January 1 - December 31, 2026

Evidence of Coverage:

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

This document gives the details of your Medicare health coverage from January 1 – December 31, 2026. **This is an important legal document. Keep it in a safe place.**

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

- Our plan premium and cost sharing
- Our medical benefits
- How to file a complaint if you're not satisfied with a service or treatment
- How to contact us
- Other protections required by Medicare law

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

This plan, Univera Medicare Freedom (HMO-POS), is offered by Univera Healthcare. (When this Evidence of Coverage says "we," "us," or "our," it means Univera Healthcare. When it says "plan" or "our plan," it means Univera Medicare Freedom (HMO-POS).)

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

Benefits, premiums and/or copayments/coinsurance may change on January 1, 2027.

Our provider network may change at any time. You'll get notice about any changes that may affect you at least 30 days in advance.

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OMB Approval 0938-1051(Expires: August 31, 2026)

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CHAPTER 1

Get started as a member

SECTION 1 You're a member of Univera Medicare Freedom (HMO-POS)

Section 1.1 You're enrolled in Univera Medicare Freedom (HMO-POS), which is a Medicare HMO Point-of-Service Plan

You're covered by Medicare, and you chose to get your Medicare health coverage through our plan, Univera Medicare Freedom (HMO-POS). Our plan covers all Part A and Part B services. However, cost-sharing and provider access in this plan are different from Original Medicare.

Univera Medicare Freedom (HMO-POS) is a Medicare Advantage HMO Plan (HMO stands for Health Maintenance Organization) with a Point-of-Service (POS) option approved by Medicare and run by a private company. Point-of-Service" means you can use providers outside our plan's network for an additional cost. (Go to Chapter 3, Section 2.4 for information about using the Point-of-Service option.). Univera Medicare Freedom doesn't include Part D drug coverage.

Section 1.2 Legal information about the Evidence of Coverage

This Evidence of Coverage is part of our contract with you about how Univera Medicare Freedom (HMO-POS) covers your care. Other parts of this contract include your enrollment form, the List of Covered Drugs (Formulary), and any notices you get 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 the months you're enrolled in Univera Medicare Freedom (HMO-POS) between January 1, 2026 and December 31, 2026.

Medicare allows us to make changes to plans we offer. This means we can change the costs and benefits of Univera Medicare Freedom (HMO-POS) after December 31, 2026. We can also choose to stop offering our plan in your service area, after December 31, 2026.

Medicare (the Centers for Medicare & Medicaid Services) must approve Univera Medicare Freedom (HMO-POS) each year. You can continue to get Medicare coverage as a member of our plan as long as we choose to continue offering our plan and Medicare renews its approval of our plan.

SECTION 2 Plan eligibility requirements

Section 2.1 Eligibility requirements

You're eligible for membership in our plan as long as you meet all these conditions:

- You have both Medicare Part A and Medicare Part B
- You live in our geographic service area (described Section 2.2). People who are incarcerated aren't considered living in the geographic service area even if they're physically located in it.
- You're a United States citizen or are lawfully present in the United States

Section 2.2 Plan service area for Univera Medicare Freedom (HMO-POS)

Univera Medicare Freedom (HMO-POS) is only available to people who live in our plan service area. To stay a member of our plan, you must continue to live in our service area. The service area is described below.

Our service area includes these counties in New York State: Allegany, Cattaraugus, Chautauqua, Erie, Genesee, Niagara, Orleans, and Wyoming.

If you move out of the service area, you can't stay a member of this plan. Call Customer Care at 1-877-883-9577 (TTY users call 711) to see if we have a plan in your new area. When you move, you'll have a Special Enrollment Period to either switch to Original Medicare or enroll in a Medicare health plan in your new location.

If you move or change your mailing address, it's also important to call Social Security. Call Social Security at 1-800-772-1213 (TTY users call 1-800-325-0778).

Section 2.3 U.S. citizen or lawful presence

You must be a U.S. citizen or lawfully present in the United States to be a member of a Medicare Health Plan. Medicare (the Centers for Medicare & Medicaid Services) will notify Univera Medicare Freedom (HMO-POS) if you're not eligible to stay a member on this basis. Univera Medicare Freedom (HMO-POS) must disenroll you if you don't meet this requirement.

SECTION 3 Important membership material

Section 3.1 Our plan membership card

Use your membership card whenever you get services covered by our plan and for prescription drugs you get at network pharmacies. You should also show the provider your Medicaid card if you have one. Sample plan membership card:





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

If our plan membership card is damaged, lost, or stolen, call Customer Care at 1-877-883-9577 (TTY users call 711) right away and we'll send you a new card.

Section 3.2 Provider Directory

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

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

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

The most recent list of providers is available on our website at medicare.univerahealthcare.com.

If you don't have a Provider Directory, you can ask for a copy (electronically or in paper form) from Customer Care at 1-877-883-9577 (TTY users call 711). Requested paper Provider Directories will be mailed to you within 3 business days.

SECTION 4 Summary of Important Costs for 2026

Monthly plan premium Your premium can be higher than this amount. Go to Section 4.1 for details.	$0
Maximum out-of-pocket amount This is the most you'll pay out of pocket for covered services. (Go to Chapter 4 Section 1 for details)	From network providers: $4,500
Primary care office visits	**In-network:** You pay a $5 copayment for a PCP per visit. **Out-of-network (POS):** You pay a 30% coinsurance per visit. The plan will reimburse a maximum of $1,500 for out-of-network (POS) services per calendar year.
Specialist office visits	**In-network:** You pay a $35 copayment for a Specialist per visit. **Out-of-network (POS):**

	You pay a 30% coinsurance per visit. The plan will reimburse a maximum of $1,500 for out-of-network (POS) services per calendar year.
Inpatient hospital stays	**In-network:** You pay a $260 copayment per day for days 1 through 5 for covered hospital care. Thereafter, you pay a $0 copayment for additional Medicare-covered days during your hospital admission **Out-of-network (POS):** 30% coinsurance per visit. The plan will reimburse a maximum of $1,500 for out-of-network (POS) services per calendar year.

Your costs may include the following:

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

Section 4.1 Plan Premium

You don't pay a separate monthly plan premium for Univera Medicare Freedom (HMO-POS).

Medicare Part B premiums differ for people with different incomes. If you have questions about these premiums, check your copy of the Medicare & You 2026 handbook in the section called 2026 Medicare Costs. Download a copy from the Medicare website (www.Medicare.gov/medicare-and-you) or order a printed copy by phone at 1-800-MEDIARE (1-800-633-4227), TTY users call 1-877-486-2048.

Section 4.2 Monthly Medicare Part B Premium

Many members are required to pay other Medicare premiums

This includes your premium for Part B. You may also pay a premium for Part A if you aren't eligible for premium-free Part A.

In 2026, we'll reduce the Part B premium that you pay to the Social Security Administration by $35 per month. If you pay your Part B premium on a monthly basis, you'll see this dollar amount credited in your Social Security check. If you pay your Part B premium quarterly, you'll see an amount equaling three months of reductions credited on your quarterly Part B premium statement. It may take a few months to see these reductions credited to either your Social Security check or premium statement, but you'll be reimbursed for any credits you did not receive during this waiting period.

SECTION 5 More information about your monthly plan premium

Section 5.1 How to pay our plan premium

If you pay a Part D late enrollment penalty, there are three ways you can pay the penalty.

Option 1: Pay by check
You may pay your Part D late enrollment penalty directly to our plan. Payments can be mailed to **Univera Healthcare**, PO Box 5267, Binghamton, NY 13902-5267. All checks must be made payable to Univera Healthcare.

Option 2: Pay Online or through our mobile app

You can pay online by visiting Medicare.UniveraHealthcare.com/BillPay or you can download and login to our mobile app to pay.

Option 3: Electronic Funds Transfer

Instead of paying by check, you can have your Part D late enrollment penalty automatically withdrawn from your bank account (checking or savings) through an Electronic Funds Transfer (EFT) on a monthly basis. If you choose to pay your Part D late enrollment penalty this way, your penalty will be deducted from your bank account on approximately the 4th day of the month in which the penalty applies to. Contact Customer Care to request a copy of the EFT authorization form to pay your Part D late enrollment penalty this way. We'll be happy to help you set this up.

Option 4: Have the Part D late enrollment penalty

Changing the way you pay your Part D late enrollment penalty If you decide to change how you pay your Part D late enrollment penalty it can take up to 3 months for your new payment method to take effect. While we process your new payment method, you're still responsible for making sure your plan premium is paid on time. To change your payment method, contact Customer Care at 1-877-883-9577 (TTY/TDD users call 711).

If you have trouble paying your Part D late enrollment penalty

Your Part D late enrollment penalty is due in our office by the first of the month. If we don't get your payment by the first of the month, we'll send you a notice letting you know our plan membership will end. If we don't get your Part D late enrollment penalty. within a 3 calendar month grace period. If you owe a Part D late enrollment penalty, you must pay the penalty to keep your coverage.

If you have trouble paying your Part D late enrollment penalty on time, call Customer Care (1-877-883-9577 (TTY/TDD users call 711) to see if we can direct you to programs that will help with your cost. (Phone numbers for Customer Care are printed on the back page of this booklet.)

If we end your membership because you didn't pay your Part D late enrollment penalty , you'll have coverage under Original Medicare. You may not be able to get Part D drug coverage until the following year if you enroll in a new plan during the Open Enrollment Period. (If you go without creditable drug coverage for more than 63 days, you may have to pay a Part D late enrollment penalty for as long as you have Part D drug coverage).

At the time we end your membership, you may still owe us for unpaid the Part D late enrollment penalty . We have the right to pursue collection of the amount you owe. If you want to enroll

again in our plan (or another plan that we offer), in the future, you'll need to pay the amount you owe before you can enroll.

If you think we wrongfully ended your membership, you can make a complaint (also called a grievance). If you had an emergency circumstance out of your control that made you unable to pay your plan premium within our grace period, you can make a complaint. For complaints, we'll review our decision again. Go to Chapter 9 to learn how to make a complaint or call us at 1-877-883-9577 between Monday - Friday, 8:00 a.m. - 8:00 p.m. Representatives are also available 8:00 a.m. - 8:00 p.m., Monday - Sunday, from October 1 - March 31. TTY/TDD users call 711. You must make your complaint no later than 60 calendar days after the date your membership ends.

Section 5.2 Our monthly plan premium won't change during the year

We're not allowed to change our plan's monthly plan premium amount during the year. If the monthly plan premium changes for next year we'll tell you in September and the new premium will take effect on January 1.

SECTION 6 Keep our plan membership record up to date

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

The doctors, hospitals, and other providers in our plan's network **use your membership record to know what services are covered and your cost-sharing amounts**. Because of this, it's very important to help us keep your information up to date.

If you have any of these changes, let us know:

- Changes to your name, address, or phone number
- Changes in any other health coverage you have (such as from your employer, your spouse or domestic partner's employer, workers' compensation, or Medicaid)
- Any liability claims, such as claims from an automobile accident
- If you're admitted to a nursing home
- If you get 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 participate in a clinical research study (**Note**: You're not required to tell our plan about the clinical research studies, you intend to participate in, but we encourage you to do so.)

If any of this information changes, let us know by calling Customer Care at 1-877-883-9577. TTY users call 711.

It's also important to contact Social Security if you move or change your mailing address. Call Social Security at 1-800-772-1213 (TTY users call 1-800-325-0778).

SECTION 7 How other insurance works with our plan

Medicare requires us to collect information about any other medical insurance coverage you have so we can coordinate any other coverage with your benefits under our plan. This is called **Coordination of Benefits.**

Once a year, we'll send you a letter that lists any other medical insurance coverage we know about. Read this information carefully. If it's correct, you don't need to do anything. If the information isn't correct, or if you have other coverage that's not listed, call Customer Care at 1-877-883-9577. TTY users call 711. You may need to give our plan member ID number to your other insurers (once you confirm their identity) so your bills are paid correctly and on time.

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

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

- If you have retiree coverage, Medicare pays first.
- 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 has more than 100 employees.
    - If you're over 65 and you (or your spouse or domestic partner) are 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 has more than 20 employees.
- If you have Medicare because of ESRD, your group health plan will pay first for the first 30 months after you become eligible for Medicare.

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

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

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

CHAPTER 2

Phone numbers and resources

SECTION 1 Univera Medicare Freedom (HMO-POS) contacts

For help with claims, billing, or member card questions, call or write to Univera Medicare Freedom (HMO-POS) Customer Care. 1-877-883-9577 (TTY users call 711). We'll be happy to help you.

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

How to ask for a coverage decision or appeal about your medical care

A coverage decision is a decision we make about your benefits and coverage or about the amount we'll pay for your medical services. An appeal is a formal way of asking us to review and change a coverage decision. For more information on how to ask for coverage decisions or appeals about your medical care, go to Chapter 9.

Coverage Decisions and Appeals for Medical Care– Contact Information	
Call	1-877-883-9577 Calls to this number are free. Hours are Monday - Friday, 8:00 a.m. - 8:00 p.m. Representatives are also available 8:00 a.m. - 8:00 p.m., Monday - Sunday, from October 1 - March 31. You may submit a request outside of regular weekday business hours and weekends by calling 1-877-444-5380.
TTY/TDD	711 This number requires special telephone equipment and is only for people who have difficulties hearing or speaking. Calls to this number are free. Hours are Monday - Friday, 8:00 a.m. - 8:00 p.m. Representatives are also available 8:00 a.m. - 8:00 p.m., Monday - Sunday, from October 1 - March 31.
Fax	**Medical Care**: 1-877-203-9401
Write	**Medical Care**: Utilization Management, PO Box 211256 Eagan, MN 55121

Coverage Decisions and Appeals for Medical Care– Contact Information	
Website	medicare.univerahealthcare.com

How to make a complaint about your medical care

You can make a complaint about us or one of our network providers or network pharmacies, including a complaint about the quality of your care. This type of complaint doesn't involve coverage or payment disputes. For more information on how to make a complaint about your medical care, go to Chapter 9 (What to do if you have a problem or complaint (coverage decisions, appeals, complaints).

Complaints About Medical Care – Contact Information	
Call	1-877-883-9577 Calls to this number are free. Hours are Monday - Friday, 8:00 a.m. - 8:00 p.m. Representatives are also available 8:00 a.m. - 8:00 p.m., Monday - Sunday, from October 1 - March 31. You may submit a request outside of regular weekday business hours and weekends by calling 1-877-444-5380.
TTY/TDD	711 This number requires special telephone equipment and is only for people who have difficulties hearing or speaking. Calls to this number are free. Hours are Monday - Friday, 8:00 a.m. - 8:00 p.m. Representatives are also available 8:00 a.m. - 8:00 p.m., Monday - Sunday, from October 1 - March 31.
Fax	1-315-671-6656
Write	PO Box 4717, Syracuse, NY 13221
Medicare website	To submit a complaint about Univera Medicare Freedom (HMO-POS) directly to Medicare, go to www.medicare.gov/my/medicare-complaint..

How to ask us to pay our share of the cost for medical care you got

If you got a bill or paid for services (like a provider bill) you think we should pay for, you may need to ask us for reimbursement or to pay the provider bill. Go to Chapter 7 for more information.

If you send us a payment request and we deny any part of your request, you can appeal our decision. Go to Chapter 9) for more information.

Payment Requests – Contact Information	
CALL	**Medical:** 1-877-883-9577 **Dental:** 1-800-724-1675
Call	Calls to these numbers are free. Hours are: Monday - Friday, 8:00 a.m. - 8:00 p.m. Representatives are also available 8:00 a.m. - 8:00 p.m., Monday - Sunday, from October 1 - March 31.

Payment Requests – Contact Information	
TTY/TDD	711 This number requires special telephone equipment and is only for people who have difficulties hearing or speaking. Calls to this number are free. Hours are Monday - Friday, 8:00 a.m. - 8:00 p.m. Representatives are also available 8:00 a.m. - 8:00 p.m., Monday - Sunday, from October 1 - March 31.
Fax	1-800-644-5840
Write	**Medical and Dental:** PO Box 211256, Eagan, MN 55121
Website	medicare.univerahealthcare.com

SECTION 2 Get help from Medicare

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

The federal agency in charge of Medicare is the Centers for Medicare & Medicaid Services (CMS). This agency contracts with Medicare Advantage organizations including our plan.

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/TDD	1-877-486-2048 This number requires special telephone equipment and is only for people who have difficulties hearing or speaking. Calls to this number are free.
Chat Live	Chat live at www.Medicare.gov/talk-to-someone
Write	Write to Medicare at PO Box 1270, Lawrence, KS 66044

Medicare – Contact Information (continued)	
Website	www.Medicare.gov • Get information about the Medicare health and drug plans in your area, including what they cost and what services they provide. • Find Medicare-participating doctors or other health care providers and suppliers. • Find out what Medicare covers, including preventative services (like screenings, shots or vaccines, and yearly "Wellness" visits). • Get Medicare appeals information and forms. • Get information about the quality of care provided by plans, nursing homes, hospitals, doctors, home health agencies, dialysis facilities, hospice centers, inpatient rehabilitation facilities, and long-term care hospitals. • Look up helpful websites and phone numbers. You can also visit www.Medicare.gov to tell Medicare about any complaints you have about Univera Medicare Freedom. **To submit a complaint to Medicare,** go to www.Medicare.gov/my/mediare-complaint. Medicare takes your complaints seriously and will use this information to help improve the quality of the Medicare program.

SECTION 3 State Health Insurance Assistance Program (SHIP)

The State Health Insurance Assistance Program (SHIP) is a government program with trained counselors in every state that offers free help, information, and answers to your Medicare questions. In New York, the SHIP is called New York State Health Insurance Information, Counseling and Assistance Program (HIICAP).

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

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

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

SECTION 4 Quality Improvement Organization (QIO)

A designated Quality Improvement Organization (QIO) serves people with Medicare in each state. For New York, the Quality Improvement Organization is called Commerce Health BFCC-QIO Program.

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

Contact Commerce Health in any of these situations:

- You have a complaint about the quality of care you got. Examples of quality-of-care concerns include getting the wrong medication, unnecessary tests or procedures, or a misdiagnosis.
- 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 is ending too soon.

Livanta BFCC-QIO Program (New York State's Quality Improvement Organization) - Contact Information	
Call	1-866-815-5440
TTY/TDD	711 This number requires special telephone equipment and is only for people who have difficulties hearing or speaking.
Write	P.O. Box 2687, Virginia Beach, Virginia 23450
Website	livantaqio.com/en/states/new_york

SECTION 5 Social Security

Social Security determines Medicare eligibility and handles Medicare enrollment.

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

Social Security – Contact Information	
Call	1-800-772-1213 Calls to this number are free. Available 8:00 am to 7:00 pm, Monday through Friday. Use Social Security's automated telephone services to get recorded information and conduct some business 24 hours a day.
TTY/TDD	1-800-325-0778 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free. Available 8:00 am to 7:00 pm, Monday through Friday.

Social Security – Contact Information	
Website	www.SSA.gov

SECTION 6 Medicaid

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

Medicaid offers programs to help people with Medicare pay their Medicare costs, such as their Medicare premiums. These "Medicare Savings Programs" include:

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

To find out more about Medicaid and Medicare Savings Programs, contact Medicaid in New York State.

Medicaid (New York State's Medicaid program) – Contact Information	
Call	1-800-541-2831
Write	New York State Department of Health, Corning Tower, Empire State Plaza, Albany, NY 12237
Website	www.health.ny.gov/health_care/medicaid/

SECTION 7 Railroad Retirement Board (RRB)

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 get Medicare through the Railroad Retirement Board, let them know if you move or change your mailing address. For questions about your benefits from the Railroad Retirement Board, contact the agency.

Railroad Retirement Board (RRB) – Contact Information	
Call	1-877-772-5772 Calls to this number are free. Press "0," to 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. Press "1", to access the automated RRB HelpLine and get recorded information 24 hours a day, including weekends and holidays.

Railroad Retirement Board (RRB) – Contact Information	
TTY/TDD	1-312-751-4701 This number requires special telephone equipment and is only for people who have difficulties hearing or speaking. Calls to this number aren't free.
Website	https://RRB.gov

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

If you (or your spouse or domestic partner) get benefits from your (or your spouse or domestic partner's) employer or retiree group as part of this plan, call the employer/union benefits administrator or Customer Care at 1-877-883-9577 (TTY users call 711) with any questions. You can ask about your (or your spouse or domestic partner's) employer or retiree health benefits, premiums, or the enrollment period. You can call 1-800-MEDICARE (1-800-633-4227) with questions about your Medicare coverage under this plan.

TTY users call 1-877-486-2048

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

CHAPTER 3

Using our plan's coverage for your medical services

SECTION 1 How to get medical care as a member of our plan

This chapter explains what you need to know about using our plan to get your medical care covered.

For details on what medical care our plan covers and how much you pay when you get care, go to the Medical Benefits Chart in Chapter 4.

Section 1.1 Network providers and covered services?

- **Providers** are doctors and other health care professionals licensed by the state to provide medical services and care. The term providers also includes hospitals and other health care facilities.
- **Network providers** are the doctors and other health care professionals, medical groups, hospitals, and other health care facilities that have an agreement with us to accept our payment and your cost sharing amount as payment in full. We 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 Medical Benefits Chart in Chapter 4.

Section 1.2 Basic rules for your medical care to be covered by our plan

As a Medicare health plan, Univera Medicare Freedom (HMO-POS) must cover all services covered by Original Medicare and follow Original Medicare's coverage rules.

