see if we were following all the rules when we set the date for ending the plan's coverage for services you were receiving.
- We will use the "fast" deadlines rather than the standard deadlines for giving you the answer to this review.

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

- **If we say yes to your fast appeal,** it means we have agreed with you that you need services longer, and will keep providing your covered services for as long as it is medically necessary. It also means that we have agreed to reimburse you for our share of the costs of care you have received since the date when we said your coverage would end. (You must pay your share of the costs and there may be coverage limitations that apply.)
- **If we say no to your fast appeal,** then your coverage will end on the date we told you and we will not pay any share of the costs after this date.
- If you continued to get home health care, or skilled nursing facility care, or Comprehensive Outpatient Rehabilitation Facility (CORF) services **after** the date when we said your coverage would end, then **you will have to pay the full cost** of this care yourself.

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

- To make sure we were following all the rules when we said no to your fast appeal, **we are required to send your appeal to the "Independent Review Organization."** When we do this, it means that you are **automatically** going on to Level 2 of the appeals process.

Step-by-Step: Level 2 Alternate Appeal Process

During the Level 2 Appeal, the **Independent Review Organization** reviews the decision we made when we said no to your "fast appeal." This organization decides whether the decision we made should be changed.

Legal Terms	The formal name for the "Independent Review Organization" is the **"Independent Review Entity."** It is sometimes called the **"IRE."**

1 Step 1: We will automatically forward your case to the Independent Review Organization.

- We are required to send the information for your Level 2 Appeal to the Independent Review Organization within 24 hours of when we tell you that we are saying no to your first appeal. (If you think we are not meeting this deadline or other deadlines, you can make a complaint. The complaint process is different from the appeal process. Section 9 of this chapter tells how to make a complaint.)

2 Step 2: The Independent Review Organization does a "fast review" of your appeal. The reviewers give you an answer within 72 hours.

- **The Independent Review Organization is an independent organization that is hired by Medicare**. This organization is not connected with our plan and it is not a government agency. This organization is a company chosen by Medicare to handle the job of being the Independent Review Organization. Medicare oversees its work.
- Reviewers at the Independent Review Organization will take a careful look at all of the information related to your appeal.
- **If this organization says yes to your appeal,** then we must reimburse you (pay you back) for our share of the costs of care you have received since the date when we said your coverage would end. We must also continue to cover the care for as long as it is medically necessary. You must continue to pay your share of the costs. If there are coverage limitations, these could limit how much we would reimburse or how long we would continue to cover your services.
- **If this organization says no to your appeal,** it means they agree with the decision our plan made to your first appeal and will not change it.
  - The notice you get from the Independent Review Organization will tell you in writing what you can do if you wish to continue with the review process. It will give you the details about how to go on to a Level 3 Appeal.

3 Step 3: If the Independent Review Organization turns down your appeal, you choose whether you want to take your appeal further.

- There are three additional levels of appeal after Level 2, for a total of five levels of appeal. If reviewers say no to your Level 2 Appeal, you can choose whether to accept that decision or whether to go on to Level 3 and make another appeal. At Level 3, your appeal is reviewed by an Administrative Law Judge or attorney adjudicator.
- Section 8 in this chapter tells more about Levels 3, 4, and 5 of the appeals process.

SECTION 8 Taking your appeal to Level 3 and beyond

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

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

If the dollar value of the item or medical service you have appealed meets certain minimum levels, you may be able to go on to additional levels of appeal. If the dollar value is less than the minimum level, you cannot appeal any further. If the dollar value is high enough, the written response you receive to your Level 2 Appeal will explain who to contact and what to do to ask for a Level 3 Appeal.

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

Level 3 Appeal	**A judge (called 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** - We will decide whether to appeal this decision to Level 4. Unlike a decision at Level 2 (Independent Review Organization), we have the right to appeal a Level 3 decision that is favorable to you.
  - If we decide **not** to appeal the decision, we must authorize or provide you with the service within 60 calendar days after receiving the Administrative Law Judge's or attorney adjudicator's decision.
  - If we decide to appeal the decision, we will send you a copy of the Level 4 Appeal request with any accompanying documents. We may wait for the Level 4 Appeal decision before authorizing or providing the service in dispute.
- **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. If the Administrative Law Judge or attorney adjudicator says no to your appeal, the notice you get will tell you what to do next if you choose to continue with your 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** - We will decide whether to appeal this decision to Level 5. Unlike a decision at Level 2 (Independent Review Organization), we have the right to appeal a Level 4 decision that is favorable to you if the value of the item or medical service meets the required dollar value.
  - If we decide **not** to appeal the decision, we must authorize or provide you with the service within 60 calendar days after receiving the Council's decision.
  - If we decide to appeal the decision, we will let you know in writing.
- **If the answer is no or if the Council denies the review request, the appeals process may or may not be over**.
  - If you decide to accept this decision that turns down your appeal, the appeals process is over.
  - If you do not want to accept the decision, you might 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. If the rules allow you to go on, the

written notice will also tell you who to contact and what to do next if you choose to continue with your appeal.

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

- This is the last step of the appeals process.

MAKING COMPLAINTS

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

If your problem is about decisions related to benefits, coverage, or payment, then this section is not for you. Instead, you need to use the process for coverage decisions and appeals. Go to Section 4 of this chapter.

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

This section explains how to use the process for making complaints. The complaint process is used for certain types of problems **only**. This includes problems related to quality of care, waiting times, and the customer service you receive. 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"

Complaint	Example
Quality of your medical care	- Are you unhappy with the quality of the care you have received (including care in the hospital)?
Respecting your privacy	- Do you believe that someone did not respect your right to privacy or shared information about you that you feel should be confidential?
Disrespect, poor customer service, or other negative behaviors	- Has someone been rude or disrespectful to you? - Are you unhappy with how our Customer Service has treated you? - Do you feel you are being encouraged to leave the plan?

Complaint	Example
Waiting times	□ Are you having trouble getting an appointment, or waiting too long to get it? □ Have you been kept waiting too long by doctors or other health professionals? Or by Customer Service or other staff at our plan? ° Examples include waiting too long on the phone, in the waiting room, or in the exam room.
Cleanliness	□ Are you unhappy with the cleanliness or condition of a clinic, hospital, or doctor's office?
Information you get from us	□ Do you believe we have not given you a notice that we are required to give? □ Do you think written information we have given you is hard to understand?
Timeliness (These types of complaints are all related to the **timeliness** of our actions related to coverage decisions and appeals)	The process of asking for a coverage decision and making appeals is explained in Sections 4-8 of this chapter. If you are asking for a coverage decision or making an appeal, you use that process, not the complaint process. However, if you have already asked us for a coverage decision or made an appeal, and you think that we are not responding quickly enough, you can also make a complaint about our slowness. Here are examples: □ If you have asked us to give you a "fast coverage decision" or a "fast appeal," and we have said we will not, you can make a complaint. □ If you believe we are not meeting the deadlines for giving you a coverage decision or an answer to an appeal you have made, you can make a complaint. □ When a coverage decision we made is reviewed and we are told that we must cover or reimburse you for certain medical services, there are deadlines that apply. If you think we are not meeting these deadlines, you can make a complaint. □ When we do not give you a decision on time, we are required to forward your case to the Independent Review Organization. If we do not do that within the required deadline, you can make a complaint.

Section 9.2 The formal name for "making a complaint" is "filing a grievance"

Legal Terms	□ What this section calls a **"complaint"** is also called a **"grievance."** □ Another term for **"making a complaint"** is **"filing a grievance."** □ Another way to say **"using the process for complaints"** is **"using the process for filing a grievance."**

Section 9.3 Step-by-step: Making a complaint

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

□ **Usually, calling Customer Service is the first step.** If there is anything else you need to do, Customer Service will let you know. 1-800-222-8600, TTY: 711, 8 a.m. - 8 p.m. local time, 7 days a week

□ **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.

□ We must receive your complaint within 60 calendar days of the event or incident you are complaining about. If something kept you from filing your complaint (you were sick, we provided incorrect information, etc.) let us know and we might be able to accept your complaint past 60 days. We will address your complaint as quickly as possible as but no later than 30 days after receiving it. Sometimes we need additional information, or you may wish to provide additional information. If that occurs, we may take an additional 14 days to respond to your complaint. If the additional 14 days is taken, you will receive a letter letting you know.

If your complaint is because we took 14 extra days to respond to your request for a coverage determination or appeal or because we decided you didn't need a fast coverage decision or a fast appeal, you can file a fast complaint. We will respond to you within 24 hours of receiving your complaint. The address and fax numbers for filing complaints are located in Chapter 2 under "How to contact us when you are making a complaint about your medical care."

- □ If you are dissatisfied with the response to your complaint, you can send a request for review in writing to our plan. Your review request may include written information from you or any other party of interest. You must submit the review request within 60 calendar days of receiving the original resolution.
- □ Our appeals and grievances coordinators will direct your review request to the appropriate committee, which will reconsider your written complaint and respond to you in writing within 30 calendar days of receipt of your request for review. The plan can present your case to the committee on your behalf, or you may choose to present your case to the committee yourself.