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

- **The care you get is included in our plan's Medical Benefits Chart** in Chapter 4.
- **The care you receive is considered medically necessary**. Medically necessary means that the services, supplies, or equipment are needed for the prevention, diagnosis, or treatment of your medical condition and meet accepted standards of medical practice.
- **You have a network primary care provider (a PCP) providing and overseeing your care.** As a member of our plan, you must choose a network PCP (go to Section 2.1 of this chapter for more information).
    - In most situations, your network PCP must give you approval in advance (a referral) before you can use other providers in our plan's network, such as specialists, hospitals, skilled nursing facilities, or home health care agencies. For more information, go to Section 2.3.
    - You don't need referrals from your PCP for emergency care or urgent care. To learn about other kinds of care you can get without getting approval in advance from your PCP, go to Section 2.2.
- **You must get your care from a network provider** go to Section 2. In most cases, care you get from an out-of-network provider (a provider who's not part of our plan's network) won't be covered. This means you have to pay the provider in full for services you get. Here are 4 exceptions:

- Our plan covers emergency care or urgent care you get from an out-of-network provider. For more information, and to see what emergency or urgent care, go to Section 3.
- If you need medical care that Medicare requires our plan to cover but there are no specialists in our network that provide this care, you can get this care from an out-of-network provider at the same cost sharing you normally pay in-network. Your provider would need to get an authorization from our plan for this. In this situation, you pay the same as you pay if you got the care from a network provider. For information about getting approval to see an out-of-network doctor, go to Section 2.4.
- Our plan covers kidney dialysis services you get at a Medicare-certified dialysis facility when you're temporarily outside our plan's service area or when your provider for this service is temporarily unavailable or inaccessible. The cost-sharing you pay our plan for dialysis can never be higher than the cost sharing in Original Medicare. If you're outside our plan's service area and get the dialysis from a provider outside our plan's network, your cost sharing cannot exceed the cost sharing you pay in-network. However, if your usual in-network provider for dialysis is temporarily unavailable and you choose to get services inside the service area from a provider outside our plan's network, your cost sharing for the dialysis may be higher.
- As a member of Univera Medicare Freedom (HMO-POS), you may get services from an out-of-network provider. Doing so may result in a higher cost share and the POS benefit does not extend to all covered services. Please see the benefits chart located in Chapter 4. Our plan's annual limit is $1,500. Costs in excess of this limit are the responsibility for the member. You are financially responsible for all services rendered by an out-of-network provider when plan rules are not followed.

SECTION 2 Use providers in our plan's network to get medical care

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

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

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

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

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

How to choose a PCP?

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

How to change your PCP

You can change your PCP for any reason, at any time. It's also possible that your PCP might leave our plan's network of providers and you'd need to choose a new PCP.

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

Section 2.2 Medical care you can get without a PCP referral

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

- Routine women's health care, including breast exams, screening mammograms (x-rays of the breast), Pap tests, and pelvic exams as long as you get them from a network provider.
- Flu shots, Covid-19 vaccines, Hepatitis B vaccines, and pneumonia vaccines as long as you get them from a network provider.
- Emergency services from network providers or from out-of-network providers.
- Urgently needed plan-covered services, are services that require immediate medical attention, (but not an emergency) if you're either temporarily outside our plan's service area, or it's unreasonable given your time, place, and circumstances to get this service from network providers. Examples of urgent care are unforeseen medical illnesses and injuries or unexpected flare-ups of existing conditions. Medically necessary routine provider visits, (like annual checkups) aren't considered urgently needed even if you're outside our plan's service area or our plan network is temporarily unavailable.
- Kidney dialysis services that you get at a Medicare-certified dialysis facility when you're temporarily outside our plan's service area. If possible, call Customer Care at 1-877-883-9577 (TTY users call 711) before you leave the service area so we can help arrange for you to have maintenance dialysis while you're away.

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

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

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

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

- Your provider may have a preference when it comes to specialists or facilities to coordinate care with. It's important to ask if they are affiliated with the hospital or facility you are seeking care at. If they are not affiliated, they may not be able to provide services to you while you are under another facility's care.
- You are not required to get referrals from your PCP to see network specialists.
- For some types of services, your PCP may need to get approval in advance from our plan (this is called getting "prior authorization"). See Chapter 4 Section 2.1 for services that require prior authorization.

When a specialist or another network provider leaves our plan

We may make changes to the hospitals, doctors, and specialists (providers) in our plan's network during the year. If your doctor or specialist leaves our plan you have these rights and protections:

- Even though our network of providers may change during the year, Medicare requires that you have uninterrupted access to qualified doctors and specialists.
- We'll notify you that your provider is leaving our plan so that you have time to choose a new provider.
    - If your primary care or behavioral health provider leaves our plan, we'll notify you if you visited that provider within the past 3 years.
    - If any of your other providers leave our plan, we'll notify you if you're assigned to the provider, currently get care from them, or visited them within the past 3 months.
- We'll help you choose a new qualified in-network provider for continued care.
- If you're undergoing medical treatment or therapies with your current provider, you have the right to ask to continue getting medically necessary treatment or therapies. We'll work with you so you can continue to get care.
- We'll give you information about available enrollment periods and options you may have for changing plans.
-
- When an in-network provider or benefit is unavailable or inadequate to meet your medical needs, we'll arrange for any medically necessary covered benefit outside of our provider network at in-network cost sharing.

- If you find out your doctor or specialist is leaving our plan, call Customer Care at 1-877-883-9577 (TTY users call 711) so we can help you choose a new provider to manage your care.
- If you believe we haven't furnished you with a qualified provider to replace your previous provider or that your care isn't being appropriately managed, you have the right to file a quality-of-care complaint to the QIO, a quality-of-care grievance to our plan, or both. Go to Chapter 7.

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

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

There is a POS plan coverage limit of $1,500 per calendar year. Once this limit is reached, you are responsible for 100% of the cost of out-of-network services. Having a POS benefit does not mean that all services are automatically covered out of the network. This POS benefit only allows the member to seek medically necessary, covered services from an out-of-network provider. All plan rules must still be followed for out-of-network services to be covered. When our plan rules are not followed, the member will be responsible for all costs. The POS benefit does not extend to all covered services. POS copayments and coinsurance do not count towards your out-of-pocket maximum costs. Please see the Benefit Chart in Chapter 4, Section 2.1 for more information.

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

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

SECTION 3 How to get services in an emergency, disaster, or urgent need for care

Section 3.1 Get care if you have a 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 (and, if you're a pregnant woman, loos of an unborn child), loss of a limb or function of a limb, or loss of or serious impairment to a bodily function. The medical symptoms may be an illness, injury, severe pain, or a medical condition that's 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 don't need to get approval or a referral first from your PCP. You don't need to use a network doctor. You can get covered emergency medical care whenever you need it, anywhere worldwide, and from any provider with an appropriate license even if they're not part of our network.
- **As soon as possible, make sure our plan has been told about your emergency.** We need to follow up on your emergency care. You or someone else should call to tell us about your emergency care, usually within 48 hours. The number to call can be found on the back of our membership card.

Covered services in a medical emergency

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

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

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

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

What if it wasn't a medical emergency?

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

However, after the doctor says it was not an emergency, we will cover additional care only if you get the additional care in one of these 2 ways:

- You go to a network provider to get the additional care.
- The additional care you get is considered urgent care and you follow the rules below for getting this urgently care.

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

A service that requires immediate medical attention (but isn't an emergency) is an urgently needed service if you're either temporarily outside our plan's service area, or if it's unreasonable given your time, place, and circumstances to get this service from network providers. Examples of urgent care are unforeseen medical illnesses and injuries, or unexpected flare-ups of existing conditions. However, medically necessary routine provider visits such as annual checkups, aren't considered urgently needed even if you're outside our plan's service area or our plan network is temporarily unavailable.

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

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

Section 3.3 Get 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're still entitled to care from our plan.

Visit: www.health.ny.gov/environmental/emergency/ for information on how to get needed care during a disaster.

If you can't use a network provider during a disaster, our plan will allow you to get care from out-of-network providers at in-network cost sharing.

SECTION 4 What if you're billed directly for the full cost of covered services?

If you paid more than our plan cost-sharing for covered services, or if you got a bill for the full cost of covered medical services, you can us to pay our share of the cost of covered medical services. Go to Chapter 5 for information about what to do.

Section 4.1 If services aren't covered by our plan, you must pay the full cost

Univera Medicare Freedom (HMO-POS) covers all medically necessary services as listed in the Medical Benefits Chart in Chapter 4. If you get services that aren't covered by our plan, or you get services out-of-network without authorization, you're responsible for paying the full costs of services.

For covered services that have a benefit limitation, you also pay the full cost of any services you get after you use up your benefit for that type of covered service. These costs will not count towards your out-of-pocket maximum.

SECTION 5 Medical services in a clinical research study

Section 5.1 What is a clinical research study

A clinical research study (also called a clinical trial) is a way that doctors and scientists test new types of medical care, like how well a new cancer drug works. Certain clinical research studies are approved by Medicare. Clinical research studies approved by Medicare typically ask for volunteers to participates in the study. When you're in a clinical research study, you can stay enrolled in our plan and continue to get the rest of your care (care that's not related to the study) through our plan.

If you participate in a Medicare-approved study, Original Medicare pays most of the costs for covered services you get as part of the study. If you tell us you're in a qualified clinical trial, then you're only responsible for the in-network cost sharing for the services in that trial. If you paid more - for example, if you already paid the Original Medicare cost-sharing amount, we'll reimburse the difference between what you paid and the in-network cost sharing. You'll need to provide documentation to show us how much you paid.

If you want to participate in any Medicare-approved clinical research study, you don't need to tell us or get approval from us or your PCP. The providers that deliver your care as part of the clinical research study don't need to be part of our plan's network. This doesn't apply to covered benefits that include, require a clinical trial or registry to assess the benefit including certain benefits requiring coverage with evidence development (NCSs-CED) and investigational exemption device (IDE) studies. These benefits may also be subject to prior authorization and other plan rules.

While you don't need our plan's permission to be in a clinical research study, we encourage you to notify us in advance when you choose to participate in Medicare-qualified clinical trials.

If you participate in a study not approved by Medicare, you'll be responsible for paying all costs for your participation in the study.

Section 5.2 Who pays for services in a clinical research study

Once you join a Medicare-approved clinical research study, Original Medicare covers the routine items and services you get 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's part of the research study.
- Treatment of side effects and complications of the new care.

After Medicare pays its share of the cost for these services, our plan will pay the difference between the cost sharing in Original Medicare and your in-network cost sharing as a member of our plan. This means you'll pay the same amount for services you get as part of the study as you would if you got these services from our plan. However, you must submit documentation showing how much cost-sharing you paid. Go Chapter 7 for more information on submitting requests for payments.

Example of cost sharing in a clinical trial: Let's say you have a lab test that costs $100 as part of the research study. Your share of the costs for this test is $20 under Original Medicare, but the test would be $10 under our plan. In this case, Original Medicare would pay $80 for the test, and you would pay the $20 copay required under Original Medicare. You would notify our plan that you got a qualified clinical trial service and submit documentation (like a provider bill) to our plan. Our plan would then directly pay you $10. This makes your net payment for the test $10, the same amount you pay under our plan's benefits.

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

- Generally, Medicare won't pay for the new item or service the study is testing unless Medicare would cover the item or service even if you weren't in a study.
- Items or services provided only to collect data and not used in your direct health care. For example, Medicare won't pay for monthly CT scans done as part of a study if your medical condition would normally require only one CT scan.
- Items and services provided by the research sponsors free-of-charge for people in the trial.

Get more information about joining a clinical research study

Get more information about joining a clinical research study in the Medicare publication Medicare and Clinical Research Studies available at www.Medicare.gov/sites/default/files/2019-09/02226-medicare-and-clinical-research-studies.pdf. You can also call 1-800-MEDICARE (1-800-633-4227). TTY/TDD users call 1-877-486-2048.

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

Section 6.1 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'll instead cover care in a religious non-medical health care institution. This benefit is provided only for Part A inpatient services (non-medical health care services).

Section 6.2 How to get 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're conscientiously opposed to getting medical treatment that is **non-excepted**.

- **Non-excepted** medical care or treatment is any medical care or treatment that's voluntary and not required by any federal, state, or local law.
- **Excepted** medical treatment is medical care or treatment you get that's 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 only covers non-religious aspects of care.
- If you get services from this institution provided to you in a facility, the following conditions apply:
    - You must have a medical condition that would allow you to get covered services for inpatient hospital care or skilled nursing facility care.
    - – and – you must get approval in advance from our plan before you're admitted to the facility, or your stay won't be covered.

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

SECTION 7 Rules for ownership of durable medical equipment

Section 7.1 You won't own some durable medical equipment after making a certain number of payments under our plan

Durable medical equipment (DME) includes items like 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 members to use in the home. The member always owns some DME items, like prosthetics. Other types of DME 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 Univera Medicare Freedom (HMO-POS), however, you usually won't get ownership of rented DME items no matter how many copayments you make for the item while a member of our plan.** You won't get ownership even if you made up to 12 consecutive payments for the DME item under Original Medicare before you joined our plan. Under some limited circumstances we'll transfer ownership of the DME item to you. Call Customer Care at 1-877-883-9577 (TTY users call 711) for more information.

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

If you didn't get ownership of the DME item while in our plan, you'll have to make 13 new consecutive payments after you switch to Original Medicare to own the DME item. The payments you made while enrolled in our plan don't count towards these 13 payments.

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

Example 2: You made 12 or fewer consecutive payments for the item in Original Medicare and then joined our plan. You didn't get ownership of the item while in our plan. You then go back to Original Medicare. You'll have to make 13 consecutive new payments to own the item once you rejoin Original Medicare. Any payments you already made (whether to our plan or to Original Medicare) don't count.

Section 7.2 Rules for oxygen equipment, supplies, and maintenance

If you qualify for Medicare oxygen equipment coverage Univera Medicare Freedom (HMO-POS) will cover:

- Rental of oxygen equipment (including stationary and portable devices)
- 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, the oxygen equipment must be returned.

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

Original Medicare requires an oxygen supplier to provide you services for 5 years. During the first 36 months, you rent the equipment. For the remaining 24 months the supplier provides the equipment and maintenance (you're still responsible for the copayment for oxygen). After 5 years you can choose to stay with the same company or go to another company. At this point, the 5-

year cycle starts over again, even if you stay with the same company, and you're again required to pay copayments for the first 36 months. If you join or leave our plan, the 5-year cycle starts over.

CHAPTER 4

Medical Benefits Chart
(what's covered and what you pay)

SECTION 1 Understanding your out of pocket costs for covered services

The Medical Benefits Chart lists your covered services and shows how much you pay for each covered service as a member of Univera Medicare Freedom (HMO-POS). This section also gives information about medical services that aren't covered and explains limits on certain services.

Section 1.1 Out of pocket costs you may pay for covered services

Types of out-of-pocket costs you may pay for covered services include:

- **Copayment**: the fixed amount you pay each time you get certain medical services. You pay a copayment at the time you get the medical service. (The Medical Benefits Chart tells you more about your copayments.)
- **Coinsurance**: 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 tells you more about your coinsurance.)

Most people who qualify for Medicaid or for the Qualified Medicare Beneficiary (QMB) program don't pay deductibles, copayments, or coinsurance. If you're in one of these programs, be sure to show your proof of Medicaid or QMB eligibility to your provider.

Section 1.2 What's the most you'll pay for Medicare Part A and Part B covered medical services?

Medicare Advantage Plas have limits on the total amount you have to pay out of pocket each year for in-network medical services covered by our plan. This limit is called the maximum out of pocket amount for medical services. For calendar year 2026 this amount is $4,500 .

The amounts you pay for copayments and coinsurance for in-network covered services count toward this maximum out of pocket amount. The amounts you pay for plan premiums. In addition, amounts you pay for some services doesn't count toward your maximum out of pocket amount. These services are marked with an asterisk in the Medical Benefits Chart. If you reach the maximum out of pocket amount of $4,500 , you won't have to pay any out-of-pocket costs for the rest of the year for in-network covered Part A and B services. However, you must continue to pay our plan premium and the Medicare Part B premium (unless your Part B premium is paid for you by Medicaid or another third party).

Section 1.3 Providers aren't allowed to balance bill you

As a member of Univera Medicare Freedom (HMO-POS), an important protection because, you only have to pay your cost sharing amount when you get services covered by our plan. Providers can't bill you for additional separate charges, called balance billing. This protection applies even if we pay the provider less than the provider charges for a service and even if there's a dispute and we don't pay certain provider charges.

Here's how protection from balance billing works:

- If your cost sharing is a copayment (a set amount of dollars, for example, $15.00), you pay only that amount for any covered services from a network provider.
- If your cost sharing is a coinsurance (a percentage of the total charges), you never pay more than that percentage. However, your cost depends on which type of provider you see:

- If you get covered services from a network provider, you pay the coinsurance percentage multiplied by our plan's reimbursement rate (as this is set in the contract between the provider and our plan).
- If you get 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. (Our plan covers services from out of network providers only in certain situations, such as when you get a referral or for emergencies or urgently needed services.)
- If you get the covered services from an out of network provider who doesn't participate with Medicare, you pay the coinsurance percentage multiplied by the Medicare payment rate for non-participating providers. (Our plan covers services from out of network providers only in certain situations, such as when you get a referral or for emergencies or for urgently needed services outside the service area.)

- If you think a provider has balance billed you, call Customer Care at 1-877-883-9577 (TTY users call 711).

SECTION 2 The Medical Benefits Chart shows your medical benefits and costs

The Medical Benefits Chart on the next pages lists the services Univera Medicare Freedom (HMO-POS) covers and what you pay out of pocket for each service. The services listed in the Medical Benefits Chart are covered only when these are met:

- Your Medicare-covered services must be provided according to the Medicare coverage guidelines.
- Your services (including medical care, services, supplies, equipment, and Part B drugs) must be medically necessary. Medically necessary means that the services, or supplies are needed for the prevention, diagnosis, or treatment of your medical condition and meet accepted standards of medical practice.
- For new enrollees, your MA coordinated care plan must provide a minimum 90-day transition period, during which time the new MA plan can't require prior authorization for any active course of treatment, even if the course of treatment was for a service that commenced with an out-of-network provider.
- You get your care from a network provider. In most cases, care you get from an out of network provider won't be covered, unless it's a emergency or urgent care or unless our plan or a network provider gave you a referral. This means you pay the provider in full out-of-network the services you get.
- You have a primary care provider (a PCP) providing and overseeing your care.
- Some 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"). Covered services that need approval in advance are marked in the Medical Benefits Chart in bold.
- If your coordinated care plan provides approval of a prior authorization request for a course of treatment, the approval must be valid for as long as medically reasonable and necessary

to avoid disruptions in care in accordance with applicable coverage criteria, your medical history, and the treating provider's recommendation.

- We may also charge you administrative fees for missed appointments or for not paying your required cost sharing at the time of service. Call Customer Care at 1-877-883-9577 (TTY users call 711) if you have questions about these administrative fees.

Other important things to know about our coverage:

- Like all Medicare health plans, we cover everything that Original Medicare covers. For some of these benefits, you pay more in our plan than you would in Original Medicare. For others, you pay less. (To learn more about the coverage and costs of Original Medicare, go to your Medicare & You 2026 handbook. View it online at www.Medicare.gov or ask for a copy by calling 1-800-MEDICARE (1-800-633-4227). TTY/TDD users call 1-877-486-2048.)
- For preventive services covered at no cost under Original Medicare, we also cover those services at no cost to you. However, if you're also treated or monitored for an existing medical condition during the visit when you get the preventive service, a copayment will apply for the care you got for the existing medical condition.
- If Medicare adds coverage for any new services during 2026, either Medicare or our plan will cover those services.

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

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

Medical Benefits Chart

Covered Services	What you pay
24/7 Nurse Call Line (Remote Access Technology) You can contact a nurse by phone anytime – 24 hours a day, seven days a week by calling 1-800-348-9786 (TTY/TDD 711). Our specially trained registered nurses can provide support and education for members with chronic or complex health conditions or answers to more general health questions. The information provided through the 24/7 Nurse Call Line is intended to help educate, not to replace the advice of a medical professional. If you are experiencing severe symptoms such as sharp pains, fever, or any other immediate medical concern, dial 911 or contact a physician directly.	There is no cost for this service.
Abdominal aortic aneurysm screening A one-time screening ultrasound for people at risk. Our 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.	**In-network:** There is no coinsurance, copayment, or deductible for members eligible for this preventive screening. When services other than preventive are performed, the cost share (copayment/ coinsurance) associated with the other service will apply. **Out-of-network (POS):** 30% coinsurance per visit. Our plan will reimburse a maximum of $1,500 for out-of-network (POS) services per calendar year.

Covered Services	What you pay
Acupuncture for chronic low back pain Covered services include: Up to 12 visits in 90 days are covered 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 8 sessions will be covered for 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.	**In-network:** 50% coinsurance per visit. **Out-of-network (POS):** Not covered.

Covered Services	What you pay
Provider Requirements: Physicians (as defined in 1861(r)(1) of the Social Security Act (the Act)) may furnish acupuncture in accordance with applicable state requirements. Physician assistants (PAs), nurse practitioners (NPs)/clinical nurse specialists (CNSs) (as identified in 1861(aa)(5) of the Act), and auxiliary personnel may furnish acupuncture if they meet all applicable state requirements and have: • a master's or doctoral level degree in acupuncture or Oriental Medicine from a school accredited by the Accreditation Commission on Acupuncture and Oriental Medicine (ACAOM); and, • a current, full, active, and unrestricted license to practice acupuncture in a State, Territory, or Commonwealth (i.e., Puerto Rico) of the United States, or District of Columbia. Auxiliary personnel furnishing acupuncture must be under the appropriate level of supervision of a physician, PA, or NP/CNS required by our regulations at 42 CFR §§ 410.26 and 410.27.	
We cover an additional 10 visits per calendar year for all other diagnosis.	**In-network:** 50% coinsurance per visit. **Out-of-network (POS):** Not covered.

Covered Services	What you pay
Ambulance services • Covered ambulance services, whether for an emergency or non-emergency situation, include fixed wing, rotary wing, and ground ambulance services, to the nearest appropriate facility that can provide care if they're furnished to a member whose medical condition is such that other means of transportation could endanger the person's health or if authorized by our plan. If the covered ambulance services aren't for an emergency situation, it should be documented that the member's condition is such that other means of transportation could endanger the person's health and that transportation by ambulance is medically required.	**In-network and Out-of-network:** $150 copayment for each separate Medicare-covered ambulance service. **Prior authorization is required for some services by your doctor or other network provider.** The copayment is not waived even if you are admitted to a hospital as an inpatient immediately following the ambulance transport.
Annual physical exam Members are entitled to one annual physical exam per calendar year performed by a primary care physician. The exam will be comprehensive, focusing on key areas such as the eyes, ears, nose, and throat, cardiovascular, respiratory, gastrointestinal and musculoskeletal systems. In additional to a direct exam, the physical exam covers four areas: medication history, social history, review of symptoms and past medical history.	**In-network:** There is no coinsurance, copayment, or deductible for the annual physical exam. Certain services rendered during a routine exam may take a copayment/ coinsurance, for example, a diagnostic test. When services other than preventive are performed, the cost share (copayment/ coinsurance) associated with the other service will apply. **Out-of-network (POS):** Not covered.