- **Whether you call or write, you should contact Customer Service right away.** The complaint must be made within 60 calendar days after you had the problem you want to complain about.
- **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**.

Legal Terms	What this section calls a **"fast complaint"** is also called an **"expedited grievance."**

2 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. If your health condition requires us to answer quickly, we will do that.
- **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 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 let you know. Our response will include our reasons for this answer. We must respond whether we agree with the complaint or not.

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

You can make your complaint about the quality of care you received by using the step-by-step process outlined above.

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

- **You can make your complaint to the Quality Improvement Organization**. If you prefer, you can make your complaint about the quality of care you received directly to this organization (**without** making the complaint to us).
  - 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.
  - To find the name, address, and phone number of the Quality Improvement Organization for your state, look in Chapter 2, Section 4, of this booklet. If you make a complaint to this organization, we will work with them to resolve your complaint.

- **Or you can make your complaint to both at the same time**. If you wish, you can make your complaint about quality of care to us and also to the Quality Improvement Organization.

Section 9.5 You can also tell Medicare about your complaint

You can submit a complaint about Peoples Health Patriot (PPO) directly to Medicare. To submit a complaint to Medicare, go to www.medicare.gov/MedicareComplaintForm/home.aspx. Medicare takes your complaints seriously and will use this information to help improve the quality of the Medicare program.

If you have any other feedback or concerns, or if you feel the plan is not addressing your issue, please call 1-800-MEDICARE (1-800-633-4227). TTY 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

Section 1.1 This chapter focuses on ending your membership in our plan

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

- You might leave our plan because you have decided that you **want** to leave.
  - There are only certain times during the year, or certain situations, when you may voluntarily end your membership in the plan. Section 2 tells you **when** you can end your membership in the plan.
  - The process for voluntarily ending your membership varies depending on what type of new coverage you are choosing. Section 3 tells you **how** to end your membership in each situation.
- There are also limited situations where you do not choose to leave, but 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, you must continue to get your medical care through our plan until your membership ends.

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

You may end your membership in our plan only during certain times of the year, known as enrollment periods. All members have the opportunity to leave the plan during the Annual Enrollment Period and during the Medicare Advantage Open Enrollment Period. In certain situations, you may also be eligible to leave the plan at other times of the year.

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

You can end your membership during the **Annual Enrollment Period** (also known as the "Annual Open Enrollment Period"). This is the time when you should review your health and drug coverage and make a decision about your coverage for the upcoming year.

- **When is the Annual Enrollment Period?** This happens from October 15 to December 7.
- **What type of plan can you switch to during the Annual Enrollment Period?** You can 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. (You can choose a plan that covers prescription drugs or one that does not cover prescription drugs.)
  - Original Medicare **with** a separate Medicare prescription drug plan.
  - - **or** - Original Medicare **without** a separate Medicare prescription drug plan.
- **When will your membership end?** Your membership will end when your new plan's coverage begins on January 1.

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

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

- **When is the Medicare Advantage Open Enrollment Period?** This happens every year from January 1 to March 31.
- **What type of plan can you switch to during the Medicare Advantage Open Enrollment Period?** During this time, you can:
  - Switch to another Medicare Advantage Plan. (You can choose a plan that covers prescription drugs or one that does not cover prescription drugs.)
  - 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 this time.
- **When will your membership end?** 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 our plan may be eligible to end their membership at other times of the year. This is known as a **Special Enrollment Period**.

- **Who is eligible for a Special Enrollment Period?** If any of the following situations apply to you, you may be eligible to end your membership during a Special Enrollment Period. 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). * PACE is not available in all states. If you would like to know if PACE is available in your state, please contact Customer Service (phone numbers are printed on the back cover of this booklet).
  - Note: If you're in a drug management program, you may not be able to change plans. Chapter 5, Section 10 tells you more about drug management programs.

- **When are Special Enrollment Periods?** The enrollment periods vary depending on your situation.
- **What can you do?** To find out if you are eligible for a Special Enrollment Period, please call Medicare at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users call 1-877-486-2048. If you are eligible to end your membership because of a special situation, you can choose to change both your Medicare health coverage and prescription drug coverage. This means you can choose any of the following types of plans:
  - Another Medicare health plan. (You can choose a plan that covers prescription drugs or one that does not cover prescription drugs.)
  - Original Medicare **with** a separate Medicare prescription drug plan.
  - **- or -** Original Medicare **without** a separate Medicare prescription drug plan.
- **When will your membership end?** Your membership will usually end on the first day of the month after your request to change your plan is received.

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

If you have any questions or would like more information on when you can end your membership:

- You can **call Customer Service** (phone numbers are printed on the back cover of this booklet).
- You can find the information in the **Medicare & You 2021** Handbook.
  - Everyone with Medicare receives a copy of **Medicare & You** each fall. Those new to Medicare receive it within a month after first signing up.
  - You can also download a copy from the Medicare website (www.medicare.gov). Or, you can order a printed copy by calling Medicare at the number below.
- You can contact **Medicare** at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

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

Section 3.1 Usually, you end your membership by enrolling in another plan

Usually, to end your membership in our plan, you simply enroll in another Medicare plan during one of the enrollment periods (see Section 2 in this chapter for information about the enrollment periods). However, if you want to switch from our plan to Original Medicare **without** a Medicare prescription drug plan, you must ask to be disenrolled from our plan. There are two ways you can ask to be disenrolled:

- You can make a request in writing to us. Contact Customer Service if you need more information on how to do this (phone numbers are printed on the back cover of this booklet).

- **–or–**You can contact Medicare at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

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

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

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

Section 4.1 Until your membership ends, you are still a member of our plan

If you leave our plan, it may take time before your membership ends and your new Medicare coverage goes into effect. (See Section 2 for information on when your new coverage begins.) During this time, you must continue to get your medical care through our plan.

- **If you are hospitalized on the day that your membership ends, your hospital stay will usually be covered by our plan until you are discharged** (even if you are discharged after your new health coverage begins).

SECTION 5 We must end your membership in the plan in certain situations

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

We 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 6 months.
  - If you move or take a long trip, you need to call Customer Service to find out if the place you are moving or traveling to is in our plan's area. (Phone numbers for Customer Service are printed on the back cover of this booklet.)
- If you become incarcerated (go to prison).
- If you are not 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 member ID card to get medical care. (We cannot make you leave our plan for this reason unless we get permission from Medicare first.)
  - If we end your membership because of this reason, Medicare may have your case investigated by the Inspector General.

Where can you get more information?

If you have questions or would like more information on when we can end your membership:

- You can call **Customer Service** for more information (phone numbers are printed on the back cover of this booklet).

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

Our plan is not allowed to ask you to leave our plan for any reason related to your health.

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). TTY users should call 1-877-486-2048. You may call 24 hours a day, 7 days a week.

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. You can also look in Chapter 7, Section 9 for information about how to make a complaint.

Chapter 9
Legal notices

Chapter 9
Legal notices

SECTION 1 Notice about governing law

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

SECTION 2 Notice about non-discrimination

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

If you want more information or have concerns about discrimination or unfair treatment, please call the Department of Health and Human Services' Office for Civil Rights at 1-800-368-1019 (TTY 1-800-537-7697) or your local Office for Civil Rights.

If you have a disability and need help with access to care, please call us at Customer Service (phone numbers are printed on the back cover of this booklet). If you have a complaint, such as a problem with wheelchair access, Customer Service can help.

SECTION 3 Notice about Medicare Secondary Payer subrogation rights

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

SECTION 4 Third party liability and subrogation

If you suffer an illness or injury for which any third party is alleged to be liable or responsible due to any negligent or intentional act or omission causing illness or injury to you, you must promptly notify us of the illness or injury. We will send you a statement of the amounts we paid for services provided in connection with the illness or injury. If you recover any sums from any third party, we shall be reimbursed out of any such recovery from any third party for the payments we made on your behalf, subject to the limitations in the following paragraphs.

1) **Our payments are less than the recovery amount**. If our payments are less than the total recovery amount from any third party (the "recovery amount"), then our reimbursement is computed as follows:
   a) **First**: Determine the ratio of the procurement costs to the recovery amount (the term "procurement costs" means the attorney fees and expenses incurred in obtaining a settlement or judgment).
   b) **Second**: Apply the ratio calculated above to our payment. The result is our share of procurement costs.
   c) **Third**: Subtract our share of procurement costs from our payments. The remainder is our reimbursement amount.
2) **Our payments equal or exceed the recovery amount**. If our payments equal or exceed the recovery amount, our reimbursement amount is the total recovery amount minus the total procurement costs.
3) **We incur procurement costs because of opposition to our reimbursement.** If we must bring suit against the party that received the recovery amount because that party opposes our reimbursement, our reimbursement amount is the lower of the following:
   a) Our payments made on your behalf for services; or
   b) the recovery amount, minus the party's total procurement cost.

Subject to the limitations stated above, you agree to grant us an assignment of, and a claim and a lien against, any amounts recovered through settlement, judgment or verdict. You may be required by us and you agree to execute documents and to provide information necessary to establish the assignment, claim, or lien to ascertain our right to reimbursement.