Covered Services	What you pay
Annual wellness visit If you've had Part B for longer than 12 months, you can get an annual wellness visit to develop or update a personalized prevention plan based on your current health and risk factors. This is covered once every 12 months. **Note:** Your first annual wellness visit can't take place within 12 months of your Welcome to Medicare preventive visit. However, you don't need to have had a Welcome to Medicare visit to be covered for annual wellness visits after you've had Part B for 12 months.	**In-network:** There is no coinsurance, copayment, or deductible for the annual wellness visit. Certain services rendered during a wellness visit may take a copayment/ coinsurance, for example, a diagnostic test. When services other than preventive are performed, the cost share (copayment/ coinsurance) associated with the other service will apply. **Out-of-network (POS**): 30% coinsurance per visit. Our plan will reimburse a maximum of $1,500 for out-of-network (POS) services per calendar year.
Bone mass measurement For qualified people (generally, this means people at risk of losing bone mass or at risk of osteoporosis), the following services are covered every 24 months or more frequently if medically necessary: procedures to identify bone mass, detect bone loss, or determine bone quality, including a physician's interpretation of the results.	**In-network:** There is no coinsurance, copayment, or deductible for Medicare-covered bone mass measurement. When services other than preventive are performed, the cost share (copayment/ coinsurance) associated with the other service will apply. **Out-of-network (POS):** 30% coinsurance per visit. Our plan will reimburse a maximum of $1,500 for out-of-network (POS) services per calendar year.

Covered Services	What you pay
Breast cancer screening (mammograms) Covered services include: • One baseline mammogram between the ages of 35 and 39 • One screening mammogram every 12 months for women aged 40 and older • Clinical breast exams once every 24 months	**In-network:** There is no coinsurance, copayment, or deductible for covered screening mammograms. Additional testing may require an x-ray copayment. When services other than preventive are performed, the cost share (copayment/ coinsurance) associated with the other service will apply. **Out-of-network (POS):** 30% coinsurance per visit. Our plan will reimburse a maximum of $1,500 for out-of-network (POS) services per calendar year.
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. Our plan also covers intensive cardiac rehabilitation programs that are typically more rigorous or more intense than cardiac rehabilitation programs.	**In-Network:** $0 copayment per Medicare-covered cardiac rehabilitation visit. **Out-of-network (POS):** 30% coinsurance per visit. Our plan will reimburse a maximum of $1,500 for out-of-network (POS) services per calendar year.
Cardiovascular disease risk reduction visit (therapy for cardiovascular disease) We cover one visit per year with your primary care doctor to help lower your risk for cardiovascular disease. During this visit, your doctor may discuss aspirin use (if appropriate), check your blood pressure, and give you tips to make sure you're eating healthy.	**In-network:** There is no coinsurance, copayment, or deductible for the intensive behavioral therapy cardiovascular disease preventive benefit. When services other than preventive are performed, the cost share (copayment/ coinsurance) associated with the other service will apply. **Out-of-network (POS):** 30% coinsurance per visit. Our plan will reimburse a maximum of $1,500 for out-of-network (POS) services per calendar year.

Covered Services	What you pay
Cardiovascular disease screening test Blood tests for the detection of cardiovascular disease (or abnormalities associated with an elevated risk of cardiovascular disease) once every 5 years (60 months).	**In-network:** There is no coinsurance, copayment, or deductible for cardiovascular disease testing that is covered once every 5 years. When services other than preventive are performed, the cost share (copayment/ coinsurance) associated with the other service will apply. **Out-of-network (POS):** 30% coinsurance per visit. Our plan will reimburse a maximum of $1,500 for out-of-network (POS) services per calendar year.
Cervical and vaginal cancer screening Covered services include: • Pap tests and pelvic exams are covered once every 24 months • If you're at high risk of cervical or vaginal cancer or you're of childbearing age and have had an abnormal Pap test within the past 3 years: one Pap test every 12 months	**In-network:** There is no coinsurance, copayment, or deductible for Medicare-covered preventive Pap and pelvic exams. When services other than preventive are performed, the cost share (copayment/ coinsurance) associated with the other service will apply. **Out-of-network (POS):** 30% coinsurance per visit. Our plan will reimburse a maximum of $1,500 for out-of-network (POS) services per calendar year.
Chiropractic services Covered services include: • We cover only manual manipulation of the spine to correct subluxation	**In-network:** $15 copayment per Medicare-covered visit. **Out-of-network (POS):** 30% coinsurance per visit. Our plan will reimburse a maximum of $1,500 for out-of-network (POS) services per calendar year.

Covered Services	What you pay
Chronic pain management and treatment services Covered monthly services for people living with chronic pain (persistent or recurring pain lasting longer than 3 months). Services may include pain assessment, medication management, and care coordination and planning.	**In-network:** $5 copayment for a PCP and $35 copayment for a Specialist per visit. **Out-of-network (POS):** 30% coinsurance per visit. The plan will reimburse a maximum of $1,500 for out-of-network (POS) services per calendar year. When individual services are performed during treatment, the cost share (copayment/coinsurance) associated with the other service may apply. Cost sharing for this service will vary depending on individual services provided under the course of treatment.

Covered Services	What you pay
Colorectal cancer screening The following screening tests are covered: • Colonoscopy has no minimum or maximum age limitation and is covered once every 120 months (10 years) for patients not at high-risk, or 48 months after a previous flexible sigmoidoscopy for patients who aren't at high risk for colorectal cancer, and once every 24 months for high-risk patients after a previous screening colonoscopy or barium enema. • Computer tomography colonography for patients 45 year and older who are not at high risk of colorectal cancer and is covered when at least 59 months have passed following the month in which the last screening computer tomography colonography was performed or 47 months have passed following the month in which the last screening flexible sigmoidoscopy or screening colonoscopy was performed. For patients at high risk for colorectal cancer, payment may be made for a screening computer tomography colonography performed after at least 23 months have passed following the month in which the last screening computed tomography colonography or the last screening colonoscopy was performed. • Flexible sigmoidoscopy for patients 45 years and older. Once every 120 months for patients not at high-risk after the patient got a screening colonoscopy. Once every 48 months for high-risk patients from the last flexible sigmoidoscopy or barium enema**.** • Screening fecal-occult blood tests for patients 45 years and older. Once every 12 months.	**In-network:** There is no coinsurance, copayment, or deductible for a Medicare-covered colorectal cancer screening exam. **Out-of-network (POS):** 30% coinsurance per visit. Our plan will reimburse a maximum of $1,500 for out-of-network (POS) services per calendar year. When services other than preventive are performed, the cost share (copayment/ coinsurance) associated with the other service will apply.

Covered Services	What you pay
• Multitarget stool DNA for patients 45 to 85 years of age and not meeting high-risk criteria. Once every 3 years. • Blood-based Biomarker Tests for patients 45 to 85 years of age and not meeting high-risk criteria. Once every 3 years. Colorectal cancer screening tests include a follow-up screening colonoscopy after a Medicare-covered non-invasive stool-based colorectal cancer screening test returns a positive result. • Cologuard test- covered once every 3 years for people ages 50 to 85. Must be asymptomatic and at average risk of developing colorectal cancer.	

Covered Services	What you pay
Dental services In general, preventive dental services (such as cleaning, routine dental exams, and dental x-rays) aren't covered by Original Medicare. However, Medicare pays for dental services in a limited number of circumstances, specifically when that service is an integral part of specific treatment of a person's primary medical condition. Examples include reconstruction of the jaw after a fracture or injury, tooth extractions done in preparation for radiation treatment for cancer involving the jaw, or oral exams prior to organ transplantation. In addition, we cover: Routine Preventive Dental: • Oral Exams – twice per calendar year. • Routine Cleanings - twice per calendar year. • X-rays (bitewings) – twice per calendar year (not to exceed maximum of four per year). • X-rays (full mouth or panorax) – once every 36 months. Coverage for routine preventive dental care is limited to these procedure codes: D1110, D0120, D0140, D0150, D9110, D0270, D0272, D0273, D0274, D0210, D0330, D0220, D0230, D0240, D0250, D0251, D0277, D0310, D0350	**In-network:** $0 copayment for each visit for covered routine dental services when provided by an in-network provider. **Out-of-Network:** When services are received from an out-of-network provider, your plan will pay 100% of the allowance or dentist's charges, whichever is less. You are responsible for balances up to the dentist's charge. When you receive preventive dental services, you are responsible for making payment to your dentist and filing a claim with us to be reimbursed for these costs. If you have any questions about what to pay a provider or where to send a paper claim you may call Customer Care (phone number for Dental Customer Care is in Chapter 2, Section 1)
Comprehensive Dental: We will pay costs for covered dental services for the calendar year until you reach the maximum plan benefit coverage amount for in & out-of-network covered dental services. Once this maximum benefit amount is reached, you are responsible for 100% of the cost of in & out-of-network dental services and dental providers may balance bill you if charges are above the allowed amount. The maximum plan benefit	**In and Out of network:** $1,000 annual allowance for covered dental services per calendar year.

Covered Services	What you pay
coverage amount does not apply to routine preventive dental services. Limited to specific dental codes (exclusions apply) and limitations may apply on the number of covered services within a service category. Limitations to services may apply. We do not reimburse dentists for charges above the allowed amount. An in-network dentist will not charge you for any balances for covered services. Out-of-network dentists, however, may bill you for any balances over the allowed amount. When you receive services from an out-of-network provider, you are responsible for making payment to your dentist and filing a claim with us. You must submit your dental claim to us within 12 months from the date of service. **Restorative** • Amalgam Restorations (once per tooth every 12 months) • Resin Filling (once per tooth every 12 months) • Composite Restorations (once per tooth every 12 months) Coverage for restorative care is limited to these procedure codes: D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394, D2940, D2951, D2990 **Periodontics** • Scaling and root planning (once per quadrant per 24 months) • Periodontal Maintenance (twice every calendar year) • Osseous Surgery • Gingivectomy or Gingivoplasty • Gingival Flap Procedure Coverage for periodontics is limited to these procedure codes: D4210, D4211, D4240,	

Covered Services	What you pay
D4241, D4249, D4260, D4261, D4341, D4342, D4910 **Extractions/Oral Surgery** • Surgical Extractions • Partial and Full Bony Extractions • Simple Extractions • Incisional Biopsy of Oral Tissue- hard or soft. This benefit covers biopsies of oral tissue that aren't covered under the medical benefit. • Alveoloplasty- without or without extractions. Only covered when preparing mouth for dentures • Incision and Drainage of Abscess Coverage for extractions/oral surgery is limited to these procedure codes: D7111, D7140, D7210, D7220, D7230, D7240, D7241, D7250, D7285, D7286, D7310, D7311, D7320, D7321, D7510, D7511 **Endodontics** • Root Canal • Endodontics Therapy (once per tooth per lifetime) • Apicoectomy • Pulp Vitality Test Coverage for endodontics is limited to these procedure codes: D0460, D3110, D3120, D3220, D3221, D3222, D3230, D3240, D3310, D3320, D3330, D3332, D3346, D3347, D3348, D3351, D3352, D3353, D3355, D3356, D3357, D3410, D3421, D3425, D3426, D3430, D3450, D3920, D3921 **Prosthodontics** • Select Crowns (once per tooth every 5 years) • Complete Dentures (once every 5 years) • Partial Dentures (once every 5 years)	

Covered Services	What you pay
• Interim Partial Dentures Maxillary and Mandibular (Only covered for anterior teeth) • Inlays/Onlays - Single (once per tooth every 5 years) • Fixed Bridges (once per tooth every 5 years) **Prosthetic Maintenance** • Recement for Select Crowns (once every 36 months) • Denture Adjustments • Denture Repairs • Denture Recline & Rebase (once every 36 months) • Bridge Repairs • Bridge Recementation (once every 36 months) • Inlays/Onlays – Recementation (once every 36 months) Coverage for prosthodontics and prosthodontic maintenance is limited to these procedure codes: D2390, D2510, D2520, D2530, D2542, D2543, D2544, D2610, D2620, D2630, D2642, D2643, D2644, D2650, D2651, D2652, D2662, D2663, D2664, D2710, D2712, D2720, D2721, D2722, D2740, D2750, D2751, D2752, D2753, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2794, D2910, D2915, D2920, D2928, D2929, D2930, D2931, D2932, D2933, D2934, D2950, D2952, D2954, D2975, D5110, D5120, D5130, D5140, D5211, D5212, D5213, D5214, D5221, D5222, D5223, D5224, D5225, D5226, D5227, D5228, D5282, D5283, D5284, D5286, D5410, D5411, D5421, D5422, D5511, D5512, D5520, D5611, D5612, D5621, D5622, D5630, D5640, D5650, D5660, D5710, D5711, D5720, D5721, D5730, D5731, D5740, D5741, D5750, D5751, D5760, D5761, D5765, D5820, D5821, D5850,	

Covered Services	What you pay
D5851, D5863, D5864, D5865, D5866, D5876, D6205, D6210, D6211, D6212, D6214, D6240, D6241, D6242, D6243, D6245, D6250, D6251, D6252, D6545, D6548, D6549, D6600, D6601, D6602, D6603, D6604, D6605, D6606, D6607, D6608, D6609, D6610, D6611, D6612, D6613, D6614, D6615, D6624, D6634, D6710, D6720, D6721, D6722, D6740, D6750, D6751, D6752, D6753, D6780, D6781, D6782, D6783, D6784, D6790, D6791, D6792, D6794, D6930, D6980 **Other** Coverage is limited to these procedure codes: D9222, D9223, D9239, D9243, D9410, D9420 In addition to the exclusions in the General Exclusions listed in Chapter 4, Section 3.1, we will not provide benefits for **any of the following conditions, treatments, services, supplies or accommodations, including any direct complications or consequences that arise from them**: • Dental procedure codes not listed in the benefit grid. • Bonding & Splinting • Consults • Cosmetic Services - We will not provide coverage for dental services and supplies that are primarily for cosmetic or aesthetic purposes and aren't medically necessary, including bleaching of teeth and labial veneers. • Fluoride • Grafting Procedures • Medications and Supplies - Charges in connection with medication, including take home drugs, pre-medications, therapeutic drug injections and	

Covered Services	What you pay
supplies associated with dental services aren't covered. • Oral Hygiene Programs - We will not provide coverage for training or supplies used for: dietary counseling; tobacco counseling; oral hygiene; or plaque control programs. • Orthodontic Services • Procedures to Increase Vertical Dimension - We will not provide coverage for procedures, restorations and appliances to increase vertical dimension or to restore occlusion. • Replacement of Prosthetic Devices - We will not provide coverage for replacement of a lost, missing or stolen prosthetic device. We will not provide coverage for replacement of a prosthetic device for which benefits were provided under this benefit unless the existing prosthetic was placed more than five years ago and cannot be made serviceable. • Tooth Implants and Transplants including select crowns and any associated care for implant placement. • Sealants • Separate Charges - Services and supplies that may be billed as separate charges (these are considered inclusive of the billed procedure), including the following: any supplies and sterilization. • Space Maintainers • Special Charges - We will not provide coverage for charges billed to you for telephone consultations, missed appointments, new patient processing, interest, copies of provider records, or completion of claim forms.	

Covered Services	What you pay
• Temporomandibular Joint - We will not provide coverage for appliances, therapy, surgery or any services rendered for what we determine in our sole judgment is for the medical treatment of the temporomandibular joint. • Veneers	
Depression screening We cover one screening for depression per year. The screening must be done in a primary care setting that can provide follow-up treatment and/or referrals.	**In-network:** There is no coinsurance, copayment, or deductible for an annual depression screening visit. When services other than preventive are performed, the cost share (copayment/ coinsurance) associated with the other service will apply. **Out-of-network (POS):** 30% coinsurance per visit. Our plan will reimburse a maximum of $1,500 for out-of-network (POS) services per calendar year.
Diabetes screening We cover this screening (includes fasting glucose tests) if you have any of these risk factors: high blood pressure (hypertension), history of abnormal cholesterol and triglyceride levels (dyslipidemia), obesity, or a history of high blood sugar (glucose). Tests may also be covered if you meet other requirements, like being overweight and having a family history of diabetes. You may be eligible for up to 2 diabetes screenings every 12 months following the date of your most recent diabetes screening test.	**In-network:** There is no coinsurance, copayment, or deductible for the Medicare-covered diabetes screening tests. When services other than preventive are performed, the cost share (copayment/ coinsurance) associated with the other service will apply. **Out-of-network (POS):** 30% coinsurance per visit. Our plan will reimburse a maximum of $1,500 for out-of-network (POS) services per calendar year.

Covered Services	What you pay
Diabetes self-management training, diabetic services, and supplies For all people who have diabetes (insulin and non-insulin users). Covered services include:	
• Diabetes self-management training is covered under certain conditions.	**In-network:** There is no coinsurance, copayment, or deductible for beneficiaries eligible for the diabetes self-management training preventive benefit. When services other than preventive are performed, the cost share (copayment/ coinsurance) associated with the other service will apply. **Out-of-network (POS):** 30% coinsurance per visit. Our plan will reimburse a maximum of $1,500 for out-of-network (POS) services per calendar year.

Covered Services	What you pay
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. Members are eligible to receive the following diabetic meters, and the associated test strips: - FreeStyle test strips - FreeStyle Lite meters and test strips - FreeStyle Freedom Lite meters - Precision Xtra meters and test strips - Precision Xtra Beta Ketone test strips - FreeStyle Precision Neo test strips - FreeStyle Precision Neo meter Continuous Glucose Monitoring (CGM) supplies can be purchased at a participating retail pharmacy, participating mail order pharmacy or a participating DME provider. We cover: - FreeStyle Libre 14-Day - FreeStyle Libre 2 - FreeStyle Libre 3 - Dexcom G6 - Dexcom G7 Prior Authorization is required. Quantity Limits may apply.	**In-network:** $5 copayment per item for each 30-day supply when received from the preferred manufacturer, Abbott. Diabetic monitors and test strips received from a non-preferred manufacturer aren't covered. Members will pay a maximum $35 copay for a 30-day supply of insulin that is used in a traditional insulin pump* (e.g., Medtronic Minimed system). * Insulin used in Omnipod™ and V-Go™ systems aren't covered under Part B. Please Note: Our plan requires you to try one of the listed Abbott products before we will cover other manufacturer test strips or meter products that aren't listed. Prior authorization required for coverage of a non-preferred manufacturer's meters and test strips. **Prior authorization is required for some services by your doctor or other network provider.** **Out-of-network (POS):** 30% coinsurance per 30-day supply when received from a preferred manufacturer. Diabetic monitors and test strips received from a non-preferred manufacturer aren't covered. Our plan will reimburse a maximum of $1,500 for out-of-network (POS) services per calendar year. Members will pay a maximum $35 copay for a 30-day supply of insulin that is used in a traditional insulin pump* (e.g., Medtronic Minimed system).

Covered Services	What you pay
• For people with diabetes who have severe diabetic foot disease: One pair per calendar year of therapeutic custom-molded shoes (including inserts provided with such shoes) and two additional pairs of inserts, or one pair of depth shoes and three pairs of inserts (not including the non-customized removable inserts provided with such shoes). Coverage includes fitting. **Two Ways We Help Members Manage diabetes.** 1. Long-term support from Care Managers. We can help you understand diabetes and stay as healthy and well as you can. Call 1-800-860-2619 (TTY/TDD: 711) Mon. – Fri., 8 a.m. to 4:30 p.m. 2. Medicare Customer Care Advocates are available to help members understand their coverage.	**In-network:** 20% coinsurance for each pair of Medicare-covered therapeutic shoes. **Out-of-network (POS):** 30% coinsurance for each pair of Medicare – covered therapeutic shoes. Our plan will reimburse a maximum of $1,500 for out-of-network (POS) services per calendar year.
Durable medical equipment (DME) and related supplies (For a definition of durable medical equipment, go to Chapter 12 and Chapter 3.) Covered items include, but aren't limited to wheelchairs, crutches, powered mattress systems, diabetic supplies, hospital beds ordered by a provider for use in the home, IV infusion pumps, speech generating devices, oxygen equipment, nebulizers, and walkers. We cover all medically necessary DME covered by Original Medicare. If our certified supplier in your area doesn't carry a particular brand or manufacturer, you can ask them if they can special order it for you. The most recent list of certified suppliers is available on our website at medicare.univerahealthcare.com.	**In-network:** 20% coinsurance for each Medicare-covered durable medical equipment item. **Prior authorization is required for some services by your doctor or other network provider.** **Out-of-network (POS):** 30% coinsurance per item. Our plan will reimburse a maximum of $1,500 for out-of-network (POS) services per calendar year. Your cost sharing for Medicare oxygen equipment coverage is 20% coinsurance. Your cost sharing will not change after being enrolled for 36 months.

Covered Services	What you pay
Emergency care Emergency care refers to services that are: • Furnished by a provider qualified to furnish emergency services, and • Needed to evaluate or stabilize an emergency medical condition. A medical emergency is when you, or any other prudent layperson with an average knowledge of health and medicine, believe that you have medical symptoms that require immediate medical attention to prevent loss of life (and, if you're a pregnant woman, loss of an unborn child), loss of a limb, or loss of function of a limb. The medical symptoms may be an illness, injury, severe pain, or a medical condition that's quickly getting worse. Cost sharing for necessary emergency services you get out-of-network is the same as when you get these services in-network. You are covered for emergency care anywhere in the world.	**In-network and Out-of-network:** $115 copayment per visit. Copayment is waived if admitted to the hospital within 24 hour(s) for the same condition. If you receive emergency care at an out-of-network hospital and need inpatient care after your emergency condition is stabilized, you must have your inpatient care at the out-of-network hospital authorized by our plan and your cost is the cost sharing you would pay at a network hospital.