SECTION 5 Member liability

In the event we fail to reimburse provider's charges for covered services, you will not be liable for any sums owed by us. Neither the plan nor Medicare will pay for non-covered services except for the following eligible expenses:

- Emergency services
- Urgently needed services
- Out-of-area and routine travel dialysis (must be received in a Medicare Certified Dialysis Facility within the United States)
- Post-stabilization services

If you enter into a private contract with a provider, neither the plan nor Medicare will pay for those services.

SECTION 6 Medicare-covered services must meet requirement of reasonable and necessary

In determining coverage, services must meet the reasonable and necessary requirements under Medicare in order to be covered under your plan, unless otherwise listed as a covered service. A service is "reasonable and necessary" if the service is:

- Safe and effective;
- Not experimental or investigational; and
- Appropriate, including the duration and frequency that is considered appropriate for the service, in terms of whether it is:

1. Furnished in accordance with accepted standards of medical practice for the diagnosis or treatment of the patient's condition or to improve the function of a malformed body member;
2. Furnished in a setting appropriate to the patient's medical needs and condition;
3. Ordered and furnished by qualified personnel;
4. One that meets, but does not exceed, the patient's medical need; and
5. At least as beneficial as an existing and available medically appropriate alternative.

SECTION 7 Non duplication of benefits with automobile, accident or liability coverage

If you are receiving benefits as a result of other automobile, accident or liability coverage, we will not duplicate those benefits. It is your responsibility to take whatever action is necessary to receive payment under automobile, accident, or liability coverage when such payments may reasonably be expected, and to notify us of such coverage when available. If we happen to duplicate benefits to which you are entitled under other automobile, accident or liability coverage, we may seek reimbursement of the reasonable value of those benefits from you, your insurance carrier, or your health care provider to the extent permitted under State and/or federal law. We will provide benefits over and above your other automobile, accident or liability coverage, if the cost of your health care services exceeds such coverage. **You are required to cooperate with us in obtaining payment from your automobile, accident or liability coverage carrier. Your failure to do so may result in termination of your plan membership**.

SECTION 8 Acts beyond our control

If, due to a natural disaster, war, riot, civil insurrection, complete or partial destruction of a facility, ordinance, law or decree of any government or quasi-governmental agency, labor dispute (when said dispute is not within our control), or any other emergency or similar event not within the control of us, providers may become unavailable to arrange or provide health services pursuant to this Evidence of Coverage and Disclosure Information, then we shall attempt to arrange for covered services insofar as practical and according to our best judgment. Neither we nor any provider shall have any liability or obligation for delay or failure to provide or arrange for covered services if such delay is the result of any of the circumstances described above.

SECTION 9 Contracting medical providers and network hospitals are independent contractors

The relationships between us and our network providers and network hospitals are independent contractor relationships. None of the network providers or network hospitals or their physicians or employees are employees or agents of UnitedHealthcare Insurance Company or one of its affiliates. An agent would be anyone authorized to act on our behalf. Neither we nor any employee of UnitedHealthcare Insurance Company or one of its affiliates is an employee or agent of the network providers or network hospitals.

SECTION 10 Technology assessment

We regularly review new procedures, devices and drugs to determine whether or not they are safe and efficacious for members. New procedures and technology that are safe and efficacious are eligible to become Covered Services. If the technology becomes a Covered Service, it will be subject to all other terms and conditions of the plan, including medical necessity and any applicable member copayments, coinsurance, deductibles or other payment contributions.

In determining whether to cover a service, we use proprietary technology guidelines to review new devices, procedures and drugs, including those related to behavioral/mental health. When clinical necessity requires a rapid determination of the safety and efficacy of a new technology or new application of an existing technology for an individual member, one of our Medical Directors makes a medical necessity determination based on individual member medical documentation, review of published scientific evidence, and, when appropriate, relevant specialty or professional opinion from an individual who has expertise in the technology.

SECTION 11 Member statements

In the absence of fraud, all statements made by you will be deemed representations and not warranties. No such representation will void coverage or reduce covered services under this Evidence of Coverage or be used in defense of a legal action unless it is contained in a written application.

SECTION 12 Information upon request

As a plan member, you have the right to request information on the following:

- General coverage and comparative plan information
- Utilization control procedures
- Quality improvement programs
- Statistical data on grievances and appeals
- The financial condition of UnitedHealthcare Insurance Company or one of its affiliates

SECTION 13 2021 Enrollee Fraud & Abuse Communication

2021 Enrollee Fraud & Abuse Communication

How you can fight healthcare fraud

Our company is committed to preventing fraud, waste, and abuse in Medicare benefit programs and we're asking for your help. If you identify a potential case of fraud, please report it to us immediately.

Here are some examples of potential Medicare fraud cases:

- A health care provider - such as a physician, or medical device company - bills for services you never got;
- A supplier bills for equipment different from what you got;
- Someone uses another person's Medicare card to get medical care, supplies or equipment;
- Someone bills for home medical equipment after it has been returned;
- A company offers a Medicare drug or health plan that hasn't been approved by Medicare; or
- A company uses false information to mislead you into joining a Medicare drug or health plan.

To report a potential case of fraud in a Medicare benefit program, call Peoples Health Patriot (PPO) Customer Service at 1-800-222-8600 (TTY 711), 8 a.m. - 8 p.m. local time, 7 days a week.

This hotline allows you to report cases anonymously and confidentially. We will make every effort to maintain your confidentiality. However, if law enforcement needs to get involved, we may not be able to guarantee your confidentiality. Please know that our organization will not take any action against you for reporting a potential fraud case in good faith.

You may also report potential medical or prescription drug fraud cases to the Medicare Drug Integrity Contractor (MEDIC) at 1-877-7SafeRx (1-877-772-3379) or to the Medicare program directly at (1-800-633-4227). The Medicare fax number is 1-717-975-4442 and the website is www.medicare.gov.

SECTION 14 Commitment of Coverage Decisions

Peoples Health's Clinical Services Staff and Physicians make decisions on the health care services you receive based on the appropriateness of care and service and existence of coverage. Clinical

Staff and Physicians making these decisions: 1. Do not specifically receive reward for issuing non-coverage (denial) decisions; 2. Do not offer incentives to physicians or other health care professionals to encourage inappropriate underutilization of care or services; and 3. Do not hire, promote, or terminate physicians or other individuals based upon the likelihood or the perceived likelihood that the individual will support or tend to support the denial of benefits.

Chapter 10

Definitions of important words

Chapter 10

Definitions of important words

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

Annual Enrollment Period – A set time each fall when members can change their health or drug plans or switch to Original Medicare. The Annual Enrollment Period is from October 15 until December 7.

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. For example, you may ask for an appeal if we don't pay for an item or service you think you should be able to receive. Chapter 7 explains appeals, including the process involved in making an appeal.

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 Peoples Health Patriot (PPO), you only have to pay our plan's allowed cost-sharing amounts when you get services covered by our plan. We do not allow network providers to "balance bill" or otherwise charge you more than the amount of cost-sharing your plan says you must pay. In some cases, out-of-network providers can balance bill you for covered services. If you obtain covered services from an out-of-network provider who does not accept Medicare assignment, you will be responsible for the plan cost-sharing, plus any difference between the amount we pay the provider and the Medicare limiting charge.

Benefit period – The way that Original Medicare measures your use of hospital and skilled nursing facility (SNF) services. A benefit period begins the day you go into a hospital or skilled nursing facility. The benefit period ends when you haven't received any inpatient hospital care (or skilled care in a SNF) for 60 days in a row. If you go into a hospital or a skilled nursing facility after one benefit period has ended, a new benefit period begins. You must pay the inpatient hospital deductible for each benefit period. There is no limit to the number of benefit periods.

Centers for Medicare & Medicaid Services (CMS) – The Federal agency that administers Medicare. Chapter 2 explains how to contact CMS.

Clinical Research Study – A clinical research study is a way that doctors and scientists test new types of medical care, like how well a new cancer drug works. They test new medical care procedures or drugs by asking for volunteers to help with the study. This kind of study is one of the final stages of a research process that helps doctors and scientists see if a new approach works and if it is safe.

Coinsurance – An amount you may be required to pay as your share of the cost for services. Coinsurance is usually a percentage (for example, 20%). Coinsurance for in-network services is based upon contractually negotiated rates (when available for the specific covered service to which the coinsurance applies) or Medicare Allowable Cost, depending on our contractual arrangements for the service.

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

Complaint – The formal name for "making a complaint" is "filing a grievance." The complaint process is used for certain types of problems only. This includes problems related to quality of care, waiting times, and the customer service you receive. See also "Grievance," in this list of definitions.

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

Copayment (or "copay") – An amount you may be required to pay as your share of the cost for a medical service or supply, like a doctor's visit, hospital outpatient visit, or a prescription . A copayment is a set amount, rather than a percentage. For example, you might pay $10 or $20 for a doctor's visit or prescription.

Cost-Sharing – Cost-sharing refers to amounts that a member has to pay when services are received. 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 general term we use in this EOC to mean all of the health care services and supplies that are covered by our plan.