Covered Services	What you pay
Health and wellness education programs Silver&Fit® Fitness Program	
• Silver&Fit participating fitness centers provide access to standard services and amenities. In addition, some offer special programs and classes exclusive to Silver&Fit members.	• There is no annual membership fee for participating fitness centers.
• The Silver&Fit Home Fitness Program provides a choice of one kit per year.	• There is no annual fee for one Home Fitness Kit. You can choose BOTH membership at a participating fitness center AND 1 Home Fitness Kit. Contact the Silver&Fit program Customer Service at 1-888-797-7925 (TTY/TDD users call 711). Monday through Friday, from 8 a.m. to 9 p.m. Silver&Fit cost shares do not apply to the Maximum Out-of-Pocket Amount
Hearing services Diagnostic hearing and balance evaluations performed by your provider to determine if you need medical treatment are covered as outpatient care when you get them from a physician, audiologist, or other qualified provider. Routine hearing exam covered once per calendar year. To schedule an appointment call 1-855-205-5526 (TTY/TDD users call 711) Monday through Friday, from 8 a.m. to 9 p.m. *The routine hearing exam copayment does not count towards your maximum out-of-pocket amount.	**In-network:** $35 copayment for each Medicare-covered diagnostic hearing exam. **Out-of-network (POS):** 30% coinsurance for each Medicare-covered diagnostic hearing exam. Our plan will reimburse a maximum of $1,500 for out-of-network (POS) services per calendar year. **In-network:** *$0 copayment for one routine hearing exam per calendar year by a TruHearing provider. **Out-of-network (POS):** Not covered. For routine hearing exams and hearing aids, you must contact TruHearing to schedule an appointment prior to visiting the provider.

Covered Services	What you pay
Hearing Aids Up to two TruHearing-branded hearing aids every year (one per ear per year). Benefit is limited to the TruHearing's Advanced and Premium hearing aids, which come in various styles and colors and are available in rechargeable style options for an additional $50 per aid. You must see a TruHearing provider to use this benefit. Hearing aid purchases includes: • First year of follow-up provider visits • 60-day trial period • 3-year extended warranty • 80 batteries per aid for non-rechargeable models	***$499** copayment per aid for Advanced Aids ***$799** copayment per aid for Premium Aids * **$50** additional cost per aid for optional hearing aid rechargeability
To schedule an appointment call 1-855-205-5526 (TTY/TDD users call 711) Monday through Friday, from 8 a.m. to 9 p.m. Benefit does not include or cover any of the following: • Additional cost for optional hearing aid rechargeability • Ear molds • Hearing aid accessories • Additional provider visits • Additional batteries: batteries when a rechargeable hearing aid is purchased • Hearing aids that aren't the TruHearing-branded hearing aids • Costs associated with loss & damage warranty claims Costs associated with excluded items are the responsibility of the member and not covered by our plan.	For routine hearing exams and hearing aids, you must contact TruHearing to schedule an appointment prior to visiting the provider. *Hearing Aid copayments do not count towards your maximum out-of-pocket amount.

Covered Services	What you pay
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 If you are pregnant, we cover: • Up to 3 screening exams during a pregnancy	**In-network:** There is no coinsurance, copayment, or deductible for members eligible for Medicare-covered preventive HIV screening. When services other than preventive are performed, the cost share (copayment/ coinsurance) associated with the other service will apply. **Out-of-network (POS):** 30% coinsurance per visit. Our plan will reimburse a maximum of $1,500 for out-of-network (POS) services per calendar year.
Home health agency care Before you get home health services, a doctor must certify that you need home health services and will order home health services to be provided by a home health agency. You must be homebound, which means leaving home is a major effort. Covered services include, but aren't limited to: • Part-time or intermittent skilled nursing and home health aide services (to be covered under the home health care benefit, your skilled nursing and home health aide services combined must total fewer than 8 hours per day and 35 hours per week) • Physical therapy, occupational therapy, and speech therapy • Medical and social services • Medical equipment and supplies	**In-network:** $0 copayment per Medicare-covered home health visit. 20% coinsurance for each Medicare-covered Durable Medical equipment item. Supplies are covered in full when medically necessary and provided by a Home Health Care Agency. **Prior authorization is required for some services by your doctor or other network provider.** **Out-of-network (POS):** 30% coinsurance per Medicare-covered home health visit. Our plan will reimburse a maximum of $1,500 for out-of-network (POS) services per calendar year.

Covered Services	What you pay
Home infusion therapy Home infusion therapy involves the intravenous or subcutaneous administration of drugs or biologicals to a person at home. The components needed to perform home infusion include the drug (for example, antivirals, immunoglobulin), equipment (for example, a pump), and supplies (for example, tubing and catheters. Covered services include, but aren't limited to: • Professional services, including nursing services, furnished in accordance with our plan of care • Patient training and education not otherwise covered under the durable medical equipment benefit • Remote monitoring • Monitoring services for the provision of home infusion therapy and home infusion drugs furnished by a qualified home infusion therapy supplier	**In-network:** $0 copayment per Medicare-covered home health visit. 20% coinsurance for each Medicare-covered Durable Medical equipment item. 20% coinsurance for each Medicare-covered Part B drug. Supplies are covered in full when medically necessary and provided by a Home Health Care Agency. **Prior authorization and Step Therapy may be required for some services by your doctor or other network provider.** **Out-of-network (POS):** 30% coinsurance per Medicare-covered home health visit. Our plan will reimburse a maximum of $1,500 for out-of-network (POS) services per calendar year. 30% coinsurance for each Medicare-covered Durable Medical equipment item. Our plan will reimburse a maximum of $1,500 for out-of-network (POS) services per calendar year. 30% coinsurance for each Medicare-covered Part B drug. Our plan will reimburse a maximum of $1,500 for out-of-network (POS) services per calendar year.

Covered Services	What you pay
Hospice care You're eligible for the hospice benefit when your doctor and the hospice medical director have given you a terminal prognosis certifying that you're terminally ill and have 6 months or less to live if your illness runs its normal course. You can get care from any Medicare-certified hospice program. Our plan is obligated to help you find Medicare-certified hospice programs in our plan's service area, including programs we own, control, or have a financial interest in. Your hospice doctor can be a network provider or an out-of-network provider. Covered services include: • Drugs for symptom control and pain relief • Short-term respite care • Home care When you're admitted to a hospice you have the right to stay in your plan; if you choose to remain in our plan you must continue to pay plan premiums. **For hospice services and services covered by Medicare Part A or B that are related to your terminal prognosis:** Original Medicare (rather than our plan) will pay your hospice provider for your hospice services and any Part A and Part B services related to your terminal prognosis. While you're in the hospice program, your hospice provider will bill Original Medicare for the services Original Medicare pays for. You'll be billed Original Medicare cost sharing.	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 Univera Medicare Freedom (HMO-POS).

Covered Services	What you pay
For services covered by Medicare Part A or B not related to your terminal prognosis: If you need non-emergency, non-urgently needed services covered under Medicare Part A or B that aren't related to your terminal prognosis, your cost for these services depends on whether you use a provider in our plan's network and follow plan rules (like if there's a requirement to obtain prior authorization). • If you get the covered services from a network provider, and follow plan rules for getting service, you pay only our plan cost-sharing amount for in-network services • If you get the covered services from an out-of-network provider, you pay the cost sharing under Original Medicare.	
For services covered by Univera Medicare Freedom (HMO-POS) but not covered by Medicare Part A or B: **Univera Medicare Freedom (HMO-POS)** will continue to cover plan-covered services that aren't covered under Part A or B whether or not they're related to your terminal prognosis. You pay our plan cost sharing amount for these services.	
Note: If you need non-hospice care (care that's not related to your terminal prognosis), contact us to arrange the services. Our plan covers hospice consultation services (one time only) for a terminally ill person who hasn't elected the hospice benefit.	**In-network:** $0 copayment for a one-time hospice consultation. **Out-of-network (POS):** 30% coinsurance per visit. Our plan will reimburse a maximum of $1,500 for out-of-network (POS) services per calendar year.

Covered Services	What you pay
Immunizations Covered Medicare Part B services include: • Pneumonia vaccines • Flu/influenza shots (or vaccines), once each flu/influenza season in the fall and winter, with additional flu/influenza shots (or vaccines) if medically necessary • Hepatitis B vaccines if you're at high or intermediate risk of getting Hepatitis B • COVID-19 vaccines • Other vaccines if you're at risk and they meet Medicare Part B coverage rules	**In-network:** There is no coinsurance, copayment, or deductible for the pneumonia, flu/influenza, Hepatitis B, and COVID-19 vaccines 20% coinsurance for all other Medicare-Part B covered immunizations. When services other than preventive are performed, the cost share (copayment/ coinsurance) associated with the other service will apply. **Out-of-network (POS):** There is no coinsurance or copayment for pneumonia vaccines, COVID-19 vaccines and flu shots. 30% coinsurance for Hepatitis B and all other Medicare Part B-covered immunizations. Our plan will reimburse a maximum of $1,500 for out-of-network (POS) services per calendar

Covered Services	What you pay
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're formally admitted to the hospital with a doctor's order. The day before you're discharged is your last inpatient day. Covered services include but aren't limited to: • Semi-private room (or a private room if medically necessary) • Meals including special diets • Regular nursing services • Costs of special care units (such as intensive care or coronary care units) • Drugs and medications • Lab tests • X-rays and other radiology services • Necessary surgical and medical supplies • Use of appliances, such as wheelchairs • Operating and recovery room costs • Physical, occupational, and speech language therapy • Inpatient substance abuse services Under certain conditions, the following types of transplants are covered: corneal, kidney, kidney-pancreatic, heart, liver, lung, heart/ lung, bone marrow, stem cell, and intestinal/ multivisceral. If you need a transplant, we'll arrange to have your case reviewed by a Medicare-approved transplant center that will decide whether you're a candidate for a transplant.	**In-network:** $260 copayment per day for days 1 through 5 for covered hospital care. Thereafter, you pay a $0 copayment for additional Medicare-covered days during your hospital admission. Copayment applies on the date of hospital admission. **Out-of-network (POS):** 30% coinsurance per visit. Our plan will reimburse a maximum of $1,500 for out-of-network (POS) services per calendar year. For inpatient hospital care, the cost sharing described above applies each time you are admitted to the hospital. This applies each time you move from acute to rehabilitation care, even if you are in the same physical facility. **Prior authorization is required by your doctor or other network provider.** If you get authorized inpatient care at an out-of-network hospital after your emergency condition is stabilized, your cost is the cost sharing you would pay at an in-network hospital. This applies when moving from acute to rehabilitation care, even if you are in the same physical facility.

Covered Services	What you pay
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 Univera Medicare Freedom (HMO-POS) provides transplant services at a location outside the pattern of care for transplants in your community and you choose to get transplants at this distant location, we'll arrange or pay for appropriate lodging and transportation costs for you and a companion up to the IRS medical mile approved rate in effect on the date of travel and up to the per diem rate for lodging specified by the U.S. General Service or the actual cost of lodging whichever is less. The maximum amount payable for all travel and lodging services is ten-thousand dollars ($10,000.00) per transplant in accordance with plan guidelines. The travel and lodging benefit period begins five days prior to the initial transplant and extends through the patient's discharge date from the transplant facility. These expenses will not count towards the Member Out-of-Pocket Maximum amount. • Physician services • Blood-including storage and administration. Coverage starts with the first pint used.	

Covered Services	What you pay
Note: To be an inpatient, your provider must write an order to admit you formally as an inpatient of the hospital. Even if you stay in the hospital overnight, you might still be considered an outpatient. If you're not sure if you're an inpatient or an outpatient, ask the hospital staff. Get more information Medicare fact sheet Medicare Hospital Benefits. This fact sheet is available at www.Medicare.gov/publications/11435-Medicare-Hospital-Benefits.pdf or by calling 1-800-MEDICARE (1-800-633-4227). TTY/TDD users call 1-877-486-2048.	
Inpatient services in a psychiatric hospital and substance abuse services • 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 doesn't apply to inpatient mental health services provided in a psychiatric unit of a general hospital. • Inpatient substance abuse services	**Prior authorization is required for by your doctor or other network provider.** **In-network:** $260 copayment per day for days 1 through 5 for covered hospital care. Thereafter, you pay a $0 copayment for additional Medicare-covered days during your hospital admission. Copayment applies on the date of hospital admission. **Out-of-network (POS):** 30% coinsurance per visit. Our plan will reimburse a maximum of $1,500 for out-of-network (POS) services per calendar year. For inpatient mental health hospital care, the cost sharing described above applies each time you are admitted to the hospital.

Covered Services	What you pay
Inpatient stay: Covered services you get in a hospital or SNF during a non-covered inpatient stay If you've used up your inpatient benefits or if the inpatient stay isn't reasonable and necessary, we won't cover your inpatient stay. In some cases, we'll cover certain services you get while you're in the hospital or the skilled nursing facility (SNF). Covered services include, but aren't limited to:	**Prior authorization is required for some services by your doctor or other network provider.**
• Physician services.	**In-network:** $5 copayment for a PCP and $35 copayment for a Specialist per visit. **Out-of-network (POS):** 30% coinsurance per visit. Our plan will reimburse a maximum of $1,500 for out-of-network (POS) services per calendar year.
• Lab test (inpatient).	**In-network:** $10 copayment for Medicare-covered lab tests. **Out-of-network (POS):** 30% coinsurance. Our plan will reimburse a maximum of $1,500 for out-of-network (POS) services per calendar year.
• Diagnostic tests (EKGs, pulmonary function tests, treadmill stress tests, etc.).	**In-network:** $10 copayment for Medicare non-radiological diagnostic tests. When services in addition to the diagnostic test are done during the visit, a $5 copayment for PCP or $35 copayment for Specialist will apply. **Out-of-network (POS):** 30% coinsurance. Our plan will reimburse a maximum of $1,500 for out-of-network (POS) services per calendar year.

Covered Services	What you pay
• X-ray.	**In-network:** $40 copayment for each Medicare-covered standard x-ray. **Out-of-network (POS):** 30% coinsurance. Our plan will reimburse a maximum of $1,500 for out-of-network (POS) services per calendar year.
• Diagnostic Imaging (CT scan, MRI/MRA, Myocardial Nuclear Perfusion Imaging and PET scans).	**In-network:** $150 copayment for each Medicare-covered service. This includes the cost of the imaging and any associated provider services. **Out-of-network (POS):** 30% coinsurance. Our plan will reimburse a maximum of $1,500 for out-of-network (POS) services per calendar year.
• Radiation Therapy: radium and isotope therapy including technician materials and services.	**In-network:** 20% coinsurance for each Medicare-covered radiation therapy. **Out-of-network (POS):** 30% coinsurance. Our plan will reimburse a maximum of $1,500 for out-of-network (POS) services per calendar year.
• Surgical dressings • Splints, casts, and other devices used to reduce fractures and dislocations.	**In-network:** 20% coinsurance for each Medicare-covered item. **Out-of-network (POS):** 30% coinsurance Our plan will reimburse a maximum of $1,500 for out-of-network (POS) services per calendar year.
• Physical therapy, speech therapy, and occupational therapy.	**In-network:** $35 copayment per treatment**.** **Out-of-network (POS):** 30% coinsurance. Our plan will reimburse a maximum of $1,500 for out-of-network (POS) services per calendar year.
• 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.	**In-network:** 20% coinsurance for each Medicare-covered item. **Out-of-network (POS):** 30% coinsurance. Our plan will reimburse a maximum of $1,500 for out-of-network (POS) services per calendar year.

Covered Services	What you pay
• 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.	**In-network:** 20% coinsurance for each Medicare-covered item. **Out-of-network (POS):** 30% coinsurance. Our plan will reimburse a maximum of $1,500 for out-of-network (POS) services per calendar year.
Medical nutrition therapy This benefit is for people with diabetes, renal (kidney) disease (but not on dialysis), or after a kidney transplant when ordered by your doctor. We cover 3 hours of one-on-one counseling services during the first year you get medical nutrition therapy services under Medicare (this includes our plan, any other Medicare Advantage plan, or Original Medicare), and 2 hours each year after that. If your condition, treatment, or diagnosis changes, you may be able to get 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.	**In-network:** There is no coinsurance, copayment, or deductible for members eligible for Medicare-covered medical nutrition therapy services. When services other than preventive are performed, the cost share (copayment/ coinsurance) associated with the other service will apply. **Out-of-network (POS):** 30% coinsurance. Our plan will reimburse a maximum of $1,500 for out-of-network (POS) services per calendar year.
Medicare Diabetes Prevention Program (MDPP) MDPP services are covered for eligible people under all Medicare health plans. MDPP is a structured health behavior change intervention that provides practical training in long-term dietary change, increased physical activity, and problem-solving strategies for overcoming challenges to sustaining weight loss and a healthy lifestyle.	**In-network:** There is no coinsurance, copayment, or deductible for the MDPP benefit. When services other than preventive are performed, the cost share (copayment/ coinsurance) associated with the other service will apply. **Out-of-network (POS):** 30% coinsurance. Our plan will reimburse a maximum of $1,500 for out-of-network (POS) services per calendar year.

Covered Services	What you pay
Medicare Part B drugs These drugs are covered under Part B of Original Medicare. Members of our plan get coverage for these drugs through our plan. Covered drugs include: • Drugs that usually aren't self-administered by the patient and are injected or infused while you get physician, hospital outpatient, or ambulatory surgical center services • Insulin furnished through an item of durable medical equipment (such as a medically necessary insulin pump) • Other drugs you take using durable medical equipment (such as nebulizers) that were authorized by our plan • The Alzheimer's drug, Leqembi ®, (generic name lecanemab), which is administered intravenously. In addition to medication costs, you may need additional scans and tests before and/or during treatment that could add to your overall costs. Talk to your doctor about what scans and tests you may need as part of your treatment • Clotting factors, you give yourself by injection if you have hemophilia • Transplant/immunosuppressive-drugs: Medicare covers transplant drug therapy if Medicare paid for your organ transplant. You must have Part A at the time of the covered transplant, and you must have Part B at the time you get immunosuppressive drugs. • Injectable osteoporosis drugs, if you're homebound, have a bone fracture that a doctor certifies was related to post-menopausal osteoporosis, and can't self-administer the drug • Some antigens: Medicare covers antigens if a doctor prepares them and a properly	**In-network:** 20% coinsurance for each covered Medicare Part B drug. Select Part B drugs may cost less than a 20% coinsurance. Medicare Part B prescription drugs may require prior authorization and step therapy. Members will pay a maximum $35 copay for a 30-day supply of insulin that is used in a traditional insulin pump* (e.g., Medtronic Minimed system). * Insulin used in Omnipod™ and V-Go™ systems aren't covered under Part B. **Out-of-network:** 30% coinsurance. Our plan will reimburse a maximum of $1,500 for out-of-network (POS) services per calendar year. If services are received during a doctor's office visit or at an outpatient facility visit, you'll pay your share of the cost for the services in addition to your copayment for the office/facility visit.

Covered Services	What you pay
instructed person (who could be you, the patient) gives them under appropriate supervision • Certain oral anti-cancer drugs: Medicare covers some oral cancer drugs you take by mouth if the same drug is available in injectable form or the drug is a prodrug (an oral form of a drug that, when ingested, breaks down into the same active ingredient found in the injectable drug) of the injectable drug. • Oral anti-nausea drugs: Medicare covers oral anti-nausea drugs you use as part of an anti-cancer chemotherapeutic regimen if they're administered before, at, or within 48 hours of chemotherapy or are used as a full therapeutic replacement for an intravenous anti-nausea drug • Certain oral End-Stage Renal Disease (ESRD) drugs covered under Medicare Part B. • Calcimimetic and phosphate-binder medications under the ESRD payment system, including the intravenous medication Parsabiv, and the oral medication Sensipar • Certain drugs for home dialysis, including heparin, the antidote for heparin, when medically necessary, and topical anesthetics • Erythropoiesis-stimulating agents: Medicare covers erythropoietin by injection if you have End-Stage Renal Disease (ESRD) or you need this drug to treat anemia related to certain other conditions [plans may delete any of the following drugs that aren't covered under our plan] (such as Epogen®, Procrit®, Retacrit®, Epoetin Alfa®, Aranesp®, Darbepoetin Alfa®, Mircera®, or Methoxy polyethylene glycol-epoetin beta)	

Covered Services	What you pay
• Intravenous Immune Globulin for the home treatment of primary immune deficiency diseases • Parenteral and enteral nutrition (intravenous and tube feeding) This link will take you to a list of Part B drugs that may be subject to Step Therapy: MyUniveraMedicare.com/Formulary	
Obesity screening and therapy to promote sustained weight loss If you have a body mass index of 30 or more, we cover intensive counseling to help you lose weight. This counseling is covered if you get it in a primary care setting, where it can be coordinated with your comprehensive prevention plan. Talk to your primary care doctor or practitioner to find out more.	**In-network:** There is no coinsurance, copayment, or deductible for preventive obesity screening and therapy. When services other than preventive are performed, the cost share (copayment/ coinsurance) associated with the other service will apply. **Out-of-network (POS):** 30% coinsurance. Our plan will reimburse a maximum of $1,500 for out-of-network (POS) services per calendar year.
Opioid Treatment Program Services Members of our plan with opioid use disorder (OUD) can get coverage of services to treat OUD through an Opioid Treatment program (OTP) which includes the following services: • U.S. Food and Drug Administration (FDA)-approved opioid agonist and antagonist medication-assisted treatment (MAT) medications. • Dispensing and administration of MAT medications (if applicable) • Substance use counseling • Individual and group therapy • Toxicology testing • Intake activities • Periodic assessments	**In-network:** 20% coinsurance for each Opioid Treatment Program visit. **Out-of-Network (POS):** 30% coinsurance for each Opioid Treatment Program visit. Our plan will reimburse a maximum of $1,500 for out-of-network (POS) services per calendar year.