Creditable Prescription Drug Coverage – 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 is personal care that can be provided by people who don't have professional skills or training, such as help with activities of daily living like bathing, dressing, eating, getting in or out of a bed or chair, moving around, and using the bathroom. It may also include the kind of health-related care that most people do themselves, like using eye drops. Medicare doesn't pay for custodial care.

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

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

Disenroll or **Disenrollment** – The process of ending your membership in our plan. Disenrollment may be voluntary (your own choice) or involuntary (not your own choice).

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, 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.

Emergency Care – Covered services that are: 1) rendered 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 us or one of our network providers, including a complaint concerning the quality of your care. This type of complaint does not involve coverage or payment disputes.

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

Home Health Care – Skilled nursing care and certain other health care services that you get in your home for the treatment of an illness or injury. Covered services are listed in the Benefits Chart in Chapter 4, Section 2.1 under the heading "Home health agency care." If you need home health care services, our plan will cover these services for you provided the Medicare coverage requirements are met. Home health care can include services from a **home health aide** if the services are part of the home health plan of care for your illness or injury. They aren't covered unless you are also getting a covered skilled service. Home health services don't include the services of housekeepers, food service arrangements, or full-time nursing care at home.

Hospice – A member who has 6 months or less to live has the right to elect hospice. 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. The hospice will provide special treatment for your state.

Hospice Care – A special way of caring for people who are terminally ill and providing counseling for their families. Hospice care is physical care and counseling that is given by a team of people who are part of a Medicare-certified public agency or private company. Depending on the situation, this care may be given in the home, a hospice facility, a hospital, or a nursing home. Care from a hospice is meant to help patients in the last months of life by giving comfort and relief from pain. The focus is on care, not cure. For more information on hospice care visit www.medicare.gov and

under “Search Tools” choose “Find a Medicare Publication” to view or download the publication “Medicare Hospice Benefits.” Or, call (1-800-633-4227). TTY users should call 1-877-486-2048. You may call 24 hours a day/7 days a week.

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

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

In-Network Maximum Out-of-Pocket Amount – The most you will pay for covered Part A and Part B services received from in-network (preferred) providers. After you have reached this limit, you will not have to pay anything when you get covered services from network providers for the rest of the contract year. However, until you reach your combined out-of-pocket amount, you must continue to pay your share of the costs when you seek care from an out-of-network (non-preferred) provider. See Chapter 4, Section 1.2 for information about your in-network maximum out-of-pocket amount.

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

Maximum Charge (Limiting Charge) – In the Original Medicare plan, the highest amount of money you can be charged for a covered service by doctors and other health care suppliers who don’t accept assignment. The limiting charge is 15% over Medicare’s approved amount. The limiting charge only applies to certain services and doesn’t apply to supplies or equipment.

Medicaid (or Medical Assistance) – A joint Federal and state program that helps with medical costs for some people with low incomes and limited resources. Medicaid programs vary from state to state, but most health care costs are covered if you qualify for both Medicare and Medicaid. See Chapter 2, Section 6 for information about how to contact Medicaid in your state.

Medical 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, 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.

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

Medicare – The Federal health insurance program for people 65 years of age or older, some people under age 65 with certain disabilities, and people with End-Stage Renal Disease (generally those with permanent kidney failure who need dialysis or a kidney transplant). People with Medicare can get their Medicare health coverage through Original Medicare, a Programs of All-inclusive Care for the Elderly (PACE) plan, or a Medicare Advantage Plan.

Medicare Advantage Open Enrollment Period – A set time each year 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 from January 1 until March 31, and 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 HMO, PPO, a Private Fee-for-Service (PFFS) plan, or a Medicare Medical Savings Account (MSA) plan. When you are enrolled in a Medicare Advantage Plan, Medicare services are covered through the plan, and are not paid for under Original Medicare. 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**. Peoples Health Patriot (PPO) does not offer Medicare prescription drug coverage. Everyone who has Medicare Part A and Part B is eligible to join any Medicare Advantage health plan that is offered in their area.

Medicare Allowable Cost – The maximum price of a service for reimbursement purposes under Original Medicare.

Medicare Assignment – In Original Medicare, a doctor or supplier "accepts assignment" when he or she agrees to accept the Medicare-approved amount as full payment for covered services. For covered out-of-network services, it can save you money if your doctor or supplier accepts assignment. If a doctor or supplier accepts assignment, your cost-sharing is limited to your copayment or coinsurance amount for the covered service.

Medicare-Covered Services – Services covered by Medicare Part A and Part B. All Medicare health plans, including our plan, must cover all of the services that are covered by Medicare Part A and B.