Covered Services	What you pay
Outpatient diagnostic tests and therapeutic services and supplies Covered services include, but aren't limited to:	**Prior authorization is required for some services by your doctor or other network provider.**
• X-rays and Ultrasounds.	**In-network:** $40 copayment for each Medicare-covered standard x-ray and ultrasound. **Out-of-network (POS):** 30% coinsurance. Our plan will reimburse a maximum of $1,500 for out-of-network (POS) services per calendar year.
• Diagnostic Imaging (CT scan, MRI/ MRA, Myocardial Nuclear Perfusion Imaging and PET scans).	**In-network:** $150 copayment for each Medicare-covered service. This includes the cost of the imaging and any associated provider services. **Out-of-network (POS):** 30% coinsurance. Our plan will reimburse a maximum of $1,500 for out-of-network (POS) services per calendar year. This includes the cost of the imaging and any associated provider services.
• Radiation Therapy: radium and isotope therapy including technician materials and supplies.	**In-network:** 20% coinsurance for Medicare-covered radiation therapy. **Out-of-network (POS):** 30% coinsurance. Our plan will reimburse a maximum of $1,500 for out-of-network (POS) services per calendar year.
• Surgical supplies, such as dressings, splints, casts, and other devices used to reduce fractures and dislocations.	**In-network:** 20% coinsurance for each Medicare-covered item. **Out-of-network (POS):** 30% coinsurance. Our plan will reimburse a maximum of $1,500 for out-of-network (POS) services per calendar year.

Covered Services	What you pay
• Laboratory tests (outpatient).	**In-network:** $10 copayment for Medicare-covered lab tests. **Out-of-network (POS):** 30% coinsurance. Our plan will reimburse a maximum of $1,500 for out-of-network (POS) services per calendar year.
• Blood - including storage and administration. Coverage of whole blood and packed red cells begins with the first pint used.	**In-network:** $0 copayment for blood service. **Out-of-network (POS):** 30% coinsurance. Our plan will reimburse a maximum of $1,500 for out-of-network (POS) services per calendar year.
• Diagnositc non-laboratory tests such as CT scans, MRIs, EKGs, and PET scans when your doctor or other health care provider orders them to treat a medical problem.	**In-network:** $10 copayment for Medicare-covered non-radiological diagnostic tests. When services in addition to the diagnostic test are done during the visit, a $5 copayment for PCP or $35 copayment for Specialist will apply. **Out-of-network (POS):** 30% coinsurance. Our plan will reimburse a maximum of $1,500 for out-of-network (POS) services per calendar year.

Covered Services	What you pay
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 Medicare criteria and be considered reasonable and necessary. Observation services are covered only when provided by the order of a physician or another person 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're an outpatient and pay the cost sharing amounts for outpatient and pay the cost sharing amounts for outpatient hospital services. Even if you stay in the hospital overnight, you might still be considered an outpatient. If you aren't sure if you're an outpatient. If you aren't sure if you are an outpatient, ask the hospital staff. Get more information Medicare fact sheet Medicare Hospital Benefits. This fact sheet is available https://www.Medicare.gov/publications/11435-Medicare-Hospital-Benefits.pdf or by calling 1-800-MEDICARE (1-800-633-4227). TTY/TDD users call 1-877-486-2048.	**In-network:** $250 copayment for each outpatient hospital observation visit. **Out-of-Network (POS):** 30% coinsurance for each outpatient hospital observation visit. $1,500 for out-of-network (POS) services per calendar year.
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 aren't limited to:	**Prior authorization is required for some services by your doctor or other network provider.**

Covered Services	What you pay
• Services in an emergency department or outpatient clinic, such as observation services or outpatient surgery.	**In-network:** $115 copayment for each emergency care service. $5 copayment for PCP and/or $35 copayment for Specialist for each outpatient clinic visit. $250 copayment for each outpatient hospital and observation service. **Out-of-network (POS):** $115 copayment for each emergency service. 30% coinsurance for each outpatient clinic visit, outpatient hospital and observation service. Our plan will reimburse a maximum of $1,500 for out-of-network (POS) services per calendar year.
• Laboratory and diagnostic tests billed by the hospital	**In-network:** $10 copayment for Medicare-covered labs and non-radiological diagnostic tests. When additional services are done during the visit, a cost share (copayment/ coinsurance) associated with the other service will apply. **Out-of-network (POS):** 30% coinsurance per visit. Our plan will reimburse a maximum of $1,500 for out-of-network (POS) services per calendar year.
• Mental health care, including care in a partial-hospitalization program, if a doctor certifies that inpatient treatment would be required without it.	**In-network:** $0 copayment per Medicare-covered visit. **Out-of-network (POS):** 30% coinsurance per mental health visit. 30% coinsurance per partial hospitalization visit. Our plan will reimburse a maximum of $1,500 for out-of-network (POS) services per calendar year.
• X-rays.	**In-network:** $40 copayment for each Medicare-covered standard x-ray. **Out-of-network (POS):** 30% coinsurance. Our plan will reimburse a maximum of $1,500 for out-of-network (POS) services per calendar year.

Covered Services	What you pay
• Diagnostic Imaging (CT scan, MRI/MRA, Myocardial Nuclear Perfusion Imaging and PET scans).	**In-network:** $150 copayment for each Medicare-covered service. This includes the cost of the imaging and any associated provider services. **Out-of-network (POS):** 30% coinsurance. Our plan will reimburse a maximum of $1,500 for out-of-network (POS) services per calendar year.
• Radiation Therapy: radium and isotope therapy, including technician materials and services.	**In-network:** 20% coinsurance for each Medicare-covered radiation therapy. **Out-of-network (POS):** 30% coinsurance. Our plan will reimburse a maximum of $1,500 for out-of-network (POS) services per calendar year.
• Medical supplies such as splints and casts.	**In-network:** 20% coinsurance for Medicare-covered supplies. **Out-of-network (POS):** 30% coinsurance. Our plan will reimburse a maximum of $1,500 for out-of-network (POS) services per calendar year.
• Certain screenings and preventive services.	**In-network**: $0 copayment. When services other than preventive are performed, the cost share (copayment/ coinsurance) associated with the other service will apply. **Out-of-network (POS):** 30% coinsurance. Our plan will reimburse a maximum of $1,500 for out-of-network (POS) services per calendar year.
• Certain drugs and biologicals you can't give yourself.	**In-network:** 20% coinsurance for each Medicare-covered Part B drug. If a Part B drug is administered in the office or outpatient hospital setting, it is subject to 20% coinsurance in addition to the office/outpatient member liability. **Out-of-network (POS):** 30% coinsurance. Our plan will reimburse a maximum of $1,500 for out-of-network (POS) services per calendar year.

Covered Services	What you pay
Note: Unless the provider has written an order to admit you as an inpatient to the hospital, you're 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 aren't sure if you are an outpatient, ask the hospital staff.	
Outpatient mental health care Covered services include: Mental health services provided by a state-licensed psychiatrist or doctor, clinical psychologist, clinical social worker, clinical nurse specialist, licensed professional counselor (LPC), licensed marriage and family therapist (LMFT), nurse practitioner (NP), physician assistant (PA), or other Medicare-qualified mental health care professional as allowed under applicable state laws.	**Prior authorization is required for some services by your doctor or other network provider.** **In-network:** $0 copayment per Medicare-covered visit. **Out-of-network (POS):** 30% coinsurance per visit. Our plan will reimburse a maximum of $1,500 for out-of-network (POS) services per calendar year.
Outpatient rehabilitation services Covered services include physical therapy, occupational therapy, and speech language therapy. Outpatient rehabilitation services are provided in various outpatient settings, such as hospital outpatient departments, independent therapist offices, and Comprehensive Outpatient Rehabilitation Facilities (CORFs).	**In-network:** $35 copayment for each Medicare-covered therapy visit. **Prior authorization is required for some services by your doctor or other network provider.** **Out-of-network (POS):** 30% coinsurance. Our plan will reimburse a maximum of $1,500 for out-of-network (POS) services per calendar year.
Outpatient substance abuse services Covered services include diagnosis, establishment of a treatment plan, and follow-up care from a physician for substance abuse.	**In-network:** $0 copayment per Medicare-covered visit. **Out-of-network (POS):** 30% coinsurance per visit. Our plan will reimburse a maximum of $1,500 for out-of-network (POS) services per calendar year.

Covered Services	What you pay
Outpatient surgery, including services provided at hospital outpatient facilities and ambulatory surgical centers **Note:** If you're having surgery in a hospital facility, you should check with your provider about whether you'll be an inpatient or outpatient. Unless the provider writes an order to admit you as an inpatient to the hospital, you're an outpatient and pay the cost sharing amounts for outpatient surgery. Even if you stay in the hospital overnight, you might still be considered an outpatient.	**In-network:** $250 copayment per visit. **Prior authorization is required for some services by your doctor or other network provider.** **Out-of-network (POS):** 30% coinsurance per visit. Our plan will reimburse a maximum of $1,500 for out-of-network (POS) services per calendar year.

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

Covered Services	What you pay
Partial hospitalization services and Intensive outpatient services Partial hospitalization is a structured program of active psychiatric treatment provided as a hospital outpatient service, or by a community mental health center that's more intense than care you get in your doctor's, therapist's, licensed marriage and family therapist's (LMFT), or licensed professional counselor's office and is an alternative to inpatient hospitalization. Intensive outpatient service is a structured program of active behavioral (mental) health therapy treatment provided in a hospital outpatient department, a community mental health center, a federally qualified health center, or a rural health clinic that's more intense than care you get in your doctor's, therapist's, licensed marriage and family therapist's (LMFT), or licensed professional counselor's office but less intense than partial hospitalization.	**In-network**: 20% coinsurance per Medicare-covered visit. **Prior authorization is required for some services by your doctor or other network provider.** **Out-of-network (POS):** 30% coinsurance per visit. Our plan will reimburse a maximum of $1,500 for out-of-network (POS) services per calendar year.

Physician/Practitioner services, including doctor's office visits Covered services include:	
• Medically necessary medical care or surgery services you get in a physician's office, certified ambulatory surgical center, hospital outpatient department, or any other location. Consultation, diagnosis, and treatment by a specialist.	**In-network:** $5 copayment per visit for PCP and $35 copayment per visit for a Specialist office visit. $0 copayment for physician services in a certified ambulatory surgery center or hospital outpatient department. **Out-of-network (POS):** 30% coinsurance per other visits. Our plan will reimburse a maximum of $1,500 for out-of-network (POS) services per calendar year.
• Basic hearing and balance exams performed by your PCP or specialist, if your doctor orders it to see if you need medical treatment.	**In-network:** $5 copayment per visit for a PCP and $35 copayment per visit for a Specialist. **Out-of-network (POS):** 30% coinsurance per visit. Our plan will reimburse a maximum of $1,500 for out-of-network (POS) services per calendar year.

• Certain telehealth services, including Primary Care Physician services, Physician Specialist services, individual sessions for Mental Health Specialist and Psychiatric services, individual sessions for Outpatient Substance Abuse, Kidney Disease Education services and Diabetes Self-Management Training. ○ You have the option of getting these services either through an in-person visit or by telehealth. If you choose to receive one of these services by telehealth, then you must use a network provider who offers the service by telehealth. ○ Electronic exchange can be by smartphone, regular telephone, computer, or tablet and can include video. Please check with your provider for their preferred method.	**In-Network:** $5 copayment for each PCP telehealth visit. $35 copayment for each Specialist telehealth visit. $0 copayment for each Individual Session for Mental Health Specialty. $0 copayment for each Individual Session for Outpatient Substance Abuse. $0 copayment for each Kidney Disease Education Service. $0 copayment for each Diabetes Self-Management Training session. Univera Healthcare is also partnering with MDLIVE® to offer this service. MDLIVE® can connect you with a network doctor regardless of time or location. Please contact Customer Care for additional benefit details or visit medicare.univerahealthcare.com to register with MDLIVE®. $5 copayment for each MDLive visit. $35 copayment for each MDLive mental health visit. **Out-of-network (POS):** Not covered out-of-network.
• Some telehealth services including consultation, diagnosis, and treatment by a physician or practitioner for patients in certain rural areas or other locations approved by Medicare.	**In-Network:** $5 copayment for a PCP and $35 copayment for a Specialist per Medicare-covered visit for consultation, diagnosis and treatment. $0 copayment for Medicare qualified mental health consultations. **Out-of-network (POS):** 30% coinsurance per visit for a consultation, diagnosis and treatment by a specialist. Our plan will reimburse a maximum of $1,500 for out-of-network (POS) services per calendar year.

• Telehealth services for monthly end-stage renal disease related visits for home dialysis members in a hospital-based or critical access hospital-based renal dialysis center, renal dialysis facility, or the member's home. • Telehealth services for members with a substance use disorder or co-occurring mental health disorder, regardless of their location.	**In-network:** $5 copayment per visit for a PCP and $35 copayment per visit for a Specialist. **Out-of-network (POS):** 30% coinsurance per visit. Our plan will reimburse a maximum of $1,500 for out-of-network (POS) services per calendar year. **In-network:** $5 copayment per visit for a PCP and $35 copayment per visit for a Specialist. **Out-of-network (POS):** 30% coinsurance per visit. Our plan will reimburse a maximum of $1,500 for out-of-network (POS) services per calendar year.
• Telehealth services to diagnose, evaluate or treat symptoms of a stroke, regardless of your location.	**In-network:** $5 copayment per visit for a PCP and $35 copayment per visit for a Specialist. **Out-of-network (POS):** 30% coinsurance per visit. Our plan will reimburse a maximum of $1,500 for out-of-network (POS) services per calendar year.

• Telehealth services for diagnosis, evaluation, and treatment of mental health disorders if:
  ○ You have an in-person visit within 6 months prior to your first telehealth visit
  ○ You have an in-person visit every 12 months while getting these telehealth services
  ○ Exceptions can be made to the above for certain circumstances
• Telehealth services for mental health visits provided by Rural Health Clinics and Federally Qualified Health Centers
	In-network: $0 copayment per Medicare-covered visit.
	
	Out-of-network (POS): 30% coinsurance per visit. Our plan will reimburse a maximum of $1,500 for out-of-network (POS) services per calendar year.

• Virtual check-ins (for example, by phone or video chat) with your doctor for 5-10 minutes if: o You're not a new patient **and** o The check-in isn't related to an office visit in the past 7 days **and** o The check-in doesn't lead to an office visit within 24 hours or the soonest available appointment.	**In-network:** $5 copayment per visit for a PCP and $35 copayment per visit for a Specialist. **Out-of-network (POS):** 30% coinsurance per visit. Our plan will reimburse a maximum of $1,500 for out-of-network (POS) services per calendar year.
• Evaluation of video and/or images you send to your doctor, and interpretation and follow-up by your doctor within 24 hours **if**: o You're not a new patient **and** o The evaluation isn't related to an office visit in the past 7 days **and** o The evaluation doesn't lead to an office visit within 24 hours or the soonest available appointment.	**In-network:** $5 copayment per visit for a PCP and $35 copayment per visit for a Specialist. **Out-of-network (POS):** 30% coinsurance per visit. Our plan will reimburse a maximum of $1,500 for out-of-network (POS) services per calendar year.
• Consultation your doctor has with other doctors by phone, internet, or electronic health record	**In-network:** $5 copayment per consultation for a PCP and $35 copayment per consultation for a Specialist. **Out-of-network (POS):** 30% coinsurance per consultation. Our plan will reimburse a maximum of $1,500 for out-of-network (POS) services per calendar year.
• Second opinion by another network provider prior to surgery.	**In-network**: $5 copayment per visit for a PCP and $35 copayment per visit for a Specialist. **Out-of-network (POS):** 30% coinsurance per visit. Our plan will reimburse a maximum of $1,500 for out-of-network (POS) services per calendar year.
Podiatry services Covered services include: • Diagnosis and the medical or surgical treatment of injuries and diseases of the feet (such as hammer toe or heel spurs). • Routine foot care for members with certain medical conditions affecting the lower limbs.	**In-network:** $35 copayment per Medicare-covered visit. **Out-of-network (POS):** 30% coinsurance per visit. Our plan will reimburse a maximum of $1,500 for out-of-network (POS) services per calendar year.

Pre-exposure prophylaxis (PrEP) for HIV prevention If you don't have HIV, but your doctor or other health care practioner determines you're at an increased risk for HIV, we cover pre-exposure prophylaxis (PrEP) medication and related services. If you quality, covered services include: • FDA-approved oral or injectable PrEP medication. If you're getting an injectable drug, we also cover the fee for injecting the drug. • Up to 8 individual counseling sessions (including HIV risk assessment, HIV risk reduction, and medication adherence) every 12 months. • Up to 8 HIV screenings every 12 months. A one time hepatitis B virus screening.	There is no coinsurance, copayment, or deductible for the PrEP benefit.
Prostate cancer screening exams For members aged 50 and older, covered services include the following once every 12 months: • Digital rectal exam • Prostate Specific Antigen (PSA) test	**In-network:** There is no coinsurance, copayment, or deductible for an annual PSA test or Digital rectal exam. When services other than preventive are performed, the cost share (copayment/ coinsurance) associated with the other service will apply. **Out-of-network (POS):** 30% coinsurance per visit. Our plan will reimburse a maximum of $1,500 for out-of-network (POS) services per calendar year.

Prosthetic and orthotic devices and related supplies Devices (other than dental) that replace all or part of a body part or function. These include but aren't limited to testing, fitting, or training in the use of prosthetic and orthotic devices; as well as: colostomy bags and supplies directly related to colostomy care, pacemakers, braces, prosthetic shoes, artificial limbs, and breast prostheses (including a surgical brassiere after a mastectomy). Includes certain supplies related to prosthetic and orthotic devices, and repair and/or replacement of prosthetic and orthotic devices. Also includes some coverage following cataract removal or cataract surgery – go to Vision Care later in this table for more detail.	**In-network:** 20% coinsurance for each Medicare-covered prosthetic device and related supplies. **Prior authorization is required for some services by your doctor or other network provider.** **Out-of-network (POS):** 30% coinsurance. Our plan will reimburse a maximum of $1,500 for out-of-network (POS) services per calendar year..
Pulmonary rehabilitation services Comprehensive programs of pulmonary rehabilitation are covered for members who have moderate to very severe chronic obstructive pulmonary disease (COPD) and an order for pulmonary rehabilitation from the doctor treating the chronic respiratory disease.	**In-network:** $15 copayment per Medicare-covered visit. **Out-of-network (POS):** 30% coinsurance. Our plan will reimburse a maximum of $1,500 for out-of-network (POS) services per calendar year.
 **Screening and counseling to reduce alcohol misuse** We cover one alcohol misuse screening for adults (including pregnant members) who misuse alcohol but aren't alcohol dependent. If you screen positive for alcohol misuse, you can get up to 4 brief face-to-face counseling sessions per year (if you're competent and alert during counseling) provided by a qualified primary care doctor or practitioner in a primary care setting.	**In-network:** There is no coinsurance, copayment, or deductible for the Medicare-covered screening and counseling to reduce alcohol misuse preventive benefit. When services other than preventive are performed, the cost share (copayment/ coinsurance) associated with the other service will apply. **Out-of-network (POS):** 30% coinsurance. Our plan will reimburse a maximum of $1,500 for out-of-network (POS) services per calendar year.

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

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

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

In-network: There is no coinsurance, copayment, or deductible for the Medicare-covered counseling and shared decision-making visit or for the LDCT.

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

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

Out-of-network (POS): 30% coinsurance.TOur plan will reimburse a maximum of $1,500 for out-of-network (POS) services per calendar year.

Screening for Hepatitis C Virus infection We cover one Hepatitis C screening if your primary care doctor or other qualified health care provider orders one and you meet one of these conditions: • You're at high risk because you use or have used illicit injection drugs. • You had a blood transfusion before 1992. • You were born between 1945-1965. If you were born between 1945-1965 and aren't considered high risk, we pay for a screening once. If you're at high risk (for example, you've continued to use illicit injection drugs since your previous negative Hepatitis C screening test), we cover yearly screenings.	**In-network:** There is no coinsurance, copayment, or deductible for the Medicare-covered screening for the Hepatitis C Virus. **Out-of-network (POS):** 30% coinsurance. Our plan will reimburse a maximum of $1,500 for out-of-network (POS) services per calendar year.
Screening for sexually transmitted infections (STIs) and counseling to prevent STIs We cover sexually transmitted infection (STI) screenings for chlamydia, gonorrhea, syphilis, and Hepatitis B. These screenings are covered for pregnant members and for certain people who are at increased risk for an STI when the tests are ordered by a primary care provider. We cover these tests once every 12 months or at certain times during pregnancy. We also cover up to 2 individual 20 to 30 minute, face-to-face high-intensity behavioral counseling sessions each year for sexually active adults at increased risk for STIs. We only cover these counseling sessions as a preventive service if they are provided by a primary care provider and take place in a primary care setting, such as a doctor's office.	**In-network:** There is no coinsurance, copayment, or deductible for the Medicare-covered screening for STIs and counseling to prevent STIs preventive benefit. When services other than preventive are performed, the cost share (copayment/ coinsurance) associated with the other service will apply. **Out-of-network (POS):** 30% coinsurance. Our plan will reimburse a maximum of $1,500 for out-of-network (POS) services per calendar year.

Services to treat kidney disease	
Covered services include:	**Prior authorization is required for some services by your doctor or other network provider.**
• 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 6 sessions of kidney disease education services per lifetime.	**In-network:** There is no copayment, coinsurance, or deductible for kidney disease education. When services other than preventive are performed, the cost share (copayment/ coinsurance) associated with the other service will apply. **Out-of-network:** 30% coinsurance for kidney disease education. Our plan will reimburse a maximum of $1,500 for out-of-network (POS) services per calendar year.
• Outpatient dialysis treatments (including dialysis treatments when temporarily out of the service area, as explained in Chapter 3)	**In-network & Out-of-network:** 20% coinsurance for each Medicare-covered dialysis treatment performed as an outpatient service.
• Inpatient dialysis treatments (if you're admitted as an inpatient to a hospital for special care)	**In-network:** $260 copayment per day for days 1 through 5 for covered hospital care. Thereafter, you pay a $0 copayment for additional Medicare-covered days during your hospital admission Copayment applies on the date of hospital admission. Cost share is applied per hospital admission. **Out-of-network (POS):** 30% coinsurance for inpatient dialysis treatment. Our plan will reimburse a maximum of $1,500 for out-of-network (POS) services per calendar year.

• Self-dialysis training (includes training for you and anyone helping you with your home dialysis treatments)	**In-network:** $5 copayment per visit for a PCP and $35 copayment per visit for a Specialist. **Out-of-network (POS):** 30% coinsurance for self-dialysis training. Our plan will reimburse a maximum of $1,500 for out-of-network (POS) services per calendar year.
• Home dialysis equipment and supplies	**In-network:** 20% coinsurance for home dialysis equipment and supplies. **Out-of-network (POS):** 30% coinsurance. Our plan will reimburse a maximum of $1,500 for out-of-network (POS) services per calendar year.
• Certain home support services (such as, when necessary, visits by trained dialysis workers to check on your home dialysis, to help in emergencies, and check your dialysis equipment and water supply) Certain drugs for dialysis are covered under Medicare Part B. For information about coverage for Part B Drugs, go to the section, Medicare Part B drugs in this table.	**In-network:** $0 copayment for Medicare-covered home support services. When services other than those listed under home support services are performed, the cost share (copayment/ coinsurance) associated with the other service will apply. **Out-of-network (POS):** 30% coinsurance for home support services. Our plan will reimburse a maximum of $1,500 for out-of-network (POS) services per calendar year.

Skilled nursing facility (SNF) care (For a definition of skilled nursing facility care, go to Chapter 12. Skilled nursing facilities are sometimes called SNFs.) Covered for up to 100 days when admitted by your doctor or other network provider. Covered services include but aren't limited to: • Semiprivate room (or a private room if medically necessary) • Meals, including special diets • Skilled nursing services	**In-network:** Days 1-20: $0 copayment per day. Days 21-100: $218 Copayment per day. **Prior authorization is required for some services by your doctor or other network provider.** **Out-of-network (POS):** 30% coinsurance. Our plan will reimburse a maximum of $1,500 for out-of-network (POS) services per calendar year. Covered up to 100 days per benefit period. A benefit period begins the day you go into a skilled nursing facility. The benefit period ends when you haven't received any inpatient hospital care (or skilled care in a SNF) for 60 days in a row. If you go into a skilled nursing facility after one benefit period has ended, a new benefit period begins. There is no limit to the number of benefit periods.

• Physical therapy, occupational therapy, and speech therapy • Drugs administered to you as part of our plan of care (this includes substances that are naturally present in the body, such as blood clotting factors.) • Blood - including storage and administration. Coverage of whole blood and packed red cells begins with the first pint used. • Medical and surgical supplies ordinarily provided by SNFs • Laboratory tests ordinarily provided by SNFs • X-rays and other radiology services ordinarily provided by SNFs • Use of appliances such as wheelchairs ordinarily provided by SNFs • Physician/Practitioner services Generally, you get SNF care from network facilities. Under certain conditions listed below, you may be able to pay in-network cost sharing for a facility that isn't a network provider, if the facility accepts our plan's amounts for payment. • A nursing home or continuing care retirement community where you were living right before you went to the hospital (as long as it provides skilled nursing facility care). • A SNF where your spouse or domestic partner is living at the time you leave the hospital.	Copayment is not waived when member is discharged from acute hospital and admitted to a SNF. This includes SNF to SNF.

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

Smoking and tobacco use cessation counseling is covered for outpatient and hospitalized patient who meet these criteria:

- Use tobacco, regardless of whether they exhibit signs or symptoms of tobacco related disease.
- Are competent and alert during counseling.
- A qualified physician or other Medicare-recognized practitioner provides counseling.

We cover 2 cessation attempts per year (each attempt may include a maximum of 4 intermediate or intensive sessions with the patient getting up to 8 sessions per year).

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

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

Out-of-network (POS): 30% coinsurance. Our plan will reimburse a maximum of $1,500 for out-of-network (POS) services per calendar year.

Supervised Exercise Therapy (SET) SET is covered for members who have symptomatic peripheral artery disease (PAD) and a referral for PAD from the physician responsible for PAD treatment. Up to 36 sessions over a 12-week period are covered if the SET program requirements are met. The SET program must: • Consist of sessions lasting 30-60 minutes, comprising a therapeutic exercise-training program for PAD in patients with claudication • Be conducted in a hospital outpatient setting or a physician's office • Be delivered by qualified auxiliary personnel necessary to ensure benefits exceed harms, and who are trained in exercise therapy for PAD • Be under the direct supervision of a physician, physician assistant, or nurse practitioner/clinical nurse specialist who must be trained in both basic and advanced life support techniques SET may be covered beyond 36 sessions over 12 weeks for an additional 36 sessions over an extended period of time if deemed medically necessary by a health care provider.	**In-network:** $15 copayment per Medicare-covered visit. **Out-of-network (POS):** 30% coinsurance. Our plan will reimburse a maximum of $1,500 for out-of-network (POS) services per calendar year.

Routine Transportation We cover up to 12 one-way trips per calendar year to take you to and from health-related locations such as in-patient facilities and medical centers provided by our designated transportation provider. Rides may be provided by rideshare services, vans, and non-emergency medical transport as determined by our transportation partner, SafeRide Health. To schedule a ride or find out how many rides you have left for the year (ride balance), please call 1-888-617-0270 (TTY/ TDD 711), Monday-Saturday 8a.m.-8p.m. There is a voicemail messaging system for members to leave messages outside of business hours. Rides must be scheduled at least two hours before your pick-up time. You must cancel rides a least 3 hours before the scheduled pick-up time. If not, the ride will be deducted from your annual ride balance.	**In-network:** $0 copayment The transportation benefit includes 12 one-way trips per year up to 50 miles maximum per trip. **Out-of-network (POS):** Not covered.
Urgently needed services A plan-covered service requiring immediate medical attention that's not an emergency is an urgently needed service if either you're temporarily outside our plan's service area, or even if you're inside our plan's service area, it's unreasonable given your time, place, and circumstances to get this service from network providers. Our plan must cover urgently needed services and only charge you in-network cost sharing. Examples of urgently needed services are unforeseen medical illnesses and injuries, or unexpected flare-ups of existing conditions. Medically necessary routine provider visits, (like annual checkups), aren't considered urgently needed even if you're outside out plan's service area or our plan network is temporarily unavailable.	**In-network and Out-of-network:** $50 copayment per visit for covered services to a medical facility or urgent care center. Services received in an emergency department of a hospital are subject to a $115 copayment per emergency room visit. You are covered worldwide for urgently needed care. Cost sharing for necessary urgently needed services furnished out-of-network is the same as for such services furnished in-network.

Vision care

Covered services include:

• Outpatient physician services for the diagnosis and treatment of diseases and injuries of the eye, including treatment for age-related macular degeneration. Original Medicare doesn't cover routine eye exams (eye refractions) for eyeglasses/contacts.	**In-network:** $0 copayment per Medicare-covered visit. If a Part B drug is administered during your visit, it may be subject to a 20% coinsurance. **Out-of-network (POS):** 30% coinsurance. Our plan will reimburse a maximum of $1,500 for out-of-network (POS) services per calendar year.
• For people who are at high risk for glaucoma, we 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.	**In-network:** $0 copayment per Medicare-covered glaucoma screening. When services other than preventive are performed, the cost share (copayment/ coinsurance) associated with the other service will apply. **Out-of-network (POS):** 30% coinsurance. Our plan will reimburse a maximum of $1,500 for out-of-network (POS) services per calendar year.
• For people with diabetes, screening for diabetic retinopathy is covered once per year.	**In-network:** $0 copayment for Medicare-covered diabetic retinopathy screening. **Out-of-network (POS):** 30% coinsurance. Our plan will reimburse a maximum of $1,500 for out-of-network (POS) services per calendar year.
• One pair of eyeglasses or contact lenses after each cataract surgery that includes insertion of an intraocular lens (If you have 2 separate cataract operations, you can't reserve the benefit after the first surgery and purchase 2 eyeglasses after the second surgery.)	**In-network:** $35 copayment for one pair of Medicare-covered standard glasses or contacts after each cataract surgery. **Out-of-network (POS):** 30% coinsurance for one pair of Medicare-covered standard glasses or contacts after each cataract surgery. Our plan will reimburse a maximum of $1,500 for out-of-network (POS) services per calendar year.

• Routine eye examinations covered once per calendar year.	**In-network:** $0 copayment per visit. **Out-of-network (POS):** Not covered for one pair of Medicare-covered standard glasses or contacts after each cataract surgery. The plan will reimburse a maximum of $1,500 for out-of-network (POS) services per calendar year.
• Reimbursement towards the purchase of eyeglasses or contact lenses. You may choose to see any provider licensed to perform these services.	**In-network and Out-of-network:** We will provide reimbursement for up to $250 allowance every calendar year.
Welcome to Medicare Preventive Visit Our 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 preventive services you need (including certain screenings and shots), and referrals for other care if needed. **Important:** We cover the Welcome to Medicare preventive visit only within the first 12 months you have Medicare Part B. When you make your appointment, let your doctor's office know you want to schedule your Welcome to Medicare preventive visit.	**In-network:** There is no coinsurance, copayment, or deductible for the Welcome to Medicare preventive visit. When services other than preventive are performed, the cost share (copayment/ coinsurance) associated with the other service will apply. **Out-of-network (POS):** 30% coinsurance. Our plan will reimburse a maximum of $1,500 for out-of-network (POS) services per calendar year.

SECTION 3 Services that aren't covered by our plan (exclusions)

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

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

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

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

Services not covered by Medicare	Covered only under specific conditions
Adaptive equipment Structural modifications such as ramps, doorways, stair lifts, and elevators including stairway elevators	Not covered under any condition.
Assistive listening devices Such as telephone amplifiers, alerting devices.	Not covered under any condition.
Auditory Osseointegrated Implant (AOI) Bone Conduction Hearing Device	Not covered under any condition.
Autopsy and Necropsy Including but not limited to gross, complete, limited, forensic, and coroner's autopsy	Not covered under any condition.
Biofeedback Including psychiatric therapy with biofeedback	Except when it is covered under Original Medicare
Birth Control Methods Including but not limited to prophylactic products such as condoms, IUDs and implantation of IUDs, injectables given by a provider, contraceptive implants, and hormone patches	Not covered under any condition.
Care provided in conjunction with an ambulance call when no transport is provided. Ambulance service is a transport benefit, and it is only payable when you're transported to a hospital. If an ambulance is called and you received care, but decide not to be transported to a hospital, we do not cover those services	Not covered under any condition.
Cellular therapy	Not covered under any condition.
Chiropractic therapy	Not covered other than manual manipulation of the spine consistent with Medicare coverage guidelines
Cosmetic surgery or procedures	Covered in cases of an accidental injury or for improvement of the functioning of a malformed body member

Services not covered by Medicare	Covered only under specific conditions
	Covered for all stages of reconstruction for a breast after a mastectomy, as well as for the unaffected breast to produce a symmetrical appearance
Concierge Care	Not covered under any condition.
Convenience items Including but not limited to, air or water purifiers, refrigerators, HEPA filters, humidifiers, portable room heaters, air conditioners, bathtub lifts, bathtub seats, bed-lounges (power or manual), carafes, emesis basins, massage devices, over-bed tables, whirlpool pumps (standard and portable), sauna baths, standing tables, toilet lifts, and raised toilet seats	Not covered under any condition.
Custodial Care Personal care that does not require the continuing attention of trained medical or paramedical personnel. This is provided in a nursing home, hospice, or other facility setting and includes care that helps you with activities of daily living, such as bathing and dressing.	Not covered under any condition.
Durable medical equipment items Including but not limited to: bed baths (home type), bed lifters, bed boards, blood glucose analyzers (Reflectance Colorimeter), braille Teaching Texts, catheters, crutch substitute- lower leg platform with or without wheels, diathermy machines (standard pulses wave types), disposable sheets and bags, electrical stimulation for wounds, esophageal dilators, fabric support or support hose, face masks (surgical), grab bars, heat and massage foam cushion pads, heating and cooling plants, incontinent pads,	Not covered under any condition.

Services not covered by Medicare	Covered only under specific conditions
oscillating beds, paraffin bath units (standard), parallel bars, preset portable oxygen units, pulse tachometers, speech teaching machines, surgical stockings, elastic (Jobst) stockings, white canes and wigs.	
Elective or voluntary enhancement procedures or services including but not limited to, hair growth, sexual performance, athletic performance, and anti-aging	Not covered under any condition.
Emergency Communication Systems Personal Emergency Response System (PERS), in-home device to notify appropriate personnel of an emergency (e.g., a fall), or telephone alert systems	Not covered under any condition.
Exercise Equipment Including but not limited to passive motion devices, treadmills, and bicycles.	Not covered under any condition.
Experimental medical and surgical procedures, equipment and medications. Experimental procedures and items are those items and procedures determined by Original Medicare to not be generally accepted by the medical community. Including but not limited to thermogenic therapy, electro sleep therapy, transcendental meditation, intravenous histamine therapy, transillumination light scanning, diaphanography.	May be covered by Original Medicare under a Medicare-approved clinical research study or by our plan. Go to Chapter 3, Section 5 for more information on clinical research studies. We have a department of physicians and nurses who, along with a committee of regional board-certified physicians, determine medical policy and coverage of new technology and medical procedures. We use a variety of sources, such as the Food and Drug Administration (FDA), clinical practice guidelines, and peer-reviewed professional journals, in researching new technologies. Our medical policy

Services not covered by Medicare	Covered only under specific conditions
	department will only allow new technology to become a part of our benefit package after it has been thoroughly investigated and determined to be safe and effective.
Fees charged for care by your immediate relatives or members of your household	Not covered under any condition.
Food Allergy testing and treatment	Not covered under any condition.
Full-time nursing care in your home	Not covered under any condition.
Gradient Compression Stockings and Garments	Compression Sleeves/Stockings are covered with a diagnosis for Venus Stasis Ulcers (dx I87.2, I87.303), procedure codes A6531, A6532 or A6545. Members are allowed 2 pair/ year or if condition changes. Compression garments are also covered with a diagnosis of Lymphedema (dx 189.0), procedure codes A6552, A6554 and A6583. Members are allowed 3 daytime garments per affected body part every 6 months, 2 nighttime garments per affected body part every 2 years. See Surgical Supplies under **Outpatient diagnostic tests and therapeutic services and supplies** section of the Medical Benefits Chart in Chapter 4, Section 2.1 for information.
Group Health Plan Items or services for which payment can reasonably be made under a group health plan under which the beneficiary may have coverage	Not covered under any condition.
Hearing aids and provider visits to service hearing aids (except as specifically described in the Covered Benefits), ear molds, hearing aid accessories, warranty claim fees, and	See Hearing Services section of the Medical Benefits Chart in Chapter 4, Section 2.1 for information on what is covered.

Services not covered by Medicare	Covered only under specific conditions
hearing aid batteries (beyond the 80 free batteries per non-rechargeable aid purchased). Over-the-counter hearing aids are not covered under your hearing benefit.	
Home-delivered meals	See "Meals – Post Discharge" section of the Medical Benefits Chart in Chapter 4.
Homemaker services Including household assistance, including light housekeeping or light meal preparation	Not covered under any condition.
Hormone replacement therapy including but not limited to pellet implantation and bioidenticals for purposes of combating aging and/or improving sexual function	Not covered under any condition.
Initial evaluations, X-rays, labs, evaluation and management codes, maintenance and therapeutic therapy, and other services at the chiropractor's office	Not covered under any condition.
Items and services furnished by a nongovernmental provider, physician, or supplier if the charges have been paid for by a government program other than Medicare. Examples of this governmental entity exclusion includes but not limited to State Veterans Homes, state and local psychiatric hospitals for individuals committed under penal statute, prisoners (since generally a state or local government has custody of a Medicare beneficiary under a penal statute has a financial obligation to pay for the cost of healthcare items and services), and vocational rehabilitation (VR) agencies.	Not covered under any condition.
Items or services which are required because of war, or of an act of war, occurring after the	Not covered under any condition.

Services not covered by Medicare	Covered only under specific conditions
effective date of the patient's current entitlement date are not covered	
Items purchased outside of the U.S. Including but not limited to prescription drugs, durable medical equipment, prosthetics, and orthotics.	Not covered under any condition.
Lifeline Screening (as named and marketed by Lifeline Screening at its website lifelinescreening.com) and any similar service. No exception will be made for the Abdominal Aortic Aneurysm screening. Please refer to the Medical Benefit Chart in this chapter for the preventive service that Medicare covers, which are noted with an apple	Not covered under any condition.
Massage Therapy	Not covered under any condition.
Medicare-covered Part D self-administered drugs provided in an outpatient setting such as an outpatient hospital, ER room or physician office.	Not covered under any condition.
Mileage for ambulance transport beyond nearest facility or to/from facility preferred by member and/or family	Not covered under any condition.
Naturopath and homeopath services Uses natural or alternative treatments	Not covered under any condition.
Nonconventional intraocular lenses (IOLs) following cataract surgery lenses which correct your vision and replace your need to wear glasses	Except for the portion of the hospital outpatient or physician charges equal to the charge for insertion of a conventional intraocular lens (standard, non-vision correcting lenses). The laser assisted portion of a cataract surgery is excluded.
Non-routine dental care and routine dental care Such as cleanings or filings. Dental splints, dental prostheses, dentures, or any dental treatment for teeth, gums, or jaw, periodontal cleaning, and	Please see the benefit chart in chapter 4 for coverage details and exclusions.

Services not covered by Medicare	Covered only under specific conditions
dental treatment related to Temporomandibular Disorders (TMD).	
Orthopedic shoes Or supportive devices for the feet	Shoes are part of a leg brace and are included in the cost of the brace. Orthopedic or therapeutic shoes for people with diabetic foot disease
Over the counter (OTC) items	See "Over the counter (OTC) Items" section of the Medical Benefits Chart in Chapter 4, Section 2.1 for information. OTC items not included in the catalog are not covered under any condition.
Paramedic Intercept-advanced life support (ALS) services billed separately from the transporting ambulance provider.	Except for rural areas where paramedic intercept services are allowed by law when a voluntary ambulance service cannot bill for transportation
Personal items in your room At the hospital or a skilled nursing facility, including but not limited to a telephone or a television	Not covered under any condition.
Personal trainers or exercise coaches for in-home sessions.	Not covered under any condition.
Physical exams and other services Such as sleep studies or drug testing (1) only required for obtaining or maintaining employment or participation in employee programs, (2) only required for insurance or licensing, (3) requested sports physicals, or (4) on court order or required for parole or probation.	Not covered under any condition.
Private duty nurses	Not covered under any condition.
Private room in a hospital	Covered only when medically necessary
Residential Treatment To prevent the reoccurrence of a condition such as, but not limited to eating disorder, alcohol addiction etc.	Not covered under any condition.
Reversal of sterilization procedures	Not covered under any condition.

Services not covered by Medicare	Covered only under specific conditions
And/or non-prescription contraceptive supplies	
Routine eye examinations, eyeglasses, radial keratotomy, LASIK surgery, refractive keratoplasty and other low vision aids. In most cases polarized lenses are excluded. Safety glasses are excluded. The laser assisted portion of a cataract surgery is excluded.	One pair of eyeglasses with standard frames (or one set of contact lenses) covered after each cataract surgery that implants an intraocular lens. Eye exam and one pair of eyeglasses (lenses and frames) or contact lenses are covered for people after cataract surgery. One routine eye exam is covered per year. You receive a $250 allowance every calendar year allowance per calendar year towards routine eyewear or contact lenses.
Routine foot care - The cutting or removal of corns and calluses; -The trimming, cutting, clipping, or debriding of nails; and - Other hygienic and preventive maintenance care, such as cleaning and soaking the feet, and any other service performed in the absence of localized illness, injury, or symptoms involving the foot	Some limited coverage provided according to Medicare guidelines, e.g., if you have diabetes.
Routine hearing exams, hearing aids, or exams to fit hearing aids.	See Hearing Services section of the Medical Benefits Chart in Chapter 4, Section 2.1 for more information.
Sanctioned or excluded providers Items or services furnished, ordered, or prescribed by any provider listed or identified on any of the following lists or databases: The U.S. Department of Health & Human Services Office of Inspector List of Excluded Individuals and Entities (LEIE), the U.S General Services Administration Excluded Parties List System (EPLS), the U.S Department of Treasury Office of Foreign Assets Control Specially Designated Nationals (SDN) List, or on	Not covered under any condition.

Services not covered by Medicare	Covered only under specific conditions
any individual state provider exclusion or sanction list or database including, but not limited to, state Office of Medicaid Inspector exclusion lists.	
Services not approved by the Federal Food and Drug Administration (FDA). Drugs, supplements, tests, vaccines, devices, radioactive material, and any other items/services that by law requires FDA approval to be sold in the U.S. but are not approved by the FDA. This exclusion applies to services provided anywhere, even outside of the U.S. It does not apply to Medicare-covered clinical trials or emergency/urgent care you receive outside the U.S.	Not covered under any condition.
Services considered not reasonable and necessary, according to Original Medicare standards	Not covered under any condition.
Services provided to veterans in Veterans Affairs (VA) facilities.	When emergency services are received at VA hospital and the VA cost sharing is more than the cost sharing under our plan, we will reimburse veterans for the difference. Members are still responsible for our cost sharing amounts.
Supportive devices for the feet Such as custom-molded orthotics or removable shoe inserts	Except for orthopedic or therapeutic shoes for people with diabetic foot disease
Surgery that is performed to alter or reshape normal structures of the body to improve appearance	Not covered under any condition.
Surgical treatment for morbid obesity	Except when it is considered medically necessary and covered under Original Medicare
Third Party insurance coverage	Not covered under any condition.