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, 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 – The doctors and other health care professionals, medical groups, hospitals, and other health care facilities or providers that have an agreement with us to provide covered services to our members and to accept our payment and any plan cost-sharing as payment in full. (See Chapter 1, Section 3.2)

Network Provider – “Provider” is the general term we use for doctors, other health care professionals, hospitals, and other health care facilities that are licensed or certified by Medicare and by the State to provide health care services. We call them “**network providers**” when they have an agreement with our plan to accept our payment as payment in full, and in some cases to

coordinate as well as provide covered services to members of our plan. Our plan pays network providers based on the agreements it has with the providers or if the providers agree to provide you with plan-covered services. Network providers may also be referred to as "plan providers."

Organization Determination – The Medicare Advantage Plan has made an organization determination when it makes a decision 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 booklet. Chapter 7 explains how to ask us for a coverage decision.

Original Medicare ("Traditional Medicare" or "Fee-for-service" Medicare) – Original Medicare is offered by the government, and not a private health plan such as 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 with which we have not arranged to coordinate or provide covered services to members of our plan. Out-of-network providers are providers that are not employed, owned, or operated by our plan or are not under contract to deliver covered services to you. Using out-of-network providers or facilities is explained in this booklet in Chapter 3.

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 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, while getting the high-quality care they need. People enrolled in PACE plans receive both their Medicare and Medicaid benefits through the plan. PACE is not available in all states. If you would like to know if PACE is available in your state, please contact Customer Service (phone numbers are printed on the back cover of this booklet).

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.)

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 in-network (preferred) providers and a higher limit on your total combined out-of-pocket costs for services from both in-network (preferred) and out-of-network (non-preferred) providers.

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

health coverage.

Primary Care Provider (PCP) – Your primary care provider is the doctor or other provider you see first for most health problems. He or she makes sure you get the care you need to keep you healthy. He or she also may talk with other doctors and health care providers about your care and refer you to them. In many Medicare health plans, you must see your primary care provider before you see any other health care provider. See Chapter 3, Section 2.1 for information about Primary Care Providers.

Prior Authorization – For medical services it means a process where your PCP or treating provider must receive approval in advance before certain medical services will be provided or payable. Covered services that need prior authorization are marked in the Benefits Chart in Chapter 4. In the network portion of a PPO, some in-network medical services are covered only if your PCP or other network provider gets "prior authorization" from our plan. In a PPO, you do not need prior authorization to obtain out-of-network services. However, you may want to check with the plan before obtaining services from out-of-network providers to confirm that the service is covered by your plan and what your cost-sharing responsibility is.

Prosthetics and Orthotics – These are medical devices ordered by your doctor or other health care provider. Covered items include, 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.

Providers – Doctors and other health care professionals that the state licenses to provide medical services and care. The term "providers" also includes hospitals and other health care facilities.

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. See Chapter 2, Section 4 for information about how to contact the QIO for your state.

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

Retail Walk-In Clinic – A provider location that generally does not require appointments and may be a standalone location or located in a retail store, supermarket or pharmacy. Walk-In Clinic Services are subject to the same cost sharing as Urgent Care Centers. (See the Benefit Chart in Chapter 4)

Service Area – A geographic area where a health plan accepts members if it limits membership based on where people live. 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 may 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 skilled nursing facility care include physical therapy or intravenous injections that can only be given by a registered nurse or doctor.

Special Enrollment Period – A set time when members can change their health or drug plans or return to Original Medicare. Situations in which you may be eligible for a Special Enrollment Period include: if you move outside the service area, if you move into a nursing home, or if we violate our contract with you.

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

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

Urgently Needed Services – Urgently needed services are provided to treat a non-emergency, unforeseen medical illness, injury, or condition that requires immediate medical care. Urgently needed services may be furnished by network providers or by out-of-network providers when network providers are temporarily unavailable or inaccessible.

Peoples Health Patriot (PPO) Customer Service:

Call **1-800-222-8600**

Calls to this number are free. 8 a.m. - 8 p.m. local time, 7 days a week. Customer Service also has free language interpreter services available for non-English speakers.

TTY **711**

Calls to this number are free. 8 a.m. - 8 p.m. local time, 7 days a week.

Write: **Three Lakeway CTR, 3838 N Causeway BLVD, STE 2200**
Metairie, LA 70002

www.peopleshealth.com

State Health Insurance Assistance Program

State Health Insurance Assistance Program is a state program that gets money from the Federal government to give free local health insurance counseling to people with Medicare.
You can call the SHIP in your state at the number listed in Chapter 2 Section 3 of the Evidence of Coverage.

PRA Disclosure Statement *According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1051. If you have comments or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.*

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