Services not covered by Medicare	Covered only under specific conditions
Services provided under another plan for which other coverage is required by federal, state, or local law to be purchased or provided through other arrangements. Examples include but not limited to Workers' Compensation, medical payment coverage under no-fault or underinsured automobile insurance, or coverage required under similar legislation.	
Transportation by commercial or private air transport, car, bus, gurney van, wheelchair van, and any other type of transportation, even if it is the only way to travel to a network provider. If you choose to use an ambulance when it is not a Medicare-covered service, you will be responsible for the entire cost. Wheelchair van (chair car) transportation is not covered even if provided by an ambulance company	Not covered under any condition.
Treatment or services rendered by, or at the direction, of a provider of health care services who is not licensed to provide the services, or who is not operating within the scope of the license	Not covered under any condition.
Treatment for the sole purpose of inducing pregnancy including, but not limited to in vitro fertilization, gamete intrafallopian transfers, zygote intrafallopian transfers, collection; transportation; or preservation of sperm, sperm banking, pharmaceuticals related to treatment of infertility. Cloning or any service incident to cloning	Not covered under any condition.
Vaccinations or inoculations that are not covered under Part B Medicare	Not all vaccinations or inoculations are covered, see Chapter 4 Medical Benefit Chart, under Immunizations.

Services not covered by Medicare	Covered only under specific conditions
Vision aids Such as handheld low vision aids and other non-spectacle mounted aids	Not covered under any condition.
Weight-loss treatment including but not limited to medications, self-help groups, non-Medicare covered weight loss programs, meal programs and dietary supplements	Not covered under any condition.

CHAPTER 5

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

SECTION 1 Situations when you should ask us to pay our share for covered services

Sometimes when you get medical care, you may need to pay the full cost. Other times, you may pay more than you expected under the coverage rules of our plan, or you may get a bill from a provider. In these cases, you can ask our plan to pay you back (reimburse you). It's your right to be paid back by our plan whenever you've paid more than your share of the cost for medical services covered by our plan. There may be deadlines that you must meet to get paid back. Go to Section 2 of this chapter.

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

Examples of situations in which you may need to ask our plan to pay you back or to pay a bill you got:

1. **When you got medical care from a provider who isn't in our plan's network**

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

   - Emergency providers are legally required to provide emergency care. You're only responsible for paying your share of the cost for emergency or urgently needed services. If you pay the entire amount yourself at the time you get the care, ask us to pay you back for our share of the cost. Send us the bill, along with documentation of any payments you made.
   - You may get a bill from the provider asking for payment you think you don't owe. Send us this bill, along with documentation of any payments you already made.
     - If the provider is owed anything, we'll pay the provider directly.
     - If you already paid more than your share of the cost of the service, we'll determine how much you owed and pay you back for our share of the cost.
   - 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 can't pay a provider who is not eligible to participate in Medicare. If the provider is not eligible to participate in Medicare, you'll be responsible for the full cost of the services you got.

2. **When a network provider sends you a bill you think you shouldn't pay**

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

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

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

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

3. If you're retroactively enrolled in our plan

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

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

When you send us a request for payment, we'll review your request and decide whether the service should be covered. This is called making a coverage decision. If we decide it should be covered, we'll pay for our share of the cost for the service. If we deny your request for payment, you can appeal our decision. Chapter 7 has information about how to make an appeal.

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

You can ask us to pay you back by sending us a request in writing. If you send a request in writing, send your bill and documentation of any payment you've made. It's a good idea to make a copy of your bill and receipts for your records.

To make sure you're 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'll help us process the information faster. **You must submit your Part C (medical) claim to us within 12 months** of the date you received the service, item, or Part B drug.
- Download a copy of the form from our website (medicare.univerahealthcare.com) or call Customer Care at 1-877-883-9577 (TTY users call 711) and ask for the form.

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

For Medical and Dental Services claims
Univera Healthcare
PO Box 211256, Eagan, MN 55121

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

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

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

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

Section 3.1 If we tell you that we won't pay for all or part of the medical care, you can make an appeal

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

CHAPTER 6

Your rights and responsibilities

SECTION 1 Our plan must honor your rights and cultural sensitivities

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

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

Our plan has free interpreter services available to answer questions from non-English speaking members. We can also give you materials in braille, in large print, or other alternate formats at no cost if you need it. We're required to give you information about our plan's benefits in a format that's accessible and appropriate for you. To get information from us in a way that works for you, call Customer Care at 1-877-883-9577 (TTY users call 711).

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

If you have any trouble getting information from our plan in a format that's accessible and appropriate for you, seeing a women's health specialist or finding a network specialist, call to file a grievance with Customer Care at 1-877-883-9577 (TTY users call 711). You can also file a complaint with Medicare by calling 1-800-MEDICARE (1-800-633-4227) or directly with the Office for Civil Rights 1-800-368-1019 or TTY/TDD 1-800-537-7697.

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

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

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

If you think you aren't getting your medical care within a reasonable amount of time, Chapter 7 tells what you can do.

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

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

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

How do we protect the privacy of your health information

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

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

You have the right to look at your medical records held by our plan, and to get a copy of your records. We're 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'll 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 aren't routine.

If you have questions or concerns about the privacy of your personal health information, call Customer Care at 1-877-883-9577 (TTY users call 711).

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

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

If you want any of the following kinds of information, call Customer Care at 1-877-883-9577 (TTY users call 711):

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

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

Section 1.5 You have the right to know your treatment options and participate in decisions about your care

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

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

- **To know about all your choices.** You have the right to be told about all treatment options recommended for your condition, no matter what they cost or whether they're covered by our plan. It also includes being told about programs our plan offers to help members manage their medications and use drugs safely.
- **To know about the risks.** You have the right to be told about any risks involved in your care. You must be told in advance if any proposed medical care or treatment is part of a research experiment. You always have the choice to refuse any experimental treatments.
- **The right to say "no."** You have the right to refuse any recommended treatment. This includes the right to leave a hospital or other medical facility, even if your doctor advises you not to leave. You also have the right to stop taking your medication. If you refuse treatment or stop taking medication, you accept full responsibility for what happens to your body as a result.
- **The right to participate in developing your care plan.** You have the right to work with your provider and health care team to develop mutually agreed-upon treatment goals, to the degree possible. Tell your provider what you are, or are not, willing or able to do as part of your plan of care.

You have the right to give instructions about what's to be done if you can't 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're in this situation. This means, *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.

Legal documents you can use to give directions in advance in these situations are called "**advance directives**". Documents like a "**living will**" and "**power of attorney for health care**" are examples of advance directives.

How to set up an "advance directive" to give instructions:

- **Get a form.** You can get an advance directive form from your lawyer, a social worker, or some office supply stores. You can sometimes get advance directive forms from organizations that give people information about Medicare. You can also call Customer Care at 1-877-883-9577 (TTY users call 711), to ask for the forms.
- **Fill out the form and sign it.** No matter where you get this form, it's a legal document. Consider having a lawyer help you prepare it.
- **Give copies of the form to the right people.** Give a copy of the form to your doctor and to the person you name on the form who can make decisions for you if you can't. You may want to give copies to close friends or family members. Keep a copy at home.

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

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

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

What if your instructions aren't followed

If you sign an advance directive, and you believe that a doctor or hospital didn't follow the instructions in it, you can file a complaint with the State of New York, Department of Health.

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

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

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

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

1. Learn about Advance Directives
2. Remove Barriers

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

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

Get Started - It's Free!

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

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

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

Section 1.7 If you believe you're being treated unfairly or your rights aren't being respected

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

If you believe you've been treated unfairly or your rights haven't been respected and it's not about discrimination, you can get help dealing with the problem you're having from these places:

- Call Customer Care at 1-877-883-9577 (TTY users call 711).
- **Call your local SHIP** at 1-800-701-0501
- **Call Medicare** at 1-800-MEDICARE (1-800-633-4227), TTY/TDD users call (1-877-486-2048).

Section 1.8 How to get more information about your rights

Get more information about your rights from these places:

- **Call Customer Care** at 1-877-883-9577 (TTY users call 711).

- **Call the SHIP** at 1-800-701-0501
- **Contact Medicare**
  - Visit www.Medicare.gov to read the publication Medicare Rights & Protections.
  - Call 1-800-MEDICARE (1-800-633-4227), (TTY/TDD users call 1-877-486-2048).

SECTION 2 Your responsibilities as a member of our plan

Things you need to do as a member of our plan are listed below. For questions, call Customer Care at 1-877-883-9577 (TTY users call 711).

- **Get familiar with your covered services and the rules you must follow to get these covered services.** Use this Evidence of Coverage to learn what's covered and the rules you need to follow to get your covered services.
  - Chapters 3 and 4 give details about medical services.
- If you have any other health coverage in addition to our plan, you're required to tell us. Chapter 1 tells you about coordinating these benefits.
- **Tell your doctor and other health care providers that you're enrolled in our plan.** Show our plan membership card whenever you get medical care.
- **Help your doctors and other providers help you by giving them information, asking questions, and following through on your care.**
  - To help get the best care, tell your doctors and other health providers about your health problems. Follow the treatment plans and instructions you and your doctors agree on.
  - Make sure your doctors know all of the drugs you're taking, including over-the-counter drugs, vitamins, and supplements.
  - If you have questions, be sure to ask and get an answer you can understand.
- **Be considerate.** We expect 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're responsible for these payments:
  - You must continue to pay a premium for your Medicare Part B to stay a member of our plan.
  - For most of your medical services covered by our plan, you must pay your share of the cost when you get the service.
- **If you move within our plan service area, we need to know** so we can keep your membership record up to date and know how to contact you.
- **If you move outside our plan service area, you can't stay a member of our plan**.
- **If you move tell Social Security (or the Railroad Retirement Board).**

CHAPTER 7

If you have a problem or complaint (coverage decisions, appeals, complaints)

Chapter 7. If you have a problem or complaint (coverage decisions, appeals, complaints)

SECTION 1 What to do if you have a problem or concern

This chapter explains 2 types of processes for handling problems and concerns:

For some problems, you need to use the **process for coverage decisions and appeals**.

For other problems, you need to use the **process for making complaints (also called grievances)**.

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

The information in this chapter will help you identify the right process to use and what to do.

Section 1.1 Legal terms

There are legal terms for some of the rules, procedures, and types of deadlines explained in this chapter. Many of these terms are unfamiliar to most people. To make things easier, this chapter: Uses more familiar words in place of some legal terms.

However, it's sometimes important to know the correct legal terms. To help you know which terms to use to get the right help or information, we include these legal terms when we give details for handling specific situations.

SECTION 2 Where to get more information and personalized help

We're always available to help you. Even if you have a complaint about our treatment of you, we're obligated to honor your right to complain. You should always call Customer Care at 1-877-883-9577 (TTY users call 711) for help. In some situations, you may also want help or guidance from someone who is not connected with us. Two organizations that can help you are:

State Health Insurance Assistance Program (SHIP).

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

The services of SHIP counselors are free. (Health Insurance Information, Counseling, and Assistance Programs (1-800-701-0501)). You will find phone numbers and website URLs in Chapter 2, Section 3 of this document.

Medicare

You can also contact Medicare for help.

- Call 1-800-MEDICARE (1-800-633-4227). TTY/TDD users call 1-877-486-2048.
- Visit www.medicare.gov

SECTION 3 Which process to use for your problem

Is your problem or concern about your benefits or coverage?

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

Yes.

Go to **Section 4, A guide to coverage decisions and appeals.**

No.

Go to **Section 10, How to make a complaint about quality of care, waiting times, customer service or other concerns.**

COVERAGE DECISIONS AND APPEALS

SECTION 4 A guide of coverage decisions and appeals

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

Asking for coverage decisions before you get services

If you want to know if we'll cover medical care before you get it, you can ask us to make a coverage decision for you. A coverage decision is a decision we make about your benefits and coverage or about the amount we'll pay for your medical care. For example, if our plan doctor refers you to a medical specialist not inside the network, this referral is considered a favorable coverage decision unless either you or your network doctor can show that you got a standard denial notice for this medical specialist, or the Evidence of Coverage makes it clear that the referred service is never covered under any condition. You or your doctor can also contact us and ask for a coverage decision if your doctor is unsure whether we'll cover a particular medical service or refuses to provide medical care you think you need.

In limited circumstances a request for a coverage decision will be dismissed, which means we won't review the request. Examples of when a request will be dismissed include if the request is incomplete, if someone makes the request on your behalf but isn't legally authorized to do so or if you ask for your request to be withdrawn. If we dismiss a request for a coverage decision, we'll send a notice explaining why the request was dismissed and how to ask for a review of the dismissal.

We make a coverage decision whenever we decide what's covered for you and how much we pay. In some cases, we might decide medical care isn't covered or is no longer covered for you. If you disagree with this coverage decision, you can make an appeal.

Making an appeal

If we make a coverage decision, whether before or after you get a benefit, and you aren't satisfied, you can **appeal** the decision. An appeal is a formal way of asking us to review and change a coverage decision we have made. Under certain circumstances, you can ask for an expedited or **fast appeal** of a coverage decision. Your appeal is handled by different reviewers than those who made the original decision.

When you appeal a decision for the first time, this is called a Level 1 appeal. In this appeal, we review the coverage decision we made to check to see if we properly followed the rules. When we complete the review, we give you our decision.

In limited circumstances a request for a Level 1 appeal will be dismissed, which means we won't review the request. Examples of when a request will be dismissed include if the request is incomplete, if someone makes the request on your behalf but isn't legally authorized to do so, or if you ask for your request to be withdrawn. If we dismiss a request for a Level 1 appeal we'll send a notice explaining why the request was dismissed and how to ask for a review of the dismissal.

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

- You don't need to do anything to start a Level 2 appeal. Medicare rules require we automatically send your appeal for medical care to Level 2 if we don't fully agree with your Level 1 appeal.

- **Go to Section 5.4** for more information about Level 2 appeals for medical care.

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

Section 4.1 Get help asking for a coverage decision or making an appeal

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

- **Call us at Customer Care at 1-877-883-9577 (TTY users call 711).**
- **Get free help** from your State Health Insurance Assistance Program.
- **Your doctor can make a request for you.** If your doctor helps with an appeal past Level 2, they need to be appointed as your representative. Call Member Services at 1-877-883-9577 (TTY users call 711) and ask for the Appointment of Representative form. (The form is also available on www.CMS.gov/Medicare/CMS-Forms/CMS-Forms/downloads/cms1696.pdf
    - For medical care or Part B drugs, your doctor can ask for a coverage decision or a Level 1 appeal on your behalf. If your appeal is denied at Level 1, it will be automatically forwarded to Level 2.
- **You can ask someone to act on your behalf.** You can name another person to act for you as your representative to ask for a coverage decision or make an appeal.
    - If you want a friend, relative, or other person to be your representative, call Customer Care and at 1-877-883-9577 (TTY users call 711) ask for the Appointment of Representative form. (The form is also available at www.CMS.gov/Medicare/CMS-Forms/CMS-Forms/downloads/cms1696.pdf) This form gives that person permission to act on your behalf. It must be signed by you and by the person you want to act on your behalf. You must give us a copy of the signed form.
    - We can accept an appeal request from a representative without the form, but we can't complete our review until we get it. If we don't get the form before our deadline for making a decision on your appeal, your appeal request will be

dismissed. If this happens, we'll send you a written notice explaining your right to ask the independent review organization to review our decision to dismiss your appeal.

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

Section 4.2 Rules and deadlines for different situations

There are 3 different situations that involve coverage decisions and appeals. Each situation has different rules and deadlines. We give the details for each of these situations:

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

If you're not sure information applies to you, call Customer Care at 1-877-883-9577 (TTY users call 711). You can also get help or information from your SHIP.

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

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

Your benefits for medical care are described in Chapter 4 in the Medical Benefits Chart. In some cases, different rules apply to a request for a Part B drug. In those cases, we'll explain how the rules for Part B drugs are different from the rules for medical items and services.

This section tells what you can do if you're in any of the 5 following situations:

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

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

Section 5.2 How to ask for a coverage decision

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

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

A standard coverage decision is usually made within 7 calendar days when the medical item or service is subject to our prior authorization rules, 14 calendar days for all other medical items and services, or 72 hours for Part B drugs. A fast coverage decision is generally made within 72 hours, for medical services, or 24 hours for Part B drugs. To get a fast coverage decision, you must meet 2 requirements:

- You may only ask for coverage for medical items and/or services (not requests for payment for items and/or services you already got).
- 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 regain function.
- **If your doctor tells us that your health requires a fast coverage decision, we'll 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'll decide whether your health requires that we give you a fast coverage decision.** If we don't approve a fast coverage decision, we'll send you a letter that:
    - Explains that we'll use the standard deadlines.
    - Explains if your doctor asks for the fast coverage decision, we'll automatically give you a fast coverage decision.
    - Explains that you can file a fast complaint about our decision to give you a standard coverage decision instead of the fast coverage decision you asked for.

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

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

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

For standard coverage decisions we use the standard deadlines.

This means we'll give you an answer within 7 calendar days after we get your request for a medical item or service that is subject to our prior authorization rules. If your

requested medical item or service is not subject to our prior authorization rules, we'll give you an answer within 14 calendar days after we get your request. If your request is for a Part B drug, we'll give you an answer within 72 hours after we get your request.

- **However**, if you ask for more time, or if we need more information that may benefit you, **we can take up to 14 more calendar days** if your request is for a medical item or service. If we take extra days, we'll tell you in writing. We can't take extra time to make a decision if your request is for a Part B drug.
- If you believe we shouldn't take extra days, you can file a fast complaint. We'll give you an answer to your complaint as soon as we make the decision. (The process for making a complaint is different from the process for coverage decisions and appeals. Go to Section 10 for information on complaints.)

For fast coverage decisions we use an expedited timeframe.

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

- **However**, if you ask for more time, or if we need more that may benefit you **we can take up to 14 more calendar days**. If we take extra days, we'll tell you in writing. We can't take extra time to make a decision if your request is for a Part B drug.
- If you believe we shouldn't take extra days, you can file a fast complaint. (Go to Section 10 of this chapter for information on complaints.) We'll call you as soon as we make the decision.
- If our answer is no to part or all of what you asked for, we'll send you a written statement that explains why we said no.

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

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

Section 5.3 How to make a Level 1 appeal

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

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

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

- If you're appealing a decision we made about coverage for care, you and/or your doctor need to decide if you need a fast appeal. If your doctor tells us that your health requires a fast appeal, we'll give you a fast appeal.
- The requirements for getting a fast appeal are the same as those for getting a fast coverage decision in Section 5.2 of this chapter.

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

- **If you're asking for a standard appeal, submit your standard appeal in writing.** Chapter 2 has contact information.
- **If you're asking for a fast appeal, make your appeal in writing or call us.** Chapter 2 has contact information.
- **You must make your appeal request within 65 calendar days** from the date on the written notice we sent to tell you our answer on the coverage decision. If you miss this deadline and have a good reason for missing it, explain the reason your appeal is late when you make your appeal. We may give you more time to make your appeal. Examples of good cause may include a serious illness that prevented you from contacting us or if we provided you with incorrect or incomplete information about the deadline for asking for an appeal.
- You can ask for a copy of the information regarding your medical decision. You and your doctor may add more information to support your appeal.

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

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

Deadlines for a fast appeal

- For fast appeals, we must give you our answer **within 72 hours after we get your appeal**. We'll give you our answer sooner if your health requires us to.
    - If you ask for more time, or if we need more information that may benefit you, we **can take up to 14 more calendar days** if your request is for a medical item or

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

- If we don't give you an answer within 72 hours (or by the end of the extended time period if we took extra days), we're required to automatically send your request to Level 2 of the appeals process, where it will be reviewed by an independent review organization. Section 5.4 explains the Level 2 appeal process.

- **If our answer is yes to part or all of what you asked for,** we must authorize or provide the coverage we agreed to within 72 hours after we get your appeal.
- **If our answer is no to part or all of what you asked for,** we'll send you our decision in writing and automatically forward your appeal to the independent review organization for a Level 2 appeal. The independent review organization will notify you in writing when it gets your appeal.

Deadlines for a standard appeal

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

Section 5.4 How a Level 2 appeal process

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

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

Step 1: The independent review organization reviews your appeal.

- We'll 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 the information related to your appeal.

If you had a fast appeal at Level 1, you'll also have a fast appeal at Level 2.

- For the fast appeal*,* the independent review organization must give you an answer to your Level 2 appeal **within 72 hours** of when it gets your appeal.
- 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 Part B drug.

If you had a standard appeal at Level 1, you'll also have a standard appeal at Level 2.

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

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

- The independent review organization will tell you it's decision in writing and explain the reasons for it.
- **If the independent 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 get the decision from the independent review organization for **standard requests**. For **expedited requests**, we have **72 hours** from the date we get the decision from the independent review organization.
- **If the independent review organization says yes to part or all of a request for a Part B drug**, we must authorize or provide the Part B prescription drug within **72 hours** after we get the decision from the independent review organization for **standard requests.** For **expedited requests** we have **24 hours** from the date we get the decision from the independent review organization**.**
- **If this organization says no to part or all of your appeal**, it means they agree with us that your request (or part of your request) for coverage for medical care shouldn't be

approved. (This is called **upholding the decision** or **turning down your appeal**.) In this case, the independent review organization will send you a letter:

- Explains the decision.
- Let's you know about your right to a Level 3 appeal if the dollar value of the medical care coverage meets a certain minimum. The written notice you get from the independent review organization will tell you the dollar amount you must meet to continue the appeals process.
- Tells you how to file a Level 3 appeal.

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

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

Section 5.5 If you're asking us to pay for our share of a bill you got for medical care

Chapter 7 describes when you may need to ask for reimbursement or to pay a bill you have got from a provider. It also tells how to send us the paperwork that asks us for payment.

Asking for reimbursement is asking for a coverage decision from us

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

- **If we say yes to your request:** If the medical care is covered and you followed all the rules, we'll send you the payment for our share of the cost typically within **30 calendar days,** but no later than 60 calendar days after we get your request. If you haven't paid for the medical care, we'll send the payment directly to the provider.
- **If we say no to your request:** If the medical care is not covered, or you did not follow all the rules, we won't send payment. Instead, we'll send you a letter that says we won't pay for the medical care and the reasons why.

If you don't agree with our decision to turn you down, **you can make an appeal**. If you make an appeal, it means you're 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 in Section 5.3. For appeals concerning reimbursement, note:

- We must give you our answer within 60 calendar days after we get your appeal. If you're asking us to pay you back for medical care you already got and paid for, you aren't allowed to ask for a fast appeal.
- If the independent review organization decides we should pay, we must send you or the provider the payment within 30 calendar days. If the answer to your appeal is yes at any

stage of the appeals process after Level 2, we must send the payment you asked for to you or the provider within 60 calendar days.

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

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

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

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

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

Within 2 calendar days of being admitted to the hospital, you'll be given a written notice called An Important Message from Medicare about Your Rights. Everyone with Medicare gets a copy of this notice. If you don't get the notice from someone at the hospital (for example, a caseworker or nurse), ask any hospital employee for it. If you need help, call Customer Care at 1-877-883-9577 (TTY users call 711) or 1-800-MEDICARE (1-800-633-4227), (TTY/TDD users call 1-877-486-2048).

1. **Read this notice carefully and ask questions if you don't understand it.** It tells you:
   - Your right to get Medicare-covered services during and after your hospital stay, as ordered by your doctor. This includes the right to know what these services are, who will pay for them, and where you can get them.
   - Your right to be involved in any decisions about your hospital stay.
   - Where to report any concerns, you have about quality of your hospital care.
   - Your right to **request an immediate review** of the decision to discharge you if you think you're being discharged from the hospital too soon. This is a formal, legal way to ask for a delay in your discharge date so we'll cover your hospital care for a longer time.
2. **You'll be asked to sign the written notice to show that you got it and understand your rights.**
   - You or someone who is acting on your behalf will be asked to sign the notice.
   - Signing the notice shows only that you got the information about your rights. The notice doesn't give your discharge date. Signing the notice **doesn't mean** you're agreeing on a discharge date.
3. **Keep your copy** of the notice so you have the information about making an appeal (or reporting a concern about quality of care) if you need it.
   - If you sign the notice more than 2 calendar days before your discharge date, you'll get another copy before you're scheduled to be discharged.

- To look at a copy of this notice in advance, call Customer Care at 1-877-883-9577 (TTY users call 711) or 1-800 MEDICARE (1-800-633-4227), (TTY/TDD users call 1-877-486-2048). You can also get the notice online at www.CMS.gov/Medicare/forms-notices/beneficiary-notices-intiatives/ffs-ma-im.

Section 6.2 How to make a Level 1 appeal to change your hospital discharge date

To ask us to cover your inpatient hospital services for a longer time, use the appeals process to make this request. Before you start, understand what you need to do and what the deadlines are.

- **Follow the process.**
- **Meet the deadlines.**
- **Ask for help if you need it**. If you have questions or need help, call Customer Care at 1-877-883-9577 (TTY users call 711). Or call your State Health Insurance Assistance Program (SHIP) for personalized help (1-800-701-0501). SHIP contact information is available in Chapter 2, Section 3.

During a Level 1 appeal, the Quality Improvement Organization reviews your appeal. It checks to see if your planned discharge date is medically appropriate for you. The Quality Improvement Organization is a group of doctors and other health care professionals paid by the federal government to check on and help improve the quality of care for people with Medicare. This includes reviewing hospital discharge dates for people with Medicare. These experts aren't part of our plan.

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

How can you contact this organization?

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

Act quickly:

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

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

You can get a sample of the **Detailed Notice of Discharge** by calling Customer Care at 1-877-883-9577 (TTY users call 711) or 1-800-MEDICARE (1-800-633-4227), (TTY/TDD 1-877-486-2048). Or you can get a sample notice online at www.CMS.gov/Medicare/forms-notices/beneficiary-notices-initiatives/ffs-ma-im.

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

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

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

What happens if the answer is yes?

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

What happens if the answer is no?

- If the independent review organization says no, they're 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 independent review organization says no to your appeal and you decide to stay in the hospital, **you may have to pay the full cost** of hospital care you get after noon on the day after the Quality Improvement Organization gives you its answer to your appeal.

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

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

Section 6.3 How to make a Level 2 appeal to change your hospital discharge date

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

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

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

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

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

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

If the independent review organization says yes:

- **We must reimburse you** for our share of the costs of hospital care you got 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's medically necessary**.
- You must continue to pay your share of the costs and coverage limitations may apply.

If the independent review organization says no:

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

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

- There are 3 additional levels in the appeals process after Level 2 (for a total of 5 levels of appeal). If you want to go to a Level 3 appeal, the details on how to do this are in the written notice you get after your level 2 appeal decision.
- The Level 3 appeal is handled by an Administrative Law Judge or attorney adjudicator. Section 9 in this chapter tells more about Levels 3, 4, and 5 of the appeals processes.

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

When you're getting covered **home health services, skilled nursing care, or rehabilitation care (Comprehensive Outpatient Rehabilitation Facility)**, you have the right to keep getting

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

When we decide it's time to stop covering any of these 3 types of care for you, we're required to tell you in advance. When your coverage for that care ends, we'll stop paying our share of the cost for your care.

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

Section 7.1 We'll tell you in advance when your coverage will be ending

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

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

Section 7.2 How to make a Level 1 appeal to have our plan cover your care for a longer time

To ask us to cover your inpatient hospital services for a longer time, use the appeals process to make this request. Before you start, understand what you need to do and what the deadlines are.

- **Follow the process.**
- **Meet the deadlines.**
- **Ask for help if you need it**. If you have questions or need help, call Customer Care at 1-877-883-9577 (TTY/TDD users call 711). Or call your State Health Insurance Assistance Program, a government organization that provides personalized assistance. SHIP contact information is available in Chapter 2, Section 3.

During a Level 1 appeal, the Quality Improvement Organization reviews your appeal. It checks to see if your planned discharge date is medically appropriate for you. The **Quality Improvement Organization** is a group of doctors and other health care professionals paid by the federal government to check on and help improve the quality of care for people with Medicare. This includes reviewing hospital discharge dates for people with Medicare. These experts aren't part of our plan.

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

How can you contact this organization?

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

Act quickly:

- To make your appeal, you must contact the **Quality Improvement Organization** before you leave the hospital and **no later than midnight the day of your discharge.**
    - **If you meet this deadline,** you can stay in the hospital after your discharge date without paying for it while you wait to get the decision from the **Quality Improvement Organization**.
    - **If you don't meet this deadline, contact us.** If you decide to stay in the hospital after your planned discharge date, you may have to pay the costs for hospital care you get after your planned discharge date.
- Once you ask for an immediate review of your hospital discharge the **Quality Improvement Organization** will contact us. By noon of the day after we're contacted, we'll give you a **Detailed Notice of Discharge.** This notice gives your planned discharge date and explains in detail the reasons why your doctor, the hospital, and we think it is right (medically appropriate) for you to be discharged on that date.
- You can get a sample of the **Detailed Notice of Discharge** by calling Customer Care at 1-877-883-9577 (TTY/TDD users call 711) or 1-800-MEDICARE (1-800-633-4227), (TTY/TDD users call 1-877-486-2048). Or you can see a sample notice online at www.cms.gov/Medicare/forms-notices/beneficiary-notices-initiative/ffs-ma-im.

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

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

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

What happens if the answer is yes?

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

What happens if the answer is no?

- If the independent review organization says no, they're 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 independent review organization says no to your appeal and you decide to stay in the hospital, **you may have to pay the full cost** of hospital care you get after noon on the day after the **Quality Improvement Organization** gives you its answer to your appeal.

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

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

Section 7.3 How to make a Level 2 appeal to have our plan cover your care for a longer time

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

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

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

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

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

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

What happens if the independent review organization says yes?

- **We must reimburse you** for our share of the costs of care you got since the date when we said your coverage would end. **We must continue providing coverage** for the care for as long as it's medically necessary.
- You must continue to pay your share of the costs and there may be coverage limitations that apply.

What happens if the independent review organization says no?

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

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

- There are 3 additional levels of appeal after Level 2, for a total of 5 levels of appeal. If you want to go on to a Level 3 appeal, the details on how to do this are in the written notice you get after your Level 2 appeal decision.
- The Level 3 appeal is handled by an Administrative Law Judge or attorney adjudicator. Section 9 in this chapter tells more about Levels 3, 4, and 5 of the appeals processes.

SECTION 8 Taking your appeal to Levels 3, 4 and 5

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

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

If the dollar value of the item or medical service you 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 can't appeal any further. The written response you get to your Level 2 appeal will explain how to make a Level 3 appeal.

For most situations that involve appeals, the last 3 levels of appeal work in much the same way as the first two levels. Here's who handles the review of your appeal at each of these levels.

Level 3 appeal

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

- **If the Administrative Law Judge or attorney adjudicator says yes to your appeal, the appeals process may or may not be over**. Unlike a decision at a Level 2 appeal, we have the right to appeal a Level 3 decision that's favorable to you. If we decide to appeal it will go to a Level 4 appeal.

- If we decide not to appeal, we must authorize or provide you with the medical care within 60 calendar days after we get the Administrative Law Judge's or attorney adjudicator's decision.
- If we decide to appeal the decision, we'll send you a copy of the Level 4 appeal request with any accompanying documents. We may wait for the Level 4 appeal decision before authorizing or providing the medical care in dispute.

- **If the Administrative Law Judge or attorney adjudicator says no to your appeal, the appeals process may or may not be over**.
  - If you decide to accept the decision that turns down your appeal, the appeals process is over.
  - If you don't want to accept the decision, you can continue to the next level of the review process. The notice you get will tell you what to do for a Level 4 appeal.

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

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

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

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

Making Complaints

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

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

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

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

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

Section 9.2 How to make a complaint

Legal Terms

- A **Complaint** is also called a **grievance.**
- **Making a complaint** is also called **filing a grievance.**

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

<u>Step 1:</u> Contact us promptly – either by phone or in writing.

- **Call Customer Care at 1-877-883-9577 (TTY/TDD users call 711) is usually the first step.** If there's anything else you need to do, Customer Care will let you know.
- **If you don't want to call (or you called and weren't satisfied), you can put your complaint in writing and send it to us.** If you put your complaint in writing, we'll respond to your complaint in writing.
- The **deadline** for making a complaint is 60 calendar days from the time you had the problem you want to complain about.

Here's how it works:

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

Option for Filing an Expedited Grievance

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

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

How to file an Expedited Grievance

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

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

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

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

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

Section 9.3 You can also make complaints about quality of care to the Quality Improvement Organization

When your complaint is about quality of care, you have 2 extra options:

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

  Or

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

Section 9.4 You can also tell Medicare about your complaint

You can submit a complaint about Univera Medicare Freedom (HMO-POS) directly to Medicare. To submit a complaint to Medicare, go to www.Medicare.gov/my/medicare-complaint. You can also call 1-800-MEDICARE (1-800-633-4227). TTY/TDD users call 1-877-486-2048.

CHAPTER 8

Ending membership in our plan

SECTION 1 Ending your membership in our plan

Ending your membership in Univera Medicare Freedom (HMO-POS) may be **voluntary** (your own choice) or **involuntary** (not your own choice):

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

If you're leaving our plan, our plan must continue to provide your medical care, and you'll continue to pay your cost share until your membership ends.

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

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

You can end your membership in our plan during the **Open Enrollment Period** each year. During this time, review your health coverage and decide about coverage for the upcoming year.

- **The Open Enrollment Period** is from **October 15 to December 7**.
- **Choose to keep your current coverage or make changes to your coverage for the upcoming year.** If you decide to change to a new plan, you can choose any of the following types of plans:
  - Another Medicare health plan, with or without drug coverage,
  - Original Medicare with a separate Medicare drug plan,
  - Original Medicare without a separate Medicare drug plan.
- **Your membership will end in our plan** when your new plan's coverage starts on January 1.

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

You can make one change to your health coverage during the annual **Medicare Advantage Open Enrollment Period** each year.

- **The Medicare Advantage Open Enrollment Period** is from January 1 to March 31 and for new Medicare enrollees in an MA plan, from the month of entitlement to Part A and Part B until the last day of the 3rd month of entitlement.
- **During the Medicare Advantage Open Enrollment Period** you can:
  - Switch to another Medicare Advantage Plan, with or without drug coverage.
  - Disenroll from our plan and get coverage through Original Medicare. If you switch to Original Medicare during this period, you can also join a separate Medicare drug plan at the same time.
- **Your membership will end** on the first day of the month after you enroll in a different Medicare Advantage plan or we get your request to switch to Original Medicare. If you also

choose to enroll in a Medicare drug plan, your membership in the drug plan will start 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 Univera Medicare Freedom (HMO-POS) may be eligible to end their membership at other times of the year. This is known as a **Special Enrollment Period**.

- **You may be eligible to end your membership during a Special Enrollment Period** if any of the following situations apply. These are just examples. For the full list you can contact the plan, call Medicare, or visit www.medicare.gov:
  - Usually, when you move
  - If you have Medicaid
  - If we violate our contract with you
  - If you're 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)

Enrollment time periods vary depending on your situation.

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

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

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

Your membership will usually end on the first day of the month after we get your request to change our plan.

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

If you have questions about ending your membership you can:

- **Call Customer Care at 1-877-883-9577 (TTY users call 711)**.
- Find the information in the **Medicare & You 2026** handbook.
- Contact **Medicare** at 1-800-MEDICARE (1-800-633-4227). TTY/TDD users call 1-877-486-2048.

SECTION 3 How to end your membership in our plan

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

To switch from our plan to:	Here's what to do:
• Another Medicare health plan.	• Enroll in the new Medicare health plan. You'll automatically be disenrolled from Univera Medicare Freedom (HMO-POS) when your new plan's coverage starts.
• Original Medicare with a separate Medicare drug plan.	• Enroll in the new Medicare prescription drug plan. You'll automatically be disenrolled from Univera Medicare Freedom (HMO-POS) when your new plan's coverage starts.
• Original Medicare without a separate Medicare drug plan.	• **Send us a written request to disenroll.** Call Customer Care at 1-877-883-9577 (TTY users call 711) if you need more information on how to do this. • You can also call **Medicare**, at 1-800-MEDICARE (1-800-633-4227), and ask to be disenrolled. TTY/TDD users call 1-877-486-2048. • You'll be disenrolled from Univera Medicare Freedom (HMO-POS) when your coverage in Original Medicare starts.

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

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

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

SECTION 5 Univera Medicare Freedom (HMO-POS) must end our plan membership in certain situations

Univera Medicare Freedom (HMO-POS) must end your membership in our 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're away from our service area for more than 6 months.
    - If you move or take a long trip, call Customer Care at 1-877-883-9577 (TTY users call 711) to find out if the place you're moving or traveling to is in our plan's area.
- If you become incarcerated (go to prison).
- If you're no longer a United States citizen or lawfully present in the United States.
- If you intentionally give us incorrect information when you're enrolling in our plan and that information affects your eligibility for our plan. (We can't make you leave our plan for this reason unless we get permission from Medicare first.)
- If you continuously behave in a way that's disruptive and makes it difficult for us to provide medical care for you and other members of our plan. (We can't make you leave our plan for this reason unless we get permission from Medicare first.)
- If you let someone else use your membership card to get medical care. (We can't make you leave our plan for this reason unless we get permission from Medicare first.)
    - If we end your membership because of this reason, Medicare may have your case investigated by the Inspector General.
- If you do not pay the plan premiums for 3 calendar months.
    - We must notify you in writing that you have 3 calendar months to pay our plan premium before we end your membership.

If you have questions or want more information on when we can end your membership, call Customer Care at 1-877-883-9577 (TTY users call 711).

Section 5.1 We can't ask you to leave our plan for any health-related reason

Univera Medicare Freedom (HMO-POS) isn't allowed to ask you to leave our plan for any health-related reason.

What should you do if this happens?

If you feel you're 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/TDD users call 1-877-486-2048).

Section 5.2 You have the right to make a complaint if we end your membership in our plan

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

CHAPTER 9

Legal notices

SECTION 1 Notice about governing law

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

SECTION 2 Notice about nondiscrimination

We don't discriminate based on race, ethnicity, national origin, color, religion, sex, 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, call the Department of Health and Human Services' **Office for Civil Rights** at 1-800-368-1019 (TTY/TDD 1-800-537-7697) or your local Office for Civil Rights. You can also review information from the Department of Health and Human Services' Office for Civil Rights at http://www.HHS.gov/ocr/index.html.

If you have a disability and need help with access to care, call Customer Care at 1-877-883-9577 (TTY users call 711). If you have a complaint, such as a problem with wheelchair access, Customer Care can help.

SECTION 3 Notice about Medicare Secondary Payer subrogation rights

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

CHAPTER 10
Definitions

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

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

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

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

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, you only have to pay our plan's cost-sharing amounts when you get services covered by our plan. We do not allow providers to **balance bill** or otherwise charge you more than the amount of cost-sharing your plan says you must pay.

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

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

Chronic-Care Special Needs Plan (C-SNP) – C-SNPs are SNPs that restrict enrollment MA eligible people who have specific severe and chronic diseases.

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

Complaint -The formal name for making a complaint is **filing a grievance**. The complaint process is used only for certain types of problems. This includes problems about quality of care, waiting times, and the customer service you receive. It also includes complaints if our plan doesn't follow the time periods in the appeal process.

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

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

Cost-sharing – Cost-sharing refers to amounts that a member has to pay when services are gotten. (This is in addition to our plan's monthly premium.) Cost-sharing includes any combination

of the following 3 types of payments: (1) any deductible amount a plan may impose before services are covered; (2) any fixed copayment amount that a plan requires when a specific service is received; or (3) any coinsurance amount, a percentage of the total amount paid for a service, that a plan requires when a specific service is received.

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

Creditable Prescription Drug Coverage – Prescription drug coverage (for example, from an employer or union) that's 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 don't need skilled medical care or skilled nursing care. Custodial care, provided by people who don't have professional skills or training, includes help with activities of daily living like bathing, dressing, eating, getting in or out of a bed or chair, moving around, and using the bathroom. It may also include the kind of health-related care that most people do themselves, like using eye drops. Medicare doesn't pay for custodial care.

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

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

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

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

Dually-Eligible Individual – A person who is eligible for Medicare and Medicaid coverage.

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

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

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

Evidence of Coverage (EOC) and Disclosure Information – This document, along with your enrollment form and any other attachments, riders, or other optional coverage selected, which

explains your coverage, what we must do, your rights, and what you have to do as a member of our plan.

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

Grievance – A type of complaint you make about our plan, providers, or pharmacies, including a complaint concerning the quality of your care. This doesn't involve coverage or payment disputes.

Home Health Aide – A person who 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).

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

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

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

Initial Coverage Limit – The maximum limit of coverage under the Initial Coverage Stage.

Initial Coverage Stage – This is the stage before your out-of-pocket costs for the year have reached the out-of-pocket threshold amount.

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

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

Institutional Equivalent Special Needs Plan (I-SNP) – I-SNPs restrict enrollment to MA eligible people who live in community but need the level of care a facility offers, or who live or are expected to live for at least 90 days straight in certain long-term facilities. I-SNPs include the

following types of plans: Institutional-equivalent SNPs (IE-SNPs), Hybrid Institutional SNPs (HI-SNPs), and Facility based Institutional SNPs (FI-SNPs)

Interchangeable Biosimilar – A biosimilar that may be used as a substitute for an original biosimilar product at the pharmacy without needing a new prescription because it meets additional requirements about the potential for automatic substitution. Automatic substitution at the pharmacy is subject to state law.

Low Income Subsidy (LIS) – Go to "Extra Help."

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

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

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

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

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

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

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

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

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 isn't a Medigap policy.)

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

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

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

Optional Supplemental Benefits – Non-Medicare-covered benefits that can be purchased for an additional premium and aren't included in your package of benefits. You must voluntarily elect Optional Supplemental Benefits to get them.

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

Original Biological Product – A biological product that has been approved by the FDA and serves as the comparison for manufacturers making a biosimilar version. It is also called a reference product.

Original Medicare (Traditional Medicare or Fee-for-service Medicare) – Original Medicare is offered by the government, and not a private health plan like Medicare Advantage plans and prescription drug plans. Under Original Medicare, Medicare services are covered by paying doctors, hospitals, and other health care providers payment amounts established by Congress. You can see any doctor, hospital, or other health care provider that accepts Medicare. You must pay the deductible. Medicare pays its share of the Medicare-approved amount, and you pay your share. Original Medicare has 2 parts: Part A (Hospital Insurance) and Part B (Medical Insurance) and is available everywhere in the United States.

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

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

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

Part C – Go to Medicare Advantage (MA) plan.

Part D Late Enrollment Penalty – An amount added to your monthly plan premium for Medicare drug coverage if you go without creditable coverage (coverage that's expected to pay, on average, at least as much as standard Medicare drug coverage) for a continuous period of 63 days or more after you're first eligible to join a Part D plan. If you lose Extra Help, you may be subject to the late enrollment penalty if you go 63 days or more in a row without Part D or other creditable drug coverage.

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're received from network or out-of-network providers. Member cost-sharing will generally be higher when plan benefits are received from out-of-network providers. PPO plans have an annual limit on your out-of-pocket costs for services received from network (preferred) providers and a higher limit on your total combined out-of-pocket costs for services from both network (preferred) and out-of-network (non-preferred) providers.

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

Preventive services – Health care to prevent illnesses or detect illness at an early stage, when treatment is likely to work best (for example, preventive services include Pap tests, flu shots, and mammogram screenings).

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

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

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

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

Referral – A written order from your primary care doctor for you to visit a specialist or get certain medical services. Without a referral, our plan may not pay for services from a specialist.

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

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

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

Special Enrollment Period – A set time when members can change their health 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 live 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 aren't the same as Social Security benefits.

Urgently Needed Services – A plan-covered service requiring immediate medical attention that's not an emergency is an urgently needed service if either you're temporarily outside our plan's service area, or it's unreasonable given your time, place, and circumstances to get this service from network providers. Examples of urgently needed services are unforeseen medical illnesses and injuries, or unexpected flare-ups of existing conditions. Medically necessary routine provider visits (like annual checkups) aren't considered urgently needed even if you're outside our plan's the service area or our plan network is temporarily unavailable.